NHS Resolution

HC 2371

Annual report and accounts 2018/19

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Chair's welcome

Ian Dilks / Chair

We are now entering the third year of the new strategy we laid out in April 2017. More detail of progress is contained in the following pages, but in summary we are very much on track and more convinced than we were before that this is the right strategy to pursue. As Chair, I have the pleasure and privilege of meeting with a wide range of stakeholders and I receive frequent feedback on how much NHS Resolution has changed in the last few years and how much more connected, visible and relevant we have become in the wider NHS family. There is also increasing international interest in some of our initiatives.

We have inevitably progressed faster in some elements of strategy implementation than others but progress is being made in all areas. We are in the process of reviewing progress in more detail in the light of other developments in the healthcare system but with one exception are not expecting major changes. The one major thing that has of course changed is the government's decision to ask us to operate (on behalf of the Secretary of State for Health and Social Care) what is now known as the Clinical Negligence Scheme for General Practice (CNSGP), similar to the Clinical Negligence Scheme for Trusts (CNST) that we have operated for over 20 years. Preparing for this has been a major task for the senior management team, but a scheme for liabilities arising from incidents after 1 April 2019 was successfully launched on that date and has met with widespread support from GPs and other key stakeholders. The current position on claims arising from incidents occurring prior to 1 April 2019 is explained in the financial statements (see Note 12 on page 177).

Although the decision to introduce CNSGP and to appoint NHS Resolution as scheme administrator and operator was not ours, we are delighted to take it on and see real benefits for the NHS in bringing clinical indemnity cover for all NHS activities in England under one roof. For the first time, one organisation will have access to the learning from all NHS clinical negligence claims and what can be done in a consistent way to reduce claims and improve patient safety. Internally, we will assess in the months ahead how, by bringing the two main clinical negligence schemes together, we can deliver more than the sum of the parts. An early example of benefits is that this has given us the scale to justify opening an office in Leeds to service both CNST and CNSGP schemes from a lower-cost site, in a location that is more attractive to some of our staff.

There are a number of early signs that our strategy is having an impact. Customer satisfaction levels continue to rise, our Early Notification scheme is beginning to deliver faster support and resolution to those impacted by serious incidents at childbirth, our maternity incentive scheme is improving adherence to recognised best practice in maternity safety and we are resolving record numbers of claims though alternative means such as mediation – again more detail is in the following pages. At the same time, we are taking more robust action against those, thankfully rare, patients who exaggerate claims for personal

gain at the expense of finite NHS funds and also against excessive legal fees. For the first time, this year we have seen exaggerated claims result in custodial sentences and a solicitor struck off by the Solicitors Regulation Authority. Our Practitioner Performance Advice and Primary Care Appeals services also continue to develop successfully.

Claim levels have remained largely stable for the last two years which, combined with the benefit of other measures, has meant that we have been able to follow a modest 2% increase in charges to our members in 2018/19 with a 2% reduction for 2019/20, the first reduction in 10 years. However, as I flagged last year, we cannot be complacent and it is sadly inevitable that the pay-as-you-go nature of our schemes means that charges will rise in future years unless there is reform of the legal environment in which we operate. I said last year that at current prices the annual 'cost of harm' was about £7-8 billion in recent years. In 2018/19 the cost of harm was approximately £9 billion, of which approximately 60% relates to maternity claims, the increase being largely attributable to the impact of decreasing discount rates. The difference between current payment levels in respect of clinical claims of £2.4 billion – of which £0.4 billion relates to the impact of the personal injury discount rate (PIDR) change in March 2017 – and the cost of harm is the main reason that our total claims provisions have increased by a further £6 billion to £83 billion, a sum which represents the value at current prices of claim payments to be made years or in some cases decades into the future. In November 2017, the Public Accounts Committee (PAC) recommended the need for a cross-government strategy to tackle the increasing costs of clinical negligence and as we said last year the initial response was expected last September. We continue to contribute our knowledge and expertise to the discussion, but ultimately it is a political decision as to the basis on which patients who have suffered harm are to be compensated and their legal representatives remunerated. We await with interest the initial response to the PAC which is now expected later this year. We also await the report on fixed recoverable costs (for clinical negligence claimant lawyers) which is due to be presented to the Civil Justice Council in summer 2019 and what the response of the Department of Health and Social Care (DHSC) to it will be in the public consultation we expect to follow. As the National Audit Office study published in September 2017 concluded, in order to tackle the drivers of cost, any strategy will need to include legal reform. However, any changes are now unlikely to take effect before 2020.

We continue to develop ways of learning from claims and feeding this information into the system to help improve patient safety and we were pleased to contribute to the new patient safety strategy being developed by NHS Improvement.

We have also made progress in looking at other factors that impact claims, in particular the research conducted for us last year by the Behavioural Insights Team which illustrated the dissatisfaction with procedures for handling incidents and complaints experienced by those who have brought claims, as well as the role of NHS staff in recommending claims on occasion as a way of getting redress.

Working with others in the system to address the issues raised by this research will be a priority for us in the year ahead.

We continue to seek external validation of the quality of what we do where this is appropriate, for example retaining our ISO 27001 accreditation as evidence of the importance we attach to maintaining confidentiality of the data we handle. One recognition in the year came from an unexpected source when, at Transform Awards Europe, alongside our creative agency Studio North, we were awarded three silver medals for best naming strategy, best brand consolidation and best brand development project. The significance of these wins, against competition from small and large companies across Europe and other parts of the UK government, is in the very positive independent assessment of the quality of the executive team of NHS Resolution and its leadership in repositioning the organisation as one focused on 'resolution' across all our activities. And I am pleased to say that this leadership has remained stable over the last year although within the executive team we have added depth to our resources in a number of key areas and last summer we made two new appointments to our Board. Nigel Trout joined as a non-executive director following a successful senior career at HSBC and brings experience in the management of projects and systems; Sir Sam Everington OBE, a distinguished GP whose awards recognise his contribution to primary care, joined as an associate non-executive director. A recently completed external board effectiveness review confirmed the many positive aspects of the way our unitary board operates and also made some helpful recommendations for further development to reflect the changing nature and role of the organisation.

The progress and successes outlined above have of course only been possible because of the dedication and hard work of NHS Resolution staff and the support of our panel firms and I would like to thank them all for their contribution.

Ian Dilks
Chair

Chief Executive's report

Helen Vernon / Chief Executive

At the heart of our strategy is how we work with others to deliver shared objectives. All of those who are involved in claims, whether that's someone who has tragically found themselves or a loved one injured as a result of something that has gone wrong in healthcare; a lawyer acting for an injured patient or an NHS trust; a healthcare professional working in the NHS; an academic, or a patient safety expert, all want the same thing. The best outcome is that we avoid the things that lead to claims in the first place. But finding solutions is not straightforward.

We know that this isn't something we and others can tackle in isolation and that we need help and commitment to turn what we know about the concerns that arise in healthcare into positive action. We have been fortunate to work with a range of partners over the course of the year in both health and justice and would like to thank them for their support and hard work in delivering together against shared objectives.

The drivers of claims costs are a combination of the number of claims received, the amount of compensation paid for those claims and the legal costs which are attached to them. In addition, discount rates, something beyond our control, can have a significant effect. The numbers of clinical negligence claims have remained relatively steady, despite rising activity in the NHS and so overall, claims are falling as a proportion of the number of treatment episodes. This is encouraging and we have seen increasing engagement of clinical staff in the learning we derive from claims although clearly there is more to do. Compensation levels are rising; this year by over 13%. The basis on which compensation is awarded for high-value claims (privately funded care for life, assessed at a point in time), has led to some substantial awards, often in excess of a value of £20 million. Finally, legal costs overall are down. There has been a further drop in claimant legal costs alongside a rise in defence costs. We believe that this, in part, is a feature of the increased focus on early investigation with investment in 'upstream' initiatives such as Early Notification, to help get to answers sooner and keep claims out of court proceedings.

The number of cases going into formal litigation has remained stubbornly more or less the same for well over a decade. We've been on a mission to change that. We set ourselves a challenge to disrupt the traditional approach taken to clinical negligence claims, to encourage mediation and other forms of alternative dispute resolution (ADR) and to reduce the number of claims going into formal court proceedings. Our aim for mediation is that it should no longer to be seen as novel in healthcare disputes. The benefits are very clear. Mediation can deliver things which go beyond compensation, which is so important when we look at what our research tells us about why people pursue claims. It provides space and time for everyone to explore and understand what happened in all its complexity, to hear what can and can't be answered and bring the conversation back to what matters to the injured person.

In the first year of our strategy, we mediated more claims than in our entire history. In our second year, the number of mediations has increased yet again, by 110% to 380 mediations. This exceeds the number of clinical negligence trials (62) six-fold. We believe that this is indicative of culture change in the clinical negligence market and we have seen a demonstrable increase in the level of interest from lawyers on both sides, as they grow in experience in mediation. Having said that, we see mediation as just one of the tools at our disposal, as is picking up the phone or holding a round-table meeting. All are valuable and all have a place when stacked up against the alternative of a litigated claim.

For the second year running, we have also been pleased to see a reduction in the rate of claims going into formal litigation, reducing the stress of that process for patients and healthcare staff and contributing to a further decrease in claimant legal costs, helping to reduce the overall cost to taxpayers.

We have a total balance sheet provision of £83 billion. As 70% of the £78 billion CNST provision relates to maternity, we have continued our focus on the thankfully small number of cases that we receive every year concerning brain injury at birth. For every baby born in England currently, around £1,100 is paid as indemnity costs. The litigation system does not work well for these families or for providers of maternity services. Historically, it has not responded to need at the time it arises. In our view, the starting point must be the incident and the terrible impact that this can have on the family and the healthcare staff involved. We've approached this with a three-pronged strategy of research, early notification and financial incentives for best practice in maternity safety.

A flagship of our five-year strategy is to get closer to the point of incident of the most serious maternity incidents so that we can share learning more rapidly and get support to families when they need it. Our Early Notification scheme has continued to build upon strengths across the organisation, in claims management, safety and learning, and advice. It provides a bridge between the imperative to reduce the burden of clinical negligence costs and to drive improvement in the safety of maternity care. The scheme is also supported by the maternity incentive scheme which includes a bundle of actions, informed by our research and our partners, that enable the indemnity scheme to act as a financial lever for improving safety in maternity care.

It is too early to say if these steps are preventing harm, not least because it is almost impossible to take sole credit for any specific outcomes against the background of the immense efforts that are taking place across the healthcare system to improve maternity care. However, we have seen positive changes in reporting to our Early Notification scheme, significant improvement in quality of reporting to NHS Digital and in the uptake of the MBRRACE[1] national Perinatal Mortality Review Tool (100% registration).

[1] Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE)

Looking at the broader claims environment, the National Audit Office rightly identified that there was a poor understanding of why some people brought a claim following an incident and others didn't. While we have acquired some insight on this, evidence has been lacking and finding this evidence has been a priority for us to ensure that we are focusing our efforts in the right area.

Surveying 10,000 former claimants (over 700 responded) with the help of the Behavioural Insights Team has helped to validate our message to trusts that transparency and candour and meaningful engagement with the patient when something goes wrong in healthcare is critical. Patients claim to find out what happened, for an apology and sometimes, to obtain compensation for their needs. We need to deliver all of those things but the first two need to happen right at the start.

We heard that the majority of former claimants were not happy with the response at the time. But we also know that this is difficult to do well. For the last year, we have targeted our efforts at free training and education on the areas which are of most relevance such as consent and communication skills and we will continue to do so.

But of course, nothing stays the same and even two years into our strategy the sands are shifting again and we have needed to respond. Possibly of most significance, in terms of our focus, has been the government announcement of a new state-backed scheme for general practice. NHS Resolution was asked to operate this scheme (CNSGP) which launched on 1 April 2019. This is the first time all information on claims in this area has been brought under one roof and is a tremendous opportunity for learning, as well as providing system-level indemnity for general practice and removing the burden of having to take out individual-level cover. This is a key plank of the new five-year framework for GP contract arrangements to support the implementation of the *NHS Long Term Plan* and has been very positively received.

We take our responsibility for holding information securely seriously, while sharing what we know to drive change and improvement. In the area of Practitioner Performance Advice, we adopt a neutral position between the employer and the practitioner, using our expertise to navigate a path through concerns which protects patients but finds an outcome which can be sustained. The service has been gradually and carefully refined, taking account of feedback to ensure that the response is proportionate and bespoke. This progress has been recognised by improving performance as well as customer feedback which has been positive about the new and changed services provided.

Similarly, our Primary Care Appeals service does a difficult job. It is slightly different in nature to our other operating arms as it operates as an adjudicator. Our aim here has been to reduce the need for intervention by making our decisions more transparent and accessible via our website and continually educating decision makers on the law governing their remit.

It is a mark of the success of this service that our decisions are rarely challenged in the courts and the expertise of our Appeals team is unmatched in this area.

While we are seeing positive trends and results from our work, we cannot be complacent. These things don't change without the concerted efforts of a whole range of people across the health and justice system and, crucially, the expertise and hard work of our staff and our panel legal firms. The delivery of a second year of our leadership programme for our staff has driven ground-up change and improvement across the entire business to support our aims. Against the background of a substantial change programme, our staff have managed very high volumes of work, in all areas of the business, to an exceptional standard. Their value-driven approach and their continual efforts to improve our services and deliver fair outcomes are at the core of what we do and it is thanks to them that we have been able to drive forward the ambitious programme that we have described in this report over the course of the year.

Helen Vernon
Chief Executive

Performance summary

This performance summary provides an overview of the work of NHS Resolution, including our purpose, the key risks to achieving our objectives and a summary of activities we have undertaken over the past year. In particular, it sets out the activity to meet the four strategic aims outlined in our business plan for 2018/19. For more detailed information about how we have delivered against our aims, please refer to the 'performance analysis' section.

Figure 1: What we do

Our purpose is to provide expertise to the NHS to resolve concerns fairly, share learning for improvement and preserve resources for patient care.

Our services

Claims Management
Delivers expertise in handling both clinical and non-clinical claims to members of our indemnity schemes.

Practitioner Performance Advice
Provides advice, support and interventions in relation to concerns about the individual performance of doctors, dentists and pharmacists.

Primary Care Appeals
Offers an impartial tribunal service for the fair handling of primary care contracting disputes.

Safety and Learning
Supports members of our indemnity schemes to better understand their claims risk profiles, to target their safety activity while sharing learning across the system.

Supported by

- Finance and Corporate Planning
- IT and Facilities
- Membership and Stakeholder Engagement

Strategic aims

Resolution
Resolve concerns and disputes fairly.

Intelligence
Provide analysis and expert knowledge to drive improvement.

Intervention
Deliver interventions that improve safety and save money.

Fit-for-purpose
Develop people, relationships and infrastructure.

Our values

- Professional
- Expert
- Ethical
- Respectful

Understanding our indemnity schemes

The bulk of our workload is handling negligence claims on behalf of the members of our indemnity schemes: NHS organisations and independent sector providers of NHS care in England.

The **five clinical negligence schemes** we manage are:

- **Clinical Negligence Scheme for Trusts** (CNST), which covers clinical negligence claims for incidents occurring on or after 1 April 1995.
- **Existing Liabilities Scheme** (ELS) is centrally funded by DHSC and covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.
- **Ex-Regional Health Authority Scheme** (Ex-RHAS) is a relatively small scheme, centrally funded by DHSC, covering clinical negligence claims against former Regional Health Authorities abolished in 1996.
- **DHSC clinical** covers clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.
- **Clinical Negligence Scheme for General Practice** (CNSGP), is a new scheme which covers clinical negligence claims for incidents occurring in general practice on, or after, 1 April 2019.

We also manage **two non-clinical schemes** under the heading of the **Risk Pooling Schemes for Trusts** (RPST):

- **Property Expenses Scheme** (PES) which covers 'first party' losses such as property damage and theft, for incidents on or after 1 April 1999.
- **Liabilities to Third Parties Scheme** (LTPS) which covers non-clinical claims such as public and employers' liability for incidents on or after 1 April 1999.

In addition, we manage one other non-clinical scheme:

- **DHSC non-clinical** – which covers non-clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.

In this document where we reference clinical negligence data, unless stated otherwise, we are referring to an amalgamation of data relating to all four of our clinical negligence schemes, excluding claims related to the CNSGP which was not in operation prior to 1 April 2019.

The year in numbers

Table 1: A financial overview

	2017/18 (£ million)	2018/19 (£ million)	Change (£ million)	
Funding for clinical schemes				
Income from members	1,953.6	1,993.5	39.9	2.0%
Funding from DHSC (budget)	522.5	496.0	(26.5)	5.1%
Total funding	**2,476.1**	**2,489.5**	**13.4**	0.5%
Payments in respect of clinical schemes				
Damages payments to claimants – excluding PIDR	1,228.0	1,393.6	165.6	13.5%
Damages payments to claimants – PIDR	404.0	384.4	(19.6)	4.8%
Claimant legal costs	466.6	442.3	(24.3)	5.2%
Defence legal costs	128.9	139.6	10.7	8.3%
Total payments	**2,227.5**	**2,359.9**	**132.4**	5.9%
Funding for non-clinical schemes				
Income from members	53.2	59.3	6.1	11.4%
Funding from DHSC (budget)	10.5	12.0	1.5	14.3%
Total funding	**63.7**	**71.3**	**7.6**	11.9%
Payments in respect of non-clinical schemes				
Damages payments to claimants – excluding PIDR	28.9	33.9	5.0	17.3%
Damages payments to claimants – PIDR	2.3	3.5	1.2	53.2%
Claimant legal costs	19.6	17.8	(1.8)	9.2%
Defence legal costs	6.9	6.6	(0.3)	4.4%
Total payments	**57.6**	**61.8**	**4.1**	7.1%
NHS Resolution administration of schemes				
Clinical	12.1	13.3	1.2	9.7%
Non-clinical	3.9	4.2	0.3	7.1%
NHS Resolution other activities				
Income	1.3	1.1	(0.2)	16.8%
Expenditure	6.9	8.3	1.4	20.0%
Staff numbers	265	293	28	10.5%
Cost of new claims provisions				
New claims provisions	13,723	8,387	(5,336)	38.9%
Total provisions at year end	**76,988**	**83,376**	**6,388**	8.3%

Activity overview

Liabilities arising from claims under all of our indemnity schemes have increased by £6.4 billion to a total of £83.4 billion, at current prices, at the end of this financial year. This is the value of liabilities arising from incidents that occurred before 31 March 2019, both in relation to claims received, and our estimate of claims that we are likely to receive in the future from those incidents which have occurred but have yet to be reported as claims.

In 2018/19 we have **received** 10,678 new clinical negligence claims, compared to 10,673 in 2017/18, a relatively flat profile with an increase of just five claims (0.08%). The number of new non-clinical claims, typically employers' and public liability claims, rose from 3,570 received in 2017/18 to 3,585 in 2018/19, a modest increase of 0.42%.

When considering **settled**[2] claims in 2018/19 of 11,417 clinical and 4,237 non-clinical claims, the proportion settled without damages was 44% and 56%, respectively.

When considering the 16,393 **closed** claims in 2018/19, of the 11,625 clinical and 4,768 non-clinical claims, the proportion settled without damages was 41% and 52%, respectively. This compares to 16,701 **closed** claims in 2017/18, when of the 12,077 clinical and 4,624 non-clinical claims, the proportion of claims settled without damages was 43% and 54%, respectively

The number of new referrals received in relation to the performance of doctors, dentists and pharmacists within the NHS remained broadly consistent, with 925 new requests for advice compared to 919 in the previous year. In addition, we received 171 appeals in accordance with the Pharmacy Regulations compared to 170 in the last financial year.

Table 2: The value of payments (damages, claimant and defence costs) across all indemnity schemes for 2018/19 demonstrating the relative size of the schemes

Clinical negligence	Value (£ million)
Clinical Negligence Scheme for Trusts	2,232
Existing Liabilities Scheme	38
Ex-Regional Health Authority Scheme	1
DHSC clinical	89
Non-clinical negligence	**Value (£ million)**
Property Expenses Scheme	8
Liabilities to Third Parties Scheme	48
DHSC non-clinical	6

[2] Settled claims include claims that have been agreed with ongoing periodical payment orders and claims where damages have been agreed or successfully defended, and costs have yet to be agreed. This is a different cohort to closed claims which do not include ongoing periodical payment orders and may fall in different years.

Key headlines

We have completed the second year of our five-year strategy and continued to deliver at pace. Some of our **key priorities and activities undertaken** in 2018/19 were:

To increase our understanding, and tackling the drivers of, claims costs including the factors which cause an incident to turn into a claim

In 2018/19, we conducted research to understand why people make a claim. The report validated what we know about the intrinsic relationship between claims and the management of complaints and incidents. Building on the findings, we have worked with others, such as the Parliamentary Health Services Ombudsman (PHSO), to identify opportunities for the NHS to get better at incident, complaints and claims handling and where we can support the NHS in developing a just culture. With the PHSO, we issued a joint statement to NHS trusts in England, particularly for those staff who manage complaints and/or compensation claims raised against their trust. It outlined our roles and how our services overlap and interact.

To resolve high numbers of clinical and non-clinical claims fairly, reaching the right answer as quickly as we can and as far as possible, keeping cases out of formal court proceedings

We continued to resolve increasing numbers of claims without litigation, to minimise unnecessary delays and improve the experience for claimants, their families and healthcare staff. Our Claims Management service supports this ambition by targeting cases that are at risk of moving into unnecessary litigation and increasing the uptake of alternative dispute resolution, including mediation. We reduced our litigation rate from 32% in 2017/18 to 31% in 2018/19. We believe that this will ultimately result in direct savings to the NHS and an improved experience for patients and healthcare staff.

This year we mediated 397 claims compared to 189 in 2017/18. We have also taken a number of legal cases to the higher courts to develop case-law in the broader interests of patients and the NHS.

Establish a state indemnity scheme for general practice

Announced in last year's annual report and accounts, we have been working this year to establish, administer and operate a state-funded indemnity scheme for general practice on behalf of DHSC from April 2019. This strand of work was an addition to the priorities we had identified as part of our five-year strategy and there was significant uncertainty in 2018/19 until we were formally asked to operate (as opposed to just administer) the CNSGP for incidents occurring after 1 April 2019.

Use the financial levers at our disposal to incentivise the provision of safer care in key areas

Maternity claims can have devastating consequences for the child and family, together with the impact on the treating clinicians and the financial cost to the NHS. They continue to represent by far the biggest area of spend for NHS Resolution on behalf of the NHS. As a result, the specialty remains a primary area of focus for us. We had considerable success with our CNST maternity incentive scheme launched in 2018. The scheme rewarded trusts meeting ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. This work had the full support of the national Maternity Safety Champions and the actions were agreed in collaboration with our system partners. Integral to the maternity priority within the *NHS Long Term Plan*, in the second year of the scheme we further incentivise the ten maternity safety actions with some additional refinement.

Move 'upstream' to work with families and NHS trusts, right from the start, in relation to those rare but tragic cases which result in brain injury at birth with life-long care requirements

A key aim of our five-year strategy is to get closer to the point of incident of the most serious maternity incidents, so that we can share learning more rapidly and get support to families when they need it. We are intervening in the usual path of an incident to payment of a claim to help earlier in the process and have now completed the second year of our Early Notification scheme for obstetric brain injury.

746 cases were accepted by the scheme between 1 April 2017 and 31 March 2018, representing 0.12% of all births in England. Overall our legal panel firms were instructed to begin liability investigations in 26% of cases that occurred in year one of the scheme. Of these cases, 14 have been concluded to date with admissions of liability, resulting in families being provided with a dedicated Early Notification case manager, explanations, formal admissions of liability and apologies. Providing families with a decision on liability so close to the point of incident is unprecedented. Normally these multi-million pound cases could take many years to reach admissions of liability. However, in those cases where liability is accepted and it is clear the baby has additional needs as a result, we have already been able to provide those families with financial support to access additional care, respite and where needed, psychological support. These cases are, however, one part of an increasingly complex investigative picture. In many cases, while the standard of care can be determined early on, it is difficult to know what the effect may be until the child is at least two years old. In other cases, our investigations have concluded that care was appropriate. In all cases, our aim is to provide families with full explanations and signpost them to independent support agencies where appropriate. We are planning to report on the first year of implementation of the scheme.

Share meaningful and valuable data at both a local and national level to drive improvement

One way we strive to reduce the cost of clinical negligence is to reduce the likelihood of incidents recurring by sharing insights gleaned from our unique dataset of claims for clinical negligence in England. This year we used our data, triangulated with information from inquests, to help inform our *Learning from suicide-related claims: a thematic review of NHS Resolution data* report with recommendations to drive improvements in the care that results in these tragic claims. We have undertaken the groundwork for a review of claims arising from the emergency care specialty by recruiting a clinical fellow in emergency medicine – because, for the first time, last year the new claim numbers associated with emergency care outstripped those for orthopaedic surgery as the top volume specialty. Work will be undertaken to better understand themes arising from these claims and to feed information back into the service to drive improvements in the next financial year.

We have contributed to the wider maternity system to improve safety and reduce harm, including the Royal College of Obstetricians and Gynaecologists' Each Baby Counts programme; the Maternity and Neonatal collaborative, and as a member of the Maternity Transformation Programme Board (workstream 2). We shared vital data to support the Getting It Right First Time programme, facilitating learning across a range of clinical specialties and shared learning back through 24 national, regional and local events.

Use the findings of our customer satisfaction survey to implement changes to our services and improve the quality of our engagement with our stakeholders

In the area of Practitioner Performance Advice, we responded to customer feedback by streamlining workplace-based assessments to focus on delivering the elements that add the most value and piloting Action Learning Sets to embed learning from case investigator and case manager training programmes at a local level. For Primary Care Appeals we issued new guidance to improve the quality of applications to amend pharmacy opening hours.

Underpinning these priorities, we also had a programme of work to ensure that as an organisation we remain fit-for-purpose, exploring how we can improve our management of data and support and develop our workforce.

Have a long-term plan for how we collect, store, process and share information which future-proofs our systems and ensures that we are able to meet our objectives while complying with existing and emerging data protection law

We have undertaken an extensive review of all our 'core systems' as a starting point to explore new technologies and develop our existing IT infrastructure to improve our ability to learn, share what we know and enhance our operational efficiency. We launched a three-year project to review our operational IT needs. Year one of the project has involved engaging with staff and stakeholders to gather our requirements in relation to our case management, customer relationship management and business intelligence systems. We have also explored how we could pilot the use of artificial intelligence in the context of the General Data Protection Regulation, and are preparing to procure partners to work with us on this.

This work explores how best to use the data we hold to improve the safety of patients, and we strive to balance this with best practice in data protection and to uphold individual rights.

We have also improved our ability to maintain business continuity, having reviewed our processes and procedures for business continuity and crisis management.

In October 2018, we launched our new corporate website to improve access to our resources, such as publications on CNSGP, and provide greater transparency around our work, such as the ease of access to our Primary Care Appeals' decisions.

Supporting and developing our staff

During 2018/19, we prepared to expand our Leeds base and moved into new premises on 12 April 2019. The aim of this move was to help continue to build a skilled workforce by tapping into a new pool of potential employees and to deliver better value for money both in recruitment and our accommodation costs. The move was in line with the government strategy to increase smarter working and support the hub strategy.

We cannot do anything without the expertise and commitment of our staff who work incredibly hard to deliver our objectives. In 2018, we adopted a new corporate workforce and organisational development strategy which included delivering an organisation-wide leadership development programme and provided training, including a wealth of activities from embedding a corporate mentoring scheme to specific training such as how to respond in a compassionate and empathetic way to those who bring claims without legal help.

The environment we work in

Cross-government strategy

Further to the National Audit Office and Public Accounts Committee recommendations to government to address the challenge of the rising costs of clinical negligence, NHS Resolution is supporting work across government to address these recommendations. We anticipate that the government will set out more detail in due course.

Personal injury discount rate and the Civil Liability Act 2018

The reduction in the PIDR from 2.5% to minus 0.75% on 20 March 2017 resulted in very significant increases to the value of claims entailing any element of future loss, especially if there is a long life expectancy.

The Civil Liability Act 2018 received Royal Assent on 20 December 2018. Its main effect from our perspective was to introduce a new basis for setting the PIDR. The Lord Chancellor remains empowered to vary the rate, but he or she will now be guided by a panel of experts for all but the first review, when consultation must be with just the Government Actuary and HM Treasury, as is the case under existing arrangements.

An important change is that recipients of damages will be deemed to accept "more risk than a very low level of risk" on their investments, but "less risk than would ordinarily be accepted by a prudent and properly advised individual investor". This replaces the previous assumption, laid down in 1998 by the House of Lords in a judicial ruling, that those investing damages are assumed to be "no risk" investors, the consequence of which was that returns on index-linked government stock were considered the appropriate benchmark for setting the PIDR.

The Act allows a maximum of 90 days for the first review to be started, and that duly commenced on 19 March 2019. It must be completed within 140 days, namely by 6 August 2019. The Government Actuary must be consulted within 20 days of the start of the 140-day period, and must respond within 80 days. The result of these provisions is that any new PIDR should be announced on or before 6 August 2019. Any change is likely to have important ramifications for both claimants and NHS Resolution and we may potentially see impacts on settlement behaviour in the legal market.

Fixed recoverable costs

It has long been a concern that the costs of claimant lawyers have been disproportionate to damages, particularly for lower value claims. Sir Rupert Jackson, until recently a senior judge in the Court of Appeal, was commissioned in 2008 to review the whole subject of costs in civil litigation and his final wide-ranging report was published in January 2010. The government accepted most of his recommendations and these were implemented in 2013, many under the umbrella of the *Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO).* For example, fixed recoverable costs were introduced in most employer's liability and public liability personal injury claims valued at up to £25,000. However, costs in clinical negligence claims and other categories such as defamation remain uncapped.

Sir Rupert gave a lecture in January 2016 advocating the extension of fixed recoverable costs regimes and he was asked to produce a further report with recommendations, which was published in July 2017. In the interim, the Department of Health (as it was then named) launched a consultation on fixed recoverable costs in lower value clinical negligence cases.

Responses to this suggested that any such regime should be accompanied by a streamlined process for these claims.

The government supported that proposal and in May 2018 the Civil Justice Council formed a working group, consisting of claimant and defendant solicitors, representatives of expert witnesses, the judiciary and Bar, and other interested parties, to formulate recommendations to streamline processes and create a grid of recoverable costs for such cases where damages are £25,000 or less. NHS Resolution is pleased to be represented on that group. It is anticipated that its report will be produced in the summer of 2019.

On 28 March 2019, the Ministry of Justice launched a consultation on introducing fixed recoverable costs to other types of claim including noise-induced hearing loss. It is scheduled to be open until 6 June 2019 and once replies have been assessed there will be a formal government response.

NHS Improvement's patient safety consultation

NHS Improvement opened a consultation on 14 December 2018 to help develop a new national patient safety strategy to support the NHS to be the safest healthcare system in the world. We are supportive of the aims and objectives in the draft plan. In our response to the consultation, we encouraged the system to view high-value claims as a key area for harm reduction. In relation to fostering a 'just culture', we noted there is variation between NHS providers in terms of openness, candour with patients and families and equitable, fair and just support for staff when involved in incidents. With many examples of good practice across the NHS, there is an opportunity to learn from excellence and encourage the sharing of best practice.

In relation to openness and transparency, our work with NHS trusts has shown staff welcome support and guidance in this area. Our research, published in 2018, on why people make claims highlighted frustration with both incident and complaints handling. We need to support complaints handlers in the NHS and we champion the use of mediation to resolve claims by bringing together trust representatives and family members.

We also need to understand why, as our research found, NHS staff sometimes recommend patients to bring a claim rather than pursuing other means of resolving concerns locally.

In relation to continuous safety improvement, we support the work NHS Improvement is doing in maternity. We also welcome the support of the other arm's length bodies and the royal colleges to consider further incentive schemes, as seen with our 2017/18 CNST maternity incentive scheme (as previously mentioned). We also welcome the development of the new patient safety incident management system, which presents many opportunities to align activity across the safety system.

Key issues and risks

Preparations for the UK's exit from the European Union

We have been actively engaged in working with DHSC on preparations for the UK's exit from the European Union (EU). In line with government requirements, we nominated a director to oversee our preparations, and related risk assessments and planning. In line with government guidance, we provided reassurance to staff members from other EU countries on their future employment status. Our self-assessment for EU exit preparedness was rated 'green', reflecting the relatively low risk to our core operations and the robustness of our emergency planning and response framework to cope with any short-term disruptions arising from an exit from the EU.

Given the work we do, there is relatively little direct impact from withdrawal from the EU, but it is not without risk. We will consider all potential risks and work with DHSC to ensure that mitigations are in place to minimise disruption across the system.

Planning for indemnity provision for general practice

In October 2017, the government announced the intention to develop a state-backed indemnity scheme for general practice, announcing: *"The Department understands that the rising cost of clinical negligence is a great source of concern for GPs and impacts negatively on the GP workforce, and we are seeking to put in place a more stable and more affordable system of indemnity for general practice."* In the following month, November 2017, DHSC announced that we would be administrators of the scheme. After supporting DHSC and others in the design of the arrangements to establish the new scheme, it was subsequently confirmed that we would also operate the CNSGP from 1 April 2019, providing indemnity cover for incidents after 1 April 2019. This strand of work presented a number of potential risks, as the activity required to establish the scheme could potentially divert resources away from delivering against our strategy.

As this is a new area of business for Claims Management, we mitigated some risk by drawing upon the expertise of colleagues from our panel firms, Practitioner Performance Advice and Primary Care Appeals services working with, and in, this sector. Ensuring clear communications to our new beneficiaries was very important to ensure that those working in general practice were properly informed.

The launch of CNSGP brings those working in general practice in line with their hospital colleagues, and bringing claims from both general practice and secondary care under one roof creates tremendous opportunities for learning. A claims helpline is available 24 hours a day, 365 days a year from 1 April 2019, and a suite of materials has been published on our website to support the scheme.

CNSGP forms part of a wider package of changes to general practitioner (GP) contractual arrangements, through which NHS England and the British Medical Association (BMA) have agreed a five-year GP contract framework from 2019/20.

Investment and evolution: A five-year framework for GP contract reform marks some of the biggest general practice contract changes in over a decade and will be essential to deliver the ambitions set out in the NHS Long Term Plan. The state-backed indemnity scheme is a crucial element of the new contract and is a clear commitment to addressing the concerns recently raised by GPs. Despite the great progress made, the work is not finished. Once the scheme has been safely introduced, we want to quickly begin to align CNSGP with our other indemnity schemes and look at ways of achieving better value for money for taxpayers through greater economies of scale and enhanced ways of working. It is vitally important that the new scheme works well for general practice and we look forward to building on our new relationships to ensure a seamless transition.

Upon announcement that NHS Resolution would be scheme operator, we commenced recruitment of a dedicated team to handle CNSGP claims. Recruitment will increase as the claims book develops over time. We developed our case management system to provide the facility to manage CNSGP claims and be able to report on the claims volumes and trends in the same way we do for our CNST scheme. Following a further competition through Lot 1 (Clinical Liabilities) of the Health-related Legal Services Framework, in February and March 2019, we appointed seven legal firms from our legal panel to assist us in the development and operation of the new CNSGP scheme.

Data protection legislation and our ambition to analyse and share data

One of the consequences of the new data protection regime has been to review the legal basis of the various ways in which we are required to use our data internally and externally to discharge our obligations in line with our statutory functions. In doing so, we have recognised that there are tensions between privacy rights and the ability to meaningfully use our data lawfully to learn from our experiences to help support the NHS to reduce harm. We are working with DHSC to consider further work that might be necessary to bolster our statutory framework to support the legal basis for using data to further our strategic aims.

Raising concerns

As an arm's length body which encompasses specialist services to the NHS, we have a unique contribution to make to the patient safety system. However, there was a risk that if we failed to appropriately act on concerns which we identify through our work, patient and/or staff safety and public protection are, or have the potential to be, compromised and this could lead to harm.

To mitigate against this, we have developed a Significant Concerns Framework to support internal arrangements to raise and consider significant concerns about patient safety when information comes to us in our day-to-day work. This framework has been developed through a cross-organisational approach, which has involved all service areas working in collaboration, reflecting the range of work we undertake to support the healthcare system to effectively manage and resolve concerns.

Policy environment

To support the policy environment and to contribute to the national policy agenda, we have been required to substantially draw upon our resources in terms of expert knowledge. This could potentially have had a significant impact on our efforts to deliver the ambitions set out in our five-year strategy *Fair resolution and learning from harm*, published in April 2017. The risk is in relation to our capacity to deliver on such a broad range of demanding fronts at once, as well as ensuring we do so in line with legislation. We recognised these challenges in our 2018/19 business plan and have been developing a workforce and organisation development strategy, targeting specific areas for skills development and recruitment to support our experienced staff in delivering this agenda while maintaining operational effectiveness.

It also creates a high degree of uncertainty around the factors affecting the cost of settling claims in the shorter term and the value of the long-term liabilities arising from negligence, which is described later in this report. We have allocated resource to ensure we are aware of policy decisions in the legal/judicial and health sectors that may impact on our work and sought to inform others, such as through formal and informal consultation, where policy changes might have inadvertently adversely impacted on our work.

Cyber security

Cyber security remains a business priority for us and as part of the programme of work in this area, we frequently review our defences and endpoint security to ensure that an alignment between ever-evolving security threats and our security capabilities is being maintained.

The expectations in relation to use of our data and experience remain high. Our internal governance arrangements, the embedding of data security awareness through training and implementation of business practices to ISO 27001 standards, certification in Cyber Essentials Plus, and our engagement with other parties over use of data to ensure compliance with legislation, support us to mitigate against inappropriate use of potentially sensitive information. Further information can be found under the Information security and governance section of the governance statement.

Going concern

The NHS Resolution Board has reviewed the financial position of the organisation and discussed future funding arrangements with DHSC, given that NHS Resolution reports significant net liabilities. The indemnity schemes that NHS Resolution operates are funded on a 'pay-as-you-go basis' – members collectively contribute sufficient funds to meet the liabilities required to be met on a yearly basis rather than holding reserves for future settlements. There is a reasonable expectation that the government, via DHSC and the NHS, will continue to fund future liabilities.

On 27 February 2017, the Lord Chancellor announced a change to the PIDR from 2.5% to minus 0.75%, effective from 20 March 2017. The government recognised that there would be a significant impact on public finances, and therefore added around £1.2 billion a year to the budget reserve to meet the expected costs to the public sector, in particular to NHS Resolution. The change resulted in additional costs during 2018/19, which were funded from this reserve. DHSC has confirmed that it will continue to provide support to NHS Resolution to meet the additional costs in settling claims arising from the current PIDR. As a result, no further claim on members of our schemes occasioned by the change in the PIDR in March 2017, and any future change arising from the Civil Liability Act 2018, will be required in 2019/20.

On this basis NHS Resolution 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 to the financial statements of 31 March 2019.

Performance analysis

Our in-year activity is now described in greater detail.

Our strategic aims

We continue to work to deliver the priorities outlined in *Our strategy to 2022: Delivering fair resolution and learning from harm.*

The strategic aims outlined in our business plan for 2017/18 were:

Priority 1 – Resolution

- To continue to provide cost-effective dispute resolution services for appeals, claims and cases.
- Inform and implement changes to the legal environment, reducing litigation and increasing the use of alternative dispute resolution.
- To reduce the unnecessary costs attached to claims and inform policy initiatives designed to achieve this outcome. To extend the reach of the Practitioner Performance Advice service into organisations that are not currently using our services.

Priority 2 – Intelligence

- To understand and respond to the drivers of cost and our customers' needs.
- To help the system, organisations and individuals identify and address issues.
- To share what we know to inform policy development.
- To 'diagnose' the issues driving costs and use this to devise and signpost interventions.

