NHS Resolution

# Annual report and accounts 2023/24

Advise / Resolve / Learn

HC 73

# NHS Resolution
# Annual report and accounts
# 2023/24

**For the period 1 April 2023 to 31 March 2024**

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# Performance report

## Performance overview

# Chair and Chief Executive's welcome

Welcome to our Annual report and accounts for 2023/24, the second year of our three-year strategy to 2025, *Advise, Resolve and Learn*.

The year saw us build on our success in resolving clinical claims for compensation against the NHS in England without exposing patients, families and healthcare staff to distressing and costly court proceedings. Innovation in dispute resolution, and a collaborative approach, have continued to deliver benefits and enhance opportunities to learn and improve safety. Eighty-one percent of clinical claims were resolved without litigation, representing a further step forward to our ambition that no case should go to court unless it is necessary. This means that over 10,800 patients and their families were able to resolve their claims against the NHS through the alternative dispute resolution processes outlined on page 59 of our report.

Our report also describes how the continued development of 'upstream' approaches such as our Early Notification (EN) scheme for birth injury have helped families to access compensation for immediate needs more rapidly. Assessing life-long care needs for children who are seriously harmed in these cases will take longer than for other claims due to the need for developmental milestones to be reached before these can be assessed. However, early interim payments can make a significant difference when it most matters.

Our report describes on page 75 how we have worked with families and their representatives to improve the EN scheme, and we are looking forward to evaluating the impact of this ground-breaking initiative in the coming year.

Delivering insights from the work we do and the information we hold is one of NHS Resolution's strategic aims. We can provide a unique perspective, informed by independent expert clinical opinion and the patient's own report of what has caused them harm and how that was handled. We need to do all that we can to prevent the same things happening again to future patients. Our insights not only drive improvements in safety in healthcare, crucial in their own right, but also come with a clear financial case for doing so.

In 2023/24 we paid out over £2.8 billion on compensation and associated costs on all of our indemnity schemes. The estimated 'annual cost of harm'[1] for our schemes was £5.1 billion, of which our main clinical scheme, Clinical Negligence Scheme for Trusts (CNST) comprised £4.7 billion – money that could be spent on improvements to healthcare for the future.

[1] The cost of harm represents the cost of claims resulting from incidents from a specific financial year, in this case 2023/24. Further details can be found at Note 2.1 to the financial statements.

On pages 21 and 22 we describe the work we have undertaken over the course of the year to help drive improvements in safety. In doing so, we are acutely aware of the pressures affecting NHS staff and services daily and that everything we do in this area should make the best use of valuable clinical time, be evidence based and in partnership with others working in safety improvement. The engagement with our work across the NHS has consequently been significant as described on page 67 illustrating the value that clinical staff derive from it. In particular, the development and piloting of our Recommendation to Implementation tool has provided practical support to staff working in the NHS in aligning and prioritising safety recommendations from external bodies such as NHS Resolution alongside existing work.

While it is challenging to draw a direct correlation between our work and trends in safety improvement, we will continue to evaluate what we do to establish where we can have the most impact. In this regard, maternity incidents, which represent almost half of the annual cost of harm, continue to be a focus and a standalone strategic priority for NHS Resolution. We set out from page 77 how we have worked with others in this area to reach a consensus on the safety actions required, and then to support and incentivise the delivery of that through our Maternity Incentive Scheme, which entered its fifth year in 2023/24.

Claims trends have remained broadly steady in 2023/24 in terms of the numbers reported and resolved. Around half of clinical claims closed with compensation in 2023/24 as they did the previous year, demonstrating our continued commitment to investigating claims robustly and fairly, making damages payments where the merits of the case warrant it.

The overall value of damages, particularly for the most severely harmed, has continued to increase, as have claimant legal costs, but with some welcome positive signs such as a further reduction in damages inflation which has reduced the overall provision for clinical negligence. Fluctuations in the provision do occur year on year due to the time lags inherent in claims processes and, significantly in 2023/24, the consequence of accounting features such as His Majesty's Treasury (HMT) discount rate (as described on page 19). Our work on accurate forecasting of the provision continues alongside our key responsibilities of resolving claims fairly and contributing our insights on patient safety to reduce the overall cost of patient harm.

The wider challenges in the NHS have also driven an increased demand for our expert Practitioner Performance Advice service which responds to concerns about practitioner performance. We saw a substantial increase of 21% in new requests for advice and a particularly high demand for assessments of professional behaviours with a clear focus on patient safety. We also experienced a high demand for our educational programmes in Practitioner Performance Advice with income from this source exceeding expectations, demonstrating the value placed on this important service to the NHS.

Our Primary Care Appeals service delivered resolution of £2.5 million of Covid-19 payment disputes, concluding this essential work under extended powers.[2] At the same time, we responded to the new NHS structures by delivering training back to integrated care boards (ICBs) to help avoid the disputes that come to us in the first place.