Priority 3 – Intervention

- To work in partnership with other arm's length bodies (ALBs), NHS trusts, patients and healthcare staff to improve the way in which the NHS responds to incidents.
- To provide the system with access to a range of intervention services that uses our expertise to support improvement.
- To inform and implement policy initiatives effectively.
- To play a unique role in incentivising safety improvement, using the indemnity schemes as both a platform for learning and a lever for change.

Priority 4 – Fit for purpose

- To ensure we have the right skills and resources in place to deliver our services.
- To be a learning organisation that continuously improves and delivers services with the most effective use of our resources.

Our performance report sets out how we have delivered against our strategic aims in-year and we:

- outline the financial challenges and the trends and key features we have observed as a result of analysing our data;
- explain the steps we have taken to share the costs of claims fairly and to incentivise improvement;
- describe how we have used our expertise in order to preserve funds for patient care by targeting our strategies on resolution, including influencing the law;
- describe how we have worked with providers of NHS care to learn from claims in order to drive improvement;
- confirm the steps we have taken to obtain and respond to external feedback; and
- summarise the activity we have undertaken within our various operating divisions to add value for our customers.

Performance measures

Our performance measures provide an objective assessment of our operational performance and how we are delivering against our strategic aims. NHS Resolution has key performance indicators (KPIs) covering all areas of operations, which are reviewed annually to ensure that they support us to continually learn and develop our services. At a high level, our KPIs provide assurance and performance information to our Board and DHSC. Internally, they drive continuous improvement for our operational teams.

Our external KPIs are agreed by our Board and DHSC and published annually via our business plan with the exception of some of our claims KPIs where publication could prejudice the effective management of claims. The performance of our legal panel firms is also monitored closely under a balanced range of KPIs that are specified in our contracts with them in order to ensure a high-quality service at a competitive price. Throughout 2018/19, we continued to review the distribution of work and performance in relative, as well as absolute, terms and intervened as required.

NHS Resolution's Board and workforce strategy group monitored a variety of workforce indicators, including establishment levels, employee turnover, recruitment, sickness absence, levels of pay, and equality and diversity statistics, to ensure that the associated HR issues flowing from our business were properly managed.

We have adopted a RAG rating (red, amber, green) to show which KPIs we have fully met, came close to meeting (within 10% of target) and failed to meet.

Some KPIs were missed, in particular in the claims area where we have since undertaken a review of the performance framework and the measures that sit beneath our KPIs. This has led to changes to ensure that performance metrics are aligned with our strategy and seeks to measure those factors we can control or influence. The Practitioner Performance Advice KPI relating to Assessments and other interventions delivered within target timeframe represents a stretching target for a particularly complex area of service delivery.

Nevertheless, we have seen a further improvement of 8% in relation to this performance metric compared with the previous financial year.

According to our annual customer survey, overall satisfaction continues to rise having achieved a 14 percentage point increase (from 55% to 69%) over the past three years – we will be exploring why this overall score has not been reflected across the scores for our individual services.

Claims Management faced a number of challenges in 2018/19, including recruitment of a new Director of Claims Management and the implementation of the new CNSGP scheme. Claims Management reviewed the performance framework and proposed substantial changes for the year 2019/20 to ensure the KPI measurements remained fit for purpose and drive the correct behaviours in the claims environment. For Claims Management, the KPI relating to the letter of response was missed by 6% for clinical claims and 5% for non-clinical claims.

The target was impacted by the challenge to recruit sufficient numbers of staff to meet the resourcing levels we need to deliver the expansion in our responsibilities and ambitions set out in our strategy. This is being partially addressed by the announcement of the expansion of the operating base in Leeds to handle claims. The time-to-resolution target has presented a challenge for most of the year and the KPI was recognised as not being fit-for-purpose because it was impacted by a number of factors outside of our control, such as the availability of experts. It was paused as a formal KPI and was not used for the year while the performance framework was reviewed. We have now agreed a revised measure as part of the new framework that is more reflective of the factors within our control and that we can influence. The rate of closure KPI was missed by 5% in clinical claims but exceeded by 20% in non-clinical claims. The reduction in the open book was met in the non-clinical teams but missed in clinical resulting in a red rating overall.

Although there was a reduction in litigation across both clinical and non-clinical teams, the overall target of 10% was missed in both areas.

Table 3: Key performance indicators

Resolution	Area	Target	Met
Response time to a letter of claim (clinical and non-clinical).	Claims Management	Internal	
Closure rate (clinical).	Claims Management	Internal	
Closure rate (non-clinical).	Claims Management	Internal	
Clinical claims closed with no damages payment.	Claims Management	Internal (monitoring)	N/A
Non-clinical claims closed with no damages payment.	Claims Management	Internal (monitoring)	N/A
Repudiated claims converting to a damages payment.	Claims Management	Internal	
Reduction in the number of cases proceeding to litigation.	Claims Management	Internal	
Reduction in the open book of claims (clinical).	Claims Management	Internal	
Reduction in the open book of claims (non-clinical).	Claims Management	Internal	
Primary Care Appeals 'first step' letters sent out within seven days of receiving the appeal or dispute.	Primary Care Appeals	90%	
Primary care appeals or disputes where at least 14 days' notice of an oral hearing is given.	Primary Care Appeals	100%	
Primary care appeals where the decision maker agreed with recommendation of case manager.	Primary Care Appeals	80%	
Time to resolve primary care appeals and disputes – internal input only.	Primary Care Appeals	15 weeks	
Time to resolve primary care appeals where external input is required.	Primary Care Appeals	25 weeks	
Time to resolve primary care disputes where external input is required.	Primary Care Appeals	33 weeks	
Positive outcome of quality audits for primary care appeals and dispute files.	Primary Care Appeals	90%	

Intelligence	Area	Target	Met
Healthcare Professional Alert Notices issued/released (where justified) within target working days.	Practitioner Performance Advice	90%	
Healthcare Professional Alert Notices revoked (where justified) within seven working days.	Practitioner Performance Advice	90%	

Intervention	Area	Target	Met
Positive feedback from trusts visited on recognition of products.	Safety and Learning	At least 60%	
Response to members 1. 95% response rate to members following a request for contact within five working days. 2. Participation in eighteen regional engagement events for members which include two national sharing and learning events. 3. Eight safety and learning products to be made available for members in 2018/19.	Safety and Learning	95% 18 events 8 products	
Practitioner Performance Advice education events rated by participants at least four out of five for effectiveness/impact.	Practitioner Performance Advice	90%	
Requests for advice from Practitioner Performance Advice responded to within two working days (or within an alternative timeframe requested by the employing/ contracting organisation).	Practitioner Performance Advice	90%	
Assessments and other interventions delivered within target timeframe.	Practitioner Performance Advice	92%	
Assessment and other intervention reports produced/issued within target timeframe.	Practitioner Performance Advice	90%	
Percentage of exclusions/suspensions critically reviewed in line with the following timescales: Stage 1: after initial four weeks. Stage 2: at three months. Stage 3: at six months.	Practitioner Performance Advice	90%	
Decisions on referrals for assessments and other interventions communicated to the referrer within 13 working days of receipt of all referral information.	Practitioner Performance Advice	90%	

Fit-for-purpose	Area	Target	Met
Indemnity scheme financial spend.	Finance	Within 5% of target	
Undertake annual customer satisfaction survey to inform service development.	Membership and Stakeholder Engagement	Complete in 2018/19	
Target for participation in our customer satisfaction survey to ensure engaged customer base.	Membership and Stakeholder Engagement	60%	
Evidence of increasing scores covered by annual customer satisfaction surveys year-on-year.	Membership and Stakeholder Engagement	Increasing scores in 50% of areas covered	
Overall approval rating in the 2017/18 customer satisfaction survey.	All	55%	
Downtime (unavailability between 7am – 7pm) of any IT system.	IT	No > 5% of working month	
Downtime (unavailability between 7am – 7 pm) for the extranet and claims reporting services.	IT	No > 2.5% of working month	
Workstation audits to be carried out monthly to ensure compliance with our security policies and standards.	IT	Completion of 10 audits	
Critical security patches for externally facing systems to be applied promptly.	IT	Within 30 days of issue	
Helpdesk to respond to calls within two hours of receipt.	IT	90%	
New projects supported by the programme management office delivered to time and budget.	Business Development	75%	

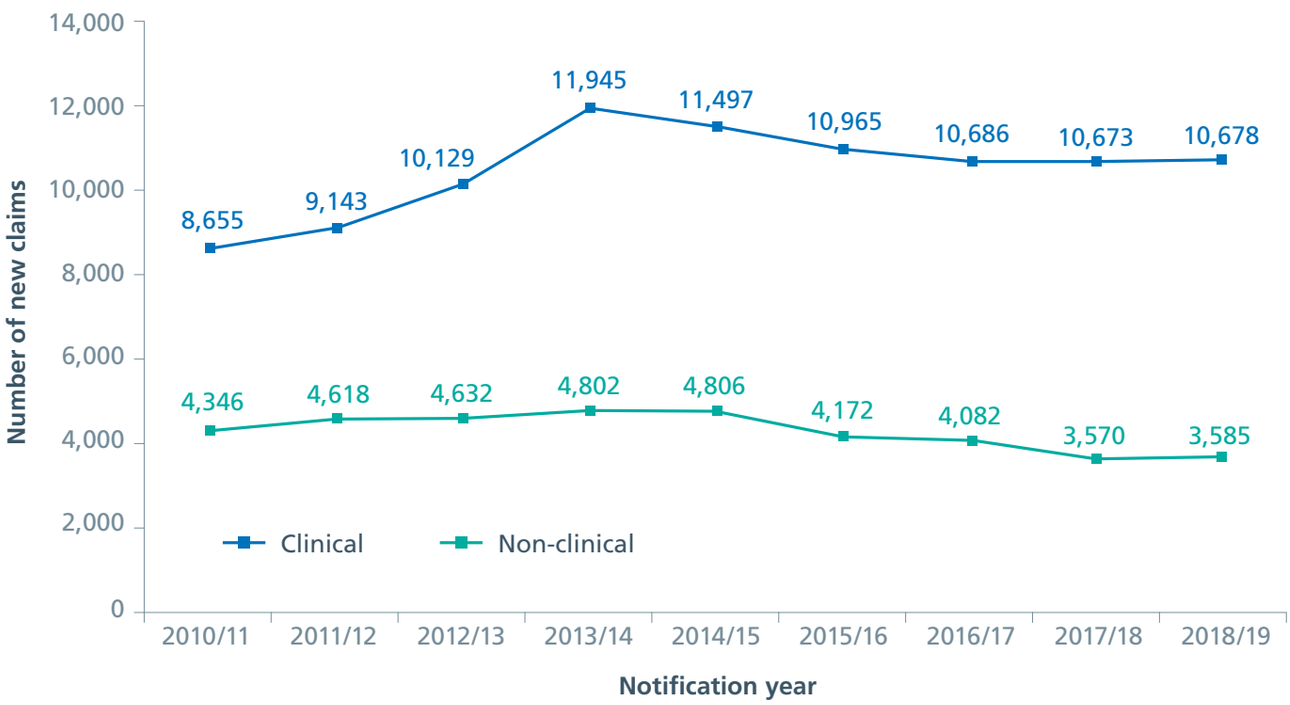
Service updates

Claims Management

Clinical and non-clinical claims

In 2018/19 we have received 10,678 new clinical negligence claims, compared to 10,673 in 2017/18, an increase of just five claims (0.08%). This suggests a continuation of the plateauing observed last year, following a surge in the numbers prior to a change in funding arrangements following the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO). Clinical claims have reduced as a proportion of increasing NHS activity.

Figure 2: The number of new clinical and non-clinical claims reported in each financial year from 2010/11 to 2018/19



We have seen an increase in the successful defence of claims brought and reductions in claimant legal costs. As a result, CNST payments have not risen as quickly as we have previously anticipated, and we have been able to make a small reduction in total contributions to the CNST by 1.9% from £1,984 million in 2018/19 to £1,947 million for 2019/20. However, the underlying trend for the settlement of CNST continues to be upwards, so contributions are expected to increase in future years.

The number of new non-clinical claims, typically employers' and public liability claims, increased from 3,570 received in 2017/18 to 3,585 in 2018/19, a modest increase of 0.42%. We reduced contributions to the Liabilities to Third Parties Scheme (LTPS) by 3.7% from £47.8 million in 2018/19 to £46 million in 2019/20.

In 2018/19, the closed claims with no payment of damages had a cumulative potential cost to the NHS of £2.68 billion. We incurred £21 million defending these claims, therefore ensuring a total sum of £2.66 billion remained available for the use in frontline services.

To better contextualise the number of claims received in-year, it is useful to broadly consider the activity undertaken by the NHS.

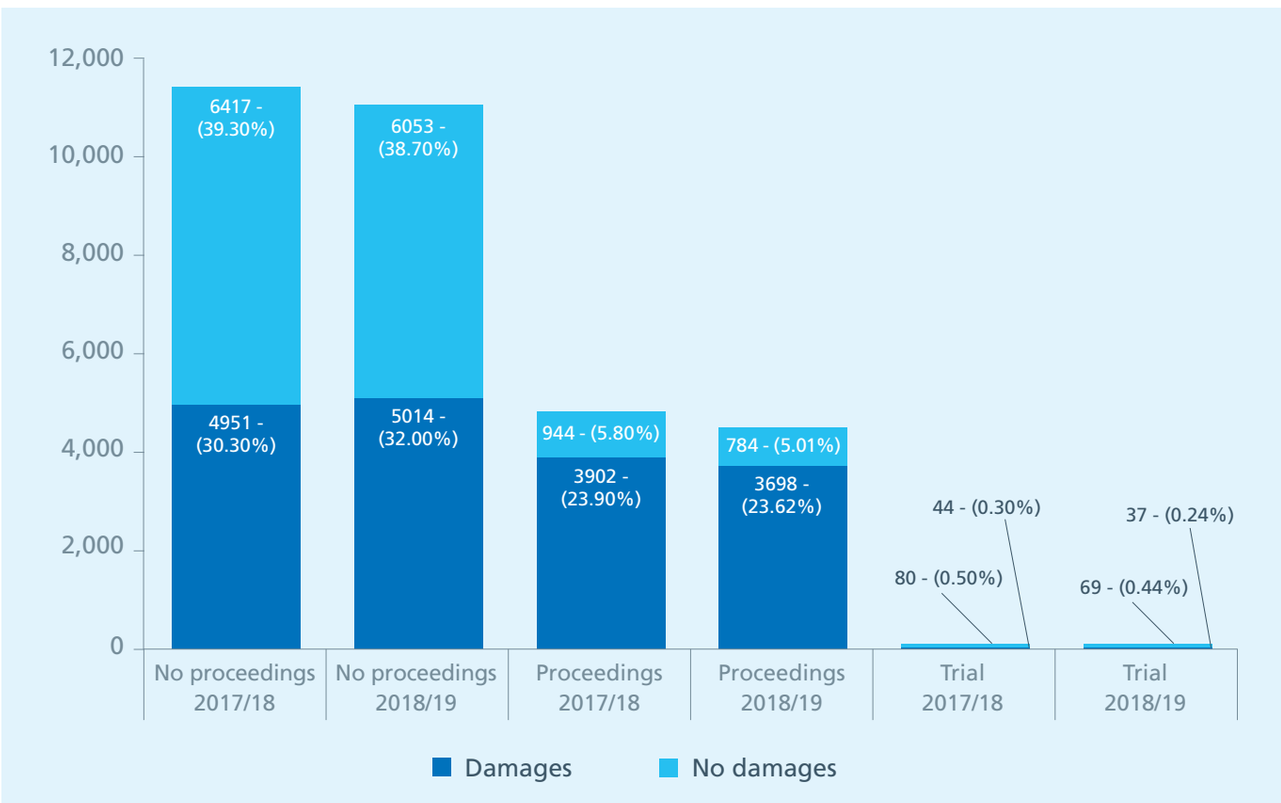
With the caveat in mind that claims received in-year include claims relating to incidents that have occurred in previous years, data supplied to NHS Resolution by NHS Digital show that the activity undertaken (inpatient and outpatient finished consultant episodes, emergency department attendances and ambulance journeys) have steadily increased from close to 110 million to in excess of 131 million episodes between 2013/14 and 2016/17. This is an increase in activity of c20 million episodes or 19% over the period.

The numbers of new clinical claims have remained comparatively stable over recent years during a period of growth in NHS activity levels.

Liabilities arising from claims under all of our indemnity schemes have increased by £6.4 billion in 2018/19 – a fuller explanation of the drivers underlying this change can be found in the Finance report on page 83.

Settled claims

Figure 3: How 15,655 claims were settled[3] in 2018/19 compared with 16,338 in 2017/18



The majority of claims we settle are resolved without formal court proceedings (70.7%, up from 69.6% the previous year) and, in these early stages, more claims are resolved without payment of damages than with payment of damages. Just under one third of claims end up in litigation with less than 1% going to a full trial (where most end in judgment in favour of the NHS). Claims resolved without the need for formal court proceedings are managed by our in-house teams and panel firms. The overwhelming majority are resolved by negotiation in correspondence, in meetings between the parties, or using some form of alternative dispute resolution, including formal mediation.

[3] This figure refers to settled claims, not closed claims, and includes claims that have been agreed with ongoing periodical payment orders. Settled claims will also include claims where damages have been agreed or successfully defended, and costs have not yet been agreed. These data are a different cohort to closed claims reported elsewhere in this document as they may fall in different years.

Closed claims, referrals and appeals

In 2018/19, we closed 16,393 clinical and non-clinical claims brought against the NHS in England compared to 16,701 in 2017/18 – these figures include claims both with and without the payment of damages.

Figure 4: The total number of clinical and non-clinical claims closed with and without the payment of damages from 2005/06 to 2018/19

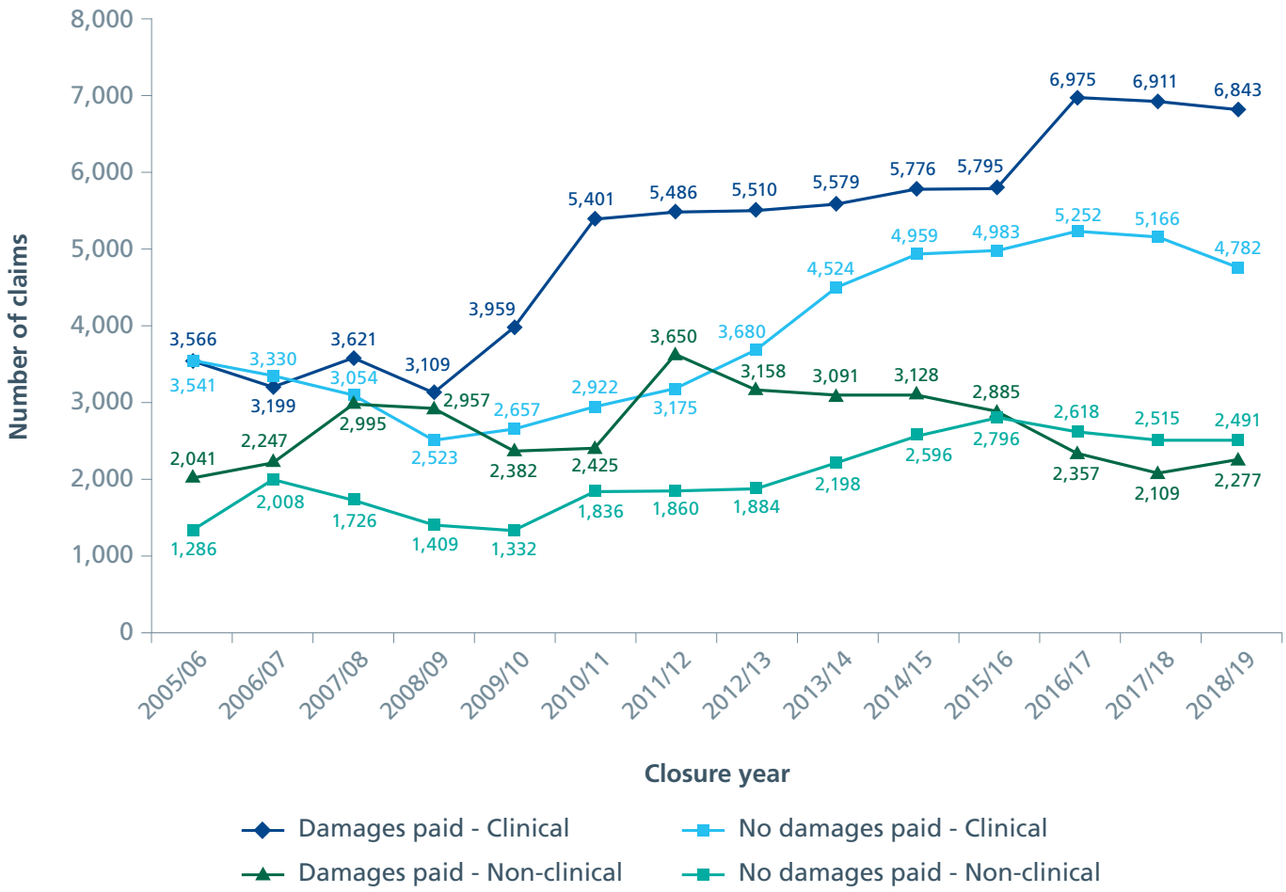
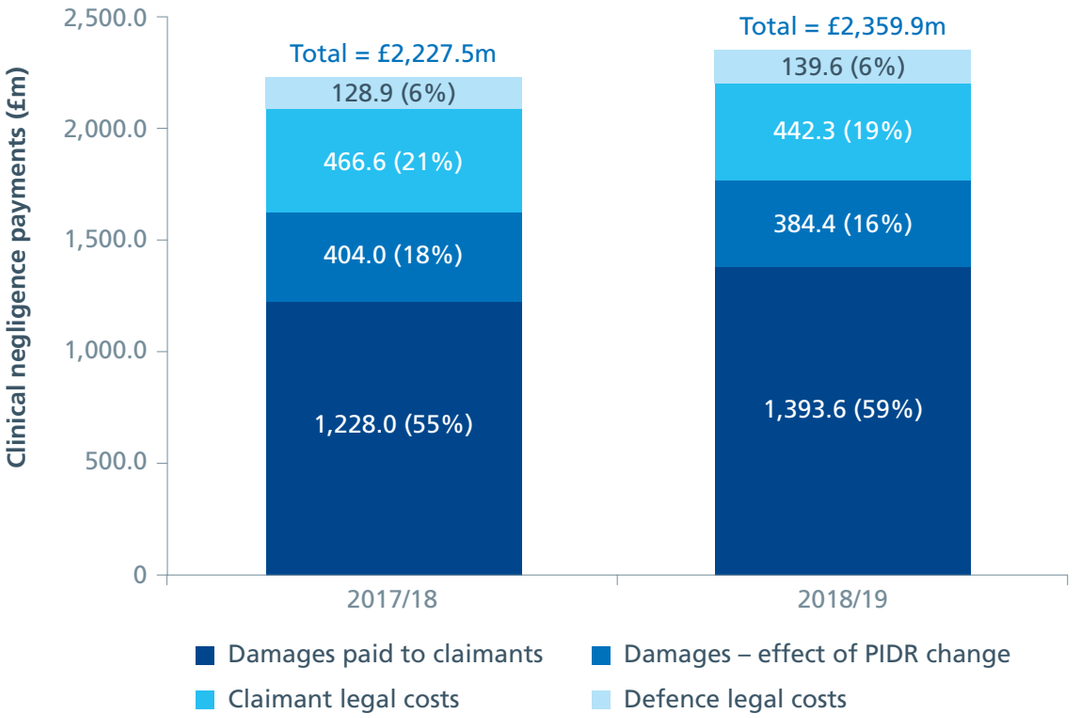


Figure 5: Clinical negligence payments including interim payments 2017/18 and 2018/19 (including PIDR)



Despite the number of claims received remaining stable and a reduction in the number of claims settled in the year, total payments relating to our clinical schemes increased by £132.4 million (5.9%), from £2,227.5 million to £2,359.9 million (inclusive of the increase due to the change in the PIDR). Damages paid to patients rose from £1,632.0 million to £1,778.0 million, an increase of £146 million (9%).

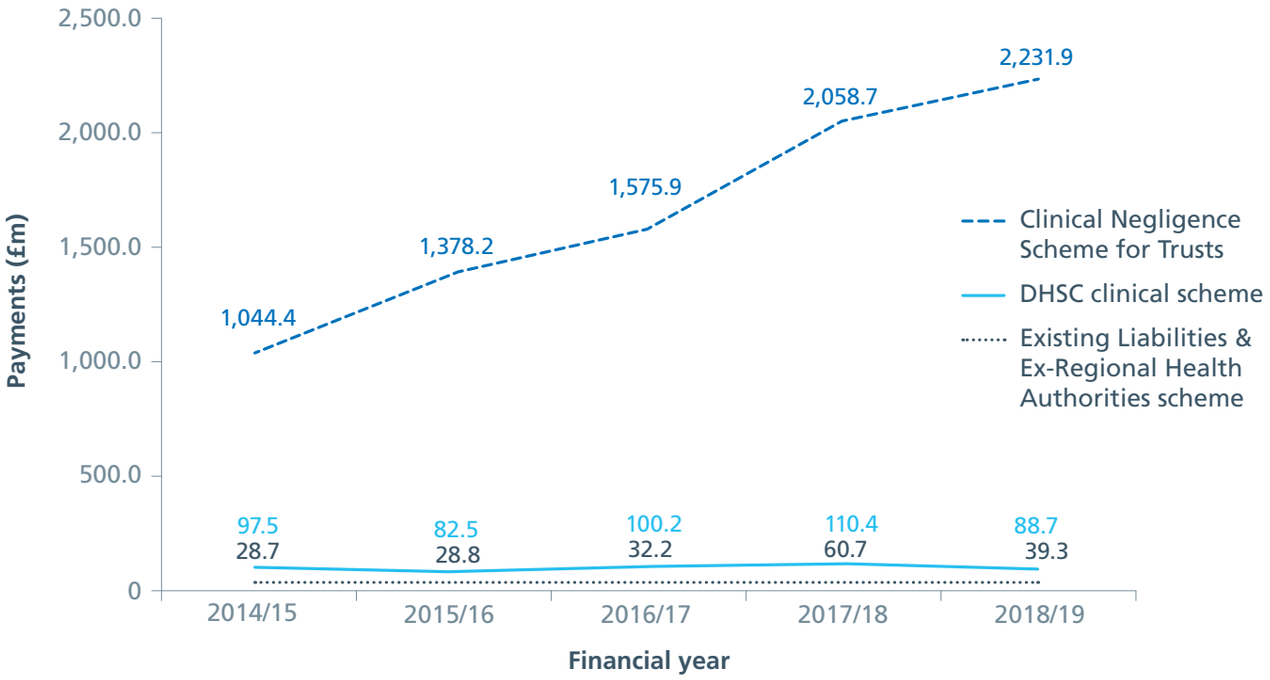
In part, this is due to the fact that payments are generally in relation to claims notified in previous years, and also reflective of the level of inflation in claims settlements.

PIDR costs have reduced year on year. In 2017/18, we paid out additional amounts on a number of claims which had been adjourned for up to seven years at the request of claimants, in anticipation of a reduction in the PIDR.

When the PIDR rate changed in March 2017, the settlement values of these claims were recalculated, and further payments of £101 million were made to those claimants on a one-off basis.

Legal costs have reduced overall, with a £24 million (5%) drop in claimant legal costs as the LASPO reforms take effect. Defence costs have increased as we have focused our activity on early investigation and took action to deal with the change to the PIDR.

Figure 6: Payments on clinical claims by financial year from 2014/15 to 2018/19 for our CNST, ELS and Ex-RHA, and DHSC clinical schemes (including that attributable to the change in the PIDR)



Clinical negligence costs continue to rise relatively steeply, with a significant year-on-year increase because of the change in the PIDR in March 2017. Details of the underlying trends affecting these costs are discussed in the Finance report from page 83 onwards.

Figure 7: The number of CNST and DHSC legacy clinical negligence cases received by estimated damages range in each financial year from 2014/15 to 2018/19

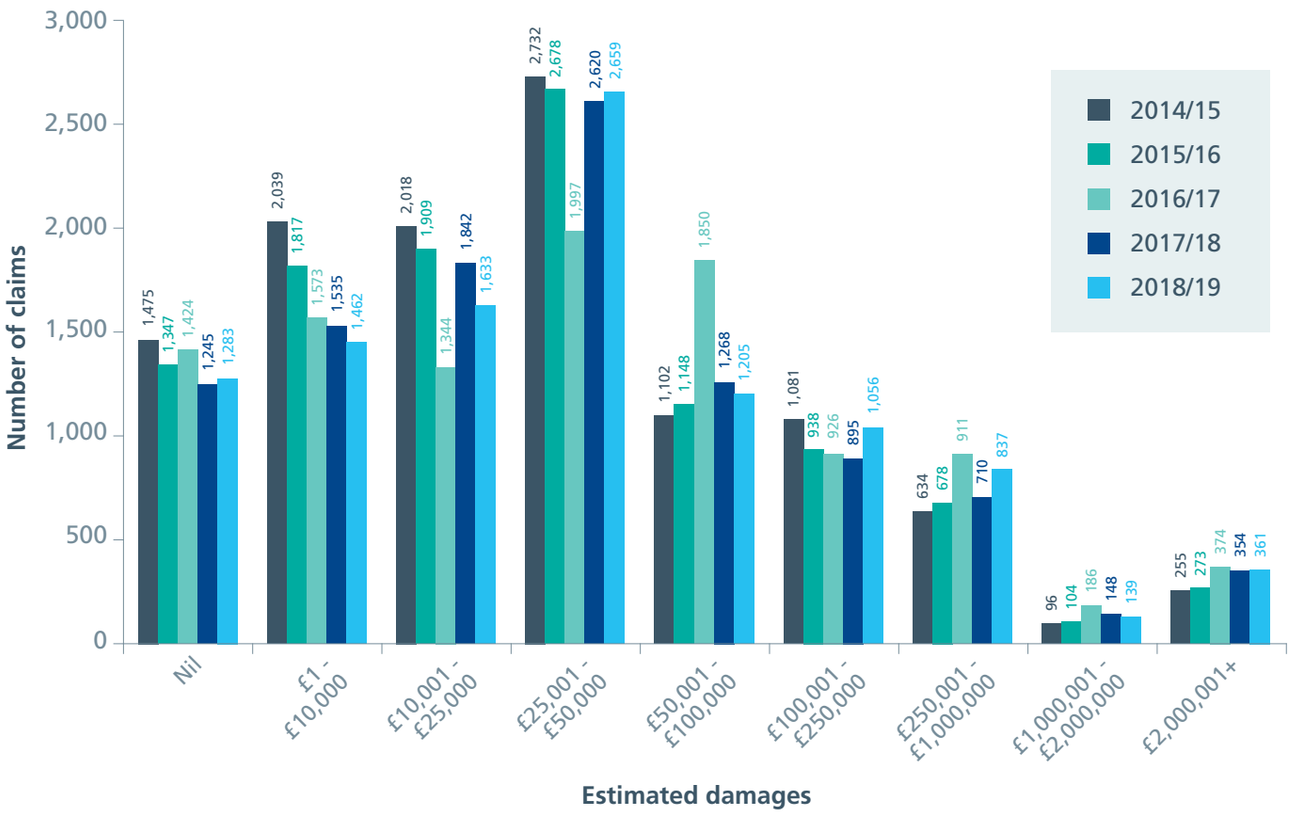


Figure 8: The number of clinical negligence claims received in 2018/19 by specialty

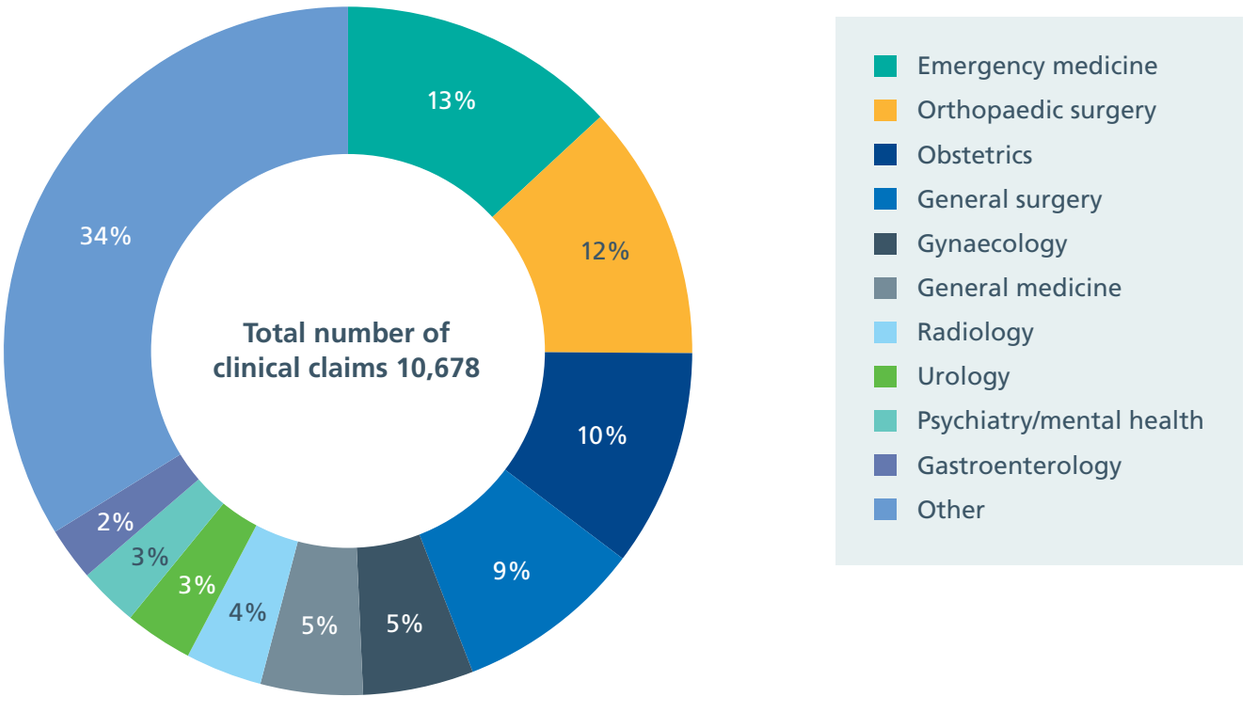


Figure 9: Value of clinical negligence claims received in 2018/19 by specialty across all clinical negligence schemes

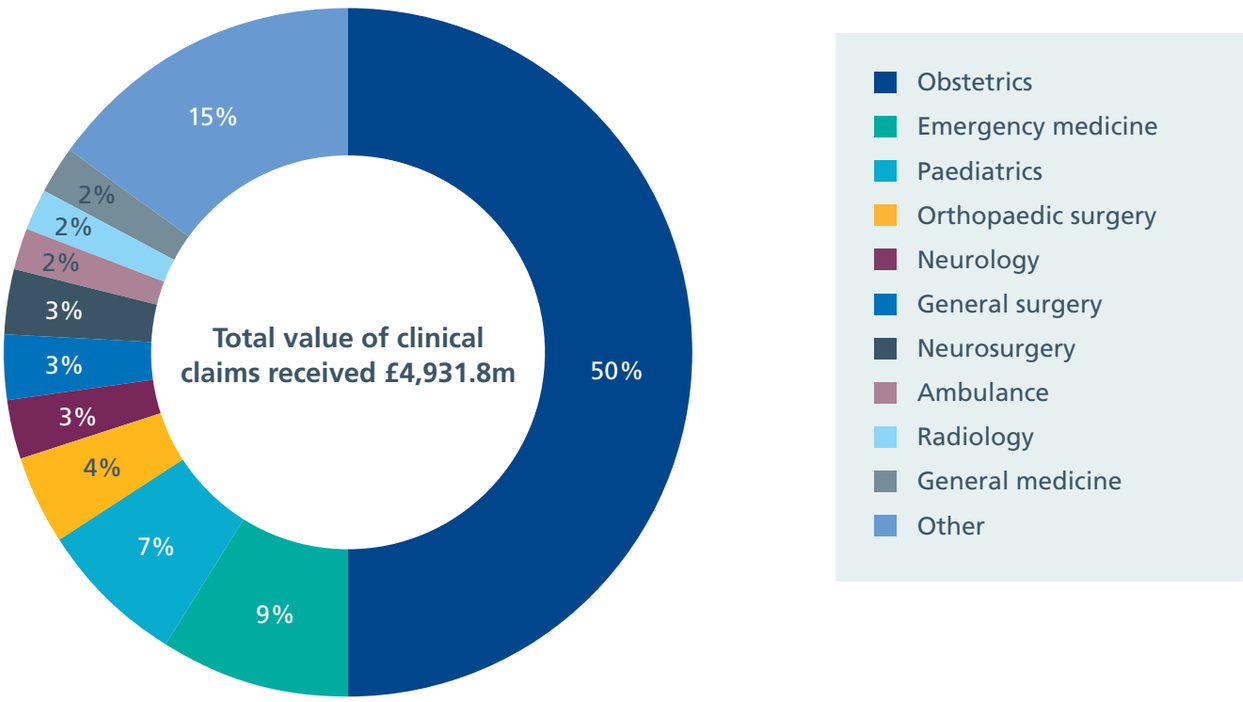
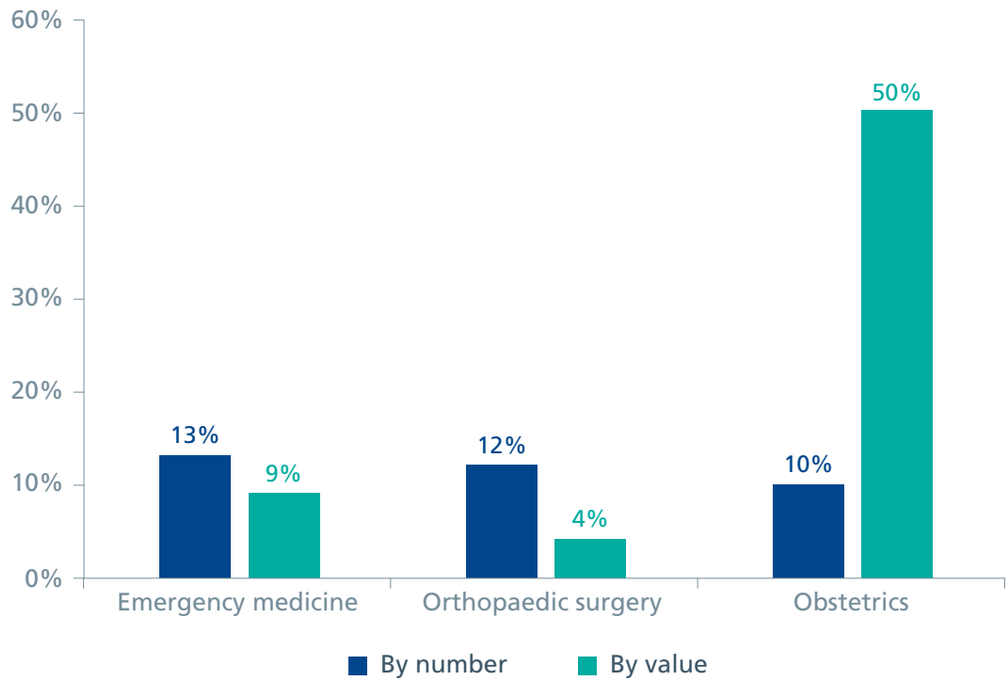


Figure 10: The top three categories of clinical claims received in 2018/19 by value and number



Emergency medicine remains the specialty from where most claims originate, which follows the pattern in 2017/18, yet only accounts for 9% of the overall estimated value of these claims.

Obstetrics claims remain the highest value, 50% of the total estimated value, while only representing 10% of the volume of claims received. This represents a similar pattern to 2017/18 with the estimated value of obstetrics claims being 48% while being only 10% of claims by volume.

Our focus therefore continues to be on maternity claims from the obstetrics speciality. Steps taken to help reduce the likelihood of harm and associated costs include for example our Early Notification scheme, which is entering its third year of operation, and our maternity incentive scheme.

Figure 11: Non-clinical negligence payments including interim payments 2017/18 and 2018/19 (including PIDR)

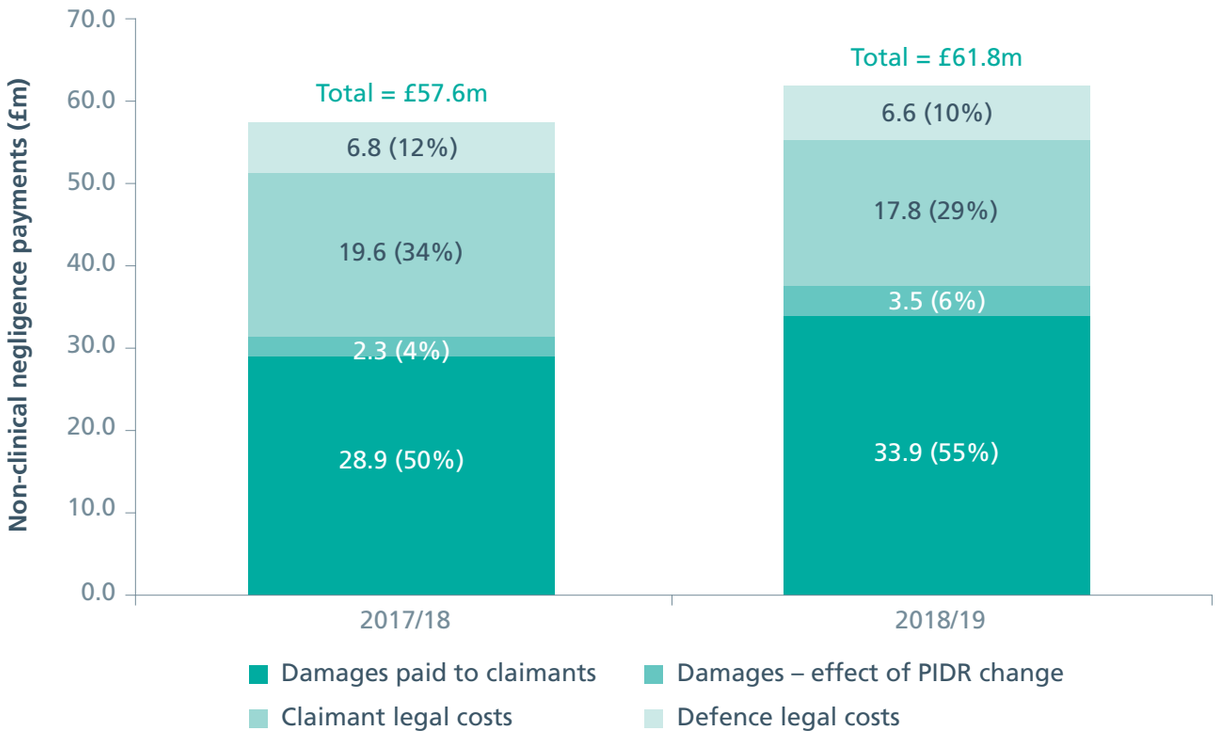
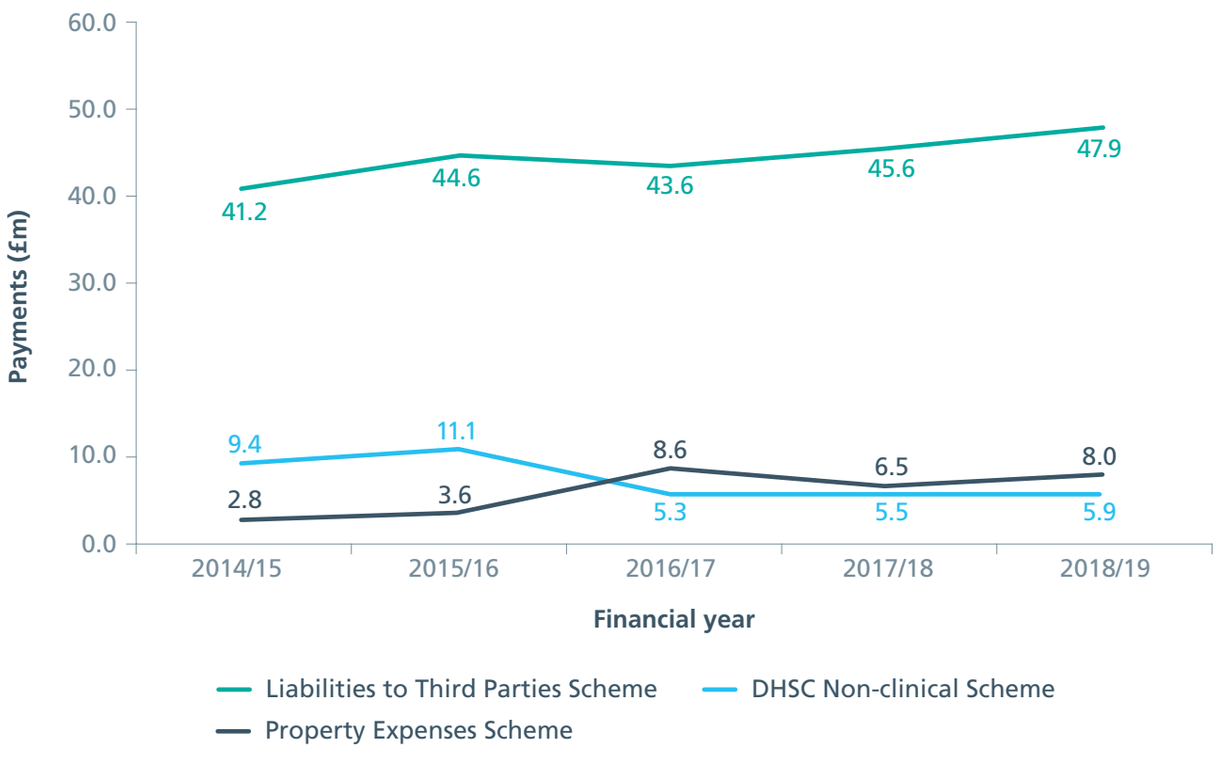


Figure 12: Payments on non-clinical claims by financial year from 2014/15 to 2018/19 for LTPS, PES and DHSC non-clinical schemes (including PIDR)



The increase in non-clinical scheme payments is primarily in the LTPS scheme. This is due to the £6.2 million (20%) increase in damages settlements including PIDR costs for a small number of high-value cases that were settled during the year.

Orthopaedic injuries account for the largest percentage of claims received (69%) which is down from 72% in 2017/18. They also account for the largest overall estimated value (53%), down from 58% last year. Our DHSC non-clinical scheme responds to historic liabilities and liabilities inherited by the Secretary of State for Health and Social Care from abolished health service bodies. The number of claims received under this scheme and the total expenditure are likely to fall over time. PES covers first-party losses arising from damage to NHS property assets. PES expenditure is typically volatile and unpredictable, since the trigger for most claims will be weather-related events.

Managing claims fairly and effectively

We manage claims fairly and effectively and continue to **develop legal precedents**, taking cases to trial or to the higher courts in areas of law which need to be challenged in the broader interests of patients and the NHS, or which require certainty. The law needs to keep pace with the dynamic healthcare environment where groundbreaking advances in science and technology can have a knock-on effect to the cost of clinical negligence. For example, improvements in prosthetics have an impact on the cost of claims because the increasingly complex technology is more expensive. However improved functionality may result in greater flexibility for claimants, removing the need for building adaptations and allowing them to return to work, or speeding up their return to work, reducing the cost of claims in other areas.

It is important that we **defend cases at trial** where there has been no negligence and **pursue alternative ways to achieve fair resolution** that do not have to involve a costly legal process, in both financial and emotional terms.

We also have a responsibility to **challenge excessive claims** for damages and costs, in order to preserve funds for NHS care.

Developing legal precedents

Testing claims at trial often has wider implications for other, similar cases and so the outcome of a case can either provide an opportunity for others to claim under similar circumstances or deter claims without merit. We take cases to trial where there is ambiguity in the law or new points of principle need to be considered.

Darnley v. Croydon – Supreme Court Who can be found to have a duty of care? Liability of emergency department receptionists

The Supreme Court gave its judgment in the case of Darnley v. Croydon Health Services NHS Trust on 10 October 2018. Following a head injury, Mr Darnley (the claimant) attended Mayday Hospital, Croydon emergency department with a friend. The receptionist advised he would have to wait up to four to five hours to be seen. Mr Darnley waited 19 minutes before leaving without telling anyone. He was not informed he would have been triaged within ~30 minutes. Had he been told this, the trial judge found he would not have left the emergency department. Deteriorating shortly after arriving home, Mr Darnley tragically suffered permanent and serious injury, which would have been avoided if he had not left the emergency department and his treatment delayed as a result.

In finding for the hospital, the original trial judge and then the Court of Appeal adopted a number of arguments, including:

- The Trust was not under a duty to provide accurate information about waiting times.
- There was no assumption of legal responsibility for the claimant.
- The information was provided as a courtesy by non-medical staff.
- The claimant was responsible for his injury because he chose to leave the emergency department, when he had in fact been advised to wait.

In overturning the ruling of the Court of Appeal, the Supreme Court found that:

- As soon as the claimant attended seeking medical attention there was a patient hospital relationship (an established category of duty of care).
- There was a duty not to provide misleading information which might foreseeably cause physical injury.
- The standard required is that of an averagely competent and well-informed person performing the function of a receptionist at a department providing emergency medical care.
- The hospital had been in breach of its duty of care.

This is a very sad case because the claimant suffered significant lasting injury. The decision is an important reminder that hospital staff must take reasonable steps to ensure patients are not provided with "misinformation" including the availability and timing of medical assistance. Both clinical and non-clinical staff must be made aware that emergency care waiting time information provided to patients must be reasonably accurate and may have legal consequences if it is misleading.

This case raises issues about the legal liability of non-clinical emergency department receptionists when giving advice to patients about waiting times and for which it was important to have a judicial decision.

This is the first case in England where an emergency department receptionist has been found negligent for failing to give accurate information about waiting times to a patient.

XX v. Whittington Hospital NHS Trust – Court of Appeal 19 December 2018 Recovering costs for arrangement abroad illegal in the UK – Californian surrogacy costs

This was a case where liability was admitted and the key issue was the correct measure of damages. There is an anonymity order in place to protect the identity of the claimant, but not that of the trust. XX developed cancer of the cervix. This was not detected, either by way of smear tests in 2008 and 2012, or biopsies in 2012 and 2013. The claimant required chemo-radiotherapy treatment which in turn led to infertility and severe radiation damage to her lower abdomen. Had the cancer been detected as it should have been, XX would have had fertility-saving surgery. She had a strong ambition for children of her own.

Prior to key treatment, XX underwent a cycle of ovarian stimulation and egg harvest which produced 12 eggs that were cryo-preserved. She and her partner decided to opt for a commercial surrogacy arrangement in California, where it is legal to pay a woman to be a surrogate mother. In the UK, however, commercial surrogacy arrangements are illegal and it is a criminal offence to advertise either for a surrogate or to offer oneself as a surrogate. However, non-commercial surrogacy is permitted to the extent that reasonable expenses may be paid to the birth mother. In the High Court, the trial judge awarded only reasonable expenses for a surrogacy arrangement, on the basis that that was the position under English law. This ruling was appealed by XX.

The Court of Appeal approached the case in a different way. It noted that what XX was proposing was entirely lawful in California and, importantly, that she would not be committing a criminal offence in England by being a party to a commercial surrogacy arrangement in a place where this was legal. Such an arrangement had other major advantages from the claimant's perspective, because under UK law the surrogate mother chooses the parent and is the legal mother of the child, whereas the opposite situation is customary in California.

In 2002, the Court of Appeal had held in the case of Briody v. St. Helens and Knowsley Area Health Authority that commercial surrogacy costs were not recoverable from the negligent health body in relatively similar circumstances, but that case was distinguishable because the chances of a successful outcome were extremely low. Here, the prospect of a live birth was significantly better. Further, public and judicial attitudes to surrogacy had moved on, and the family courts had recently approved payments made in connection with surrogacy in California.

The court therefore overturned the first instance ruling and allowed recovery of the costs of four surrogacy arrangements in California, on the basis that the parent has always intended to have a large family. It concluded that to bar XX from recovering the costs would prevent her from obtaining damages to reflect the loss of her personal autonomy in being able to found a family.

Various claimants v. W M Morrisons Supermarkets PLC – Court of Appeal 22 October 2018
Vicarious liability, employers held accountable for the action of their employees

Andrew Skelton was a senior IT internal auditor employed by the supermarket chain. He developed a grudge against his employers after receiving a warning for unauthorised use of their postal facilities for private purposes. As part of his legitimate duties he received an encrypted USB stick containing personal details of thousands of his fellow employees. He downloaded the data onto his work computer and then copied the information onto a personal stick. He posted these details on the internet and sent CDs containing the same information to three newspapers, none of which published any of it. He was eventually convicted of a number of criminal offences arising from this unauthorised disclosure and sent to prison for eight years.

Over 5,000 Morrisons employees sued the company for misuse of private information, breach of confidence and breach of the Data Protection Act (DPA). The trial judge held that Morrisons were not data controllers under the DPA and therefore not liable for breach of statutory duty. They were not directly liable in respect of the other heads of claim because Mr Skelton had acted without authority. However, they were vicariously liable for misuse of private information and for breaching confidentiality because they had put Mr Skelton in a position of trust and there was a sufficient connection between the role in which he had been employed and his conduct to make that a fair outcome. The company appealed.

This first instance ruling was upheld by the Court of Appeal, which agreed unanimously that sending staff data to third parties was "within the field of activities assigned to" Mr Skelton by Morrisons. It was argued on behalf of the company that since Skelton's motive was to cause financial or reputational damage to his employers, they should not be held liable, but the court rejected that proposition and held that motivation was irrelevant in such circumstances. The outcome therefore was that Morrisons were held vicariously liable to the claimants at common law for Mr Skelton's actions.

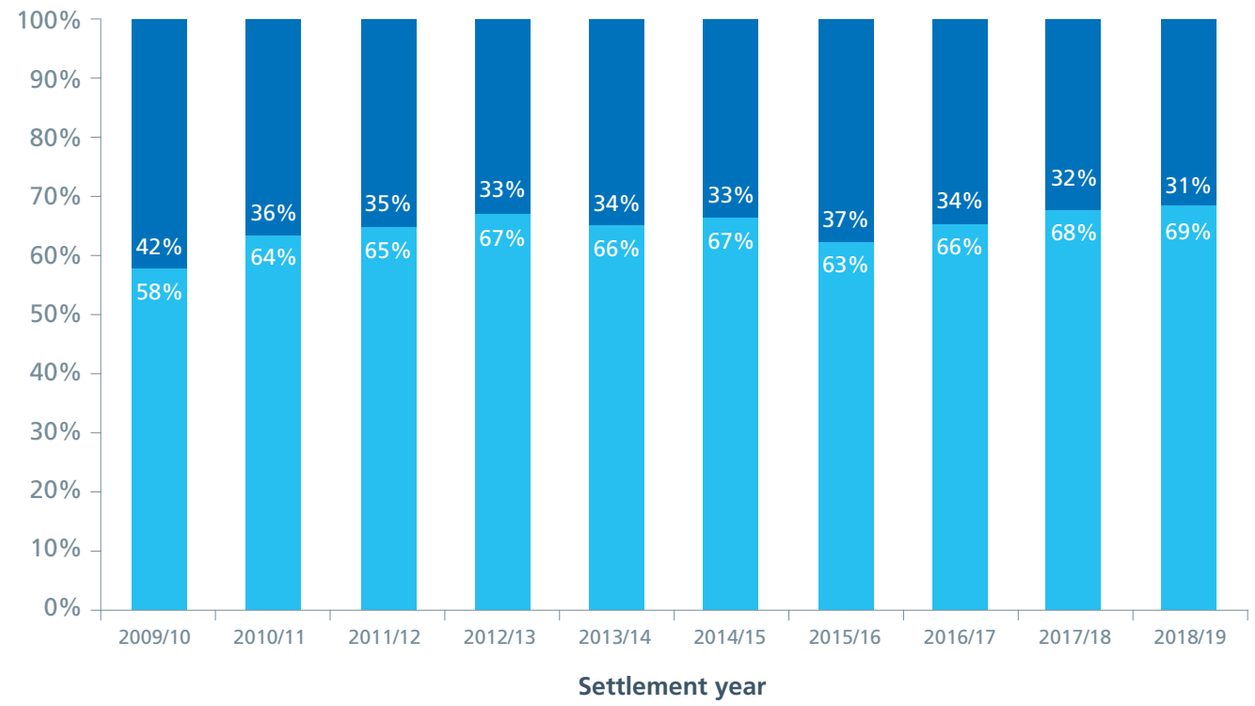
Comment

While this is not an NHS Resolution case, we have included it because it is one of the most important rulings of the courts on civil liability issues all year. Because Mr Skelton had acquired the data as part of his legitimate duties, and distributing data was likewise part of his job, the Court of Appeal considered it appropriate for vicarious liability to attach to the employers whatever his motivation might have been. Arguably this judgment expands still further the situations in which employers may incur a civil liability for criminal acts by their employees.

Defending cases to trial

We continue to defend cases to trial where we consider there has been no negligence or where the amount claimed is thought to be excessive. We have taken 116 cases across all schemes to trial in 2018/19. Court judgments have been handed down in 106 of these cases with a success rate of 69%. This represents an increase of 1% (six cases) in cases taken to trial on the previous year and an increase in the success rate by 2 percentage points from 67%. 73 cases were successfully defended.

Figure 13: Litigation rate[4]



The proportion of cases settled after court proceedings start has reduced further by 1% on the previous year to 31%. This represents the continuation of our strategy to keep cases out of formal court proceedings wherever possible by utilising all forms of alternative dispute resolution.

[4] The data in this figure relate to clinical claims only and it differs from the earlier Figure 3: Settled claims, which represents both clinical and non-clinical claims.

D v. Worcestershire Acute Hospitals NHS Trust – Court of Appeal 7 June 2018 When medical knowledge has changed since the time of failure to warn

This was an appeal by the claimant against a finding of Birmingham County Court in February 2016. She alleged that she was not warned of the risk of pain prior to a total abdominal hysterectomy (TAH) and surgery to remove both ovaries and fallopian tubes (bilateral salpingo-oophorectomy) performed on 25 March 2008.

The claimant had a history of painful and heavy periods and during a consultation in December 2007 she discussed the possibility of a TAH to relieve her symptoms. During another clinic visit in February 2008 she was insistent that she wanted a TAH, even though the doctor explained that it was a major procedure with associated risks. She wanted it "all taken away", in accordance with the clinician's note.

She was reviewed again on 4 March 2008 and once more confirmed that she wanted a TAH and would not consider any other treatment option. The consultation note recorded "risks explained" and the consultant's usual practice was to provide a leaflet at that stage, although she could not recall the actual meeting. The trial judge had accepted that prior to the operation on 25 March 2008, there had been a discussion during which the registrar had explained that the procedure might not relieve D's existing pain.

The operation was performed non-negligently, but unfortunately D sustained nerve damage as a result of which she suffered ongoing pain in her abdominal wall, which was subsequently categorised as chronic post-surgical pain (CPSP).

D alleged that she should have been warned of the possibility of CPSP. However, contemporary guidance on TAH from the Royal College of Obstetricians and Gynaecologists did not refer to a risk of long-term neuropathic (or nerve) pain. The respective gynaecological experts for D and the trust had agreed that CPSP was not common knowledge amongst gynaecologists in 2008 and that therefore it would not normally have been mentioned when taking consent for hysterectomy at that time.

The trial judge had found that even had she been warned of the risk of CPSP the claimant would still have proceeded with the operation that day. D's legal team argued that that was not the right test, but the Court of Appeal concurred with the trust's view that this argument amounted to a wholesale disapplication of conventional causation principles in consent cases. The court held that a claimant must still demonstrate a "but for" causative effect of breach of duty in such cases and that D needed to prove on the balance of probabilities that the operation would not have taken place when it did, had appropriate warning been given (i.e. but for the alleged failure to explain the risk, she would not have had the operation that day). Consequently, judgment was given in favour of the trust.

Comment

The issue of a lack of warning of the risk of CPSP involved a standard application of the Bolam principle – the claimant failed on this point because the condition was not known about by most competent gynaecologists in 2008. However, the main thrust of this case was the attempt to overturn the existing law in consent cases. That attempt failed. Had it succeeded, the NHS would have been legally liable in many more such cases. It is unfortunate that the claimant suffered ongoing pain, but both breach of duty and causation must be demonstrated for liability to attach.

EH v. Dorset Healthcare University NHS Foundation Trust – Court of Appeal 3 August 2018 Challenging a claim on the basis of illegality

The claimant had a history of psychiatric problems, resulting in various formal and informal hospital admissions. On 25 August 2010, while experiencing a serious psychotic episode, she stabbed her mother to death.

An independent investigation found that there had been failings by the trust in caring for and treating EH. While killing her mother could not have been predicted, a serious untoward incident of some kind was foreseeable and it was therefore accepted by the trust that they had breached their duty in failing to respond appropriately to EH's mental collapse. The claimant was charged with murder and, through her legal advisers, pleaded guilty to manslaughter by reason of diminished responsibility. She has been held in detention under the Mental Health Act ever since.

This claim sought damages under a number of headings including loss of liberty consequent on EH's conviction, loss of amenity, the cost of psychotherapy and losing a share in her mother's estate owing to operation of the Forfeiture Act 1982. The trust argued that all these claims should fail on grounds of illegality or public policy. Mr Justice Jay found in favour of the trust on 19 December 2016 and the claimant appealed.

The Court of Appeal agreed with the first instance judge. They noted that in *Clunis v. Camden and Islington Health Authority (1998)* they had struck out a relatively similar claim in its entirety because it was barred by public policy. Likewise, in *Gray v. Thames Trains Ltd.* the House of Lords rejected a claim from a victim of the Ladbroke Grove railway disaster who had suffered post-traumatic stress disorder as a consequence and gone on to kill a man. Critically, in all three cases, the criminal trial had resulted in a conviction based on "diminished responsibility". In other words, the killer had accepted that he or she retained some measure of responsibility for their actions, albeit in the present case that degree was not significant, in the opinion of the judge.

Consequently, the court ruled that this claim could not succeed. It was barred by public policy. The judges expressed the view that the claim for loss of inheritance was "particularly egregious".

Comment

This was a tragic case where there had been failings by the trust and the death of an innocent person. Nevertheless, EH accepted partial responsibility for her actions at her criminal trial and therefore her claim for damages was ruled unsustainable. The Supreme Court agreed in March 2019 to hear a further appeal in this case, however, so there is likely to be another important ruling for the NHS in the next year or so.

Extending corporate liabilities

This year has witnessed a number of rulings from the higher courts in which corporate entities, including NHS bodies, have been held liable in novel situations, or for new heads of loss. These cases[5], discussed previously, highlight that these decisions collectively represent a trend which is of concern to NHS Resolution. Taken together, these decisions appear to reflect a growing willingness by the courts to impose greater liabilities on solvent bodies, in an attempt to compensate innocent victims.

[5] Various claimants v. W M Morrison Supermarkets PLC – Court of Appeal 22 October 2018
Darnley v. Croydon – Supreme Court
XX v. Whittington Hospital NHS Trust – Court of Appeal 19 December 2018

Factors that influence the cost and number of claims

Understanding why people make a claim underpins any work to prevent concerns and complaints resulting in a claim. On 23 October 2018, we published research exploring the factors which lead patients to consider a claim for compensation when something goes wrong in their healthcare. Undertaken on our behalf by the Behavioural Insights Team (BIT), the research considered the experience reported by 728 patients who agreed to participate in a survey, with a small number of in-depth telephone interviews to provide additional insights. In the main, the experience of these patients will have pre-dated the introduction of the statutory duty of candour and unsurprisingly the research found that the response following an incident and the handling of any complaint made at the time featured highly in decisions to make a claim for compensation. This validates NHS Resolution's advice, *Saying Sorry* in that transparency and candour with patients who have suffered avoidable harm are critical.

Detailed examination of the response to incidents which subsequently turned into claims for compensation found:

- Almost two thirds (63%) of respondents felt that no explanation for why an incident occurred was given to them. The majority of those that did receive an explanation waited ten days or more to receive it following the incident.
- Less than one third (31%) felt they received an apology. A minority of those that did receive an apology rated the apology highly.
- The majority (71%) of respondents did not think that their healthcare provider undertook any actions to investigate the incident in the first instance.
- Only 6% of respondents felt that actions were taken that would prevent the same incident happening again.
- Of those who did not make a complaint, the majority (72%) reported not knowing how to complain.
- The majority (69-75%) rated the response to their complaint as 'poor or very poor' in terms of accuracy, empathy, speed of the response and level of detail.

In approximately three quarters of cases considered, the incident took place before the introduction of the statutory duty of candour which set out specific requirements for an open and transparent response when things go wrong with care and treatment. We would therefore hope that levels of candour have significantly improved in the interim.

In partnership with the Parliamentary and Health Service Ombudsman, we have produced a document for NHS trusts in England to help outline our roles and how our services overlap and interact. This may help tackle some of the findings of this research by bringing greater clarity to the complaints process. Staff who manage NHS complaints and/or compensation claims should find this a helpful guide when deciding when to involve the Parliamentary and Health Service Ombudsman or NHS Resolution in complaints or compensation claims.

Alternative dispute resolution and mediation

NHS Resolution remains committed to embracing all forms of alternative dispute resolution, to include written offers, mediation, settlement meetings and telephone discussions, among many options. In 2018/19, we have worked collaboratively with claimant lawyers and other stakeholder groups on a number of initiatives to reduce the number of cases going into formal litigation, limit the escalation of legal costs and secure earlier resolution.

The research to determine the factors which lead patients to consider a claim for compensation demonstrated that in some cases it was a lack of candour and transparency that caused patients to take legal action. In such cases in particular, where it is not possible to stave off a claim by better handling in the first instance, we can improve the patient experience by utilising mediation and other forms of dispute resolution.

Mediation

NHS Resolution launched a claims mediation service in December 2016 in order to support patients, families and NHS staff in working together towards the resolution of incidents, complaints, legal claims and costs disputes and avoiding the need, expense, and potential emotional stress of going to court.

Contracts were awarded to the Centre for Effective Dispute Resolution (CEDR) and Trust Mediation Limited to mediate disputes arising from personal injury and clinical negligence incidents and claims.

Costs Alternative Dispute Resolution (CADR) was appointed to mediate disputes arising from the recoverability of legal costs.

2018/19 has seen the continued successful growth of the claims mediation service which has attracted considerable interest from claimants, claimant lawyers, NHS providers and other stakeholders.

The year in numbers:

- **400** cases formally instructed under NHS Resolution's claims mediation service
- **397** cases proceeded to mediation
- **3** cases settled before the mediation date
- **74%** of cases settled on the mediation day or within 28 days of the mediation date
- **110%** increase in the use of mediation up from **189** cases in 2017/18 to **397** cases in 2018/19
- **606** completed mediations undertaken since the inception of the service to 31 March 2019.

Mediation case studies

Case study one

The claimant underwent treatment for ulcerative colitis. It was alleged that there was a delay in the treatment provided by the NHS trust which caused the claimant to sustain avoidable pain and suffering, the worsening of her condition and the loss of her unborn baby. Partial admissions of liability had been made on behalf of the trust, but extent of the claimant's injuries and value of the claim was in issue.

The case was at the pre-action stage and the parties agreed to use mediation to resolve the issues in dispute. Settlement was achieved at the mediation which avoided the need to commence legal proceedings and the ongoing emotional distress this would have caused the claimant and her family. A financial settlement was agreed and in addition the representative from the NHS trust was able to speak to the claimant at length and provide an apology, reassurances of the lessons learned since the incident and explain the changes in process.

A separate meeting with the clinicians was also offered to the claimant, at the trust, to provide more information about the preventative processes in place to deal with similar cases expeditiously and to discuss more about the claimant's specific case should she wish. The claimant and her family confirmed at the conclusion of the mediation that they accepted this offer. A member of NHS Resolution's Safety and Learning team was in attendance at the mediation and was also able to advise the claimant that the learning from her case would be shared to drive patient safety and learning.

Case study two

The claim concerned the management of the claimant's labour and delivery of her child. It was alleged that the NHS trust was negligent in allowing the labour to become too prolonged which caused the claimant to suffer a perineal tear. It was also alleged that inadequate repair of the tear caused the claimant to sustain a post-partum haemorrhage and subsequent perineal wound breakdown.

This was a fully contested claim with both parties relying upon independent expert evidence. A mediation was arranged in advance of the trial date.

During the opening plenary session, the parties set out their respective positions on liability and the perceived weaknesses in the opposing party's case.

With the benefit of the mediator, the parties were able to keep up the momentum of an ongoing dialogue throughout the day. The claimant's suffering was recognised and detailed explanations provided why liability was not accepted and a financial offer could not be made.

A resolution was subsequently achieved on the day with the claimant discontinuing the claim without costs penalties.

Challenging excessive claims – fraud and exaggeration

We take fraud and exaggeration very seriously and in a landmark case, on 1 June 2018, Sandip Singh Atwal was sentenced to three months in jail for deliberately attempting to defraud the NHS and deceive the Court.

NHS Resolution on behalf of Calderdale & Huddersfield NHS Foundation Trust, successfully established that Mr Atwal was in contempt of court for grossly exaggerating the effect of minor injuries sustained and deliberately and fraudulently claiming compensation in excess of £800,000 in a clinical negligence claim against the NHS.

Covert video surveillance of Mr Atwal was commissioned in 2015 that exposed him working and lifting heavy items, using his phone and driving with ease. His social media posts also showed him working as a DJ, which included him featuring in a music video.

In his remarks, The Honourable Mr Justice Spencer said: *"In August 2011, when notified of your prospective claim, the trust immediately made a realistic offer of settlement, £30,000. That was, if anything, a generous offer. You did not accept it. Instead you pursued a dishonestly aggravated claim, and by November 2014 when your schedule of loss and damage was served, the claim was pleaded at over £837,000. It included a claim for £255,000 for future loss of earnings, and a claim for £421,000 for future care needs and equipment and the cost of employing someone for household tasks you could no longer do yourself. Those claims were based upon what you were falsely telling the medical and care experts was your continuing level of disability resulting from the negligent hospital treatment. The depths of your deception were revealed by covert video surveillance in October 2015, which proved that you were perfectly able to work, to drive, and to lift and to carry activities which you were still claiming not be able to manage… …My firm and clear conclusion is that a sentence of immediate custody is necessary to mark these serious contempts, and* ***to deter others****. I am satisfied that appropriate punishment can only be achieved by an immediate custodial sentence…"*

During the year, we pursued another case which concluded on 5 April 2019:

Lesley Elder v. George Eliot Hospital NHS Trust

Lesley Elder was sentenced and fined for contempt of court after fraudulently exaggerating injuries she sustained in an attempt to seek in excess of £2.5 million in compensation from the NHS.

NHS Resolution on behalf of George Eliot Hospital NHS Trust, successfully established that Ms Elder lied about the extent of her injuries and disability following mesh surgeries.

Ms Elder underwent a transobturator tape insertion operation in December 2010 which allegedly left her in constant debilitating pain and with restricted mobility. The trust accepted that Ms Elder did not receive adequate pre-operative counselling regarding the likely success of the procedure or the risk of certain possible complications. Following the surgery, she underwent several procedures between September 2011 and January 2014 to remove parts of the tape and mesh but continued to experience pain and mobility problems.

It was admitted that with proper advice, Ms Elder would not have undergone the transobturator tape procedure and would have avoided the associated complications.

Ms Elder alleged that as a consequence of the admitted negligence she suffered severe unremitting pain which was exacerbated by movement that she walked with the aid of a walking stick, using crutches on occasions and a wheelchair for longer trips. She also claimed that she had not been able to go on holiday since the surgery, save for a trip to Egypt in October 2015, that she was unable to work from 2013 onwards and that she needed care and assistance during the day and night.

However, surveillance was obtained in 2016 in which she was observed walking without any mobility aids, including trips to the shops with her daughter and to the supermarket. Further evidence obtained showed her in Ibiza on a hen party in 2012 for one of her daughters.

Ms Elder had sought to recover in excess of £2.5 million, but was ultimately awarded £120,012 by the Court in 2016 following the submission of surveillance evidence. However, the judge concluded her claim was dishonest to the criminal standard and she was sentenced to five months in jail.

Fraud is a serious offence and these decisions send a very clear message that the NHS is not an easy target and that claimants cannot submit fraudulent claims with impunity.

Fraud against the NHS will be investigated by our staff and, significantly, dealt with robustly by the Court. Both these cases highlight the very serious consequences of submitting dishonest and exaggerated claims.

We work alongside the NHS Counter Fraud Authority in certain cases to ensure a joined-up approach to the identification and investigation of potentially fraudulent cases. However, we continue to ensure genuine claimants are properly compensated.

Challenging legal costs

In addition to protecting the NHS from unmeritorious claims, the legal costs associated with handling a claim are scrutinised by NHS Resolution and our costs panel (Acumension and Keoghs). For the claims managed by Acumension this fiscal year, judges reduced claimants' budgets by over £62 million (based on cases proceeding the whole way to trial). In addition to some specific legal cases which were pivotal and of wider significance to the NHS, Acumension and Keoghs have advised NHS Resolution in many individual cases, where costs budgets have been reduced by hundreds of thousands of pounds.

Figure 14: Average of claimant costs paid on claims where damages are between £1 and £100,000 by financial year from 2005/06 to 2018/19 for all clinical negligence schemes

There has been a decrease in clamant costs as a percentage of damages in claims paid, with a value of less than £100,000, which continues the trend from 2016/17 and 2017/18. This is likely to have been contributed to by the change in how claimants can fund the pursuit of claims and recover costs following reforms in 2013.

On 1 April 2013, the LASPO reforms created a new regime for the civil litigation costs system, intending to promote access to justice at a cost proportionate to the value and complexity of claims. However, there remains uncertainty as to how the 'proportionality test' should be applied and also regarding the costs budgeting rules (where the court sets budgets for the legal costs during the case). The rules state the court cannot depart from the budgeted costs unless there is 'good reason' to do so – and the judiciary have been working to come to a clear understanding as to what that means in practice. This does represent a challenge to NHS Resolution in trying to manage hundreds of millions of pounds of public spend in such an uncertain legal environment. A challenge which is met by NHS Resolution capturing data and market intelligence to better inform decision making on legal spend management matters at both a strategic and tactical level, while supporting proposals for fixed costs to be introduced in lower value clinical negligence claims.

In the case of *Barts Health NHS Trust v. Salmon* (County Court 17 January 2019), NHS Resolution brought a successful appeal in relation to what constitutes 'good reason' to depart from a costs budget. The court ruled that where the bill of costs claims less than the budgeted sum, then the paying party does not need to establish a 'further' good reason in order to reduce the costs to a greater extent. As the vast majority of claims settle before trial and before all budgeted tasks/ work is undertaken in various phases of the bill, the decision provides the opportunity to have many phases of the bill properly assessed by a costs judge at the end of the case.

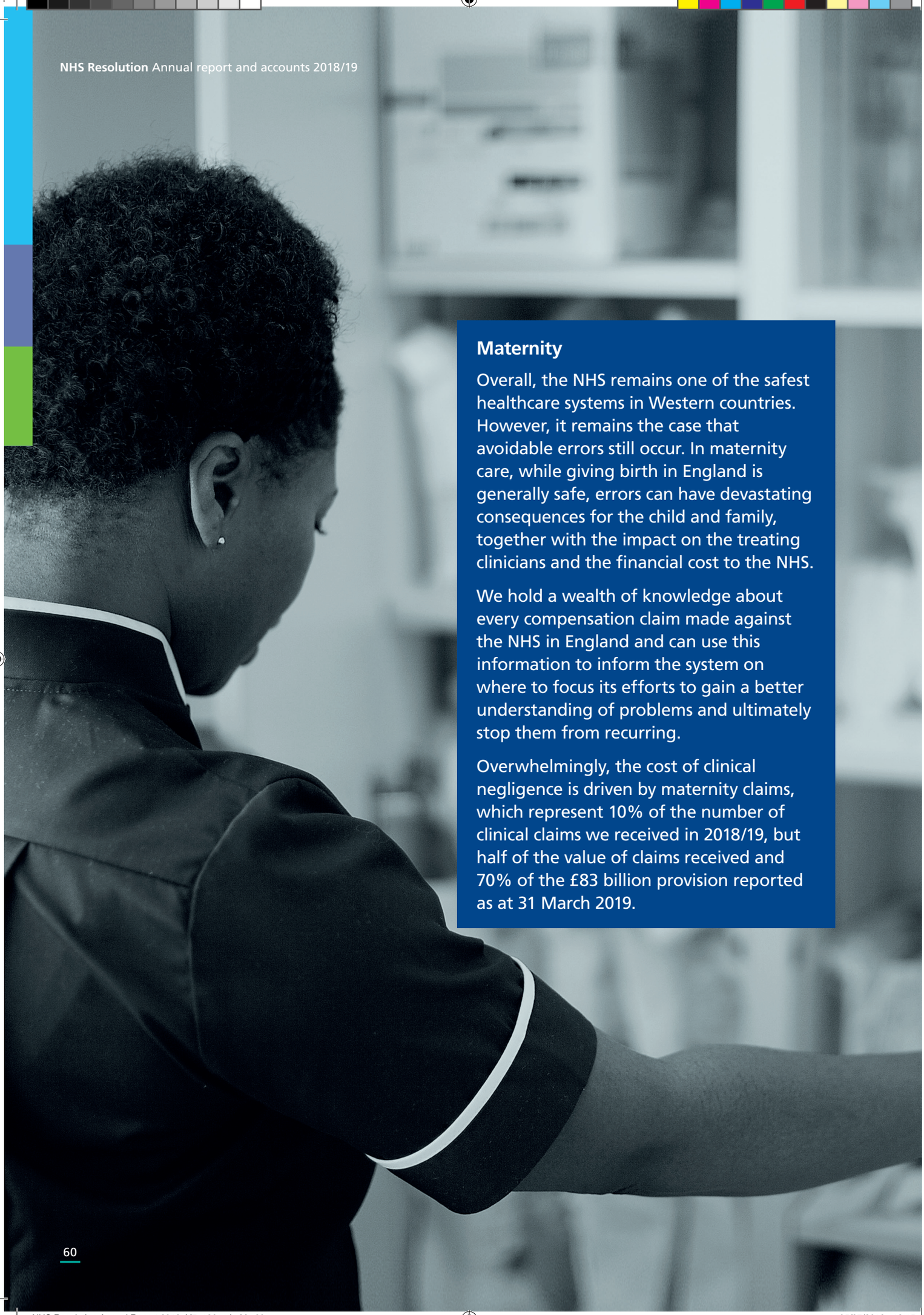
ATE insurance and change of funding claims

The case of *Peterborough & Stamford Hospitals NHS Trust v. McMenemy & Ors* (Court of Appeal November 2017) examined the recoverability of post-LASPO after the event (ATE) premiums. The court did not consider whether the quantum of premium was reasonable or proportionate. The case of *West and Demouilpied v. Stockport NHS Foundation Trust*, to be heard by the Court of Appeal in June 2019 is expected to be a seminal case in relation to the assessment of post-LASPO ATE insurance premiums.