[2] This relates to Secretary of State for Health and Social Care directions to NHS Resolution to determine pharmacy payment disputes in relation to the costs incurred by pharmacies for providing services during the Covid-19 pandemic. Our Primary Care Appeals service resolved the remaining Covid-19 payment disputes in relation to decisions taken by NHS Business Services Authority to either refuse to make payments or to recover past payments. The appeals window closed on 31 March 2023, so no cases were received in 2023/24.

Throughout all of this work our focus has been to deliver an efficient and effective service that provides the best possible value for public funds, and this has driven many of the programmes that sit below our last strategic priority, to invest in our people and our systems. Multi-year programmes to replace our core systems and invest in analytics to derive even greater value from our data while enhancing our governance and controls, such as cyber security, have driven an increase in our capital expenditure and our staff numbers, some of which will be temporary. These programmes will deliver an invaluable step-change in our ability to drive efficiencies in our processes over the medium to long-term as well as improving how we interface with the NHS and the legal and justice systems.

In our Claims Management service, our success in keeping cases out of litigation opens up the opportunity to invest in our staff to manage more work in-house and over time, reduce our external legal spend. In addition, the expansion of our remit into general practice, resulting in increased work for our organisation, provided the opportunity to shift the service to a regional model in line with NHS structures and deliver efficiencies through new models such as our new Claims Support Service. Together, this work forms our Claims Evolution Programme (CEP), described on page 78.

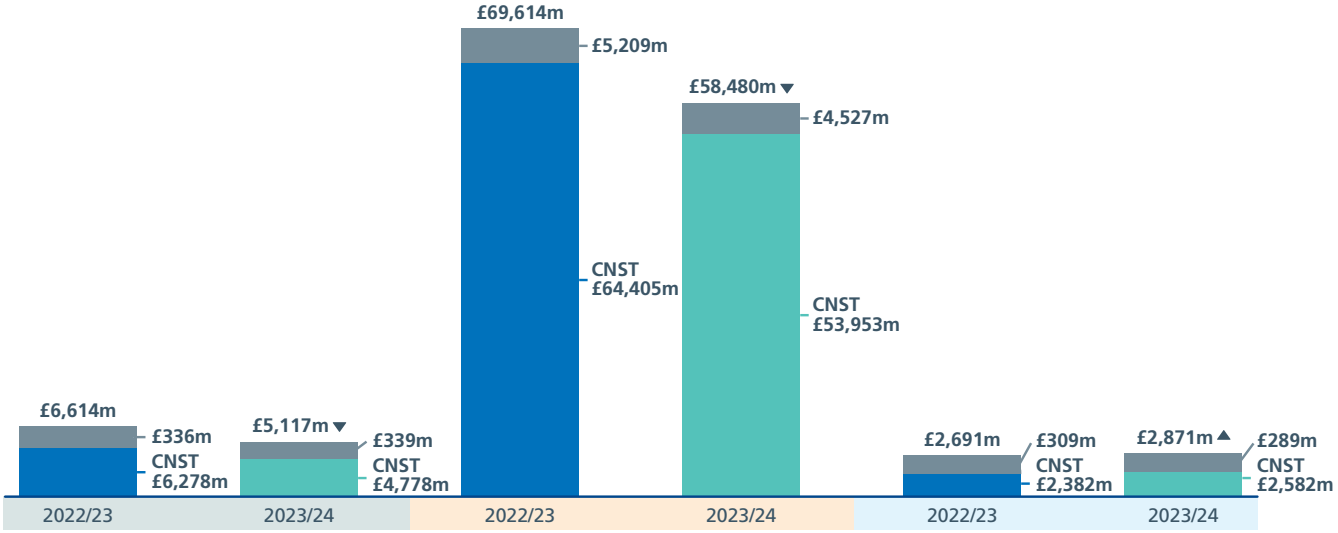
The move to a regional model for all our services is providing us with a deeper understanding of the needs, challenges and risk profiles of the NHS organisations we work with. Our work relies heavily on the input of frontline staff as treating clinicians who are witnesses to the events, as well as experts in relevant disciplines, to provide understanding of what happened and whether actions were reasonable or led to harm. We have in previous reports described the challenges of obtaining witness input and expert advice on claims given NHS pressures. By building strong relationships with our NHS partners and the legal market we have developed ways to navigate these challenges, meeting all of the key performance indicators (KPIs) for the Claims Management service this year.

Being a collaborative organisation which works closely with others with shared objectives is increasingly important and we are extremely grateful to all of those who have worked with us throughout the year and who continue to support our work. Finally, our own staff and suppliers, such as our panel law firms who work as one team, have worked incredibly hard to respond to an increasingly challenging programme of work. Our thanks go to them for all that they do to continue to deliver an excellent service and for the progress and achievements described in this report.

**Sally Cheshire CBE**
Chair

**Helen Vernon**
CEO

## Key financial components relating to all schemes in 2023/24 compared to 2022/23, highlighting our main scheme CNST




The estimated **'annual cost of harm'** for CNST and other schemes. The cost of harm is the estimated cost of claims incurred from incidents in the financial year.