NHS Resolution continues to make very substantial savings in 'change of funding claims' following the Court of Appeal's decision in *Surrey v. Barnet and Chase Farm Hospitals NHS Trust* and other appeals. These are instances when we question the rationale for moving from one form of funding to another – in particular where the claimant may see less benefit than the solicitors representing them. *XDE v. North Middlesex University Hospitals NHS Trust* (High Court 12 September 2018) is an example where the judge disallowed additional liabilities of around £1 million in a single case.

Solicitor struck off for overcharging the NHS

Andrew Good, joint owner of Hull law firm Rapid Response, was struck off on 2 April 2019 after a High Court judgment concluded that he showed a "serious lack of integrity" for overcharging the NHS. Lord Justice Flaux overturned a previous ruling that saw Good fined £30,000 for misconduct. We first reported our concerns to the Solicitors Regulation Authority in 2013, after which an investigation was launched.



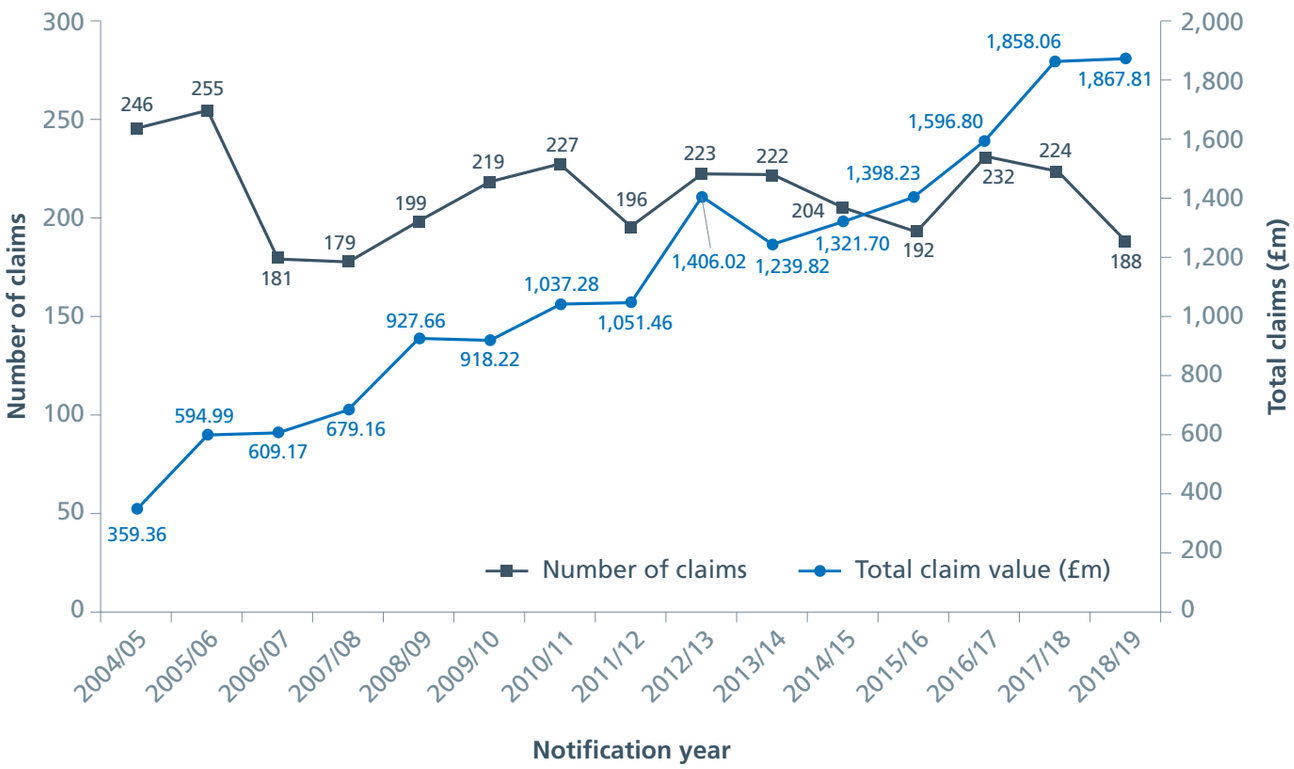
Maternity

Overall, the NHS remains one of the safest healthcare systems in Western countries. However, it remains the case that avoidable errors still occur. In maternity care, while giving birth in England is generally safe, errors can have devastating consequences for the child and family, together with the impact on the treating clinicians and the financial cost to the NHS.

We hold a wealth of knowledge about every compensation claim made against the NHS in England and can use this information to inform the system on where to focus its efforts to gain a better understanding of problems and ultimately stop them from recurring.

Overwhelmingly, the cost of clinical negligence is driven by maternity claims, which represent 10% of the number of clinical claims we received in 2018/19, but half of the value of claims received and 70% of the £83 billion provision reported as at 31 March 2019.

Figure 15: A comparison of the number and total value of claims for maternity cerebral palsy/brain damage claims over time across all clinical negligence schemes



The number of claims has remained relatively steady while the value has significantly increased, and hospitals now pay around £1,100 per birth in indemnity costs. And this is why we focus considerable effort and energy in seeking to reduce the occurrence of cerebral palsy, taking a three-pronged approach using:

- **research** – in-house clinical staff conducting a deep dive into the causes of maternity incidents and the adequacy of the investigations that follow;
- **early notification** – moving upstream to capture incidents, share learning in real time and apply what we know to support the hospital in their response. An early liability investigation and compensating for needs; and
- **incentives** – using the pricing lever to reward trusts who deliver against safety which have cross-system agreement.

Early Notification scheme

Early notification of obstetric brain injury has been a flagship of our strategy giving us the opportunity to capture those incidents, within 30 days of their occurrence, that meet criteria defined by the Royal College of Obstetricians and Gynaecologists. This gives us the opportunity to disrupt what has become over the years quite a formulaic and lengthy path from the incident to a settlement. It is relatively uncharted territory, but for the first time we are making admissions and payments to families within months, rather than several years, of the birth and providing support for those involved at the time of the incident.

In response to the feedback we received from NHS staff reporting into the Early Notification scheme, we delivered three *Finding the words: compassionate conversations with parents* national training events for maternity teams to help look at the challenge of delivering difficult news to families and effectively delivering duty of candour.

Maternity incentive scheme

Our maternity incentive scheme uses the pricing lever of the CNST scheme to reward hospitals that deliver against safety actions which have cross-system support. The ten actions (and the refinements for year two) have been agreed with the national maternity safety champions in partnership with our Collaborative Advisory Group. The group[6] was established by NHS Resolution to bring together other arm's length bodies, royal colleges and others to support the delivery of the CNST maternity incentive scheme and has also advised us on the refined safety actions. We have identified ten actions which we collectively think are fundamental to the national ambition to reduce the rate of maternal and neonatal deaths, stillbirths and brain injuries by 20% by 2020. In the first year, for which we have published the results, hospitals self-certified against the ten actions. There was no new funding for this. We collected an additional 10% on top of the maternity component of the CNST contribution to create a £73.5 million fund and returned that 10% plus a share of the proceeds to those who were successful in all ten actions. Those who were unsuccessful had an opportunity to bid for a payment capped at 35% of their contribution to the fund to help them make progress against the actions they did not meet. 75 out of 132 members delivering maternity services achieved ten out of the ten required actions. In the second year of the scheme we further incentivise the ten maternity safety actions with some additional refinement.

[6] Members of the group include: DHSC, NHS Digital, NHS England, NHS Improvement, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Royal College of Anaesthetists, and the Care Quality Commission.

Mental health and preventing suicide-related claims

Each year we appoint a clinical fellow to undertake an in-depth study of either high-value or high-volume claims in a specific area. They identify themes, interpret findings and publish a national report. Recommendations are agreed collaboratively with other bodies. As previously referenced, our report in 2017 was *Five years of cerebral palsy claims* and in September 2018 we published *Learning from suicide-related claims: a thematic review of NHS Resolution data* following a review of inquests in the area of suicide.

The report, launched on 10 September 2018, to coincide with World Suicide Prevention Day, examined some of the factors that contribute to suicide claims and the quality of investigations following these tragic incidents. 101 deaths occurring between 2010 and 2017 were examined in detail. The NHS trusts involved in these cases were supported through NHS Resolution's inquest scheme[7]. In addition, 25 claims relating to non-fatal suicide attempts were also analysed for comparison.

To reduce the risk of suicide-related incidents and to improve the response of trusts, we made nine recommendations for NHS trusts and national bodies. The recommendations highlight potential learning for those delivering mental health services in England. We worked with external bodies to agree the recommendations and are grateful for their support and commitment to action them, such as the Royal College of Psychiatrists, NHS England, NHS Improvement, and Her Majesty's Prison and Probation Service.

Key areas explored included:

- the shared clinical characteristics of those ending their lives by suicide that result in a claim for compensation;
- how well families, carers and staff are supported following suicide; and
- the investigation process.

Psychiatry/mental health claims represented 320 (3%) of clinical claims by number in 2017/18, and accounted for just 2% of the total value of new claims reported. However, these cases are devastating for all involved: individuals, their families and carers and often the NHS staff that are involved in their care. The report launch was supported by ten events ranging from local and regional to national events delivered with our partners to share the key findings and recommendations from the report.

Raising significant concerns

As an arm's length body which encompasses specialist services to the NHS, we have a unique contribution to make to the patient safety system. With this in mind, we have looked to strengthen internal arrangements to raise and consider significant concerns about patient safety when information comes to us in our day-to-day work, across different areas of our business, which suggests prompt action is needed to support the healthcare system to prevent or to reduce the risk of further harm. The delivery of this important initiative will begin to be rolled out at the start of 2019/20 and we recognise will evolve as our experience increases.

[7] Since 1 April 2013, NHS Resolution has offered discretionary funding under its CNST, to provide legal representation for member trusts at inquests. If an application for funding is successful, the trust is then supported by one of ten legal 'panel' firms.

Working with our members, beneficiaries and the wider NHS to learn and improve safety

Safety and learning is integral to all our work and across all our services, raising awareness and driving analysis of member claims and promoting learning from these. Our Safety and Learning team have a regional focus and are responsive to wider issues in patient and staff safety in a number of ways. Their work includes: individual engagement visits to trusts where claims scorecards are discussed and learning from claims is encouraged, supported by local and regional events which share learning across trusts and organisations. These events bring clinicians together to share best practice and to receive feedback from organisations on our products and initiatives.

As part of our external engagement activities we delivered a range of events in 2018/19. These included three national events which shared learning from claims to help our members improve patient safety and reduce claims against the NHS.

The events focused on mental health, consent and assaults on ambulance staff and involved over 460 delegates from our member organisations. With regard to our Primary Care Appeals service, we delivered a one-day workshop for those working at NHS England involved in applications to the pharmaceutical list. Delegates learned about the regulatory tests and our Appeals service's experience of handling matters. We also exhibited at ten external conferences to promote our work and provided expert speakers for a growing number of events. These were both within the health environment as well as on medico-legal matters.

We have already touched on the use of publications and national events to raise awareness of the causes of claims and to drive improvements. Our teams are also involved in external initiatives and collaborate with other NHS and patient-focused bodies at regional and national levels to promote the patient and family voice to ensure key messages around saying sorry and the importance of learning are heard.

Faculty of Learning and resources to learn from claims

Our organisation-wide Faculty of Learning brings together a range of education and learning products and access to events under a single umbrella. The project has involved developing the distinct learning resource to support the health service to learn from harm, adding value to the services we provide to our CNST membership and more widely.

The Faculty works in partnership with other arm's length bodies, the royal colleges, other stakeholders and charities to promote best practice and support joint working and collaboration, to avoid duplication of effort within the system.

Scorecards

Claims scorecards were released to members and independent sector provider members in July 2017. This year we have seen an increase in the use of scorecards as a quality improvement tool, triangulating data on claims with incidents and complaints. We have continued to hold sessions with members to explain how best to interrogate the data in the scorecards and how to support patients and staff involved in incidents. We have been pleased to see an increase this year in the engagement of clinicians and would welcome this information playing a greater role in board-level governance.

Videos

Videos are available to members on request which feature staff that have been involved in cases of litigation and provide opportunities for sharing learning from claims. We are currently developing a training tool for staff who may be required to attend inquests in video format. At patient safety events, we have used *Christine's story*, our video highlighting the journey of a woman where there were issues with communication related to the consent process for a surgical procedure. She was not aware of the potential outcome and when she complained the apology from the trust was so inadequate it resulted in her becoming a claimant.

Did you know? leaflets

We continue to highlight the value and volume of certain claims or groups of claims for clinicians via our *Did you know?* leaflets. This year, in addition to raising the profile of these topics and preparing an imminent leaflet about assault, we have published specific material around the *Benefits of supported decision making* (consent), *Neonatal jaundice* and a refreshed version of our *Maternity pressure ulcers* Did you know? leaflet.

Practitioner Performance Advice

Advice

Practitioner Performance Advice has, through the link adviser model, continued to strengthen the case advice service we provide to healthcare employers on the effective local management and resolution of performance concerns about individual doctors, dentists and pharmacists. Demand for our advice service has remained extremely high and was consistent with previous years: over the course of the year, we received 925 new requests for advice on a range of issues affecting individuals' performance, including on matters of clinical capability, performance, workplace behaviour and conduct. As a snapshot, we are in contact with four fifths of all secondary care trusts in England.

Secondary care NHS trusts have continued to be the most frequent users of our services, accounting for 82% of all new requests for advice, with 18% of requests from primary care health organisations. We are, in addition, taking steps to strengthen our profile in this sector through proactively increasing our stakeholder engagement and educational reach in primary care, as well as closer partnership working with NHS England. As in previous years, doctors accounted for the majority of new cases (88%), with 55% of those cases being in relation to clinicians at consultant grade or GP principal level.

In addition to the core services we provide to NHS organisations in England, the reach of our Practitioner Performance Advice service has continued to include healthcare organisations based in other regions, including Wales, Northern Ireland, Jersey, Guernsey and the Isle of Man, where we have provided the full scope of our specialist advice, intervention and education services.

Case study – advice on the management and resolution of performance concerns

A long-serving consultant, who in the past had been viewed by his colleagues and employing trust as a capable clinical leader, but whose more recent conduct had been a cause for concern, was the subject of further concerns about his allegedly deteriorating behaviour towards his clinical and nursing colleagues. These concerns were then escalated to his trust's medical director (MD) for action. The MD in turn contacted NHS Resolution's Practitioner Performance Advice service to discuss the trust's options in its future management of the case, viewing these as being serious and repetitious.

We provided advice in accordance with the trust's local disciplinary policies and procedures, and with reference to further guidance in the framework *Maintaining High Professional Standards in the Modern NHS*. Following our advice, the trust instigated a formal case investigation into the further concerns raised regarding the practitioner's behaviour, which upheld the validity of those regarding the alleged misconduct. During the process, the practitioner accepted responsibility for his behaviour, but also expressed frustration with his work environment and with the demands of his clinical leadership role.

In order to support the case to a resolution, we recommended that the practitioner undergo an independent behavioural assessment carried out by Practitioner Performance Advice, as an appropriate and supportive developmental mechanism to effect sustained improvement in workplace behaviour.

The doctor agreed to proceed with the assessment, and following the process he reported that he found it to be rigorous, but fair and thorough, and that it had provided him with an important opportunity, in a professional and friendly environment, to speak in detail about his situation. The assessment process subsequently enabled the trust and the practitioner to make informed decisions about changes to his day-to-day working arrangements. He stood down from his clinical leadership role, and with the trust's support he took on more programmed activities to increase his direct clinical activity and expand his participation in the trust's medical education programmes.

Several months on from the behavioural assessment, the trust MD confirmed that he received what he described as "extremely positive" feedback from the practitioner's colleagues about his performance, and about the way he is now engaging with his colleagues. The practitioner has also offered to act as a mentor/adviser to any medical practitioner colleagues who may find themselves in a similar situation to that which he found himself in.

Stakeholder engagement

We have continued to successfully oversee and administer the Healthcare Professional Alert Notice system, which provides a means by which NHS bodies and others can be informed of healthcare professionals whose performance or conduct gives rise to concern.

We have also increased our engagement with key groups and stakeholders including medical royal colleges and the General Medical Council to share learning and best practice, with the ultimate aim of moving upstream to support the early identification, fair and effective management, and satisfactory resolution of concerns in the interests of patient safety and public protection.

Of particular significance has been our renewed focus on engagement through Responsible Officer networks, which has afforded a critical platform to maintain our organisational profile and to understand the particular challenges in the wider healthcare system relating to performance management and the differing regional needs of our users. In conjunction with our Safety and Learning service, we have taken the opportunity afforded by Responsible Officer Network meetings to raise the profile of the scorecards providing organisations with information on their claims history and our work with other organisations to promote a just culture.

Assessment

We embarked on a major programme of development work to build a more responsive and streamlined range of assessments to ensure these continue to be robust and meet the needs of our users. The review of our assessment framework was informed by a detailed evaluation of our methods and processes, as well as feedback from our users on how we can ensure that we provide the most suitable intervention at the right time to support the resolution of a case.

This has led to a number of changes to our model which were being introduced in the final quarter of 2018/19 and will continue to be progressed as we move into 2019/20.

The outcome of our review is that we are able to offer the following:

- Clinical performance assessment – to provide an independent view on the clinical performance of the practitioner, identifying both satisfactory practice and any areas of poor practice.
- Behavioural assessment (either as a standalone component or alongside a clinical component) – to provide an independent view on the behavioural characteristics of the practitioner, including any areas which require consideration.

Moving to a more flexible model, the assessment we offer will be determined by and tailored according to the circumstances of each case. We will also cease to duplicate procedures that are now routinely carried out locally. In all cases, our assessment services are intended to provide key information to assist the employer in deciding on the next steps in their management of the case, with patient safety and public protection being our paramount concerns.

Ongoing improvement is at the heart of what we do, and we will evaluate the impact of the changes over 2019/20, which will include drawing on the views of our users in order to ensure that the services we offer continue to be fit for purpose and meet the evolving needs of healthcare organisations in managing and resolving complex concerns about the performance of individual practitioners.

Professional support and remediation

We have continued to successfully meet demand for our professional support and remediation service, aimed at enabling employers and practitioners to engage in a structured framework to support the effective return of

individual clinicians to safe and valued clinical practice. With demand for this service consistent with the previous year, this intervention has been of particular value where we have undertaken an assessment or where the employer has taken action to clarify the precise nature of concerns to be addressed, or has sought our assistance to help a practitioner to return to work after a period of absence.

Assisted mediation

Following the successful launch of our workplace-based assisted mediation in April 2018, we have seen a steady increase in the number of referrals for this service.

Our highly tailored and specialist approach has successfully supported parties to better understand the nature of the conflict in which they are engaged, as well as to work with them towards achieving a resolution that restores effective team-working in the interests of clinical care.

We will continue to monitor closely the impact of our interventions in circumstances where behaviours have the potential to impact on the safe and effective delivery of clinical services, and to that end are exploring opportunities to extend the reach of our interventions to include team reviews for clinical teams in secondary care.

Case study – workplace-based assisted mediation[8]

Two consultants in general medicine had been working together for a number of years, one of whom had been a trainee of her colleague and she had found him to be supportive and helpful to the progression of her career. Difficulties began when the former trainee progressed to a consultant and subsequently the clinical lead for the department, a role the other consultant had occupied for a good number of years. This led to a deterioration in relationship between the two practitioners, particularly where the new clinical lead had attempted to introduce changes to working practices within the department, leaving her feeling undermined, bullied and harassed.

The situation created tensions in the wider team and this was expressed in acrimonious departmental meetings, complaints and upset between other members of the multi-disciplinary team. The trust requested an assisted mediation and both parties agreed to this. Allowing a safe space to have a candid discussion of the issues enabled both practitioners to clarify previous misunderstandings about each other's intentions and to demonstrate that they were both keen to improve current working relations and to work collegiately.

The outcome of the mediation was that both parties agreed to draw a line under previous difficulties and to draw from the aspects of their relationship which had originally worked well, using this as a platform to move forward more constructively and to ensure they presented a united front to the team. They agreed to achieve this by reflecting on communication styles and arranging regular meetings as an effective means of managing and resolving previous tensions.

[8] Based on composite cases to preserve confidentiality.

Education

The demand for our education services has remained extremely high: across the UK, we delivered 55 skills-based workshops to over 1,100 frontline clinicians and healthcare managers on a range of key areas such as case investigation and management, as well as resolving performance concerns. At the core of what we do is sharing our expertise and experience with healthcare professionals and managers in order to increase their capacity and capability to understand, manage and resolve performance concerns locally and as early as possible.

We saw a 17% increase in education activity in 2018/19 compared with the previous year and all participants providing feedback rated the impact as four out of five or higher. We also successfully updated our educational materials to reflect changes within the NHS and professional regulation, as well as current best practice and key developments in case law.

In response to the need clearly expressed by those who access our educational services, we have also commenced a pilot programme on action learning sets to further support and embed learning and the sharing of best practice at a local level – we will continue this work into 2019/20 and evaluate the impact before considering potential further roll out.

Healthcare professional alert notices

NHS Resolution's Practitioner Performance Advice service issues Healthcare Professional Alert Notices (HPANs). The HPAN system is a process used to inform NHS bodies and others of healthcare professionals whose performance or conduct gives rise to concern. HPANs are usually used while the relevant professional regulator is considering the concerns and provides an additional safeguard during the pre-employment checking process. HPANs are issued where it is considered that:

- patients or staff may be at risk of harm from inadequate or unsafe clinical practice or from inappropriate behaviour;
- there is a risk that an individual may pose a threat to patients or staff because their conduct compromises the effective functions of a team or local primary care service.

They can also be used to notify NHS bodies and others of a bogus healthcare practitioner. The number of active HPANs at the end of March 2019 was 12, this is around half the number recorded in the previous four years when the number of HPANs were 26, 25, 27 and 25 for 2014/15, 2015/16, 2016/17 and 2017/18, respectively.

Primary Care Appeals

In April 2005, the Secretary of State for Health and Social Care delegated appellate and other functions to NHS Resolution and since then our Primary Care Appeals service (formerly the Family Health Services Appeal Unit) has been responsible for discharging these functions. Primary Care Appeals receives and determines appeals where NHS England and primary care contractors, or those wishing to provide primary care services, cannot reach agreement at local level.

Pharmaceutical appeals

The number of pharmacy appeals we received in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Pharmacy Regulations) and associated Directions was about the same as those we received in the previous year. We received the usual mix of case types, our largest number being those relating to applications from pharmacists to either join the Pharmaceutical List, or to change the terms of those listings. Overall, we received 171 appeals in accordance with the Pharmacy Regulations as opposed to 170 in the last financial year.

Of those pharmacy market entry and change of listing appeals that resulted in a substantive determination (i.e. not withdrawn or summarily dismissed) and which did not require an oral hearing or any additional input (e.g. additional comments needed to be sought from parties over and above usual process), 98% were issued within a target of 15 weeks and within an average of 12 weeks. For those which required an oral hearing, 50% were issued within a target of 25 weeks but within an average of 24 weeks. The reason for the reduction in targets hit was due to a number of factors outside our control including difficulties for NHS England in finding accommodation, and parties being unavailable for hearing dates.

Across all application types (including "hours" appeals), of those pharmacy appeals determined under the Pharmacy Regulations, 67% of NHS England's decisions were quashed and re-determined, which resulted in 40% of applications being granted. 21% of NHS England decisions were confirmed which resulted in no applications being granted. 12% of applications were remitted back.

While it is not appropriate to comment on individual cases, it is important for wider learning to reflect on the challenges we faced during the year with regard to the handling and determination of some appeals.

During the year, we were required to establish an approach to dealing with appeals where a new Pharmaceutical Needs Assessment (PNA) came into force prior to consideration of the application. The approach we took was to inform parties that Regulation 22 requires the decision maker to apply the relevant PNA and the Regulations envisage there being a revised PNA from 1 April. For Regulation 13, 15 and 17 applications, the PNA is central to the application and applying a revised PNA could significantly affect the outcome of the appeal. As a result, the fairest approach might be to remit the application(s) back to NHS England for re-determination which will include a requirement to consider Regulation 22 (if the only way to determine justly is to use an earlier PNA).

Parties were invited to make submissions on this point following which the Pharmacy Appeals Committee made its decision.

In another matter, we were required to consider appeals (from two separate applicants) regarding NHS England's decision to refuse their applications to open an NHS community pharmacy because it had determined that the granting of any application would cause significant detriment to the arrangements it has in place for the provision of pharmaceutical services in that area; having found detriment NHS England did not consider the matter of reasonable choice, protected characteristics and innovation under Regulation 18(2)(b) i.e. whether there would be any benefits that would flow from the granting of the application.

The Pharmacy Appeals Committee considered that reference to "arrangements in place for provision of pharmaceutical services" was very broad in scope. It is not limited to detriment to a particular person, class of person, patient, patient group or provider of pharmaceutical services whether this is a dispensing practice or community pharmacy.

The Committee concluded that any finding can only be achieved after a consideration of all the consequences of granting the application, both positive and negative, provided that these consequences were all linked to the broad concept of arrangements in place for the provision of pharmaceutical services. The Committee's view was that NHS England needed to weigh up any detriment against any benefits before it could reach a reasonable decision. The decision was therefore quashed and the applications were remitted back to NHS England.

During the year, in a number of cases, parties (objecting to the application) had sought to argue that the benefits the application would purportedly confer on patients had been foreseen by the authors of the PNA and, as such, the application(s) should fail.

The Regulations state that if:

(a) NHS England receives a routine application and is required to determine whether it is satisfied that granting the application, or granting it in respect of only some of the services specified in it, would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in the area of the relevant Health and Wellbeing Board (HWB); and

(b) the improvements or better access that would be secured were or was not included in the relevant pharmaceutical needs assessment in accordance with paragraph 4 of Schedule 1. Paragraph 4 of Schedule 1 requires the PNA to include: "a statement of the pharmaceutical services that the HWB had identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied

> (a) would if they were provided…secure improvements or better access, to pharmaceutical services…
>
> (b) would if in specified future circumstances they were provided…secure future improvements or better access to pharmaceutical services…"

In these cases, the Pharmacy Appeals Committee was not satisfied that the PNA had made such statements, and as such the applications could proceed to be considered under later provisions.

An example of considering multiple applications to open an NHS community pharmacy

Two applications were received for a pharmacy at the site of the new medical centre near to Braintree College. Both applicants argued that there was not a reasonable choice for patients to obtain pharmaceutical services, but they did not suggest that both applications should be granted.

In looking at both applications, the Pharmacy Appeals Committee's (the Committee) approach was to consider each application individually, then compare the two if, in principle, it was decided that an application be granted.

Regulation 18(2) was used as a basis for considering the two applications, assessing the relative merits of each application against the other. The Committee noted that neither party suggested that two pharmacies were required and commented that it may be irrational to grant both applications. Consideration was given to the judgment of Mr Justice Kerr, R (on the application of Rushport Advisory LLP) [2016] and the comments made on granting multiple applications to the same site. The Committee determined that approving more than one application could lead to over-provision of NHS pharmaceutical services at the expense of the public purse and therefore only one pharmacy was necessary to secure improvements or better access.

Having considered the accessibility of pharmaceutical services, the changing population and the reliance on a limited public transport system, the Committee confirmed that there wasn't reasonable choice in obtaining pharmaceutical services in the area and that granting an application would confer significant benefits for patients. While neither applicant was further forward with purchasing premises and both applicants offered similarly enhanced services, one applicant (reference 18826) proposed marginally longer opening hours and had an existing relationship with the surgery which had relocated to the new medical centre, therefore their application was preferred.

New directions

In August 2018, NHS Resolution received new directions to determine appeals from pharmacists who had been given notice of NHS England's intention to recover overpayments made under the Quality Payments Scheme. We are pleased that DHSC have delegated this work to us and have continued confidence in our experience and ability to ensure that appeals are fairly and effectively handled and determined.

Panel Members

During late summer and early autumn, we ran an exercise to recruit lay members (committee chairs and wing members) to our list of Panel Members. We reappointed six of our previous members and appointed ten new members. We held an induction event for our new members to explain our interpretation and application of the Pharmacy Regulations. Our Panel Members have experience in a variety of areas and in adjudicating in disputes in other jurisdictions; their biographies can be found on our website at https://resolution.nhs.uk/services/primary-care-appeals/pharmacy-appeal-committee/

We would like to take this opportunity to acknowledge the contributions of our outgoing Panel Members, some of whom have service dating back to the early 1990s. In November 2018, we held our annual Panel Member event which was invaluable

for providing a forum for discussion and case review. We take this opportunity to thank all our Panel Members for all their hard work over the year.

Pharmacy Appeals User Group

The Pharmacy Appeals User Group met twice during the year. The aim of this group is to consult service users and their representatives on current and proposed changes to practice and procedure. Feedback from external group members remains very positive. During the year, among many things, we continued to facilitate discussions with Primary Care Support England (which processes market entry applications for NHS England); discussed the outcomes of the 2018 customer survey and our proposed customer survey recommendations action plan; discussed oral hearing arrangements and procedure; and provided an update (as previously noted) on our Panel Member recruitment.

The Group's Terms of Reference and notes of minutes are available at https://resolution.nhs.uk/services/primary-care-appeals/pharmacy-appeals-user-group/

Dispute resolution

Disputes relating to GPs and their contracts were again the main source of applications for dispute resolution (45 determined during this financial year compared with 20 last year). Of the 45 determinations, 13 related to reimbursement of premises costs to GPs of which four required rental valuation. Other medical, dental and ophthalmic disputes raised the usual mix of issues such as remuneration, clawback of monies, payment of quality outcomes framework monies, and termination of contract.

Judicial reviews

During the year, we received two challenges to our decisions. The first was made to a decision made under the Pharmacy Regulations because, at the time we made our decision, we were not made aware that a new PNA had been published; we consented to the decision being set aside and re-determined. The second challenge was with regard to a number of decisions we made under special delegation from the Secretary of State for Health and Social Care regarding Alternative Primary Medical Services Contracts. The judicial review is restricted to whether or not the contractor is entitled to be awarded interest on the monies he is owed. We await the outcome of this application.

Performers lists notifications and pre-contract checks

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

Between 1 April 2018 and 31 March 2019, Primary Care Appeals received notification of 79 suspensions compared to 58 in 2017/18. The breakdown by profession is shown in Figure 16. There were 73 suspensions still in force as at 31 March 2019. There were also 2,709 other decisions under the aforementioned regulations. In addition, we concluded a significant piece of work with NHS England reconciling notifiable decisions taken under the aforementioned Regulations. This piece of work covered data for 2013/14 onwards and has helped ensure that the information we hold is accurate.

Figure 16: The number of suspensions notified to the Performers lists in 2018/19, by profession

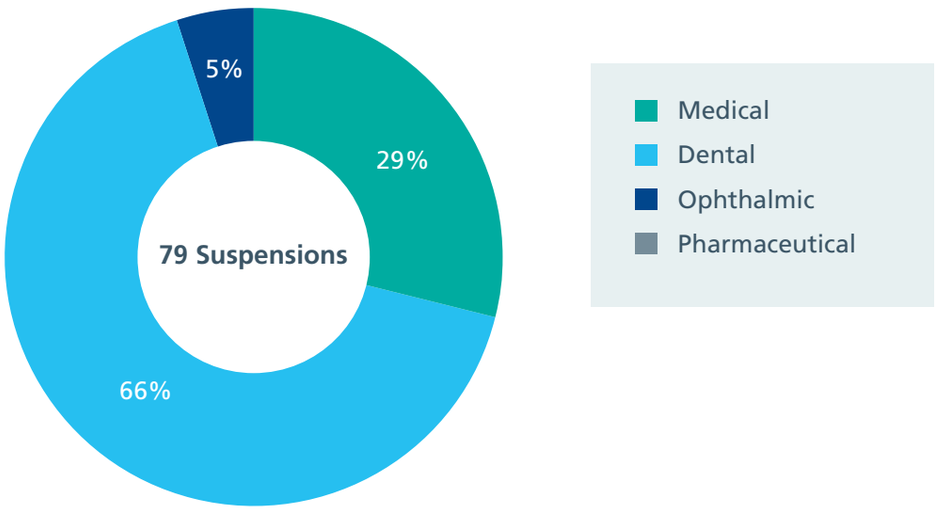
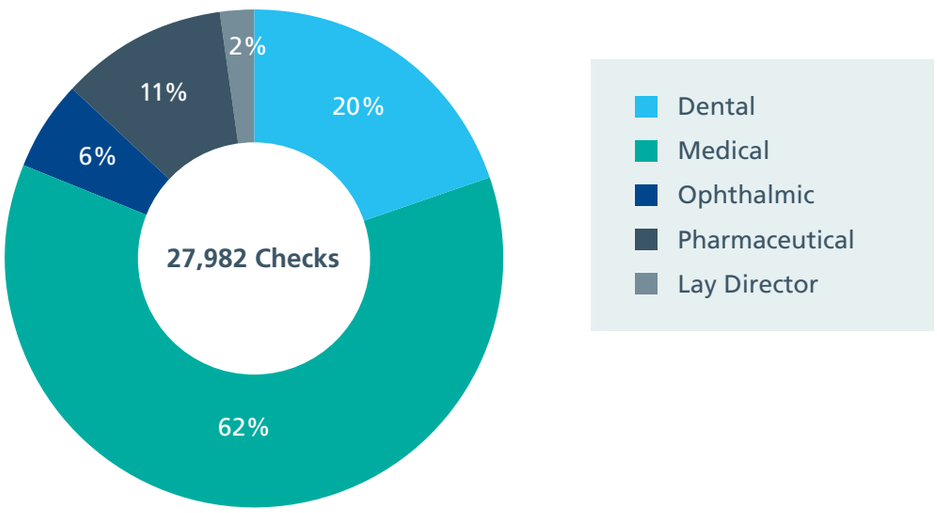


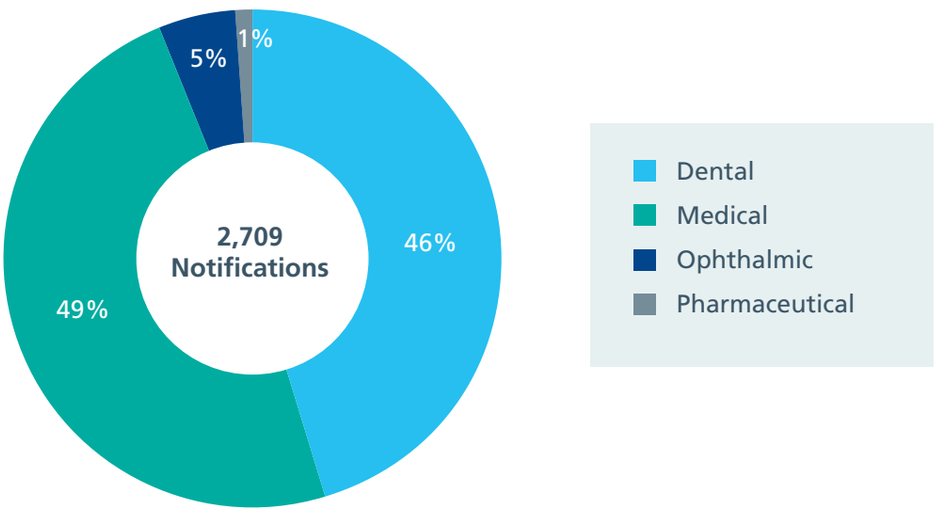
Figure 17: 2018/19 Performers list regulations: checks by profession



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

During the year, Primary Care Appeals received 27,982 requests for information compared to 26,684 in 2017/18 using our secure, online checking system, and which provided immediate clearance for 98% of checks. The remaining 2% were referred to us for further analysis before disclosure. The breakdown of checks by profession is shown in Figure 17.

Figure 18: 2018/19 Performers list regulations: notifications (other than suspensions) by profession



A fit-for-purpose organisation

Action on the 2017/18 customer survey

We received a response to our 2017/18 customer survey from 385 separate organisations. The responses contained rich comment and clear feedback on how our customers viewed doing business with us, particularly on where we could better meet their needs and wants.

Customers supported NHS Resolution's strategic direction, particularly our commitment to shared learning, making better use of intelligence and early interventions to reduce legal costs. Our customers perceived NHS Resolution as supportive, helpful, professional and approachable but wanted more proactive engagement, particularly around learning from claims. Overall satisfaction with NHS Resolution was 66%, compared to 55% in the previous year, representing a significant increase year-on-year. Most were satisfied with all service areas with low levels of expressed dissatisfaction. Importantly, 21% said they'd made changes to practices or procedures as a result of NHS Resolution services or products.

Some of the changes we made as a result of the survey responses were:

- launch of a new NHS Resolution website with improved functionality and content;
- streamlined our Practitioner Performance Advice clinical performance assessments;
- better explained to our members how our contributions are calculated;
- produced an interactive guide to using the scorecard on the website;
- rolled out team reviews to help improve relationships within clinical teams;
- delivered *Finding the words* training for maternity teams.

As a result of feedback about our Primary Care Appeals services we have:

- updated our online guidance for parties involved in pharmacy appeals;
- provided new guidance on pharmacy opening hours cases;
- delivered training to NHS England on the application of the Pharmacy Regulations;
- provided more clarity as to why in some cases we have not confirmed NHS England's decision; and
- amended the structure of our dispute determinations.

Also following the launch of NHS Resolution's new website, we made over 500 past decisions available and created a new search engine for decisions.

Our systems

In May 2018, we commenced a Core Systems Review project to understand how well our current legacy systems meet our current and future needs. The scope of the project includes case management, document management and transfer, customer relationship management, event management, business intelligence, corporate governance workflows and text analytics. As part of the discovery phase, we held 78 multi-disciplinary workshops with 109 internal staff and 72 external users including key contractors. These workshops identified opportunities for improvements in processes, data collection and stakeholder management. From these workshops and subsequent process mapping, we have pulled together the user requirements for any future system as well as performing a gap analysis on what we currently have.

Our Practitioner Performance Advice service successfully implemented a major upgrade to its case management system, supporting a number of important efficiencies in how we process and track our casework.

Data security

During 2018/19, we implemented a number of changes to further safeguard our information and enhance our controls. We:

- reviewed and revised the operational standards of our IT function to help us react more quickly to security alerts from NHS Digital and other security resources and subscribed to the Public DNS service. Additionally, we revised our standards around the application of software security patches and fixes; and
- reviewed our endpoint security and removed support for even authorised USB and other portable media.

General Data Protection Regulation

General Data Protection Regulation is now part of our 'business as usual' and is considered during ongoing development of information systems and projects, as well as in our development work going forward. With the increased obligations on data controllers and processors, our Primary Care Appeals service was required to adopt new ways of processing personal data, in particular where parties provide evidence containing the personal data of third parties (such as, but not limited to, petitions and questionnaires). We take this opportunity to remind such parties of their own obligation, when collecting such evidence, to inform third parties that their data might be submitted or is being submitted to us, and to direct them to our online privacy notice at: https://resolution.nhs.uk/privacy-cookies/primary-care-appeals/

ISO 27001

We successfully passed our second ISO 27001 surveillance audit and work is ongoing to further embed our information security management system into all areas of our business.

Cyber security

We achieved Cyber Essential Plus certification and revised a key endpoint security tool. We provide ongoing communications and advice to our staff to ensure that a high level of cyber security awareness is maintained. With a continued programme of penetration and vulnerability testing, the Board and Audit and Risk Committee are fully appraised of emerging threats and our ability to deal with them.

Sustainability

We are committed to improving environmental sustainability across all our activities and actively contribute to the government's commitment to reduce greenhouse gas emissions, waste disposal and water usage by 2021.

Our approach

NHS Resolution's main activities are run from two offices; Buckingham Palace Road, London and up until 15 April 2019 Trevelyan Square, Leeds, when we moved to Arena Point, Leeds. Both are leased as serviced offices with the landlord taking primary responsibility for providing gas, electricity, water and waste services. The service charges are built into the lease terms. This means our direct influence on energy, water and waste management is limited and therefore much of our work around sustainability is through our commitment to the wider government initiatives around smarter working and the hub strategy.

Despite increases in our business remit in 2018/19, we undertook a number of projects to further reduce the need for office space and cut running costs for energy, IT and the use of scarce resources. We actively promote smarter working and are redesigning our IT systems to better support this. We therefore closed our small Trevelyan Square, Leeds office and relocated our Primary Care Appeals service to a larger but temporary office nearby, (Arena Point, Leeds) to accommodate the increase in staff numbers. We will continue to recruit directly to Leeds and the office is forecasted to run at a desk ratio of almost five desks to ten staff by the end of 2019/20.

Our ongoing commitment to the wider government hub strategy means that we will maintain a short-term lease for these premises to enable us to further reduce costs by relocating to a hub in Leeds once space is available.

We operate hot desking for staff at the Buckingham Palace Road site. We currently operate at approximately ten staff members per seven desks. This ratio will move to ten staff per six desks as our London headcount slightly increases in 2019/20.

We have an ongoing initiative to work 'paperlite'. This reduces printing and the need for physical records, printer toner and their associated storage; we recycle unwanted IT equipment within the wider NHS where possible.

In 2018/19, our IT team migrated our IT systems to a data centre provider under a Crown Commercial Service framework thereby substantially reducing localised energy and IT infrastructure costs and our long-term IT plans include further cloud adoption to produce further efficiencies.

Biodiversity

The premises we currently occupy do not lend themselves to us directly impacting biodiversity. However, we run a variety of training opportunities for all staff on work and personal development topics. In 2018/19, we expanded the scope of this training to include sessions on educating staff to improve sustainability and biodiversity at home and seek suggestions for how we can do more to help the environment.

Climate change and rural proofing

We have considered the likely impact of climate change on our activities, including extreme weather, flooding and other extreme events. We have a robust disaster recovery plan in place to ensure we continue to be able to deliver a good service in the event of an emergency.

Greenhouse gas (GHG) emissions

The GHG protocol provides an international accounting framework for GHG emissions and divides these into three scopes. The scope types are:

- Scope 1 emissions cover sources controlled by us and include gas consumption, fuel oil usage and fugitive emissions.
- Scope 2 emissions cover electricity.
- Scope 3 covers all other emissions including delivery and distribution, purchase of materials and consumables, use of owned and leased assets, contracted out services and waste disposal. All categories are an optional reporting category except business travel.

Table 4: GHG emissions

GHG emissions: tonnes CO_2		2018/19	2017/18	2016/17
Gross emissions for scopes 1 and 2	As occupiers of serviced offices, we do not have any energy usage under scopes 1 and 2			
Gross emissions for scope 3	Electricity	52	107	151
	Gas	18	18	16
	Business travel	44	24	46

GHG emissions have been calculated using conversion tables published by DEFRA.

Table 5: Energy consumption

Scope 3 – Building energy consumption	2018/19		2017/18		2016/17	
	Quantity (MWh)	Cost (£)	Quantity (MWh)	Cost (£)	Quantity (MWh)	Cost (£)
Electricity	184	22,411	304	38,113	366	45,804
Natural gas	99	4,460	98	4,351	85	3,810

Energy consumption and cost is calculated as 10% of the whole building consumption at Buckingham Palace Road. This is based on the floor area occupied by NHS Resolution.

Table 6: Travel

Business travel	2018/19		2017/18		2016/17	
	Miles	Cost (£)	Miles	Cost (£)	Miles	Cost (£)
Scope 3 – mileage	42,966	23,624	46,203	25,874	24,537	13,740
Scope 3 – air	43,683	11,356	42,873	12,510	71,624	23,975
Scope 3 – rail	290,131	115,979	333,172	112,160	247,611	92,321

Table 7: Waste

Waste	2018/19		2017/18		2016/17	
	Quantity (tonnes)	Cost (£)	Quantity (tonnes)	Cost (£)	Quantity (tonnes)	Cost (£)
	14.6	1,805	12.7	1,563	14.5	1,790

Waste is calculated as 10% of the whole building consumption and cost at Buckingham Palace Road. This is based on the floor area occupied by NHS Resolution.

Table 8: Use of finite resources

Waste	2018/19		2017/18		2016/17	
	Quantity	Cost (£)	Quantity	Cost (£)	Quantity	Cost (£)
Water consumption	1,343 m^3	3,233	1,400 m^3	3,370	1,297 m^3	3,123
Administrative paper	2,500 reams A4 equivalent	5,570	2,655 reams A4 equivalent	6,662	2,338 reams A4 equivalent	5,867

Paper use is paper purchased for use in printers only. Paper usage for outsourced printing of collateral has not been included.

Finance report

Headlines:

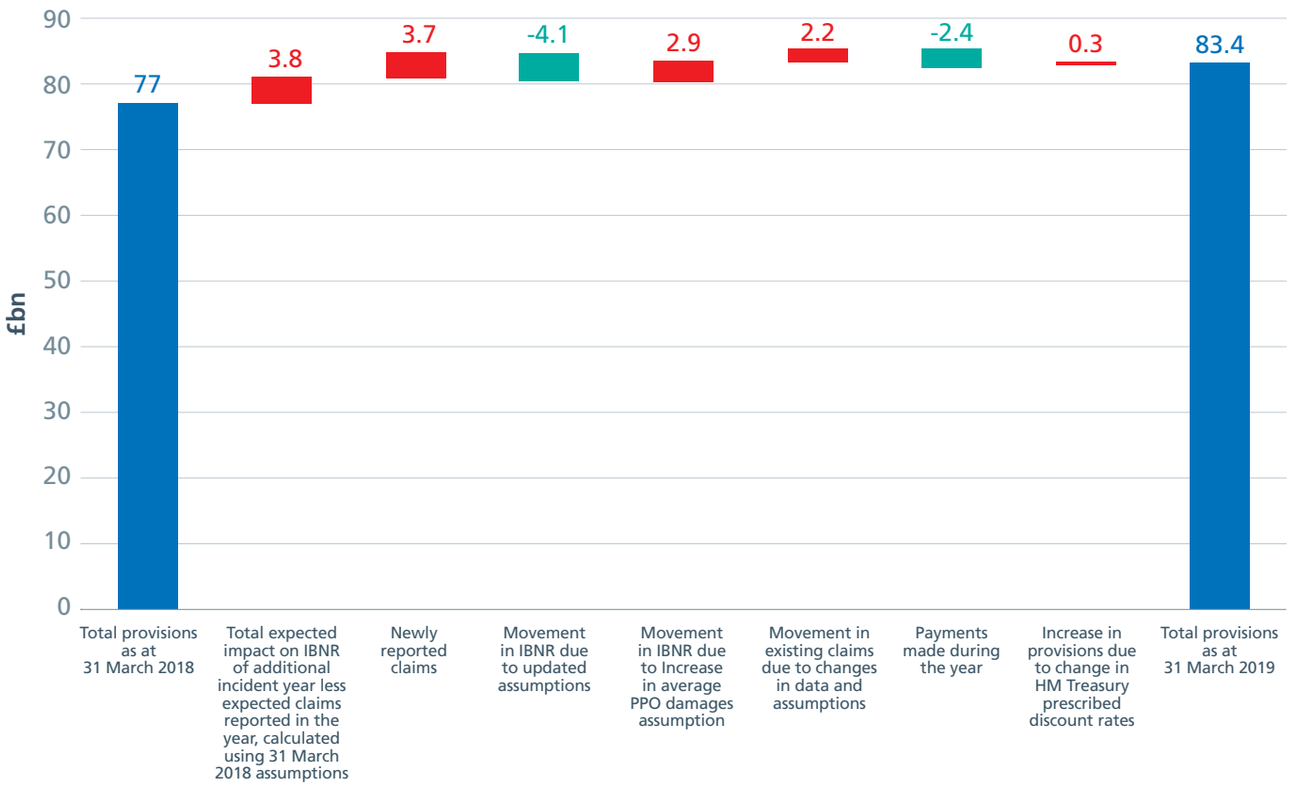
- Provision for the liabilities arising from claims: increase by £6.4 billion to £83.4 billion.
- The cost of settling claims increased by £137 million to £2.4 billion.
- Administration costs increased by £2.8 million (12%) to £25.8 million.
- Budget position: Department Expenditure Limit (DEL) £123 million under budget.
- Annually Managed Expenditure (AME) £4.2 billion under budget.

The overall financial picture this year shows that trends continue to be better than forecast in relation to the assumptions affecting the provision. However, we continue to experience increases in liabilities and the cost of settling claims. Two key aspects to the financial position are the year budgetary performance and the provision for costs arising from incidents which have already happened.

The key dimension of NHS Resolution's accounts is the provision for the liabilities arising from the indemnity schemes that we operate on behalf of the NHS and DHSC.

The provision for liabilities has increased from £77 billion at 31 March 2018 by £6.4 billion, to £83.4 billion at the end of this financial year. This is the value of liabilities arising from incidents that occurred before 31 March 2019 at current prices, both in relation to claims received, and our estimate of claims that we are likely to receive in the future from those incidents which have occurred but have yet to be reported as claims (incurred but not reported, IBNR). Figure 19 sets out a breakdown of the changes in the provision.

Figure 19: Change in NHS Resolution provisions for all schemes



The total value of claims incurred as a result of incidents that occurred in the 2018/19 financial year alone is estimated at around £9 billion – this represents the cost of harm incurred during the reporting year. It includes the estimated cost of claims that we haven't received as yet, as well as those that we have, the effect of inflation in relation to when we expect to settle those claims, and the effect of discounting to value expected future payments at today's prices.

Figure 19 above shows how the provision for liabilities has changed over the last year for all incident years, not just 2018/19, and this is discussed in more detail below.

Liabilities from another year's worth of activity (shown before key assumptions have been updated, the effects of which are shown separately in Figure 19) are growing by more than the amount we are settling them (£2.4 billion), even though our open book of claims remains fairly stable. This is primarily because we generally settle high value cases, where ongoing care is a feature, with a periodical payment order (PPO), which gives a regular payment to the claimant over the rest of their life.

Four years ago, (2014/15) the number of PPOs in payment was 1,634 with £138 million paid out that year, and a whole life value of £4.6 billion. At the end of this reporting year, the equivalent figures were 2,192, £248 million and £18.8 billion respectively. Many of those types of cases involve long life-expectancy, so the liability will continue to grow for some time, as each year we add another year's worth of activity to the existing claims book.

Figure 19 shows a reduction of £4.1 billion, due to changes in assumptions affecting the IBNR provision. The main drivers of the reduction in the IBNR, are;

- A reduction in the projected IBNR claims numbers for both PPO and non-PPO claims.
- A fall in average costs and inflation relative to expectations for claimant costs and lower than expected inflation increases for PPO damages.

These favourable trends have been partially offset by an increase in the estimated average cost of PPO damages which allows for a different mix of claims between maternity (which are higher in value) and non-maternity specialties, compared to the average for the claims book as a whole.

The liability has increased by £2.2 billion in respect of changes in assumptions affecting known claims. This is due to changes to the value of liabilities over the year:

- A net movement of £2.3 billion relating to claims that were open at 31 March 2018 and remain open at 31 March 2019. This is due to reserve values, estimated settlement year and probability of success of individual claims being revised as more information becomes available.
- An increase of £0.7 billion from the updating of standard reserves for cerebral palsy/brain damage cases.
- A decrease of £800 million in the liability where claims closed during the year, either at a lower value than expected, or where the claim was repudiated.

The HM Treasury discount rates have changed by very small amounts in 2018/19, and therefore had minimal impact (£0.3 billion increase) on the provision. A more detailed explanation of the HM Treasury discount rate changes is provided in Note 7.1 to the financial statements.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. Resulting small changes in assumptions can have significant impacts on the provision valuation from one year to the next. This is discussed in more detail at Note 7.2 on page 155 in the Notes to the accounts section of this report.

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 DHSC arm's length bodies), and financing from DHSC.

DHSC sets a budget in respect of this financing on a Departmental Expenditure Limit (DEL) basis. This is a HM Treasury budgetary control[9], which covers income and spending on general administration costs, e.g. salaries and goods and services, but also the settlement (utilisation) of the provisions in the financial year (see Note 7 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 in the HM Treasury budgetary controls framework. The public sector funding regime does not require NHS Resolution to have sufficient assets to cover the long-term liabilities as these will be financed through government borrowing and taxation at the time they become due for settlement. Therefore, NHS Resolution only collects the cash needed to settle claims in the financial year in question.

The Personal Injury Discount Rate (PIDR), which is used by the courts to place a current value on claims settlements where there is an element of future loss, has not changed from the minus 0.75% set in March 2017, and therefore has not been a factor in the change in the liability from last year. However, it has increased the amount of funds needed in order to settle claims in year.

During the year, NHS Resolution estimated that £369 million of additional funding was needed for all schemes to cover the costs arising from the PIDR change. This funding was provided through the Parliamentary Supply process from the reserves that the government had set aside in the 2017 Budget. Actual expenditure incurred was £388 million. The PIDR forecast was based on an assumed percentage uplift on damages expenditure. Actual PIDR expenditure was more than forecast due to the higher than expected level of damages expenditure, particularly for high-value claims.

DHSC has confirmed that funding for the effect of the change in PIDR will continue be provided centrally in 2019/20 and therefore member contributions have not increased to cover these costs. The Civil Liability Act 2018 introduced changes to the way the PIDR is to be set in future. A review will take place and the outcome will be known during 2019/20.

Expenditure on clinical schemes against income and budget set by DHSC is shown in Table 9.

[9] HM Treasury Consolidated Budgeting Guidance can be found at https://www.gov.uk/government/publications/consolidated-budgeting-guidance-2017-to-2018.

Table 9: Clinical schemes financial performance

	Income/ budget	Expenditure	Under/ (over)spend	Percentage under/ (over)spend
	£ million	£ million	£ million	%
Member funded – CNST	1,994	1,876	118	6%
PIDR funding – CNST	345	369	(24)	(7%)
DHSC funded schemes	130	112	18	14%
PIDR funding – DHSC schemes	21	16	5	24%
Total clinical schemes	**2,490**	**2,373**	**117**	**5%**

Contributions from members for our largest scheme, CNST, increased by 1.8% from 2017/18, while expenditure increased by 10% excluding the impact of the change in the PIDR rate in March 2017.

In recent years, the rate of growth in CNST expenditure has been lower than forecast as a result of more favourable trends than expected in key factors such as claims volumes and inflation.

When contributions were set for 2015/16, annual growth in costs was expected to be around 17%. However, as Table 10 shows, costs have grown at a slower rate, with claimant legal costs actually reducing year on year, since a high point in 2016/17.

Table 10: CNST payments by type

	Damages (excluding PIDR costs)	PPOs	Claimant legal costs	Defence legal costs	Admin expenses	Total	Increase	Increase
	£m	£m	£m	£m	£m	£m	£m	%
2015/16	757	105	400	116	9	1,387		
2016/17	850	124	480	122	10	1,586	199	14%
2017/18	967	152	454	126	12	1,711	125	8%
2018/19	1,108	185	433	137	13	1,876	165	10%
Increase between 2015/16 and 2018/19	351	80	33	21	4	489		35%
Average increase per annum	88	20	8	5	1	122		9%

As these favourable trends have become more established, we have been able to reduce the percentage increase in contributions to members, and in 2019/20, the total collect from CNST members will be reduced by 1.9% to £1,947 million. Nevertheless, Table 10 shows that costs have steadily grown, and we expect that contributions will rise in future if recent trends continue.

Damages costs have grown, largely due to the effect of inflation in damages settlements. As mentioned above in this report, PPO payments have increased, as we settle around an additional 100 to 200 claims per year on this basis. As these cases generally have a long life expectancy, PPO payments will continue to rise annually for some time to come, as will contributions from scheme members to fund them.

Claimant legal costs have reduced since the high point in 2016/17. This is as a result of the tailing off of claims funded using pre-LASPO conditional fee agreements (CFAs) which are more expensive on average than post-LASPO CFAs, which have increased over the same period and fewer cases going into formal litigation.

Defence costs have increased by £11 million (9%) due to a combination of factors. Complexity arising from changes in the legal environment, such as the PIDR change, the general increase in interest from indemnity scheme members in individual cases, investment in the investigation and negotiation of cases 'pre-action' in order to avoid expensive litigation and the increase in rates payable under the last contract framework tender in line with inflation have contributed to the increase in cost.

Table 11: Non-clinical schemes financial performance

	Income/ budget	Expenditure	Under/ (over)spend	Percentage under/ (over)spend
	£ million	£ million	£ million	%
Member funded – LTPS	48	49	(1)	(2%)
PIDR funding – LTPS	2	3	(1)	(50%)
Member funded schemes – PES	12	8	4	33%
DHSC funded scheme	9	5	4	44%
PIDR funding – DHSC scheme	1	1	0	0%
Total non-clinical schemes	**72**	**66**	**6**	**8%**

Non-clinical claims expenditure has been stabilising over recent years, which is considered to be a result of the introduction of limits on recoverable claimant legal costs and more efficient claims processing.

Table 12: LTPS payments by type

	Damages (excluding PIDR costs)	PPOs	Claimant legal costs	Defence legal costs	Admin expenses	Total	Increase	Increase
	£m	£m	£m	£m	£m	£m	£m	%
2015/16	18	0	20	7	3	47		
2016/17	19	0	18	6	3	47	0	-1%
2017/18	19	0	18	6	4	48	1	1%
2018/19	23	0	16	6	4	49	2	4%
Increase between 2015/16 and 2018/19	6	0	(4)	1	1	2		4%
Average increase per annum	1	0	(1)	0	0	0		1%

Table 12 shows how claimant legal costs, a significant proportion of LTPS costs have reduced, while damages have increased gradually, but with a 21% increase in 2018/19, while the number of claims settled where damages were agreed reduced from 1,885 in 2017/18 to 1,789 in 2018/19. The increase in damages costs in 2018/19 is primarily due to the settlement of a small number of high-value claims during the year, which did not occur during the previous year.

The PES scheme has experienced an underspend in 2018/19, however expenditure has increased by 23% this year. The nature of PES claims means that volumes and timings of cashflow can be difficult to predict. In recent years, claims volumes have been relatively stable. However, we have observed an increase in the average value of claims, driving the increase in scheme costs.

DHSC-funded schemes cover claims arising from organisations that are no longer in existence. Claims numbers reported, damages and legal costs have all reduced.

The exception to this trend is PPO costs which have increased as the larger value cases tend to be settled on this basis. Notwithstanding inflationary pressures, we would expect the costs arising under these schemes to reduce over time as existing claims are settled, and the likelihood of new claims diminishes.

Government also has a budget for Annually Managed Expenditure (AME). This is to cover expenditure on volatile or difficult-to-manage budget items, and is set on an annual basis.

NHS Resolution'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 in the year (see Note 7 in the accounts). Performance against budget is forecast in line with the Parliamentary timetable, but this is before the work on setting the key assumptions from observed experience has commenced.

Prudent estimates in relation to key potential variables are therefore used to inform the budget, in discussion with DHSC and HM Treasury.

As noted above, some favourable movements in key assumptions have had a positive impact on AME expenditure this year, contributing to a £4.2 billion underspend.

Table 13: Annually Managed Expenditure

	£m	£m
Budget		**10,600**
Expenditure:		
Cost of new claims provisions	8,540	
Change in discount rate	269	
Settlement of provisions	(2,422)	
Total expenditure		**6,387**
Under/(overspend)		**4,213**

Administration costs

This year we have invested in developing our systems to enhance security and efficiency and have had some growth in the claims management team to reduce caseloads and drive better outcomes on claims.

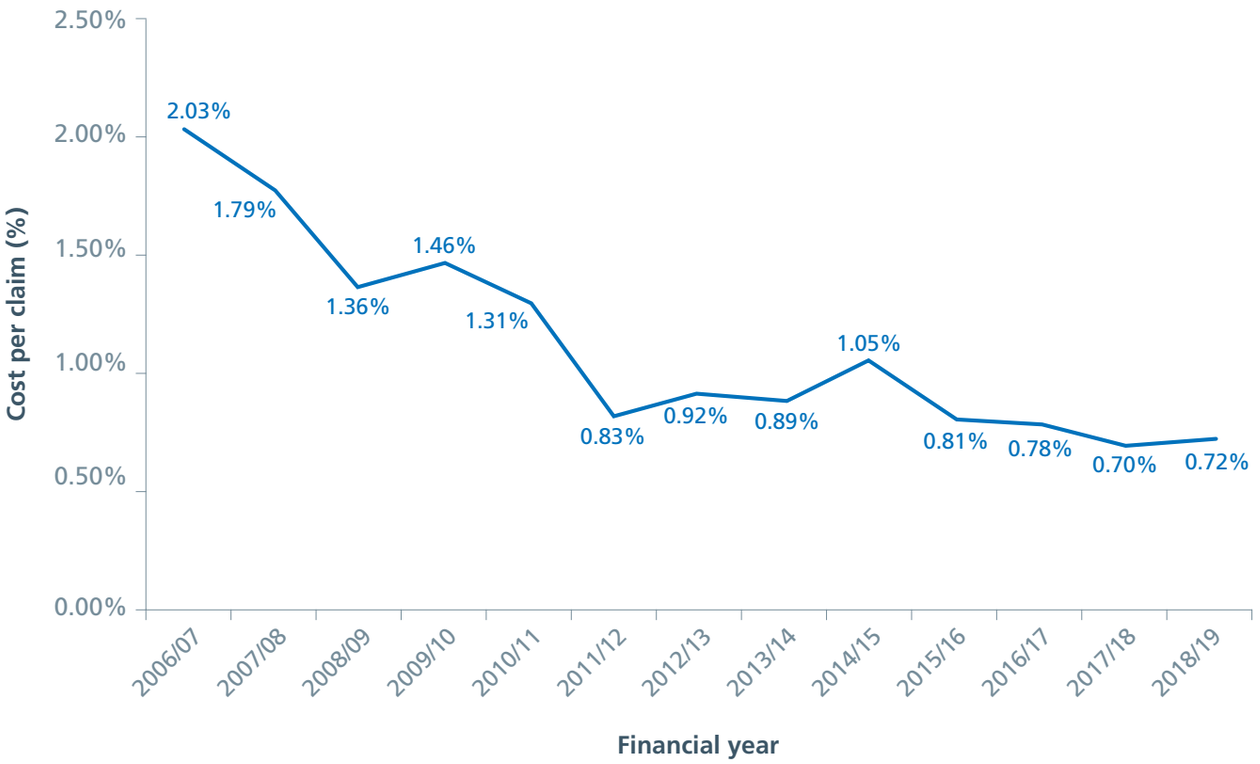
Administration costs for all of our activities (including the costs of administering member-funded schemes which have been allocated to the scheme DEL budgets above) have increased by £2.8 million (12%) to £25.8 million.

This primarily relates to staffing costs, as full-time equivalent staff numbers have increased by 28 (11%) to 293. However, both expenditure and staffing levels are below those outlined in our business plan mainly due to the ongoing challenges of filling vacancies during the year, and putting on hold the Claims Management service restructure due to the emergence of policy developments, particularly in relation to the preparations to implement a state-backed General Practice Indemnity scheme.

In addition, this year we have generated £1.1 million (£1.3 million in 2017/18) of income from commercial activity, primarily in respect of education activities and services to other national governments delivered by our Practitioner Performance Advice service. These activities made a loss of £62k (6%) during the year and efficiency and contract reviews are being undertaken to address this.

The average administration cost of resolving claims has increased in recent years as a result of our investment in staffing in order to meet our widened remit and objectives in tackling the broader drivers of claims costs.

Figure 20: Administration spend as a percentage of the value of total claims settlement



As a proportion of the value of total claims settlement, administration costs have increased, but very marginally by 0.2%, and this is still well below the figure for recent years.

As noted elsewhere in this report, we have continued to invest in our staff and our systems to deliver the ambitions as set out in our five-year strategy to proactively manage the costs of claims and help the health system learn from when things go wrong. The benefits and savings from investing in our strategy have been described in the report on performance earlier in this document.

Capital

The budget for capital purchases for the year was £989k. This was increased in year by a further £762k to open a new office in Leeds. The total spend for the year was £1,461k, an underspend of £290k due to the delay in gaining access to the Leeds office to complete the set-up of the infrastructure.

Cash

The cash balance at the start of the year was £388 million. This had arisen because of underspends in recent years on the schemes we operate, primarily on CNST, as described earlier in this report.

The balance has reduced to £182 million by the end of the year despite incurring a further underspend, primarily on CNST. We have been discussing with DHSC the options for utilising cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. In these circumstances, we have agreed with DHSC to utilise cash balances to fund PIDR costs in relation to each of the schemes up to the limit of cash available. DEL budgetary cover has been provided by DHSC as described above.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2018/19.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 3 July 2019

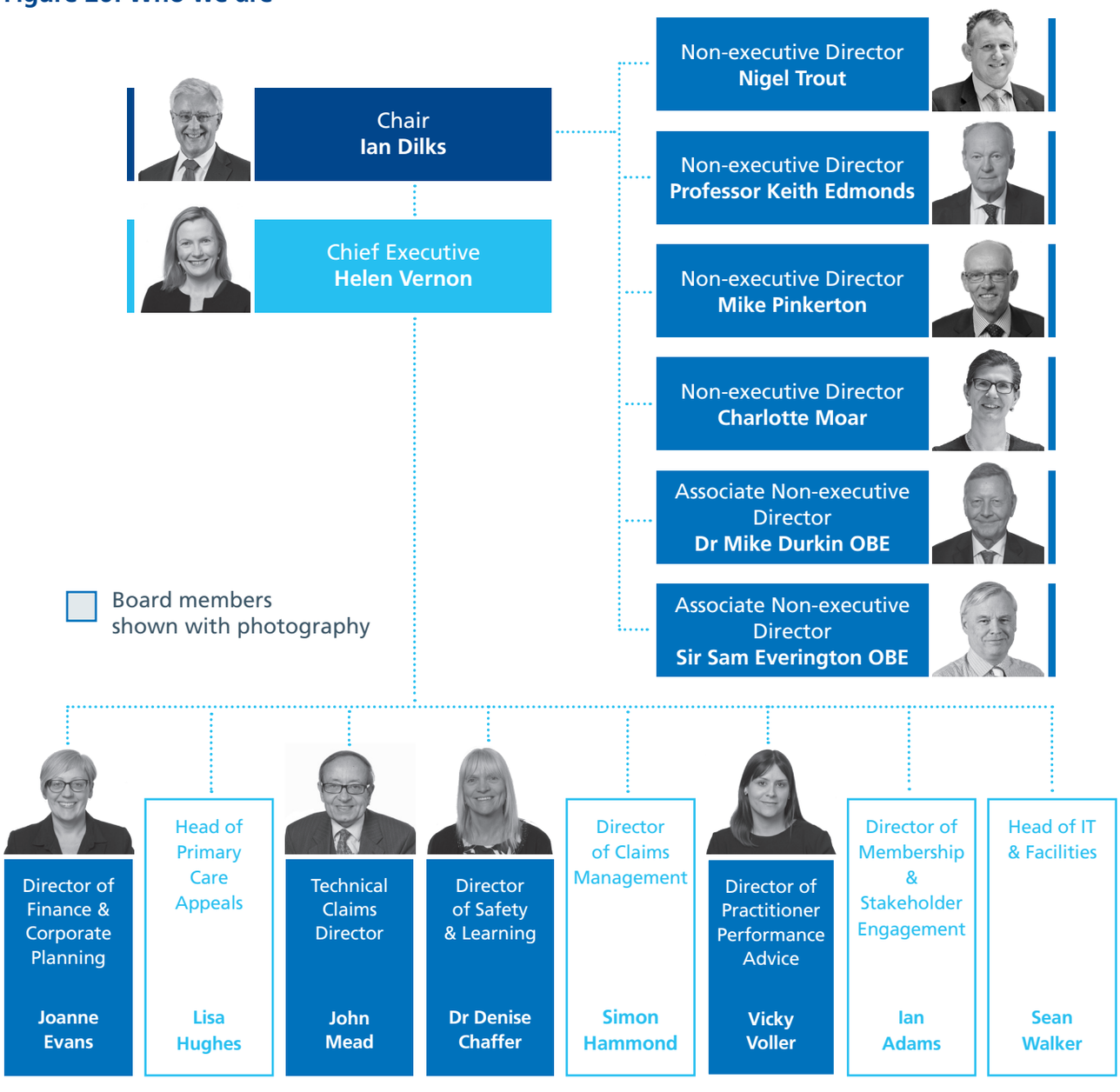
Accountability report

Corporate governance report

Directors' report

This report primarily provides information about the composition of the Board of NHS Resolution which had authority or responsibility for directing or controlling the major activities of the entity during the year.

Figure 26: Who we are



NHS Resolution publishes a register of interests of Board members on its website: https://resolution.nhs.uk/leadership/

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State for Health and Social Care has directed NHS Resolution 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 NHS Resolution and of its net expenditure, statement of financial position 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 for Health and Social Care, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the annual report and accounts as a whole is fair, balanced and understandable and take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

The Accounting Officer of DHSC has designated the Chief Executive as Accounting Officer of NHS Resolution. 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 NHS Resolution's assets, are set out in *Managing Public Money* published by the HM Treasury.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accounting Officer. As far as I am aware, there is no relevant audit information of which our auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that our auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable.

Governance statement

Scope of responsibility

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

I have responsibility for the delivery of our strategic aims and objectives within NHS Resolution's legislative and regulatory parameters, as directed by DHSC, and in conjunction with the Board through development of strategy and effective governance arrangements, I am responsible for:

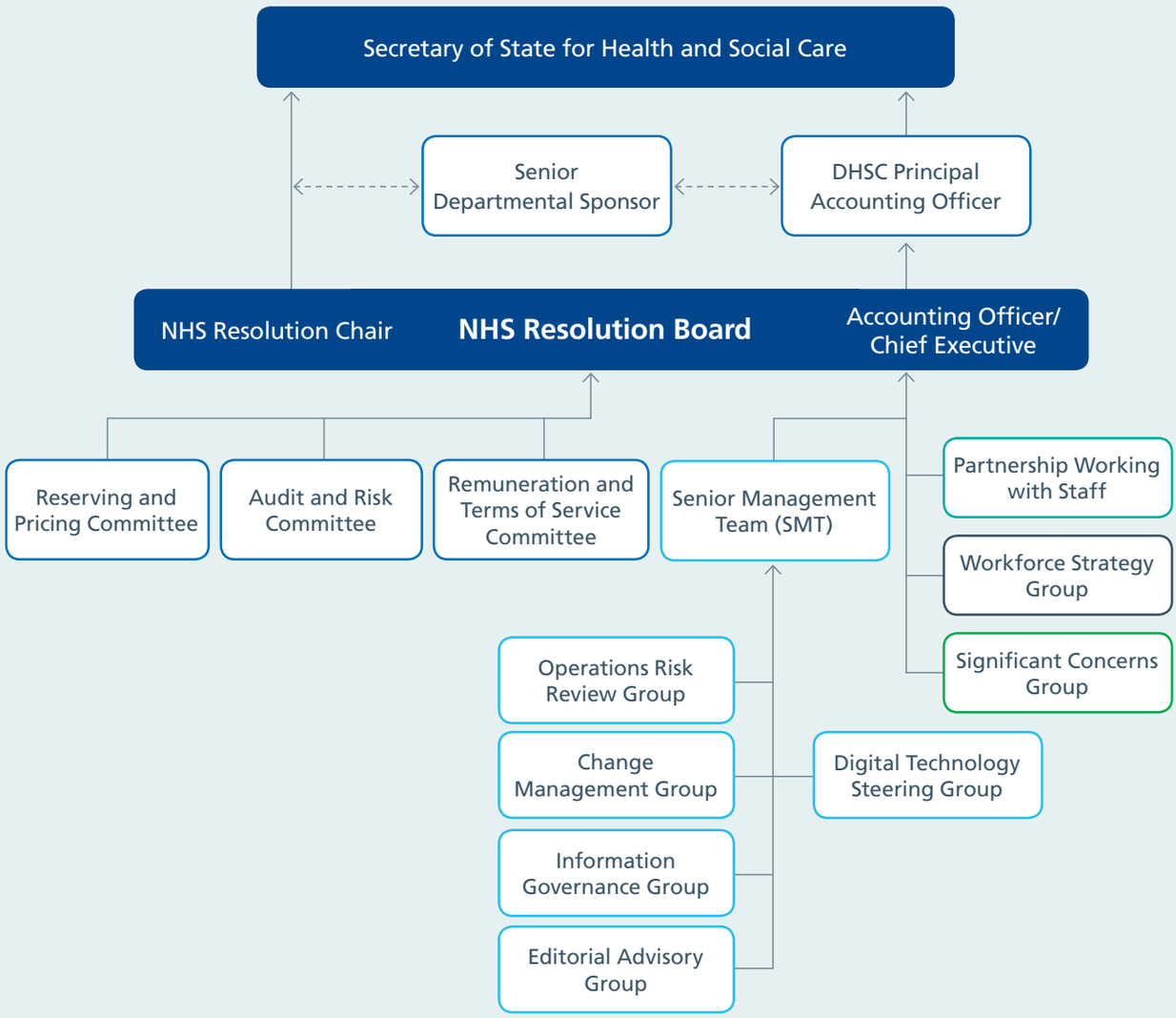
- compliance with and delivery against our framework agreement and business plan as agreed with DHSC;
- delivery against key performance indicators as agreed with DHSC;
- provision and effective oversight of internal control systems;
- oversight of the complaints process and ensuring that the learning from complaints is embedded into how we operate;
- risk management processes; and
- our operational and financial systems.

As Accounting Officer, I am supported by NHS Resolution's Senior Management Team (SMT), internal audit and Audit and Risk Committee (ARC) and make recommendations to the Board on the matters outlined in this statement as they relate to effective governance. I am supported by the Board and SMT in ensuring we commit to and embed the organisation's values in everything we do to help us deliver our aims.

I delegate day-to-day operational responsibility for our 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 NHS Resolution.

The governance framework and structures

Figure 22: NHS Resolution governance structure and subgroups reporting to the SMT[10]



Solid line = reporting and accountability

Dotted line = monitoring and/or the provision of advice and support

[10] For more information see **Table 17: Senior Management Team sub-groups**

NHS Resolution's Board

The NHS Resolution Board is led by a non-executive chair and in the year its complement comprised of four non-executives and four executive members with a balance of skills and experience appropriate to its responsibilities. The Board has the option of appointing between three and five non-executive directors and executive directors.

Board composition

As of 31 March 2019, the Board consisted of the non-executive chair, four non-executive members and four executive members.

There are also two associate non-executive and one associate executive Board directors. The Board provides leadership and strategic direction for the organisation and is collectively accountable, through the chair, to the Secretary of State for Health and Social Care 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.

I report on the organisation's performance to the Board and to DHSC on a regular basis. Variations from anticipated performance are, where appropriate, accompanied by reports from the ARC and/or SMT, to give me, the Board, and, where appropriate, DHSC, assurance on progress and the action being taken.
The Board regularly reviews these reports to ensure it remains satisfied regarding the quality of information, and also that it is relevant and sufficient to inform the business of the Board.

During the period from 1 April 2018 to 31 March 2019, the NHS Resolution Board met on six occasions and attendance details are as follows:

Table 14: NHS Resolution Board meeting attendance

Name	Post	Meetings attended
Ian Dilks	Chair	6/6
Keith Edmonds	Non-executive Director	6/6
Charlotte Moar	Non-executive Director	6/6
Mike Pinkerton	Non-executive Director	6/6
Nigel Trout	Non-executive Director	4/5 first meeting in July 2018
Helen Vernon	Chief Executive	6/6
Joanne Evans	Director of Finance and Corporate Planning	4/6
Denise Chaffer	Director of Safety and Learning	6/6
Vicky Voller	Director of Practitioner Performance Advice	5/5
Mike Durkin	Associate Non-executive Director	4/6
Sam Everington	Associate Non-executive Director	4/5 first meeting in July 2018
John Mead	Associate Board Member	6/6

Table 15: Frequency of some key matters discussed at Board meetings in 2018/19

Operational matters	Number of meetings discussed
Chief Executive's report	6
Performance review	6
Complaints report	6
Information governance report	1
Claims performance framework	2
Management proposals requiring board input or approval	
Primary Care Appeals service – scheme of delegation	1
Appeals Unit panel appointments	1
Patient safety update	1
Liaison with key stakeholders	
Membership and Stakeholder Engagement report	4
Customer survey	1
Key developments	
Updates on key claims case reports	5
Legal updates	2
Project oversight	
Customer survey update	2
Claims mediation service	2
Early Notification scheme	2
Maternity incentive scheme	5
Change Management reports	4
Practitioner Performance Advice reports	1
System and technology review	2
Guidance on significant concerns	1
Other matters requiring Board approval	
Internal policy approvals and updates	5
Responsible Officer's report	1
Scheme of delegation	1
Risk report	2
Risk appetite statement	2

Compliance with the corporate governance code

We have reviewed our governance arrangements in line with the Code of Good Practice required for central government departments ('The Code') and have complied with the requirements where relevant.

Board effectiveness

We commissioned an independent, external review of Board effectiveness by a specialist Board and leadership consultancy – in line with the Government's Code of Good Practice[11] and, where relevant, the Corporate Governance Code[12]. The review was based on confidential interviews held with all members of the Board and a number of others who have a role in the governance of NHS Resolution. The areas the review covered included: Board leadership, the Board's effectiveness as a team and Board ways of working. The review did not include an appraisal of the Chair or the Non-executive Directors nor of the Board Committees.

The review highlighted areas of particular Board strength including: clarity of organisational purpose; key stakeholder engagement; strategy development, adaptation and delivery oversight; Board composition and dynamics. The review also highlighted areas for further Board development including: leading the evolution of our culture to support our role as a 'system leader' in reducing claims costs by taking an holistic approach to drivers of cost such as patient safety; confirming that the Board's governance structure fully supports its work as a high-performing team to oversee delivery of the five-year strategy across the whole primary and secondary patient pathway.

The Board has committed to developing a plan based on the review which will help support continuous improvement in the Board's performance; the Board will review its progress against its plan towards the end of 2019/20.

Committees of the Board

The Board is supported by three committees which were established to enable the Board and me as Accounting Officer, to discharge our responsibilities and to ensure that effective financial stewardship and internal controls are in place. A review of the terms of reference for the three committees was carried out in 2018/19 to assure their fitness for purpose.

Audit and Risk Committee

The ARC supports me and the Board in our responsibilities on matters related to internal and external audit, corporate governance, anti-fraud policies, internal control and risk management, and the NHS Resolution's annual report and accounts. The ARC is chaired by a Non-executive Director, Charlotte Moar, and is supported in delivery of its function by internal and external auditors.

The ARC is attended regularly by a representative of DHSC. The Chair of DHSC ARC attended the ARC meeting of 10 June 2018.

To address a previous issue of the Committee having access to a sufficiently broad and deep range of skills, ARC has co-opted two independent lay members.

[11] Corporate Governance in Central Government Departments Code of Good Practice 2017

[12] Financial Reporting Council: The UK Corporate Governance Code and Guidance on Board Effectiveness 2018

Table 16: ARC meeting attendance

Name	Post	Meetings attended
Charlotte Moar	Non-executive Director and Chair of ARC	4/4
Keith Edmonds	Non-executive Director	4/4
Charles Bellringer	Independent Lay Member	3/3 first meeting in October 2018
Julia Wortley	Independent Lay Member	3/3 first meeting in October 2018

Some of the key areas the Committee continued to support and challenge the NHS Resolution Senior Management Team on were:

- Scrutinising risks which are outside the risk appetite statement and reviewing plans and timescales to redress this.
- Receiving updates on incidents and the overall position in relation to cyber security.
- Deep dives into particular areas of risk such as HR/workforce and cyber security.
- Receiving updates on progress towards achieving and sustaining ISO 27001 and other information governance requirements.

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 Executive and Senior Managers (ESM). All meetings were quorate.

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, Head of Reserving and Pricing and a Non-executive Director, currently our Chair.

The Committee is attended by our actuarial advisers from the Government Actuary's Department. At each RPC meeting members and attendees are asked to declare conflicts of interest, which are then documented in the approved minutes. For example, the Government Actuary has declared a conflict as the advisor to the Lord Chancellor on setting the PIDR.

The Committee meets regularly in order to:

- set the methodology and assumptions for calculating the value of the provisions for the statutory financial accounts;
- develop cash flow estimates to inform budgetary requirements and set contribution levels for indemnity scheme members; and
- ensure that the framework for assurance for models used for calculating business critical information is applied in line with the Macpherson recommendations[13].

The results of the work undertaken by RPC on calculating the key estimates for the accounts in respect of the provision are recommended to ARC and the Board for approval. The actuarial adviser has provided an opinion on the methodology and assumptions used to calculate a key estimate in the accounts, the 'incurred but not reported' provision.

[13] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/206946/review_of_qa_of_govt_analytical_models_final_report_040313.pdf

I, Colin Wilson, am Deputy Government Actuary and a Fellow of the Institute and Faculty of Actuaries. In my opinion, the IBNR provisions for NHS Resolution as at 31 March 2019 to be included in NHS Resolution's report and accounts have been calculated using an appropriate actuarial methodology and assumptions which are within a reasonable range, given the purpose of the calculation and taking into account discussions held with NHS Resolution's Reserving and Pricing Committee. The actuarial assumptions were selected on a best estimate basis, with explicit adjustment for risk and uncertainty included within the claims inflation assumption. There are no such margins included elsewhere in the assumptions. I have calculated the IBNR provisions to be £47,978 million for all schemes combined as at 31 March 2019 using the method and assumptions selected by NHS Resolution. This opinion statement should be considered in the context of my advice to the Reserving and Pricing Committee.

There are a number of uncertainties underlying the IBNR provisions. My advice to the Reserving and Pricing Committee and Note 7 to NHS Resolution's report and accounts describe this uncertainty and quantify the sensitivity of the IBNR provisions to key assumptions. This opinion does not negate the fact that the future cash flows will not develop exactly as projected and may, in fact, vary significantly from the projections.

Senior management team

The SMT includes directors and heads of the operating areas in the organisation. SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which SMT oversight or approval is required, including resource management and planning, governance arrangements, complaints and stakeholder management.

The SMT reviews particular areas of NHS Resolution's activity or areas of development and considers any changes in the external environment that may have an impact on NHS Resolution and its services.

During the year, SMT held a series of sessions to develop aspects of our five-year strategy in more detail with a view to producing a business plan for 2019/20 and to taking a longer-term view of our key change and operational deliverables.

I report on the work of the SMT to the Board, and hold members of the SMT to account for delivering against agreed objectives which are linked to delivery of NHS Resolution's strategy and business plan.

Table 17: SMT sub-groups

SMT Sub-group	Function
Change Management Group (CMG)	Oversight of financial investment decisions relating to business change
Information Governance Group (IG)	Provides assurance on the release of data, ensuring compliance with ISO 27001 standards and information governance requirements
Significant Concerns Group (SCG)	Supports the prompt and effective management of significant concerns identified by individual NHS Services functions where these give rise to a need for a coordinated organisational response
Operations Risk Review Group (ORG)	Provides assurance of cross functional review of incidents, risk and escalation
Workforce Strategy Group (WSG)	Oversight on recruitment decisions and workforce planning which are outside of delegated director controls
Digital Technology Steering Group (DTSG)	Provides assurance to CMG that IT-related projects/ tasks are reviewed to ensure alignment of purpose with strategy and to escalate any issues or risks to CMG
Editorial Advisory Group (EAG)	Provides assurance on published content that it is consistent, aligned with our strategy and compliant with information governance

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.

The key risks to our organisation are set out below with some of the key controls we have in place to manage those risks.

Capacity to handle risk

With the support of our risk management framework we regularly considered the risks and issues that could have an impact on the achievement of our business objectives. This included consideration of the controls we have in place to mitigate those risks and then, where required, develop plans to bring those risks within appetite. The risk register is reviewed by SMT, who review the framework put in place and the application of that framework in the consideration and treatment of risk.

Table 18: Strategic aims, their associated high-level risks and controls to mitigate them

Strategic aim	Identify – Risk identified as potential threat (or opportunity) to meeting NHS Resolution objectives	Assess and evaluate – risk assessment and evaluation A risk assessment is a qualitative or quantitative evaluation of the nature and magnitude of the risk. The assessment is completed by scoring the likelihood of the risk occurring and the impact should it occur
	Risk	**Assurance of the controls in place to mitigate the risk**
All strategic aims	Uncertainty in the policy environment	• Regular engagement with DHSC sponsor team and policy leads to develop plans to respond to requirements and prioritise within capacity constraints • Ministers informed of our priorities and strategy • Change Management Group review of programmes and key projects • Appointment of the deputy director of policy and strategy
All strategic aims	Uncertainty in relation to the administration of liabilities in general practice	• NHS Resolution representation on the DHSC's General Practice Indemnity Working Group • NHS Resolution programme management in place • Regular reports to the Board
Help the system, organisations and individuals identify and address issues and work in partnership with other arm's length bodies (ALBs), NHS trusts, patients and healthcare staff to improve the way in which the NHS responds to incidents	Support a system of early warning to identify harm to an individual or organisation	• Early Notification scheme launched for maternity • Incentivisation of members to identify concerns early • Significant Concerns Group and framework in place
All strategic aims	Cyber security	• IT policies and procedures in place • System controls including firewalls • IG group review metrics for virus incident log • IG group review incidents and take forward learning • IG reports to SMT, ARC and the Board • External company carry out regular penetration tests and report findings and improvements • Internal Audit reviews and deep dives • ISO 27001 certification • Cyber Essentials Plus audit and certification

Through the regular review of the risk register and the assessment of the controls and required treatments, we were able to reduce risk scores in the area of delivering the strategy and financial sustainability. We also considered changes to description of the risk in relation to financial sustainability, to ensure it reflects the challenges and possible impacts we as an organisation face.

Key issues which could have an impact are also logged and reviewed through the risk management framework. This includes considering the actions required to address issues and the monitoring of progress through the escalation process.

Table 16: The escalation and management of risks through NHS Resolution

Risk score	Risk response	Action	By whom	Escalation
High risk	**Treat/Transfer/Terminate**			
	Risks deemed as high require a systems approach to identify the root causes of the risk and thereby help choose an appropriate risk response. Where it is not possible to terminate or transfer the risk, a treatment plan will be in place.	• Corporate operational risk register reviewed by SMT to consider escalation to strategic risk register. • SMT review strategic risk register for addition or removal of risks and recommend to the Board.	SMT	
Moderate risk	**Treat**			
	Risks deemed as moderate to high will require a treatment plan in line with the risk appetite. Those risks where it is deemed no further treatment can reduce the risk will be reviewed regularly to assess impact on the organisation.	• Risk register discussed with director/head of service. • Risks identifed as amber and red reported to the Operations Risk Review/ Information Governance groups for inclusion on the corporate operational risk register. • Amber and red risks and associated treatment plans reviewed by ORG/IG and reported to SMT. • SMT review report from ORG and directors.	Directors and CE direct reports ORG/IG SMT	
Low risk	**Tolerate**			
	Risks graded as low either require no action or can be managed through local action or by an appropriate person or department.	• Risk is identified. • Risk added to team risk register. • Action to reduce risk where necessary is considered. • Teams discuss risk register.	All staff	

Risk appetite

The Board has developed and continues to review the statement of risk appetite. The Board's approach is to minimise its exposure to risk in relation to the delivery of its operations and compliance with good standards of governance. The Board generally has a low appetite for risk given the nature of the organisation's activities but is prepared to accept a greater degree of risk in certain cases where it is clear that this relates to a valid pursuit of the organisation's strategic objectives.

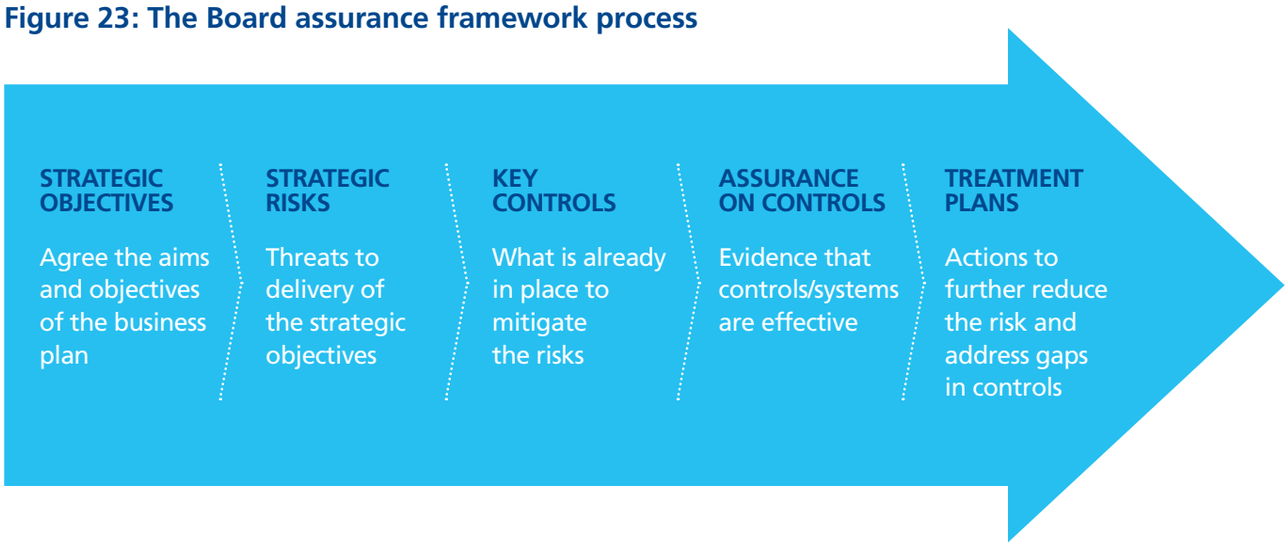
With the introduction of General Data Protection Regulation it was acknowledged that, on occasion, the framework within which we operate may be uncertain or open to interpretation, which creates risk of challenge in relation to potential courses of action.

A key area where this was evident was data sharing across the health sector for learning purposes, so to mitigate working outside of our risk appetite we have been working closely with DHSC on the framework that we may need in place, and the processes we should consider when requests for our data are made.

Management assurance

NHS Resolution's assurance framework brings together governance and quality linked to our strategic objectives. Its purpose is to ensure that systems and information are available to provide assurance on identified strategic risks and that such risks are being controlled and objectives achieved.

Figure 23: The Board assurance framework process



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.

The Head of Internal Audit gave 'moderate' assurance to the Accounting Officer that NHS Resolution has had adequate and effective systems of control, governance and risk management in place for the reporting year 2018/19.

Performance and financial controls

NHS Resolution's financial and operational performance is reported regularly to SMT, to the Board and to me. NHS Resolution's financial position, together with operational KPIs, is reported quarterly to DHSC 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 RPC for the setting of reserves for claims are set out earlier in this statement.

Fraud

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of NHS Resolution's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members, and we take a zero-tolerance approach to fraud and bribery. Through 2018/19, we completed a number of actions to strengthen our internal controls for this area and have in place an up-to-date Anti-fraud, bribery & corruption policy and procedure advising staff on how to recognise and deal with potential instances of fraud and bribery.

We continue to engage with our counter-fraud team, who work in accordance with the NHS Counter Fraud Authority Standards for Providers to prevent, deter, detect and investigate fraud and bribery.

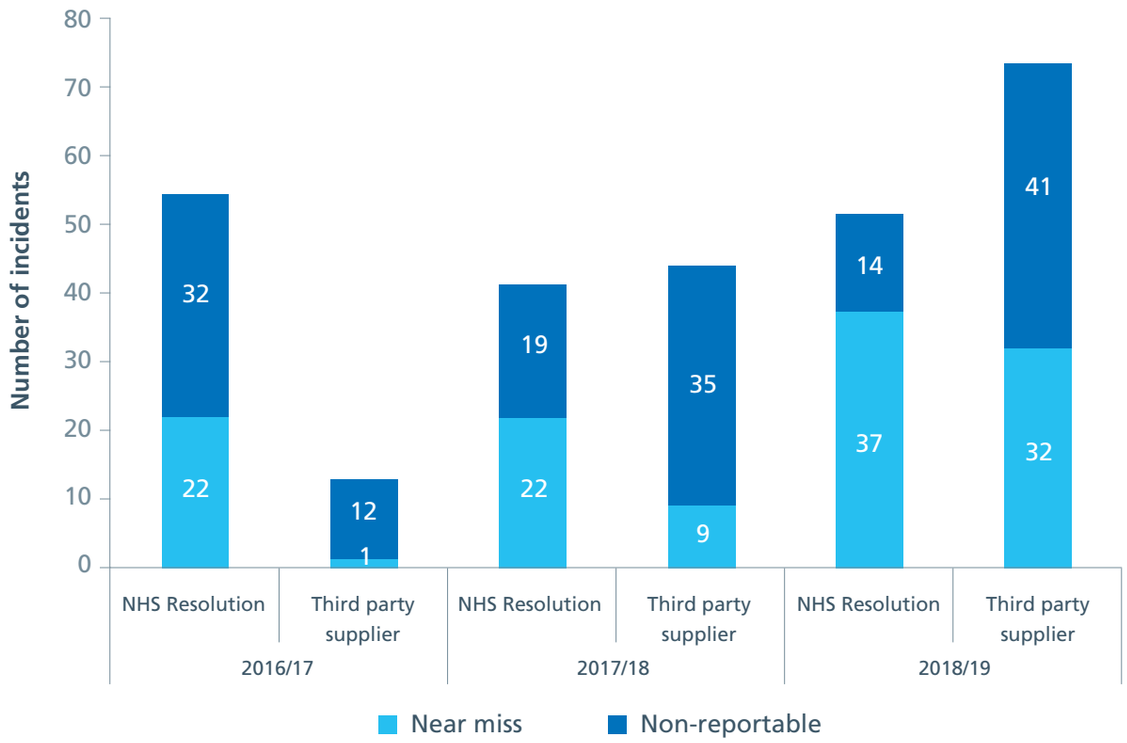
We completed the NHS Counter Fraud Authority's Self Review Tool (SRT) which resulted in an overall rating of amber. Full compliance was demonstrated for a number of standards, with work continuing to ensure the effectiveness of Counter Fraud activities completed as part of the 2019/20 plan, we will take forward actions to address those areas for improvement. We continue our membership to the Claims and Underwriting Exchange (CUE), 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.

Information security and governance

NHS Resolution has maintained ISO 27001 Information Security certification which provides evidence that we have an effective information security management system. We have also achieved Cyber Essential Plus certification which is a UK government scheme of good practice in information security. It includes an assurance framework and a set of security controls to protect information from threats coming from the internet. This illustrates the importance we place on protecting our information and the quality of the arrangements we have in place to manage and protect our information assets.

NHS Resolution is committed to minimising the risks associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to information governance. During the year, NHS Resolution submitted its annual return on the NHS Digital Information Governance toolkit.

Figure 24: Information governance incidents reported between 2016/17 to 2018/19 by severity[14]

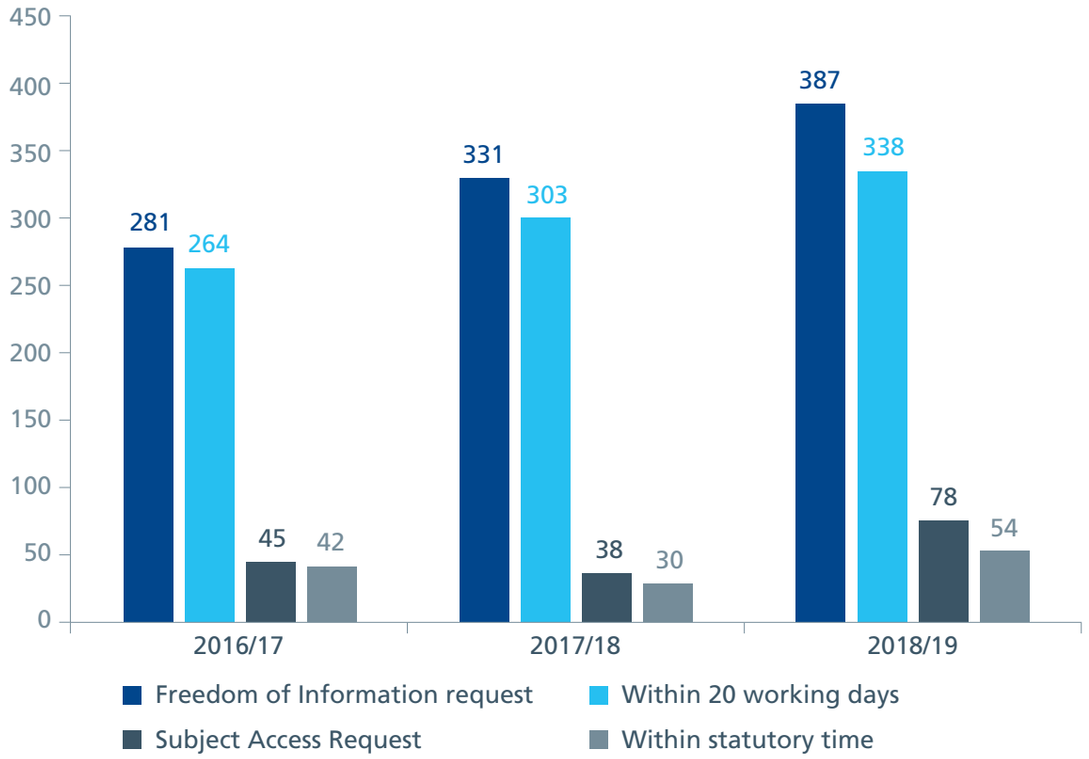


During this year, there were 51 information governance incidents recorded by NHS Resolution, of which 37 were 'near misses'. These are defined as an incident that did not lead to harm, loss or damage, but could have done, and are reported in order that we can learn from the incident. This year, the figure has not, as previously, included incidents which are reported by contractors working for NHS Resolution where they are Data Controllers in their own right and therefore have obligations to report incidents separately. NHS Resolution is notified when that is the case so that we can identify any remedial action to be taken and learning to be followed up through contractual arrangements. We are working with our third party suppliers to ensure root cause analysis and learning from incidents is taken forward so as to ensure mitigations are put in place to reduce the risk of such incidents occurring in the future.

NHS Resolution did not have any incidents during this period which required reporting to the Information Commissioner. The figures indicate a significant reduction in the number of non-reportable incidents, but an increase in reported near misses, which is perhaps a reflection of the continuing awareness of information security being embedded within business operations. We do not, however, wish to be complacent and do continue to learn from and encourage reporting and use examples from our incidents to shape

[14] There were no serious incidents reported over the period 2016/17 to 2018/19

Figure 25: Freedom of Information requests and Subject Access Requests received between 2016/17 and 2018/19



future information governance learning, which is a mandatory requirement for all staff and Board members.

Further awareness-raising sessions are taking place to increase the understanding of these types of errors through root cause analysis and regular review by our IG group. Where we identify trends, or repeated incidents, we work closely with the relevant function to consider a range of options which might assist with reducing levels of incidents. We have also strengthened information governance requirements with key contractors as part of our work to assess our key information risks, and informed by learning from individual incidents.

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. NHS Resolution received 387 requests under the Freedom of Information Act (FoIA). 338 (87%) were completed within the statutory 20 working day deadline, compared to 92% the previous year. Several requests were completed late in 2018/19; the reasons for lateness were due to complexity of the request or where we needed to seek further advice, and staff turnover within the team. As the number of requests received was higher than the preceding year, they represent a significant workload and also reflect the continuing interest in the organisation.

Data Protection Requests

NHS Resolution 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 which allows NHS Resolution to share information where the disclosure is for the purposes of crime and taxation. 77 SARs were received in 2018/19, 54 of which were completed within the statutory deadline of 40 calendar days.

Complaints and feedback

From 1 April 2018 to 31 March 2019, we received 49 complaints, which were reviewed through our formal complaints policy. This compares to 52 complaints logged in 2017/18 which is a small decrease. There have been no complaints escalated from our reviews that were referred to the Parliamentary and Health Service Ombudsman. We are committed to ensuring that complaints and feedback about our services are reviewed and that we are engaging with complainants by offering meetings and considering the best approach to resolving a complaint. We are also encouraging more informal approaches to resolve dissatisfaction with our services quickly. The SMT and I review complaints and feedback about our services and I report the findings to the Board. We have identified the need for additional resource to support our handling of complaints and capturing and taking forward learning.

An example where we have identified learning is that we recognise that the tone of our communication is key to the handling of complaints and we have put in place training for staff, which includes empathy training to support how we manage complaints.

Freedom to Speak Up

We implemented our Freedom to Speak Up Policy and have in place two Freedom to Speak Up Champions as well as a Non-executive Director who is the Freedom to Speak Up Officer. For 2018/19, there were three issues raised through this route. We will continue to work with the Freedom to Speak Up Champions and staff to review the effectiveness of the policy and local process at least every two years, the first review will take place in 2020 with the outcome published and changes made as appropriate.

Health and safety

To ensure the health, safety and wellbeing of our staff, we have in place policies and procedures. Staff are required to participate in the training provided to ensure awareness. This year, we engaged a Health and Safety Adviser to carry out a full assessment of all aspects of health and safety legislation. From the assessment, we have taken forward a number of critical actions and will continue to address all recommended actions through 2019/20 with the Operational Risk Review Group continuing to support the health and safety agenda.

Procurement and contracting

We comply with Public Procurement Regulations in relation to procurement. We have developed procurement plans to ensure that acquisitions for goods and services are supported through a robust procurement process and are completed in line with Public Procurement Regulations. All procurement is considered in terms of business need and is the most economically advantageous for us. We continue to develop and embed best practice in contract management to ensure we achieve good value for money on the contracts we enter into. Through the procurement process, we ensure key consideration is given to The UK Modern Slavery Act (2015) and as such is included in our tender documents for procurements over £15,000.

Accounting Officer's conclusion

The governance arrangements detailed in the statement aim to support NHS Resolution 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 NHS Resolution is responsible, and, that they are in line with the recommendations as set out in the Harris Review[15].

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 2018/19.

[15] https://www.gov.uk/government/publications/independent-review-into-delegation-of-approval-functions-under-the-mental-health-act-1983

Remuneration and staff report

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee whose members have a role that includes the determination of the remuneration, benefits and terms of services of all posts covered by the Pay Framework for Executive and Senior Managers (ESM).

The Remuneration and Terms of Service Committee met four times during the 2018/19 year. All meetings were quorate.

Table 20: Remuneration and Terms of Service Committee meeting attendance

Name	Post	Meetings attended
Ian Dilks	Chair	4 of 4
Keith Edmonds	Non-executive Director	4 of 4
Charlotte Moar	Non-executive Director	4 of 4
Mike Pinkerton	Non-executive Director	4 of 4
Nigel Trout	Non-executive Director*	1 of 2

***Nigel Trout joined the organisation on 1 July 2018.**

The Committee approved the extension of an Associate Non-executive Director appointment with effect from 1 July 2018 on a 12-month rolling basis. The annual Directors' performance reviews presented by the Chief Executive, who was in attendance, were considered and noted by the Committee.

The annual pay award and performance-related payments were determined and approved by the Committee, using advice and guidance provided by DHSC. Where required, approval of the pay awards and performance-related payments was received from DHSC by the Chair of the Committee. Confirmation of the pay awards and performance-related payments approved were notified to DHSC by the Chair of the Committee as required.

Other matters dealt with by the Committee during the year included:

- Approval to extend an existing temporary additional responsibilities allowance (TARA) for an Executive Director to 30 September 2019.
- The performance and objectives of the Chief Executive.
- Consideration/approval of the approach taken in relation to the Director of Claims recruitment.
- Approval of the Director of Claims salary following successful recruitment.
- Review of succession planning and talent management activities and intentions for the executive and senior manager positions.

The Committee considered its performance in 2018 as satisfactory and concluded that it had discharged its obligations as set out in the terms of reference.

The Committee also considered that the terms of reference remain appropriate, subject to one minor addition in relation to the Committee's responsibility for agreeing the appointment and renewal of any associate non-executive director posts, including, where appropriate, the associated remuneration and terms of appointment. The revised terms of reference were submitted to, and received approval from, the Board.

Remuneration policy

NHS Resolution is bound by the NHS terms and conditions of service (known as Agenda for Change). With the exception of the directors who are paid in accordance with *DHSC pay framework for executive and senior managers in ALBs*, all staff are paid in accordance with Agenda for Change.

Full details on the *Agenda for Change terms and conditions of service*, including a copy of the current handbook, can be found on the NHS Employers website. The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees which supports modernised working practices. Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system which supports NHS service modernisation and meets the reasonable aspirations of staff.

The relevant NHS Resolution policies applied during the financial year in relation to salaries were the *Recruitment and selection policy and procedure (HR16)* and the *National terms and conditions of service* noted above. Allowances to staff in payment during the year other than basic salary were high cost area supplement, recruitment and retention payments (RRP), and on-call allowances for information systems and governance staff.

Remuneration for directors

The following tables provide the contractual salary and pension details of those senior managers and non-executive directors who had control over the major activities of NHS Resolution during 2018/19. Tables 21, 22 and 23 are subject to audit. There were some changes to our Board membership throughout 2018/19.

Table 21: Executive and non-executive director salaries and allowances for 2018/19

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	N/A	N/A	**60–65**
Helen Vernon *(Chief Executive)*	145–150	0	5–10	0	20–22.5	**175–180**
Joanne Evans *(Director of Finance and Corporate Planning)*	120–125	0	0–5	0	27.5–30	**150–155**
Denise Chaffer *(Director of Safety and Learning)*	110–115	0	0	0	0	**110–115**
Vicky Voller[1] *(Director of Practitioner Performance Advice)*	65–70	0	0	0	17.5–20	**85–90**
Keith Edmonds *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Charlotte Moar[2] *(Non-executive Member)*	10–15	0	N/A	N/A	N/A	**10–15**
Mike Pinkerton *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Nigel Trout[3] *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Mike Durkin[4] *(Associate Non-executive Member)*	5–10	1	N/A	N/A	N/A	**5–10**
Sam Everington[5] *(Associate Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**

[1] Vicky Voller's post title changed to Director of Practitioner Performance Advice from July 2018. Vicky Voller's full year equivalent salary is in the band £100k-105k.

[2] Charlotte Moar is also the Chair of the ARC.

[3] Nigel Trout was appointed as a Non-executive Director from 1 July 2018.

[4] Mike Durkin's appointment as Associate Non-executive Director was remunerated from 1 July 2018.

[5] Sir Sam Everington was appointed as an Associate Non-executive Director from 1 July 2018.

The executive and non-executive directors do not receive any non-cash benefits.

Table 22: Executive and non-executive director salaries and allowances for 2017/18

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	5–10	0	47.5–50	**200–205**
Joanne Evans *(Director of Finance and Corporate Planning)*	115–120	0	0–5	0	27.5–30	**150–155**
Denise Chaffer *(Director of Safety and Learning)*	110–115	0	0	0	15–17.5	**125–130**
Vicky Voller *(Director of Practitioner Performance Advice)*	95–100	0	0	0	15–17.5	**115–120**
Keith Edmonds *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Charlotte Moar[1] *(Non-executive Member)*	0–5	0	N/A	N/A	N/A	**0–5**
Andrew Hauser[2] *(Non-executive Member)*	N/A	N/A	N/A	N/A	N/A	**N/A**
Mike Pinkerton *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Mike Durkin[3] *(Associate Non-executive Member)*	N/A	0	N/A	N/A	N/A	**N/A**

[1] Charlotte Moar was appointed as a Non-executive Director from 1 September 2017. Charlotte also became the Chair of the Audit and Risk Committee with effect from 1 December 2017. Full year equivalent salary is in the band £10k–15k.

[2] Andrew Hauser left the Board with effect from 30 November 2017. This Non-executive Director appointment was unpaid.

[3] Mike Durkin's appointment as Associate Non-executive Director is unpaid.

The executive and non-executive directors do not receive any non-cash benefits.

Pension entitlements for Executive Directors

All directors at NHS Resolution 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 and further details are set out in the financial statements section.

Table 23: 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 2019 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2019 £000	Cash equivalent transfer value at 31 March 2018 £000	Real increase in Cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Helen Vernon *(Chief Executive)*	0-2.5	(0-2.5)	35-40	80-85	642	528	76	23
Joanne Evans *(Director of Finance and Corporate Planning)*	0-2.5	0	5-10	0	98	59	20	18
Vicky Voller *(Director of Practitioner Performance Advice)*	0-2.5	(0-2.5)	20-25	40-45	294	266	11	14
Denise Chaffer *(Director of Safety and Learning)*	0-2.5	0-2.5	40-45	120-125	0	891	0	16

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 that 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. This is subject to audit.

Payments to past directors

There were no payments made to past directors. This is subject to audit.

Fair pay disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

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

The banded remuneration of the highest-paid director in NHS Resolution in the financial year 2018-19 was £155,000-£160,000 (2017-18, £150,000-£155,000). This was 3.30 times (2017-18, 3.25) the median remuneration of the workforce, which was £47,697 (2017-18, £46,897).

In 2018-19, no employees received remuneration in excess of the highest-paid director (2017-18, was also zero). Remuneration ranged from £20,150 to £156,559 (2017-18 £19,604-£153,882).

The fair pay disclosures are subject to audit.

Staff report

Tables 24 and 25 set out staff costs and average staff numbers, which are subject to audit.

Table 24: Staff costs for 2017/18 and 2018/19

Staff numbers and related costs	Permanently employed staff £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	13,559	769	**14,328**	12,821
Social security costs	1,542	0	**1,542**	1,344
Employer contributions to NHS Pensions	1,680	0	**1,680**	1,563
NEST pension contributions	2	0	**2**	1
Apprenticeship levy	53	0	**53**	47
Total	**16,836**	**769**	**17,605**	**15,776**

Table 25: Average full-time equivalent staff numbers

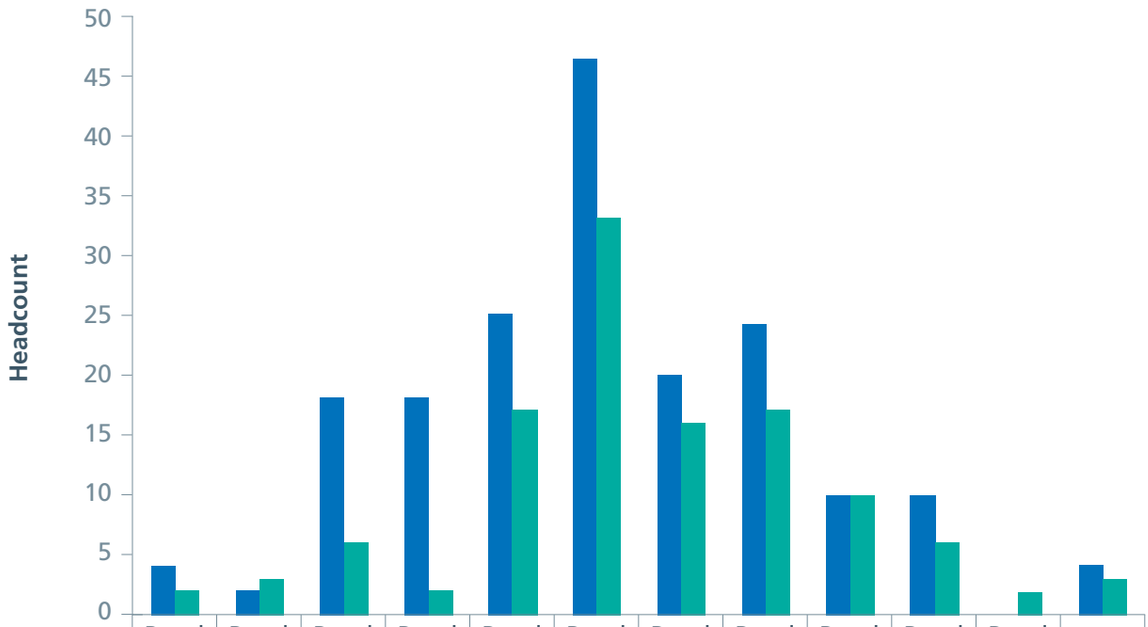
Average number of persons employed / staff numbers and related costs	Permanently employed staff	Other*	2018/19 Total	2017/18 Total
Total	275	18	**293**	265

*Other is temporary/agency workers engaged with the organisation.

As at 31 March 2019, of the seven executive and senior managers, three were male (43%) and four were female (57%). The gender split ratio for the whole of NHS Resolution was 39% male and 61% female. The organisation regularly reports to the Board the details of its workforce gender by pay band including executive and senior managers.

Figure 26: Headcount by gender and grade

The following graphs detail how the organisation's workforce is made up in respect of the other monitored characteristics which are included under the Equality Act 2010:



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	ESM
Female	4	2	18	18	25	46	20	24	10	10		4
Male	2	3	6	2	17	33	16	17	10	6	2	3

Figure 27: Workforce – disability

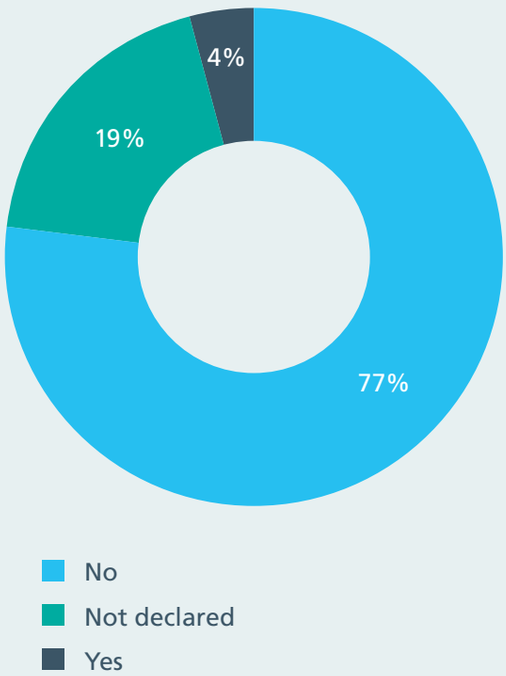
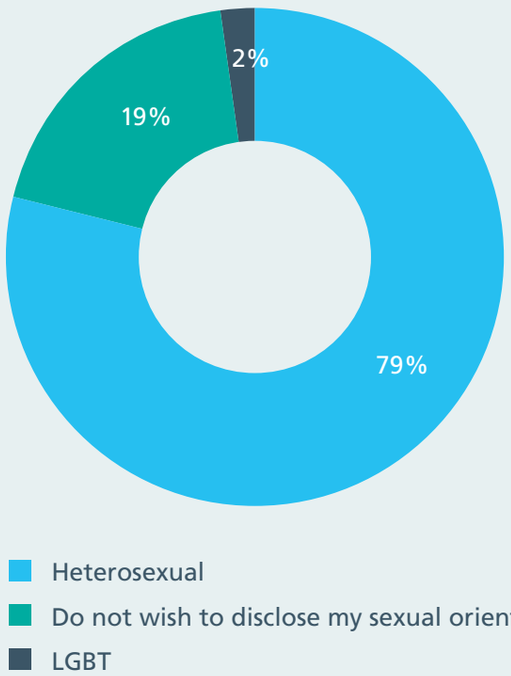


Figure 28: Workforce – sexual orientation



Disability

NHS Resolution applies the *Two Ticks* symbol for internal and external applicants during recruitment exercises, recognising our commitment regarding the employment, retention, training and career development of disabled employees. Employers who have signed up to the *Two Ticks* scheme guarantee disabled people an interview if they meet the minimum criteria for the job vacancy. We remain a member of the Mindful Employer Charter[16], which is intended to support the organisation in attracting a more diverse workforce. The percentage of applicants during 2018/19 who identified themselves as having a disability and who were offered an interview was 14%. This was lower than the percentage of applicants who did not declare themselves as having a disability, which was 21%. When considering the percentage of appointments made from the number of applications received, this was 0.6% for those who considered themselves as having a disability and 2.4% for those who did not.

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

Figure 29: Workforce – ethnicity

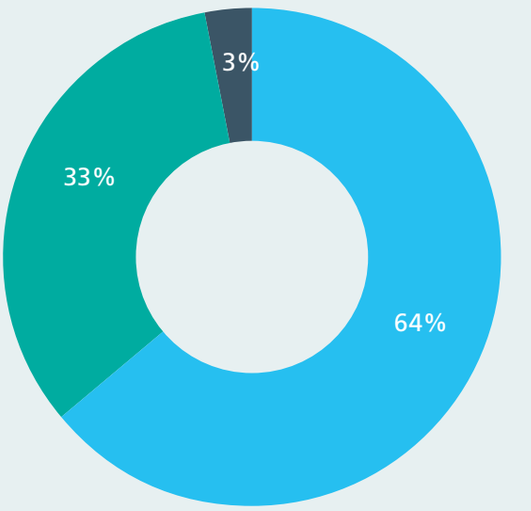
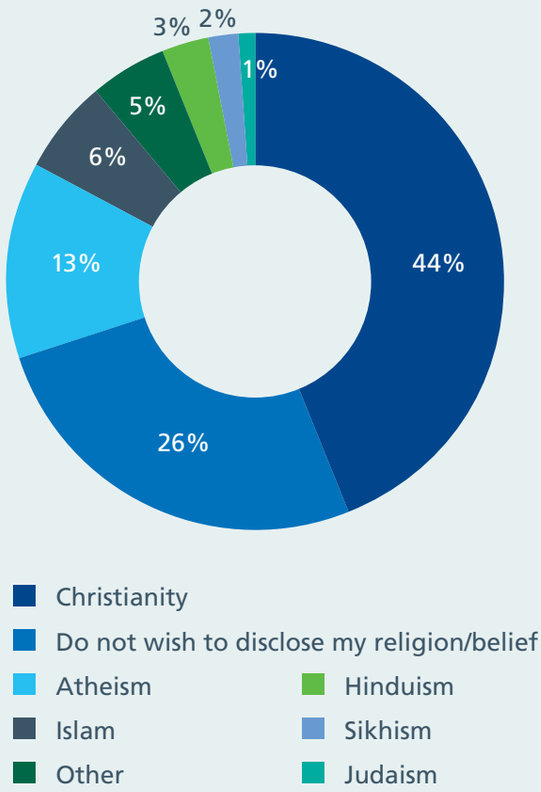


Figure 30: Workforce – religion/belief



The percentage of those who did not wish to disclose this information was 2.5%.

Ethnicity

The proportion of Black, Asian and Minority Ethnic (BAME) employees has remained consistent throughout 2018/19 at 33%. While the ratios are closely aligned to the regional figures of 60% white and 40% BAME, we still show a slight underrepresentation within the BAME categories. The organisation regularly reports to the Board the details of its workforce ethnicity by pay band including senior managers.

In September 2018 and in discussion with DHSC, NHS Resolution signed up to the Business in the Community Race at Work Charter which includes the following five calls to action:

- Appoint an Executive Sponsor for race
- Capture ethnicity data and publicise progress
- Commit at Board level to zero tolerance of harassment and bullying
- Make clear that supporting equality in the workplace is the responsibility of all leaders and managers
- Take action that supports ethnic minority career progression.

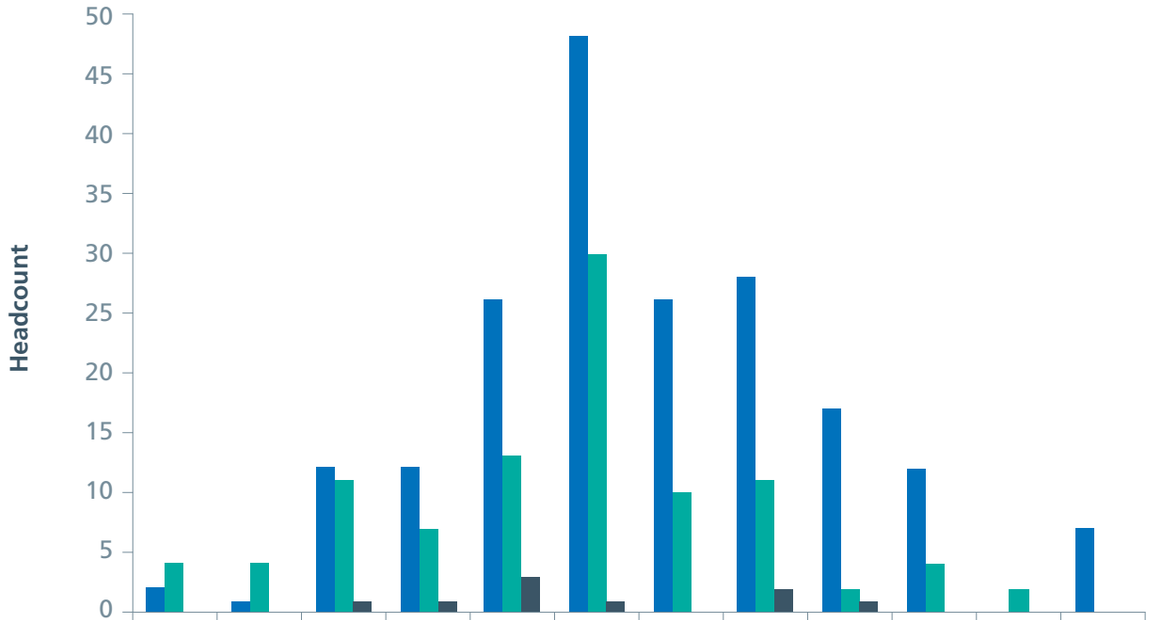
In addition and throughout 2018, a report was completed taking an initial look into race equality at NHS Resolution.

The final version of the report was discussed with SMT in December 2018. The report concludes with three recommendations as part of an implementation plan which included the organisation voluntarily publishing its race data in accordance with the Workforce Race Equality Standards (WRES).

The organisation recognises the importance of the report content and recommendations, and therefore held a facilitated session in April 2019, which considered the report further and discussed some action areas which will form part of our wider development of an equality, diversity and inclusion agenda in the coming year.

The Department for Business, Energy and Industrial Strategy published a consultation on the proposal to introduce ethnicity pay reporting. This report has been discussed at SMT and NHS Resolution responded to the consultation in January 2019.

Figure 31: Headcount by ethnicity



	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	Band 9	ESM
White	2	1	12	12	26	48	26	28	17	12		7
BAME	4	4	11	7	13	30	10	11	2	4	2	
Not disclosed			1	1	3	1		2	1			

Table 26 notes an increase in the average number of sick days per full-time equivalent (FTE), up from 3.1 days reported in 2017/18 to 4.6 days in 2018/19. This can be largely attributed to an increase in the level of long-term sickness absence cases reported throughout the year, a number of which have since returned to work or left their employment with NHS Resolution. Our monthly absence rate has remained well below the NHS national average and is lower than the average rate reported for similar organisations.

Table 26: Sickness absence for the period January 2018 to December 2018

Figures converted by DHSC to best estimates of required data items			Statistics produced by NHS Digital from the Electronic Staff Record data warehouse	
Average FTE for period	Adjusted FTE days lost (to Cabinet Office definitions)	Average sick days per FTE	FTE-days available	FTE-days lost to sickness absence
272	**1,443**	**4.6**	**99,449**	**2,016**

Notes

1. NHS sickness absence statistics are published by NHS Digital, using data from the NHS Electronic Staff Record Data Warehouse.
2. The number of FTE-days lost to sickness absence has been taken directly from the NHS Digital data. 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.

Off-payroll engagements

As of 31 March 2019, NHS Resolution has one off-payroll appointment costing more than £245 per day, and which is likely to last longer than six months. This appointment was a new engagement within the reporting period.

The appropriate pre-placement checks were completed for this and all of the off-payroll engagements, with the required assurances obtained to confirm these placements were assessed to ensure that the appropriate tax and national insurance arrangements were in place as they were not covered by IR35[17].

[17] IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

Table 27: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019.	1
Of which...	
No. that have existed for less than one year at time of reporting.	1
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 28: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019.	2
Of which...	
No. assessed as caught by IR35.	0
No. assessed as not caught by IR35.	2
No. engaged directly (via PSC contracted to department) and are on the departmental payroll.	0
No. of engagements reassessed for consistency / assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review.	0

Table 29: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year.	10

Exit packages

There were no compulsory or voluntary redundancies during the 2018/19 financial year. This is subject to audit.

Trade Union Regulations 2017

The Trade Union (Facilities Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require relevant public sector organisations to report on the trade union facility time in their organisation. The following tables detail the number of union officials within NHS Resolution, the percentage of their time spent on facilities time, the percentage of pay bill spent on facilities time and the percentage of paid trade union activities.

Table 30: Relevant Union officials

Number of employees who were relevant union officials during 2018/19	Full-time equivalent employee number
1	1

Table 31: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	1
51-99%	0
100%	0

Table 32: Percentage of pay bill spent on facility time

Total cost of facility time	£2,716.39
Total pay bill	£16,899,258
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 33: Paid trade union activities

Hours spent by employees who were relevant union officials during 2018/19 on paid trade union activities, as a percentage of total paid facility time hours.

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0.65%

People

The year 2018/19 has been very productive and successful in respect of our workforce and organisational development activities, which have supported the delivery of the organisation's annual business plan and strategic priorities.

NHS Resolution has seen a continued period of growth throughout the year with an increase of nearly 10.5% on the average full-time equivalent (FTE) staff in post, up from 268 in 2017/18 to 293 in 2018/19. While increasing our budgeted establishment and headcount we have maintained a consistent level of annual staff turnover of just under 12%.

The organisation is continuing through a significant period of change in order to support the delivery of its strategy. This has required the development of strategic and policy-focused roles across all parts of the business. Through a series of open recruitment campaigns, a number of internal promotions were made into these positions. As a result, the organisation has seen an increase in the number of vacancies and subsequent recruitment campaigns for the technical roles within the operational areas.

There have been a considerable number of staff engagement activities throughout the year, the most notable being the design and delivery of year two of our leadership development programme, full details of which are noted below. Other staff engagement activities have seen the level of completion of our staff annual appraisals remaining at 90% for 2018 and a positive response rate of 73.2% to our recent interim staff survey.

We have progressed a significant number of the key priorities noted in our workforce and organisational development strategy. Activities delivered throughout 2018/19 include the following.

Investors in People

Having successfully obtained the Investors in People (IiP) accreditation in early 2017, the organisation has made some significant progress on the recommendations noted in the final assessment report. These improvements ensure that we continue to improve against the assessment indicators and demonstrate our continued commitment to people management excellence.

In order to ensure that we are in the best possible position to retain or even improve on our accreditation, we will be considering the implementation of champion roles throughout 2019 while providing oversight of our performance to the SMT. The IiP standard is integral to everything we do and is a framework that influences all current and planned human resource and organisational development activities. We had an interim review of progress to date with our IiP lead on 20 March 2019.

Staff survey

Following on from our 2017 staff survey and a series of staff engagement sessions held throughout 2018, the organisation ran an interim staff survey in March 2019. The survey focused on four main areas:

- Work life balance and working hours
- Equality, diversity and inclusion
- Dignity at work
- SMT communications.

Feedback from this interim survey will help to inform our future programme of support for staff and managers, and the specific interventions required in response to the areas of concern noted. The results will also assist with the development of our equality, diversity and inclusion agenda.

In order to ensure a process of ongoing staff engagement, the organisation has also agreed its approach to running a full annual staff survey from 2019 onwards.

Leadership development

A major investment by the organisation in 2017/18 saw the launch of its Leadership development programme. The second wave of this programme has been delivered in 2018/19. This was managed in 3 cohorts and covered a further 45 delegates from across all parts of the organisation and all levels of staff. In total 90 employees have attended and completed the leadership programme which accounts for over 30% of our current workforce. Each attendee has produced a service improvement plan as part of the programme, with benefits aligned to delivering our strategy or improving business processes within NHS Resolution.

Succession planning

Throughout 2018/19, the organisation established and successfully recruited to a number of deputy director positions. The introduction of these roles intended to ensure that the organisation was appropriately resourced to deliver its strategic intentions including the implementation of the CNSGP. The introduction of these roles supports the succession plans for our senior business critical roles while offering better career pathways within a majority of our services.

An update on the succession plans for each of our executive and senior manager (ESM) positions was presented to our Remuneration Committee in November 2018. Our talent pipeline for each directorate is underpinned by individual career conversations, intentions and aspirations, which continue to be held outside of the annual appraisal process.

We have maintained our membership with the Health and Care Leaders Scheme (HCLS) and continued to offer and access various external leadership development opportunities which include the Ready Now, Stepping Up, Leaders 2025 and Nye Bevan programmes.

Although not at the aspired level, we have managed to support the placement of an apprenticeship role within our IT and Facilities function. Work is under way to identify other appropriate positions across the organisation in order to ensure that we are able to utilise our apprenticeship levy as much as possible. We are also exploring the use of the levy for the appointment of graduate management trainees via the NHS Leadership Academy.

Mentoring

During 2017/18, 17 employees accessed mentoring opportunities made available to them by the SMT. We have recently trained a further 15 employees to become workplace mentors and the offer to access this mentoring has recently been made available to staff.

This rolling programme of mentoring opportunities for staff will support ongoing personal and professional development. We have also provided access to external mentorship opportunities which are available via the NHS Leadership Academy.

Gender pay gap

In March 2019, in accordance with the requirements under the Equality Act 2010, NHS Resolution published its second gender pay gap report. The report was published on the GOV.UK website in advance of the April 2019 deadline. NHS Resolution reported a median gender pay gap of 6%, down from 8.1% in the previous year.

Over the last 12 months, NHS Resolution has continued to implement a number of programmes and activities to promote pay balance in the workplace. Given that we have more females than males at almost every level of the organisation, in addition to the activity previously mentioned some additional actions/ activities include:

- return to work mentoring by an executive director following a period of maternity leave;
- continuing to encourage flexible working across our organisation at every level, to ensure that our employees have the opportunity to balance their home life and career aspirations;
- commissioned an internal audit which among other areas looked at recruitment compliance and starting salaries by gender. The report shows that there were no specific outliers in this area;
- delivered a workshop on managing menopause in the workplace, which included practical support and guidance for engaging in conversations about difficulties which may otherwise go unsupported; and
- advertised our ARC external member roles on 'Women on Boards'; a job website specifically aimed at supporting women into board positions.

As a fair and equal employer, we appoint the best candidates during our recruitment campaign regardless of gender or other protected characteristics. We are currently in the process of developing an equality, diversity and inclusion agenda, a part of which will focus on improvements in the recruitment process to ensure that all individuals have equal access to opportunities before their applications are even submitted.

Parliamentary accountability and audit report

The following disclosures are subject to audit.

Losses and special payments

There were no losses and special payments made in 2018/19 above £300,000 nor in 2017/18.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES schemes, are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy at Note 1.3 to the accounts on page 142. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the accounts on page 150.

Expenditure on consultancy

No expenditure was incurred on consultancy in 2018/19. £80,000 was spent on consultancy services for expert advice on risk management in the previous year.

Publicity and advertising

Publicity and advertising spend for the year was £100,711. This compares to £60,620 in the previous year.

Regularity of expenditure – gifts

We have not received or made any gifts where the value exceeded £300,000.

Indemnity Scheme Cover for NHS Resolution

For 2018/19, NHS Resolution was covered under both LTPS and PES.

Remote contingent liabilities

The judgments taken to place a value on the provision and contingent liabilities (see Notes 7 and 8 to the accounts) arising from the indemnity schemes that NHS Resolution 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), and considerations relating to applying a limit to recoverable claimant costs for lower value claims.

At this stage, following the change in the PIDR in March 2017, no adjustments have been made to the value or timing of liabilities arising from potential increases in claims numbers, or changes in claimant preferences for lump sums rather than periodical payment orders. No changes to the PIDR assumption have been made pending any announcements due to be made by the Lord Chancellor following the passing of the Civil Liability Act 2018.

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2018/19.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 3 July 2019

The certificate and report of the Comptroller and Auditor General to the Houses of Parliament

Opinion on financial statements

I certify that I have audited the financial statements of NHS Litigation Authority (herein referred to as NHS Resolution) for the year ended 31 March 2019 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, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion:

- the financial statements give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2019 and of its net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

Without qualifying my opinion, I draw attention to the disclosures made in note 7 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 7, 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 NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by NHS Resolution.

Opinion on regularity

In my opinion, in all material respects the income and expenditure 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.

Basis of opinions

I conducted my audit in accordance with International Standards on Auditing (ISAs) (UK) and Practice Note 10 'Audit of Financial Statements of Public Sector Entities in the United Kingdom'. My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate. Those standards require me and my staff to comply with the Financial Reporting Council's Revised Ethical Standard 2016. I am independent of NHS Resolution in accordance with the ethical requirements that are relevant to my audit and the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

I am required to conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on NHS Resolution's ability to continue as a going concern for a period of at least twelve months from the date of approval of the financial statements. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion.

My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern. I have nothing to report in these respects.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

Auditor's responsibilities for the audit of the financial statements

My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006.

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. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs (UK), I exercise professional judgment and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of NHS Resolution's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the consolidated financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

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

Other information

The Accounting Officer is responsible for the other information. The other information comprises information included in the annual report, but does not include the parts of the Accountability Report described in that report as having been audited, the financial statements and my auditor's report thereon. My opinion on the financial statements does not cover the other information and I do not express any form of assurance conclusion thereon. In connection with my audit of the financial statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact. I have nothing to report in this regard.

Opinion on other matters

In my opinion:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;
- in the light of the knowledge and understanding of NHS Resolution and its environment obtained in the course of the audit, I have not identified any material misstatements in the Performance Report or the Accountability Report; and
- 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 Accountability Report 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.

Gareth Davies Date: Friday 5 July 2019
Comptroller and Auditor General

National Audit Office
157–197 Buckingham Palace Road
Victoria, London
SW1W 9SP

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2019

	Notes	31 March 2019 £000	31 March 2018 £000
Other operating income	3	**(2,053,909)**	(2,008,155)
Total operating income		**(2,053,909)**	(2,008,155)
Staff costs	2	17,605	15,776
Purchase of goods and services	2	5,907	5,151
Depreciation and impairment charges	2	820	640
Provision expense	7	8,386,821	13,723,095
Other operating expenditure	2	1,503	1,450
Total operating expenditure		**8,412,656**	13,746,112
Net operating expenditure		**6,358,747**	11,737,957
Finance expenditure	7	422,465	552,255
Net expenditure for the year		**6,781,212**	**12,290,212**
Other comprehensive net expenditure		0	0
Comprehensive net expenditure for the year		**6,781,212**	**12,290,212**

The Notes at pages 142 to 177 form part of these accounts.

Statement of financial position as at 31 March 2019

	Notes	31 March 2019 £000	31 March 2018 £000
Non-current assets:			
Property, plant and equipment		**1,972**	1,662
Intangible assets		**984**	653
Total non-current assets		**2,956**	2,315
Current assets:			
Trade and other receivables	4	**15,652**	15,281
Cash and cash equivalents	5	**182,092**	388,311
Total current assets		**197,744**	403,592
Total assets		**200,700**	405,907
Current liabilities:			
Trade and other payables	6	**(78,850)**	(38,580)
Provisions for liabilities and charges – known claims	7	**(2,476,653)**	(2,665,179)
Total current liabilities		**(2,555,503)**	(2,703,759)
Total assets less current liabilities		**(2,354,803)**	(2,297,852)
Non-current liabilities:			
Provisions for liabilities and charges – known claims	7	**(32,920,914)**	(29,106,772)
Provisions for liabilities and charges – IBNR	7	**(47,978,000)**	(45,216,000)
Total non-current liabilities		**(80,898,914)**	(74,322,772)
Total assets less liabilities		**(83,253,717)**	(76,620,624)
Taxpayers' equity			
General fund		**3,821**	1,930
ELS reserve		**(1,447,553)**	(1,446,402)
Ex-RHA reserve		**(73,492)**	(74,118)
DHSC clinical reserve		**(3,903,402)**	(3,872,347)
DHSC non-clinical reserve		**(111,409)**	(98,558)
CNST reserve		**(77,565,305)**	(70,979,436)
PES reserve		**(4,974)**	(6,819)
LTPS reserve		**(151,403)**	(144,874)
Total taxpayers' equity		**(83,253,717)**	(76,620,624)

The General Fund and individual scheme reserves are used to account for all financial resources. See the Understanding our indemnity schemes section for a brief description of each scheme to which the reserves relate.

The financial statements on pages 136 to 141 were approved by the Board on Wednesday 19 June 2019 and signed by Helen Vernon. The Notes at pages 142 to 177 form part of these accounts.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 3 July 2019

Statement of cash flows for the year ended 31 March 2019

	Notes	31 March 2019 £000	31 March 2018 £000
Cash flows from operating activities			
Net expenditure		**(6,781,212)**	(12,290,212)
Other cash flow adjustments	2	**820**	640
(Increase)/decrease in receivables	4	**(371)**	5,138
Increase/(decrease) in payables	6	**40,270**	(9,594)
Increase/(decrease) in provisions	7	**6,387,616**	11,990,186
Net cash (outflow) from operating activities		**(352,877)**	(303,842)
Cash flows from investing activities			
Purchase of property, plant and equipment		**(943)**	(660)
Purchase of intangible assets		**(518)**	(314)
Asset write-off		**0**	3
Net cash (outflow) from investing activities		**(1,461)**	(971)
Cash flows from financing activities			
Net Parliamentary funding		**148,119**	540,451
Net financing		**148,119**	540,451
Net (decrease)/increase in cash and cash equivalents		**(206,219)**	235,638
Cash and cash equivalents at the beginning of the period		**388,311**	152,673
Cash and cash equivalents at the end of the period	5	**182,092**	388,311

The Notes at pages 142 to 177 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2019

	Notes	General Fund £000	ELS Reserve £000	Ex-RHAs Reserve £000	DHSC Clinical Reserve £000	DHSC Non-clinical Reserve £000	CNST Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
Balance at 31 March 2017		98	(1,264,929)	(80,260)	(3,516,788)	(122,692)	(59,720,617)	(2,303)	(163,372)	(64,870,863)
Changes in taxpayers' equity for 2017/18										
Net expenditure for the year		(5,642)	(224,080)	4,014	(487,667)	15,134	(11,604,453)	(4,516)	16,998	(12,290,212)
Total recognised income and expense as at 2017/18		(5,544)	(1,489,009)	(76,246)	(4,004,455)	(107,558)	(71,325,070)	(6,819)	(146,374)	(77,161,075)
Net Parliamentary funding		7,474	42,607	2,128	132,108	9,000	345,634	0	1,500	540,451
Balance at 31 March 2018		**1,930**	**(1,446,402)**	**(74,118)**	**(3,872,347)**	**(98,558)**	**(70,979,436)**	**(6,819)**	**(144,874)**	**(76,620,624)**
Changes in taxpayers' equity for 2018/19										
Expenditure										
Authority and claims administration	2	(8,315)	(125)	(8)	(425)	(131)	(12,757)	(59)	(4,015)	(25,835)
(Increase)/decrease in provision for known claims	7	0	(23,026)	1,634	(221,630)	(1,720)	(5,753,628)	(8,596)	(40,320)	(6,047,286)
(Increase)/decrease in the provision for IBNR	7	0	(7,000)	(2,000)	91,000	(20,000)	(2,813,000)	(1,000)	(10,000)	(2,762,000)
		(8,315)	(30,151)	(374)	(131,055)	(21,851)	(8,579,385)	(9,655)	(54,335)	(8,835,121)
Income										
Scheme and other income	3	1,087	0	0	0	0	1,993,516	11,500	47,806	2,053,909
Total recognised income and expense for 2018/19		(7,228)	(30,151)	(374)	(131,055)	(21,851)	(6,585,869)	1,845	(6,529)	(6,781,212)
Net Parliamentary funding[1]		9,119	29,000	1,000	100,000	9,000	0	0	0	148,119
Balance at 31 March 2019		**3,821**	**(1,447,553)**	**(73,492)**	**(3,903,402)**	**(111,409)**	**(77,565,305)**	**(4,974)**	**(151,403)**	**(83,253,717)**

[1] The Net Parliamentary funding represents the cash drawdown of £148,119 in 2018/19 for DHSC-funded indemnity schemes and administration costs. The Notes at pages 142 to 177 form part of these accounts.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2018/19 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRSs) 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 NHS Resolution for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS Resolution 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 pounds (£000). The functional currency of NHS Resolution 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 Social Care and approved by HM Treasury.

1.2. Early adoption of standards, amendments and interpretations

NHS Resolution 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 16 Leases: The effective date is for accounting periods beginning on, or after 1 January 2019, but not yet adopted by the FReM.
- IFRS 17 Insurance Contracts: The effective date is for accounting periods beginning on, or after 1 January 2021, but not yet adopted by the FReM.
- IFRIC 23 Uncertainty over Income Tax Treatments: The effective date is for accounting periods beginning on, or after 1 January 2019.

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

1.3. Income

The IFRS 15 (Revenue from contracts with customers) standard has superseded the IAS 18 (Revenue) standard, effective for reporting periods beginning on or after 1 January 2018. The standard has been adapted for the FReM, which expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset from another entity Contracts are seen to exist for fees, levies and charges as the supporting legislation is deemed to enforce obligations on both parties.

NHS Resolution have undertaken an assessment of all income to ensure that, where within the scope of IFRS15, the provisions of the new standard have been met. There has been no material change in revenue recognition as a consequence of applying IFRS 15. No restatements are required in respect of the prior period.

A source of funding for NHS Resolution as a Special Health Authority is Parliamentary grant from DHSC within an approved cash limit, which funds the ELS, Ex-RHA, DHSC clinical and DHSC liabilities schemes, the additional costs of the personal injury discount rate arising from the change in the rate announced by the Lord Chancellor in March 2017, and some administration costs. Parliamentary funding is recognised in the financial period in which it is received.

The operating income disclosed in Note 3 to the accounts is that which relates directly to the operating activities of NHS Resolution. NHS Resolution currently has the following income streams, the accounting treatment of which have been assessed against the requirements of IFRS15:

- Revenue from contracts with customers in relation to indemnity schemes: NHS Resolution receives contributions for the provision of indemnity cover for the CNST, LTPS and PES schemes, which their authorising legislation gives them the right to collect. This is deemed, per the FREM adaptation of IFRS15, to constitute a contractual arrangement between NHS Resolution and its scheme members. The period of cover is annual, commencing on 1 April each year (contracts do not span financial years). Invoices are raised yearly, quarterly, over 10 months and monthly according to the contract agreed with each member. Revenue is recognised in our accounts in equal monthly instalments over the term of the yearly contract, as NHS Resolution's performance obligations are fulfilled.
- Revenue from contracts in relation to professional services: Invoices are raised either yearly or quarterly as per the agreed contract. Regardless of the timing on raising invoices for payment, we recognise revenue in equal instalments over the accounting year, as performance obligations within the contractual agreements are fulfilled.
- Revenue from contracts in relation to training courses: We only recognise revenue in this category after the training has taken place; which is the point at which NHS Resolution's performance obligations are assessed to have been fulfilled.

1.4. Taxation

NHS Resolution 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. NHS Pensions Scheme

NHS Resolution offers two defined contribution pension schemes to staff, the NHS pension scheme and the National Employment Savings Trust (NEST). 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 NHS Pension 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 for Health and Social Care, 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019 is based on valuation data as at 31 March 2018, updated to 31 March 2019 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 2019.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health and Social Care, 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 2015 scheme is calculated using career average re-valued earnings (CARE) based on a proportion of pensionable earnings in each year of membership. The 1995/2008 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 to members in membership for over two years.

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 Additional Voluntary Contributions run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

The expected contribution to the plan for 2019/20 is £3.1 million (£0.7 million of which is due to the 2019/20 increase in pension contribution).

1.6. 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, NHS Resolution used 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 £6,032 up to £46,350, but will be reviewed every year by the government. The initial employee contribution was 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

There are no restrictions on how much can go into a worker's NEST pot. However, members may pay additional tax on contributions that go over the annual allowance set by the government. Most members won't go over this amount. 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 NHS Resolution 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.

1.7. 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.

1.8. Provisions

NHS Resolution 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.

In November 2017, following consultation with HM Treasury, the Financial Reporting Advisory Board (FRAB) recommended that nominal discount rates should be applied to general provisions rather than the real discount rates previously applied to an inflation rate. This change did not require a restatement of prior year balances as this was a change in accounting estimates and not a policy change. In December 2018, the following nominal discount rates were used: short-term (< 5 years) 0.76%, medium-term (5-10 years) 1.14%, long-term (10-40 years) 1.99%, and very long-term (over 40 years) 1.99%. The nominal rate derived from the real discount rate applied to the RPI inflation rate used in December 2017 was short- 0.95%, medium- 1.54% and long-term 1.84%. There is now a very long-term rate which was not set out in 2017/18.

The ELS, Ex-RHA and DHSC clinical and non-clinical schemes are funded by DHSC, CNST, LTPS and PES from member contributions, and the accounts for the schemes are prepared in accordance with IAS 37. A provision for these schemes is calculated in accordance with IAS 37 by discounting the gross value of all claims received: this is disclosed in Note 7.1.

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, and claims inflation (varying between schemes) of between 4.35% and 9.10%, 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.

Resolution of claims is difficult to predict as many factors can lead to delay during the settlement process while emerging evidence can alter valuation and thus NHS Resolution 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 alter the value provided.

1.9. Financial assets

IFRS 9 supersedes IAS 39. IFRS 9 introduces a new impairment model for financial assets that is based on expected losses rather than incurred losses. It applies to amortised-cost financial assets and those categorised as fair value through other comprehensive income (FVTOCI) and fair value through profit and loss (FVTPL).

The simplified approach to impairment, in accordance with IFRS 9, measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses (stage 1). For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2).

DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and as such NHS Resolution does not recognise stage 1 or stage 2 losses against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), NHS Resolution measures expected credit losses at the reporting date as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss. In the current year, following review of NHS Resolution debts, we have recognised an expected credit loss of £170,644.

1.10. Financial liabilities

Financial liabilities are recognised in the Statement of Financial Position when NHS Resolution 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.

1.11. Critical judgments and key sources of estimation uncertainty

In the application of NHS Resolution's accounting policies, which are described in Note 1, the directors are required to make judgments, 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 judgments 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 7. Actual results may differ from these estimates.

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

NHS Resolution's Reserving and Pricing Committee documents this ongoing review process, 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 NHS Resolution and also a representative non-executive director.

NHS Resolution does not consider that any of our indemnity schemes (see Understanding our indemnity schemes) fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because they are risk-pooling schemes and the significant insurance risk is passed back to the members through annual contributions which cover the expected costs of the schemes, or directly to DHSC through the provision of financing.

1.12. IFRS 8 – operating segments

NHS Resolution 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.

1.13. Maternity incentive scheme (MIS)

The MIS has been introduced to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the Clinical Negligence Schemes for Trusts (CNST).

Where a trust has successfully demonstrated achievement against the 10 safety actions, it will recover its element of CNST contribution that went in to the maternity incentive fund, plus a share of any unallocated funds. Trusts unable to demonstrate achievement of the 10 actions may be able to recover a lesser sum from the fund to help them achieve all actions.

As NHS Resolution is not deemed a customer in this arrangement, the monies received from the scheme are considered out of scope of IFRS 15. Instead they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme.

2. Expenditure

	Notes	2018/19 £000	2018/19 £000	2017/18 £000
Non-executive Members' remuneration		123		92
Other salaries and wages[1]				
Salaries and wages		14,328		12,821
Social security costs		1,542		1,344
Pension costs		1,682		1,564
Apprenticeship levy		53		47
Education, training and conferences		154		146
Establishment expenses		1,001		810
Hire and operating lease rental				
Land and buildings		1,061		1,127
Lease cars		9		4
Photocopiers		25		19
Franking machine		2		13
Vending machine		3		4
Insurance		227		244
Transport (business travel)		156		165
Premises and fixed plant		2,820		2,173
External contractors				
Actuary's advice		734		700
Primary Care Appeals advisory expenditure		39		25
Consultancy		0		80
External corporate legal fees[2]		221		138
Practitioner Performance Advice assessment expenditure		239		452
Practitioner Performance Advice professional services		9		38
Other[3]		349		115
Auditor's remuneration: audit fees[4]		154		154
Internal audit fees		74		75
Bank charges and interest		10		27
			25,015	22,377
Depreciation		633		431
Amortisation		187		209
			820	640
			25,835	23,017
Other finance costs - unwinding of discount	7	422,465		552,255
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	7	5,518,713		2,564,825
Change in the discount rate[5]	7	269,108		15,599,270
Increase / (decrease) in the provision for IBNR	7	2,599,000		(4,441,000)
			8,809,286	
			8,835,121[6]	14,298,367

[1] Additional explanations can be found in Remuneration and Staff Report in the Accountability Report section.
[2] External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included within Note 7 Provisions.
[3] Other includes the recognition of expected credit loss under IFRS 9 of £171k.
[4] NHS Resolution did not make any payments to its auditors for non-audit work.
[5] The discount rates used are mandated by HM Treasury and are set out at Note 7.3 to the accounts (Sensitivity analysis).
[6] Of the £8,835 million shown above, £6.9 million is shown as administration expenditure in DHSC consolidated group accounts.

3. Operating income

	2018/19 £000	2017/18 £000
CNST contributions	**1,993,516**	1,953,604
LTPS contributions	**47,806**	49,172
PES contributions	**11,500**	4,069
Practitioner Performance Advice	**1,054**	1,269
Other income	**33**	41
Total	**2,053,909**	2,008,155

4. Receivables

	Ex-RHA £000	ELS £000	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2019 £000	Total 31 March 2018 £000
NHS receivables – revenue	0	0	0	0	139	211	3,892	43	**4,285**	2,776
Expected credit loss	0	0	0	0	(171)	0	0	0	**(171)**	0
Accrued income	0	0	0	0	0	0	0	0	**0**	12
Prepayments	38	369	1,739	0	634	0	0	705	**3,485**	4,241
Other receivables	1	253	9	12	7,195	11	140	432	**8,053**	8,252
	39	**622**	**1,748**	**12**	**7,797**	**222**	**4,032**	**1,180**	**15,652**	**15,281**

5. Cash and cash equivalents

	Ex-RHA £000	ELS £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2019 £000	Total 31 March 2018 £000
At 1 April 2018	100	13,938	330,488	3,054	39,331	1,400	**388,311**	152,673
Change during the year	**852**	**6,327**	**(216,177)**	**3,354**	**(188)**	**(387)**	**(206,219)**	235,638
At 31 March 2019[1]	**952**	**20,265**	**114,311**	**6,408**	**39,143**	**1,013**	**182,092**	388,311

[1] All Cash balances are held in Government Banking Service accounts.

6. Trade payables and other current liabilities

	ELS £000	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2019 £000	Total 31 March 2018 £000
NHS payables revenue	0	0	0	0	0	174	0	**174**	36
Prepaid income	2,208	0	0	3,133	0	0	132	**5,473**	5,527
Accruals	68	356	71	14,579	6	814	2,439	**18,333**	13,142
Other payables	199	284	269	49,774	0	1,053	3,291	**54,870**	19,875
	2,475	**640**	**340**	**67,486**	**6**	**2,041**	**5,862**	**78,850**	**38,580**

7. Provisions for liabilities and charges

	Ex-RHA £000	ELS £000	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	65,114	1,213,983	2,794,434	16,935	27,570,260	9,348	101,877	**31,771,951**
Opening provisions for IBNR	9,000	251,000	1,098,000	88,000	43,701,000	3,000	66,000	**45,216,000**
Total provisions as at 1 April 2018	**74,114**	**1,464,983**	**3,892,434**	**104,935**	**71,271,260**	**12,348**	**167,877**	**76,987,951**
Movement in known claims								
Provided in the year	145	44,958	234,253	9,848	7,374,294	11,767	67,480	**7,742,745**
Provision not required written back	(3,210)	(46,419)	(70,608)	(8,142)	(2,065,906)	(3,166)	(26,581)	**(2,224,032)**
Unwinding of discount	1,150	20,434	45,512	25	355,288	1	55	**422,465**
Change in discount rate [1]	281	4,053	12,473	(11)	89,952	(6)	(634)	**106,108**
Provisions utilised in the year	(1,163)	(38,120)	(88,679)	(5,941)	(2,231,904)	(7,963)	(47,900)	**(2,421,670)**
	(2,797)	(15,094)	132,951	(4,221)	3,521,724	633	(7,580)	**3,625,616**
Movement in IBNR								
Change in discount rate [1]	0	1,000	1,000	1,000	160,000	0	0	**163,000**
Provided in the year	2,000	6,000	(92,000)	19,000	2,653,000	1,000	10,000	**2,599,000**
	2,000	7,000	(91,000)	20,000	2,813,000	1,000	10,000	**2,762,000**
Closing provision for known claims	62,317	1,198,889	2,927,385	12,714	31,091,984	9,981	94,297	**35,397,567**
Closing provisions for IBNR	11,000	258,000	1,007,000	108,000	46,514,000	4,000	76,000	**47,978,000**
Total provision as at 31 March 2019	**73,317**	**1,456,889**	**3,934,385**	**120,714**	**77,605,984**	**13,981**	**170,297**	**83,375,567**
Analysis of expected timing of discounted cash flows [2]								
Not later than one year	1,096	35,863	95,635	3,986	2,291,259	5,977	42,837	**2,476,653**
Later than one year and not later than five years	3,618	133,936	333,430	15,641	11,243,062	8,004	127,460	**11,865,151**
Later than 5 years	68,603	1,287,090	3,505,320	101,087	64,071,663	0	0	**69,033,763**
	73,317	**1,456,889**	**3,934,385**	**120,714**	**77,605,984**	**13,981**	**170,297**	**83,375,567**

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

[1] The change in discount rate represents the change in provision as a result of a change in the discount rates set by HM Treasury. The total change in provision due to the change in discount rates is £269 million (£106 million for known claims and £163 million for IBNR).

[2] Discounted cash flow timings are based upon actuarial estimates for known claims and IBNR. Actual cash flows 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	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	67,421	1,054,093	2,390,597	13,716	22,326,571	8,302	103,065	**25,963,765**
Opening provisions for IBNR	13,000	243,000	1,125,000	112,000	37,457,000	2,000	82,000	**39,034,000**
Total provisions as at 1 April 2017	**80,421**	**1,297,093**	**3,515,597**	**125,716**	**59,783,571**	**10,302**	**185,065**	**64,997,765**
Movement in known claims								
Provided in the year	86	108,068	214,733	12,528	5,859,760	9,843	70,810	**6,275,828**
Provision not required written back	(13,381)	(140,244)	(216,193)	(3,883)	(3,308,275)	(2,313)	(26,714)	**(3,711,003)**
Unwinding of discount	1,535	25,609	58,185	25	466,774	0	127	**552,255**
Change in discount rate	11,739	222,534	457,557	74	4,284,164	0	202	**4,976,270**
Provisions utilised in the year	(2,286)	(56,077)	(110,445)	(5,525)	(2,058,734)	(6,484)	(45,613)	**(2,285,164)**
	(2,307)	159,890	403,837	3,219	5,243,689	1,046	(1,188)	**5,808,186**
Movement in Net IBNR								
Change in discount rate	3,000	55,000	323,000	11,000	10,230,000	0	1,000	**10,623,000**
Provided in the year	(7,000)	(47,000)	(350,000)	(35,000)	(3,986,000)	1,000	(17,000)	**(4,441,000)**
	(4,000)	8,000	(27,000)	(24,000)	6,244,000	1,000	(16,000)	**6,182,000**
Closing provision for known claims	65,114	1,213,983	2,794,434	16,935	27,570,260	9,348	101,877	**31,771,951**
Closing provisions for IBNR	9,000	251,000	1,098,000	88,000	43,701,000	3,000	66,000	**45,216,000**
Total provisions as at 31 March 2018	**74,114**	**1,464,983**	**3,892,434**	**104,935**	**71,271,260**	**12,348**	**167,877**	**76,987,951**
Analysis of expected timing of discounted cash flows								
Not later than one year	1,294	35,831	122,422	9,953	2,438,685	11,346	45,648	**2,665,179**
Later than one year and not later than five years	8,166	155,552	495,850	19,444	12,224,574	1,002	122,229	**13,026,817**
Later than 5 years	64,654	1,273,600	3,274,162	75,538	56,608,001	0	0	**61,295,955**
	74,114	**1,464,983**	**3,892,434**	**104,935**	**71,271,260**	**12,348**	**167,877**	**76,987,951**

7.1. Reconciliation of Note 7 to Statement of comprehensive net expenditure

	Ex-RHA £000	ELS £000	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Unwinding of discount / Finance charge	**1,150**	**20,434**	**45,512**	**25**	**355,288**	**1**	**55**	**422,465**
Increase in known claims provision (Gross of payments)	145	44,958	234,253	9,848	7,374,294	11,767	67,480	**7,742,745**
Provision not required written back	(3,210)	(46,419)	(70,608)	(8,142)	(2,065,906)	(3,166)	(26,581)	**(2,224,032)**
Change in discount rate (known claims and IBNR)	281	5,053	13,473	989	249,952	(6)	(634)	**269,108**
Increase /(decrease) in provision for IBNR	2,000	6,000	(92,000)	19,000	2,653,000	1,000	10,000	**2,599,000**
Provision expense charged to Statement of comprehensive net expenditure	**(784)**	**9,592**	**85,118**	**21,695**	**8,211,340**	**9,595**	**50,265**	**8,386,821**
Total charge to Statement of comprehensive net expenditure	**366**	**30,026**	**130,630**	**21,720**	**8,566,628**	**9,596**	**50,320**	**8,809,286**

7.2. Explanatory notes

Nature of the obligation

NHS Resolution provides indemnity cover for clinical negligence and non-clinical claims under seven schemes. Provisions are calculated in accordance with IAS 37, and relate to liabilities arising from incidents covered by these schemes:

- Claims received by NHS Resolution (known claims)
- Settled Periodical Payment Orders (PPOs) where the settlement of a claim involves payments to the claimant into the future, generally for their lifetime
- Incurred but not reported (IBNR) provision where claims have not yet been received but where it can be reasonably predicted that:
  - an adverse incident has occurred, and
  - a transfer of economic benefits will occur, and
  - a reasonable estimate of the likely value can be made.

Scope of the schemes

Existing Liabilities Scheme (ELS), Ex-Regional Health Authorities (Ex-RHA) and DHSC clinical and non-clinical Liabilities Schemes

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

Clinical Negligence Scheme for Trusts (CNST)

This scheme provides indemnity cover to providers of NHS services, NHS commissioners, and DHSC arm's length bodies for claims arising from incidents involving clinical negligence. Contributions are collected from members to make settlements and administer claims on their behalf. The scheme has been operating since 1 April 1995, and claims are included in the provision where:

- NHS Resolution has assessed the probable cost and time to settlement in accordance with the scheme guidelines;
- they are qualifying incidents; and
- the organisation against which the claim is being made remains a member of the scheme.

As at 31 March 2002, all outstanding claims for incidents post 1 April 1995 became the direct responsibility of NHS Resolution. 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)

The PES and LTPS schemes were introduced in April 1999 following the Secretary of State for Health and Social Care's decision that NHS trusts should not insure with commercial companies for non-clinical risks, other than motor vehicles and other defined areas (e.g. PFI schemes).

The schemes are managed and funded via the same mechanisms as the CNST except that specific excesses exist for some types of claims. Thus, the provision recorded in these accounts relates only to NHS Resolution's proportion of each claim.

Assumption of liabilities upon cessation

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State for Health and Social Care to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This includes the liabilities assumed by NHS Resolution in respect of all schemes.

Process and methodology for setting the provision

NHS Resolution contracts actuarial advisers, the Government Actuary's Department, to assist with the preparation of financial statements through analysis and modelling of claims data. This is combined with information provided by management on the current economic and claims environment in order to provide estimates for management to consider in relation to determining the valuation of the liabilities for the accounts.

NHS Resolution's Reserving and Pricing Committee is responsible for making decisions on the key judgments and estimates, supported by the advice of the actuaries.

One of the key assumptions used in the production of the estimates reported is outside the formal control of NHS Resolution, as HM Treasury prescribes the discount rates to be used in calculating the provisions. There are other factors that influence the provision that are also outside NHS Resolution's control, for example patients (and their legal representatives) have an element of control over the timing of the reporting of claims. The 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.

The methodologies for the three key elements in NHS Resolution's provisions are as follows:

- **Known claims** – The provision is based on the case estimates of individual reported claims received by NHS Resolution. 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 structured settlements – with part of the claim paid over the life of the claimant as a periodical payment order (PPO) rather than purely as a lump sum – and for the assumed additional cost if the case were to settle as a PPO. The resulting adjusted claim values are then discounted for the time value of money (at the Treasury-prescribed rates) to give a present value at the accounting date.
- **Settled PPOs** – To estimate the provision for settled PPO claims, the expected future cash flows from each individual settled PPO are projected and weighted by the claimants' probability of survival to each payment. The present value of these cash flows is calculated using the 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 probability of survival of the claimant to each future payment. The probabilities of survival for each claimant are based on estimated life expectancy, agreed by medical experts in each case.
- **IBNR** – To estimate the IBNR provision at the accounting date, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a present value (at the Treasury-prescribed discount rates).

The steps to arrive at an estimate are:

- 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 claims inflation.
- By combining the average claim sizes with the claim numbers and patterns for the reporting to payment time lag 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, based on mortality assumptions derived from the settled PPO claims. Lump sum settlements are assumed to be paid out in full around settlement time.
- The final step in the process is to calculate the present value of the projected future cash flows (using the Treasury-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.
- For CNST, ELS and DHSC Clinical Liabilities, these calculations are carried out separately for damages, defence costs and claimant costs, and for PPO and non-PPO type claims.

7.3 Key assumptions and areas of uncertainty

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

The following table shows the key assumptions used to determine the CNST IBNR and settled PPO provisions, as the CNST IBNR provision is the largest single element of total provisions, and therefore where uncertainty has the greatest effect. 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 following 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 value of the provision.

The legal environment is a particular area of uncertainty, given there have been a number of recent consultations that might impact the schemes' provisions in the future ('Introducing a Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury' and 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims', both issued by DHSC).

The provisions have been valued using the current PIDR of minus 0.75%. The Civil Liability Act 2018 has introduced changes to how the PIDR will be set in future. As there is no certainty on the decisions or arrangements that will arise out of these consultations, nor the value of a revised PIDR, no adjustments have been made to the IBNR for the potential effects of such changes at this stage.

Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes	Change in assumption between 31 March 2018 and 31 March 2019	Effect of change
Ultimate number of claims	Derived from past claim numbers and development patterns	Medium	High	Both the expected number of future PO claims and non-PPO claims has reduced, reflecting emerging experience	-£1.8bn
Propensity to settle as PPO	Value threshold derived from recent years' settled claims data	Medium	Medium	A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold remains unchanged	No impact
Average cost per claim	Derived from past settled claims – set separately for damages, defence costs and claimant costs	High	High	Generally average damages costs for PPOs have increased by less than expected (excluding the adjustment made to CNST PPO average damages costs to reflect the maternity/non-maternity speciality mix of claims). Average claimant costs have reduced compared with last year's assumptions	Total combined effect (with claims inflation): +£0.4bn. This includes a +£2.9bn increase as a consequence of allowing for the maternity/non-maternity speciality mix in the calculation of the CNST IBNR provision
Claims inflation	Derived from past settled claims	High	High	The inflation assumption for non-PPO damages has increased by 0.7% compared with last year. The inflation assumption for PPO damages has decreased by 0.05% compared with last year, both include 0.3% pa margin for risk and uncertainty	
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium	There is no change in the assumption. Non-PPOs: 63%, PPOs: 54% for all future claims reported	No impact
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)	Lag range from 2.8 to 7.5 years, reducing by 0.1 year at the lower end of the range and increased by 0.5 year at the higher end of the range since last year	Relatively small
Cash flow pattern for PPO payments	Based on analysis of past settled PPO claims	Medium	Low	Expected future lifetime of PPO claimants at settlement has remained the same (37 years)	Relatively small
Nominal discount rates (relative to RPI)	HM Treasury prescribed	Prescribed	High	Short and medium term rates have reduced by 0.19% and 0.40% respectively. The long term rate has increased by 0.15%	+£0.2bn
ASHE 6115 (80th percentile)	Based on earnings increases relative to RPI over the longer-term	Medium	High	No change to assumption. RPI + 0.75% pa	No impact

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

Clinical negligence claims can take a number of years to be reported following the incident that gives rise to the claim. The IBNR provision depends on an assumed time lag pattern for how claims are reported to NHS Resolution 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 overestimated, and vice versa. Changing trends in this pattern over time, for example as a result of changes to the legal environment, increased awareness of the availability of compensation and a lack of past data preceding the formation of NHS Resolution, increases the uncertainty in this assumption.

The number of clinical claims reported to NHS Resolution continues to level 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.

PPOs remain a key area of uncertainty, given the high value of PPO settlements, the limited stable past data to base future claim number projections upon and the changing propensity to award PPOs to claimants. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

The IBNR provisions are subject to considerable uncertainty. At a high level, the method used to calculate the provisions assumes that future experience will be in line with past experience. In particular, the provisions are calculated on the basis of the current legal and claims environment, including the current PIDR. The recent PIDR change in March 2017 and the prospect of future changes contributes to the inherent uncertainty in the calculation of the provisions. Changes to the PIDR could impact both the value of indemnity awards and the behaviour of claimants. For example, a change in the PIDR could impact the propensity for claims to be settled as PPOs and the volume and timing of reported claims.

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, inflation is affected by a number of external factors such as the PIDR, changes in legal precedent (e.g. rules relating to accommodation costs determined by Roberts v. Johnstone) and changes in legal costs. The variety of potential external influences on future claims inflation means that this assumption is subject to significant uncertainty.

The HM Treasury PES discount rate note from December 2018 (which specifies the financial assumptions to be used for valuing provisions at March 2019) states that all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) CPI forecasts unless certain conditions are met for this assumption to be rebutted. These conditions are set out in Paragraph 18 of Annex B to the HM Treasury PES note. For NHS Resolution's IBNR provisions, these conditions have been met:

Condition 1: there is a logical basis for not applying OBR CPI inflation rates, in that the proposed alternative inflation rates would be clearly more applicable to the underlying nature of the cash flows. For NHS Resolution, past claims inflation and the mandated rates of PPO increases have been demonstrably different to CPI increases, so the assumptions for future inflation rates have been selected to reflect the historical data.

Condition 2: the proposed alternative rates must be free from management bias. An indication of this may be an independent or professional assessment of the proposed alternative inflation rates, such as by a committee, third party or other experts. The claims inflation assumptions have been based on the actuarial adviser's assessment of historical claims inflation which have then been reviewed and adopted by NHS Resolution's Reserving and Pricing Committee.

Condition 3: the inflation rates instead applied should be based on logical and relevant calculations and reasonable underlying assumptions. For example, they may be comparable to existing financial indices or based on historical trends. The claims inflation assumptions adopted have been based on historical claims data as well as making references to historical levels of other indices, such as the Annual Survey of Hours and Earnings (ASHE), and market-consistent assumptions for price inflation.

The change in the PIDR in March 2017 has resulted in a significant increase in the value of settlements which involve future losses. There is the potential for this to result in lump settlements becoming more attractive to claimants, which may affect the propensity for claims to settle with PPOs, or shift the balance between the amount of the settlement paid up front, thereby affecting the timing of cash flows. In addition, the application of a discount rate with a minus value affects the calculation of accommodation costs under Roberts v. Johnstone. Over the reporting period, NHS Resolution has not observed any significant changes in claimant behaviour due to the change in PIDR in March 2017 or due to any anticipated future change to the PIDR. Consequently, no adjustments have been made to the assumptions used to calculate the provisions for changes to claimant behaviour in this respect.

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

There is additionally some uncertainty in relation to the impact of the Early Notification scheme, which impacts some maternity incidents that occurred on or after 1 April 2017, on claims costs and reporting trends. At this stage there is insufficient information to ascertain what those impacts may be.

CNST IBNR sensitivities as at 31 March 2019

Reasonable range of results

The CNST IBNR provision is the single largest element within the total provision. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision.

The provision in the accounts is based on a set of chosen assumptions. It is possible to have a range of different results if a different set of assumptions had been chosen. Estimation of a reasonable range of results is possible, by selecting assumptions based on analysis of historical data that could reasonably have served the purpose of providing an estimate for the accounts.

A reasonable range of results is set out below, although it should be noted that this in itself does not reflect the potential uncertainty in the assumptions underpinning the provision as future experience may differ to the past, changes may occur in the claims and legal environment, and the modelling approach may not be a perfect representation of real life.

CNST IBNR reasonable range

	Value	Difference to accounts estimate
Baseline CNST IBNR	£46.5bn	
Reasonable upper range	£54.6bn	+17.4%
Reasonable lower range	£39.8bn	-14.4%

These results were achieved by varying the following assumptions, all of which could have reasonably been applied:

- The estimate for PPO damages claims for incident years 2014/15 onwards;
- The probability of defence for PPO type claims;
- The average cost for PPO damages;
- PPO damages claims inflation;
- The creation to settlement lag for PPO claims.

In summary, the provision in the accounts for CNST IBNR could have been reasonably set at a value between £39.8 billion and £54.6 billion, if the same data, method and approach were used, but different reasonable assumptions were selected on the basis of the past data. This is compared to the accounts estimate of £46.5 billion.

Changes in individual assumptions may have a greater or smaller impact on the provisions estimate.

Sensitivity analysis

The following tables show the impacts of adjusting the key assumptions used for the IBNR estimate for CNST.

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, as different assumptions can be correlated.

The sensitivity analysis is included in this note to enable readers to understand the impacts such adjustments would have on the accounts. It should be noted that the relationship between changes in the value of assumptions and the IBNR provision is not always linear, particularly for assumptions such as inflation and the HM Treasury-prescribed discount rate.

Figure 32: CNST IBNR sensitivities as at 31 March 2019

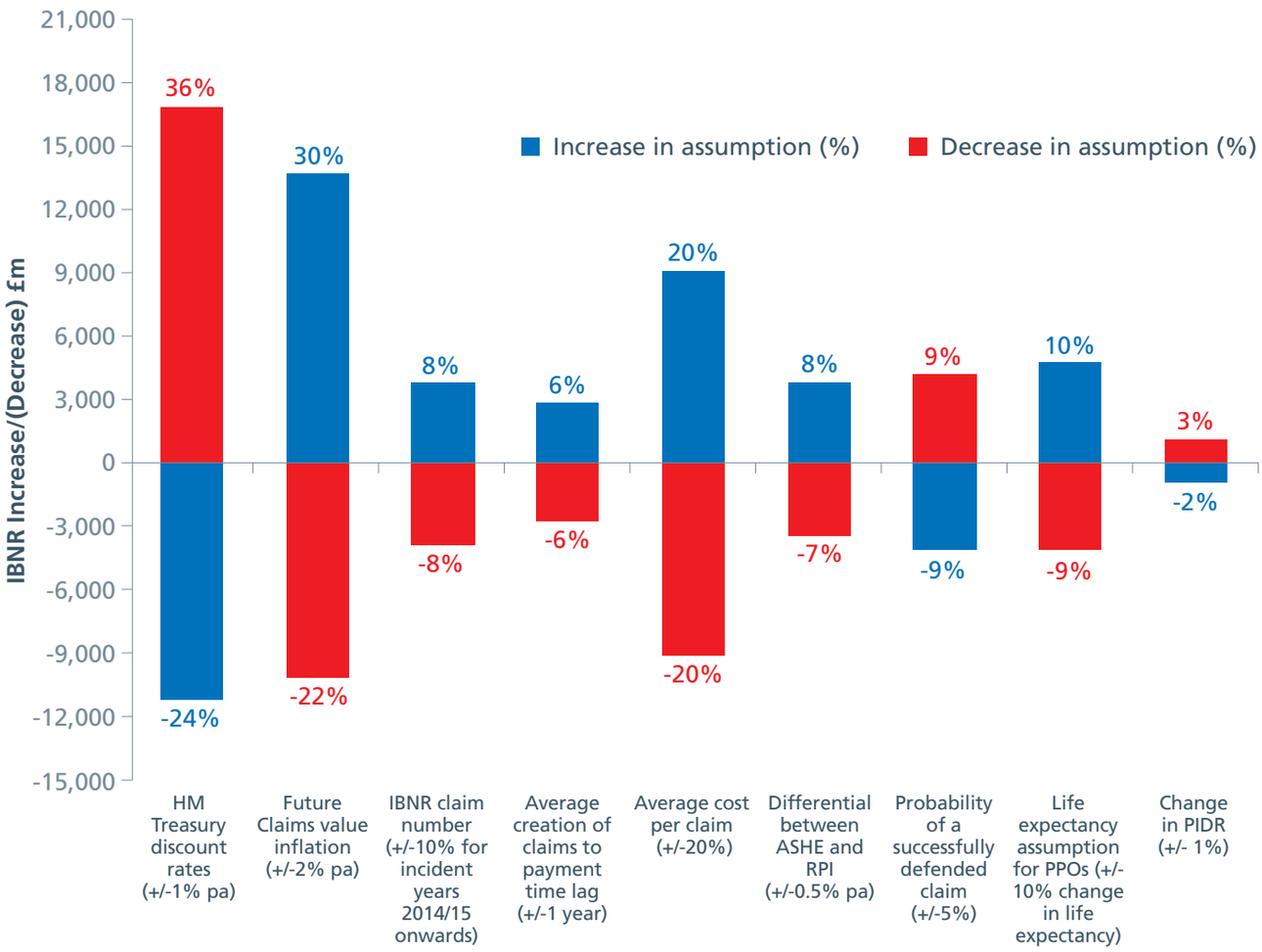


Figure 32 sets out both the value and percentage impact of variations in the key assumptions within the CNST IBNR estimate, which are also explained in the remainder of this note.

Sensitivity of estimated CNST IBNR provision as at 31 March 2019 to movements in the HM Treasury tiered nominal discount rates

For 2017-18, the discount rates specified by HM Treasury were relative to amounts expressed in current prices, referred to as "real" discount rates. These were adjusted to reflect market-consistent expectations of RPI inflation rates published in the 2017 HM Treasury PES note to provide the implied nominal rates below. These rates were used for the purposes of discounting NHS Resolution's inflated projected cash flows for last year's accounting provisions.

From 2018-19 onwards, HM Treasury is publishing PES discount rates in nominal terms as shown below.

The short- and medium-term nominal discount rates have decreased this year and the long-term rates have increased. The impacts of these changes on the IBNR provisions vary by scheme, depending on the type and duration of the expected future claim payments.

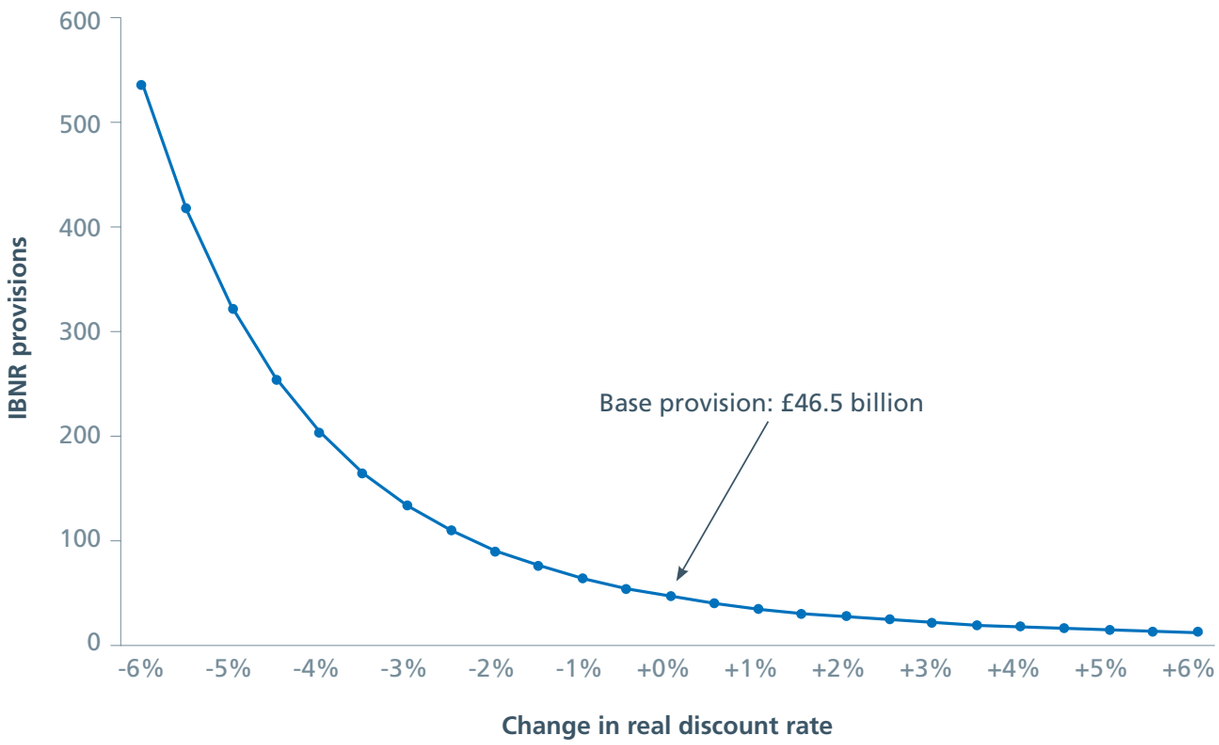
	31/03/2019 nominal rates (%pa)	31/03/2018 nominal rates (%pa)
Short term (<5 years)	0.76%	0.95%
Medium term (5-10 years)	1.14%	1.54%
Long term (10-40 years)	1.99%	1.84%
Very long term (over 40 years)	1.99%	1.84%

The following table shows that if the HM Treasury nominal discount rates were to be increased by 1% pa, the IBNR recorded in the Statement of Financial Position would reduce by £11,168 million and likewise a reduction of 1% pa would increase the IBNR by £16,919 million.

Sensitivity to changes in the HM Treasury-prescribed discount rates 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%	35,346	(11,168)	-24%
All rates -1%	63,433	16,919	36%

Figure 33: Sensitivity of the CNST IBNR provision to changes in the nominal discount rates assumption (£ billion, by change in discount rate from base assumption)



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

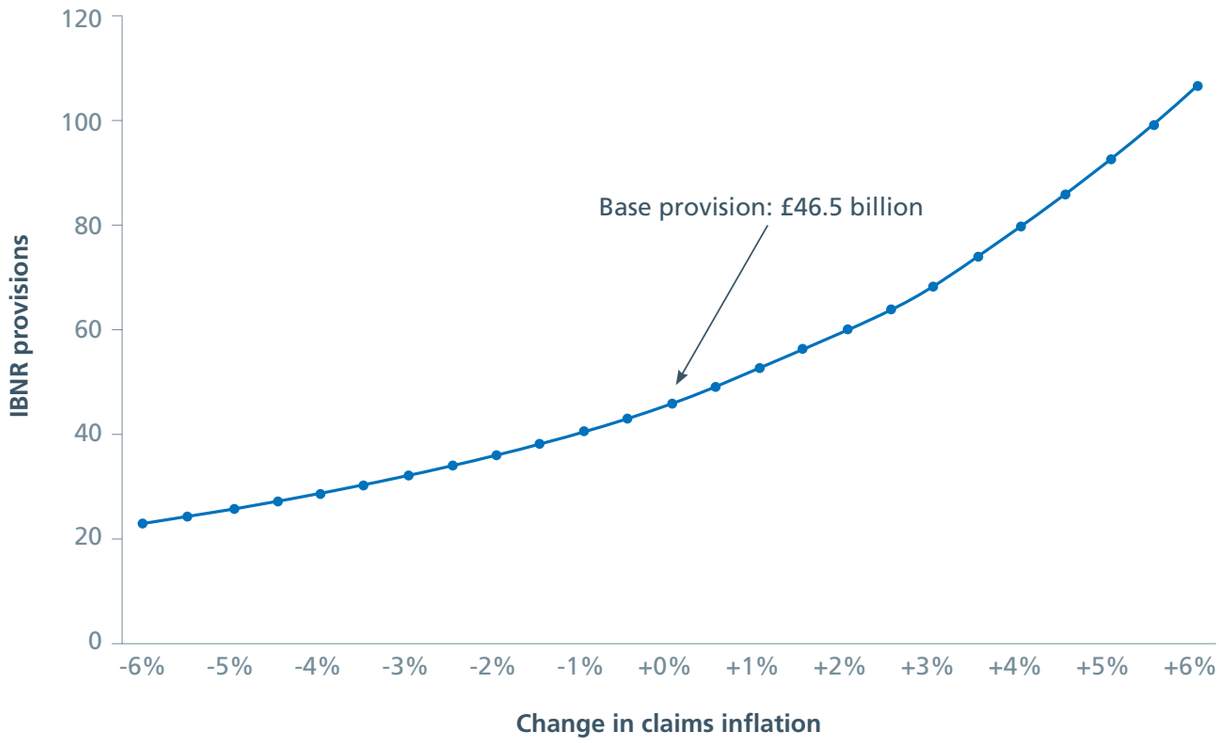
For the clinical schemes, the changes in discount rates this year have had a relatively small impact on the IBNR provisions.

This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than 10 years' time. In addition, the increase in the long-term discount rates has been matched by an increase in the assumption for the RPI inflation from 3.45% to 3.60% (the rate of 3.60% is taken from HM Treasury's PES note published in December 2018, reflecting market expectations at 30 November 2018, consistent with the derivation of the nominal discount rates). This means that the impact of the increase in the nominal discount rate has been offset by an increase in the rate at which claims are assumed to increase.

Sensitivity to future claims value inflation assumption

Claims value inflation	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
All rates +2%	60,260	13,745	30%
All rates -2%	36,440	(10,075)	-22%

Figure 34: CNST IBNR (£bn) adjusted by claims inflation



From the previous Figure 33 for CNST IBNR sensitivities and Figure 34, we can see that an increase in inflation has a greater impact on the provision than a decrease in inflation would have at the same rate.

While a 2% increase in inflation would increase the overall provision by 30%, a 2% decrease would only reduce the provision by 22%.

Sensitivity to assumptions of number of IBNR claims

IBNR claims number assumptions	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
+10% for incident years 2014/15 onwards	50,290	3,776	8%
-10% for incident years 2014/15 onwards	42,731	(3,784)	-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% for incidents from recent years, 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	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
Increase in average time lag of one year	49,314	2,800	6%
Reduction in average time lag of one year	43,821	(2,694)	-6%

A pattern is used to describe the lag between when a claim is created and when it is 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. This sensitivity approximately adjusts the lag pattern to be one year longer and one year shorter, which results in a 6% increase as a result and vice versa.

Sensitivity to average costs of claim assumption

Factor applied to all average claim value assumptions	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
All rates +20%	55,620	9,106	20%
All rates -20%	37,409	(9,106)	-20%

The average claim value assumptions are derived from claims settled in previous years, with separate calculations for damages, defence costs and claimant costs.

As we can see from the previous table, an increase of average claim value of 20% will result in a 20% increase in the value of the provision.

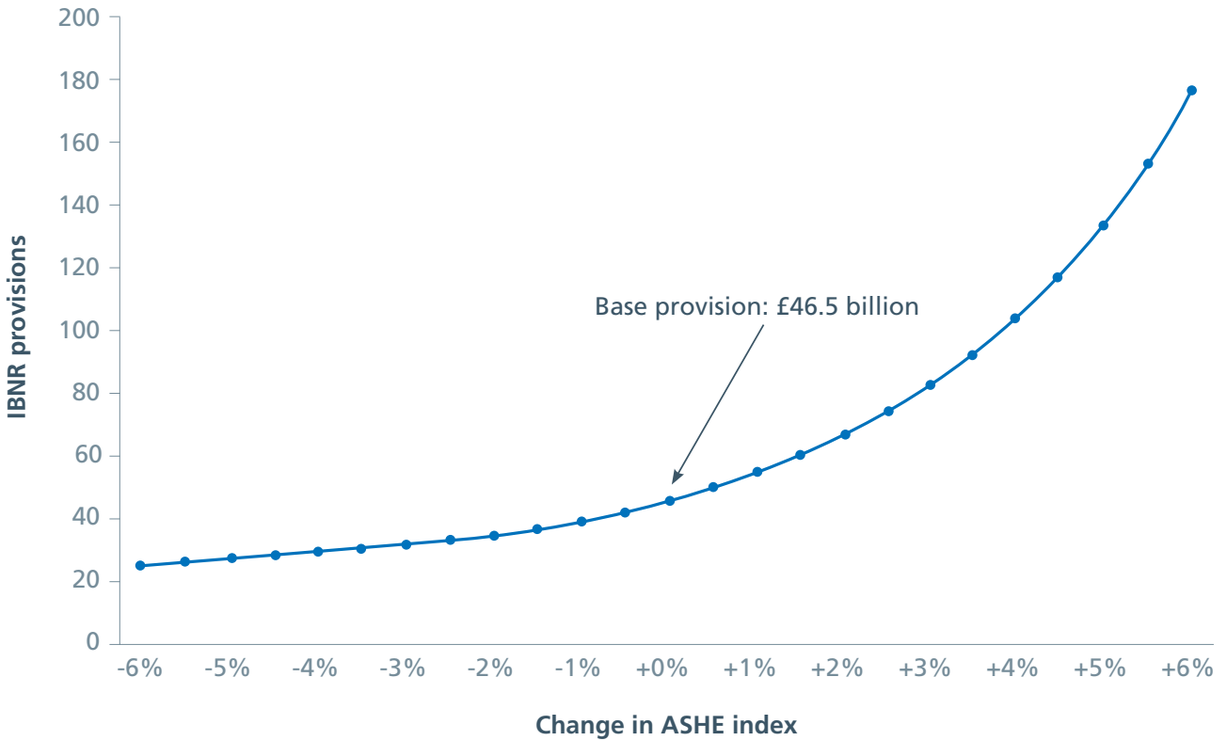
Sensitivity to differential between ASHE and RPI

Differential between ASHE and RPI assumption	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
All rates +0.5%	50,445	3,930	8%
All rates -0.5%	43,123	(3,391)	-7%

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 current assumption is that the rate of inflation in carers' wages is 0.75% higher than RPI price inflation each year.

The table and graph show the effect on the value of the CNST IBNR provision where this differential is varied and as the chart below shows, this is a non-linear relationship. An additional +/- 0.5% difference between ASHE and RPI will either increase the provision by 8% or reduce it by 7% respectively.

Figure 35: CNST IBNR (£bn) adjusted by ASHE index



Sensitivity to the assumed probability of a successfully defended claim

Probability of a successfully defended claim in every incident year	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
Increase of 5%	42,368	(4,147)	-9%
Decrease of 5%	50,661	4,147	9%

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 9%, for example.

Sensitivity to changes in the PIDR

Sensitivity to changes in the PIDR	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
Rates +1%	45,623	(891)	-2%
Rates +0.5%	46,037	(477)	-1%
Rates -0.5%	47,091	577	1%
Rates -1%	47,763	1,248	3%

The assumption for the sensitivity of the CNST IBNR provision to changes in the PIDR is based on evidence of cases settled during the year. As a significant proportion of the IBNR provision relates to PPO settlements, which are not affected by the PIDR, the impact of a change in the PIDR is relatively small.

There is uncertainty about whether the propensity to settle claims through PPOs will be affected by the PIDR change in March 2017 or any future anticipated PIDR change. The impact of the 2017 change could have made lump sum settlements relatively more attractive, however this has not been observed in the settlement of claims during 2018/19.

The IBNR provision is based on assumptions relating to the expectation of the number of claims where damages are expected to be paid, that certain proportions will settle as lump sums rather than PPOs, and average time lags for reporting and settlement. The impact of a change in the number of PPO settlements arising as a result of potential claimant behaviour changes (keeping all other assumptions the same) is set out as follows.

Proportionate change in number of PPO claims	IBNR effect £bn	IBNR effect (%)
+/-5%	+/-£0.5bn	+/-1.1%
+/-10%	+/-£0.9bn	+/-1.9%
+/-20%	+/-£1.8bn	+/-3.9%
+/-50%	+/-£4.5bn	+/-9.7%

The effect of changes in the propensity of claims to settle as PPOs would be significant on cash flows in the immediate term as the cost of lump sum settlements would change accordingly.

There may be other behavioural impacts of the PIDR change. The sensitivity analysis set out above in relation to the potential effect of changes in claims numbers, average costs, claims inflation and the probability of successfully defending claims, can be used to consider the potential effects.

Sensitivity of provision for settled periodical payment orders (PPOs) to key assumptions

HM Treasury discount rate assumptions

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 changes in the HM Treasury-prescribed discount rate, especially the long-term discount rate. In general, the clinical schemes are more sensitive to changes in the discount rate than non-clinical schemes, again, due to the longer-term nature of clinical claims.

As shown previously in the discussion of the CNST IBNR provision sensitivity, 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 41%, but a 1% increase will reduce the provision by 26%.

Provision for settled PPOs at 31 March 2019							
HM Treasury Discount rate	Total £m	CNST £m	ELS £m	DHSC clinical £m	Ex-RHA £m	LTPS £m	DHSC non-clinical £m
All rates -1% pa	26,148	21,282	1,434	3,345	83	3	1
Base assumption	18,805	15,141	1,056	2,543	62	2	1
All rates +1% pa	14,085	11,238	804	1,992	48	2	1

Percentage change to provision							
HM Treasury Discount rate	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -1% pa	39%	41%	36%	32%	34%	50%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%
All rates +1% pa	-25%	-26%	-24%	-22%	-23%	0%	0%

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

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. It is currently assumed that the rate of inflation in carers' wages is 0.75% higher than RPI annually.

The table below shows the effect on the value of the PPO element of the schemes' provisions where this differential is varied. An additional +/- 0.5% difference between ASHE and RPI will either increase the CNST PPO provision by 17% or reduce it by 14% respectively.

Provision for settled PPOs at 31 March 2018							
Differential between RPI and ASHE	Total £m	CNST £m	ELS £m	DHSC clinical £m	Ex-RHA £m	LTPS £m	DHSC non-clinical £m
All rates -0.5%	16,402	13,096	947	2,301	55	2	1
Base assumption: 0.75% pa	18,805	15,141	1,056	2,543	62	2	1
All rates +0.5%	21,769	17,672	1,189	2,834	71	2	1

Percentage change to provision							
Differential between RPI and ASHE	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -0.5%	-13%	-14%	-10%	-10%	-11%	0%	0%
Base assumption: 0.75% pa	0%	0%	0%	0%	0%	0%	0%
All rates +0.5%	16%	17%	13%	11%	15%	0%	0%

Life expectancy assumptions

The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Where the life expectancy of individual claimants at settlement is increased by 10%, the provision for CNST PPOs will increase by 19%. A 10% reduction in life expectancy will reduce the CNST provision by 17%.

Provision for settled PPOs at 31 March 2019							
	Total £m	CNST £m	ELS £m	DHSC clinical £m	Ex-RHA £m	LTPS £m	DHSC non-clinical £m
All rates -10%	15,603	12,556	874	2,118	52	2	1
Base assumption: 0.75% pa	18,805	15,141	1,056	2,543	62	2	1
All rates +10%	22,430	18,061	1,263	3,026	76	3	1

Percentage change to provision							
	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -10%	-17%	-17%	-17%	-17%	-16%	0%	0%
Base assumption: 0.75% pa	0%	0%	0%	0%	0%	0%	0%
All rates +10%	19%	19%	20%	19%	23%	50%	0%

8. Contingent liabilities

	Ex-RHA £000	ELS £000	DHSC clinical £000	DHSC non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Contingent liability as at 31 March 2019	**22,081**	**675,258**	**1,077,652**	**102,773**	**47,546,614**	**7,137**	**138,175**	**49,569,690**
Contingent liability as at 31 March 2018	14,162	662,283	1,144,116	131,689	44,298,593	13,007	154,507	46,418,357

NHS Resolution 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 primary care trusts and strategic health authorities (on 1 April 2013), NHS Resolution has taken on responsibility for any outstanding criminal liabilities, on behalf of the Secretary of State for Health and Social Care. Any valid claims arising from the activities of those organisations will be dealt with by NHS Resolution and funded in full by DHSC.

9. 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		2018/19 £000	2017/18 £000
Amounts payable:	within 1 year	**1,117**	1,135
	between 1 and 5 years	**1,105**	2,170
	after 5 years	**0**	0
		2,222	3,305
Other leases			
Amounts payable:	within 1 year	**32**	5
	between 1 and 5 years	**0**	0
	after 5 years	**0**	0
		32	5

10. Related parties

NHS Resolution is a body corporate established by order of the Secretary of State for Health and Social Care. DHSC is regarded as a controlling related party. During the year, NHS Resolution has had a significant number of material transactions with DHSC and with other entities, to whom NHS Resolution provides clinical and non-clinical risk pooling services, for which DHSC is regarded as the parent Department, for example:

All clinical commissioning groups
All commissioning support units
All English NHS foundation trusts
All English NHS trusts
Care Quality Commission
NHS Digital
Health Education England
Health Research Authority
NHS Blood and Transplant
NHS Business Services Authority
NHS England
NHS Property Services
NHS Trust Development Authority (now part of NHS Improvement)
Public Health England
NHS Counter Fraud Authority

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution 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 Resolution is disclosed in the Remuneration and staff report on page 114.

The transactions between NHS Resolution and the related parties concern solely those arising from NHS Resolution indemnity schemes, not the individuals referred to in the following table.

Name and position in NHS Resolution	Party	Nature of relationship	Payments to related organisation £000	Receipts from related organisation £000	Amount owed to related organisation £000	Amount due from related organisation £000
Denise Chaffer, Director of Safety and Learning	Epsom and St Helier NHS Trust	Midwife	-	14,102	-	1
Denise Chaffer, Director of Safety and Learning	Croydon University NHS Trust	Partner is a Consultant Radiologist	-	15,217	-	29
Helen Vernon, Chief Executive	NHS England	Brother is National Clinical Director for Older People and Person Centred Integrated Care	-	12,781	-	38
Helen Vernon, Chief Executive	Central Manchester NHS Trust	Brother is a Consultant Geriatrician	-	37,461	-	-
Charlotte Moar, Non-executive Director	NHS England	Programme Director, Transformation and Efficiency	-	12,781	-	38
Charlotte Moar, Non-executive Director	Avon & Wiltshire NHS Partnership Trust	Non-executive Director	-	789	-	-
Professor Sir Sam Everington, Associate Non-executive Director	NHS England	Director of Community Health Partnerships National Adviser to NHS England	-	12,781	-	38
Professor Sir Sam Everington, Associate Non-executive Director	Tower Hamlets CCG	Wife is a Board member	-	7	-	-
Professor Sir Sam Everington, Associate Non-executive Director	NHS Property Services	Wife is a Board member	-	523	-	281

11. 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, NHS Resolution 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. NHS Resolution 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 NHS Resolution in undertaking its activities.

NHS Resolution holds financial assets in the form of NHS and other receivables, and cash, as set out in Notes 4 and 5 respectively, and financial liabilities in the form of NHS and other payables, as set out in Note 6. As these receivables and payables are due to mature or become payable within 12 months from the Statement of Financial Position date, NHS Resolution considers that the carrying value is a reasonable approximation to fair value for these financial instruments.

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

None of NHS Resolution's financial assets and liabilities carry rates of interest.

NHS Resolution has negligible foreign currency income and expenditure. NHS Resolution is, therefore, not exposed to significant interest rate or foreign currency risk.

Credit risk

As the majority of NHS Resolution's income comes from contracts with other NHS bodies, NHS Resolution has low exposure to credit risk. The maximum exposures are in receivables from customers, as disclosed in Note 4: Receivables.

12. Events after the reporting period

Subsequent to the Balance Sheet date, on the 1 April 2019, NHS Resolution is operating a new state-backed indemnity scheme for general practice in England called the Clinical Negligence Scheme for General Practice (CNSGP). It covers clinical negligence liabilities arising in general practice in relation to incidents that occur on or after 1 April 2019. The value of the liability in 2019/20 is not expected to be material to the accounts, however, the business impact in 2019/20 will be a staged increase in staffing to manage the additional scheme.

In addition, DHSC has reached agreement with the Medical Protection Society Limited (MPS), one of the medical defence organisations (MDOs), in relation to existing in-scope liabilities for general practice in England for incidents prior to 1 April 2019. NHS Resolution has oversight of the arrangements for the new existing liabilities scheme and, for an interim period, claims handing will be retained by the MPS. Disclosure of any estimate of the financial impact is considered to be commercially sensitive.

These financial statements were authorised for issue on the date that the Comptroller and Auditor General certified the accounts.

Glossary

ALB – Arm's length body.

CCGs – Clinical commissioning groups have taken over commissioning from primary care trusts.

CNSGP – Clinical Negligence Scheme for General Practice

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

DHSC – Department of Health and Social Care.

HM Treasury discount rates – These discount rates are 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 DHSC and is a clinical negligence claims scheme that indemnifies pre-April 1995 incidents.

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

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

FHSAU – Family Health Services Appeal Unit, now known as Primary Care Appeals.

HPAN – Healthcare Professional Alert Notice is an alert system managed nationally by Practitioner Performance Advice to alert employers to the existence of serious grounds for concern about a regulated health practitioner who has departed an organisation and for whom concerns were unresolved. This differs from performers' list management (restrictions on practice), which are logged centrally by Primary Care Appeals 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, among other matters, the amount that claimant solicitors can recover from the defendant under conditional fee agreements and limit after-the-event insurance.

Legal costs – Amounts paid out by NHS Resolution in legal costs for claims resolved: including defence and claimant costs, this can include expert and counsel's fees as well as court 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 – NHS Resolution is a membership organisation comprising NHS trusts, CCGs, independent healthcare providers to the NHS and other government agencies related to healthcare.

NCAS – The National Clinical Assessment Service helps resolve concerns about the professional practice of individual doctors, dentists and pharmacists in the UK – now known as Practitioner Performance Advice.

NHS LA – National Health Service Litigation Authority, the former operating name of NHS Resolution.

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

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

PIDR – Personal injury discount rate.

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.

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