The **year-end provisions** for CNST and other schemes. A helpful way to understand the provision is to think of it as the amount of money needed to settle all liabilities from claims arising from incidents up to the balance sheet date if they had to be settled on that date.

**Payments** made in-year in relation to CNST and other schemes. This includes payments for damages, claimant legal and NHS Legal costs.

2022/23 CNST | 2023/24 CNST | Other schemes

# Who we are and what we do

## We are an arm's length body of the Department of Health and Social Care (DHSC), tasked with:

- administering a range of indemnity schemes to cover the risks involved in delivering general practice and secondary healthcare services in England;
- delivering expert advice and support on the management of concerns about the performance of doctors, dentists and pharmacists;
- resolving contracting disputes between primary care contractors and commissioners of primary care, operating independently and transparently; and
- using our unique perspective across the causes of claims, performance concerns and contracting disputes to provide insights back to the NHS to help to improve safety and manage risk.

In 2022 we launched our three-year strategy, *Advise, resolve and learn: Our strategy to 2025*. As we head towards the final year of this strategy we have continued our focus on its four key priorities:

1. delivering fair resolution;
2. sharing data and insights as a catalyst for improvement;
3. collaborating to improve maternity outcomes; and
4. investing in our people and systems to transform our business.

The first three priorities rightly take precedence in our day-to-day activities as we work collaboratively with our partners and providers to resolve claims fairly and share insights with the aim of mitigating the risk of patient harm in the future.

At the same time, we are maintaining our paced and pragmatic approach to the major internal projects due to complete in the next financial year that sit under the fourth priority that will enhance our ability to provide services to the NHS.

We report in detail against each of these priorities in the Performance analysis section from page 36 onwards of this report.

**Figure 1: Our indemnity schemes**

Figure 1 gives a brief description of each indemnity scheme that we administer. The bulk of our work involves managing negligence claims against the NHS in England on behalf of our secondary care sector members and primary care beneficiaries of our indemnity schemes.

The members and beneficiaries of our indemnity schemes are predominantly NHS trusts and foundation trusts, together with general practice and independent sector providers of NHS care.

We manage seven clinical negligence indemnity schemes and four non-clinical indemnity schemes.

## Clinical negligence schemes

**Clinical Negligence Scheme for Trusts (CNST)**
This covers clinical negligence claims for incidents occurring on or after 1 April 1995.

**Existing Liabilities Scheme (ELS)**
This covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.

**Ex-Regional Health Authority Scheme (Ex-RHA)**
This is a relatively small scheme and covers clinical negligence claims against former regional health authorities abolished in 1996.

**DHSC clinical**
This 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)**
This covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.

**Clinical Negligence Scheme for Coronavirus (CNSC)**
Launched on 3 April 2020, this scheme meets clinical liabilities arising from certain special healthcare arrangements that were put in place in response to the coronavirus pandemic where no other indemnity or insurance arrangements were already in place to cover such liabilities.

**Existing Liabilities Scheme for General Practice (ELSGP)**
This covers claims for historical NHS clinical negligence and other tortious incidents that occurred any time before 1 April 2019 involving GPs who were members of participating MDOs. This scheme covered members of the Medical and Dental Defence Union of Scotland (MDDUS) from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.

## Non-clinical schemes

**DHSC non-clinical**
This 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.

**Coronavirus Temporary Indemnity Scheme (CTIS)**
This provided state cover until 31 March 2022 for employer's liability and public liability. It filled gaps where designated care home settings were unable to secure sufficient private insurance cover.

## Non-clinical schemes managed under the heading of the Risk Pooling Schemes for Trusts (RPST)

**Property Expenses Scheme (PES)**
This covers 'first party' losses such as property damage and theft for incidents on or after 1 April 1999.

**Liabilities to Third Parties Scheme (LTPS)**
This covers non-clinical claims such as public and employers' liability for incidents on or after 1 April 1999.

More information about our schemes is available on our website at https://resolution.nhs.uk/services/claims-management

**Figure 2: Our strategic priorities 2022–2025 and organisational structure in 2023/24**

## Our strategic priorities

**Priority 1.**
**Deliver fair resolution.**

All of our services will focus on achieving fair and timely resolution, wherever possible keeping patients and healthcare staff out of formal processes to minimise distress and cost.

**Priority 2.**
**Share data and insights as a catalyst for improvement.**

Ensuring that our unique datasets help derive usable insights that benefit patients and the healthcare and justice systems.

**Priority 3.**
**Collaborate to improve maternity outcomes.**

Bringing together key parties to determine what further improvements can be made within our areas of expertise to support the Government's maternity safety ambition.

**Priority 4.**
**Invest in our people and systems to transform our business.**

Developing our people, systems and services so that we can continue to deliver best value for public funds.

## Our services

**Claims Management**
Delivers expertise in handling both clinical and non-clinical claims through our indemnity schemes.

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

**Practitioner Performance Advice**
Delivers expert advice, support and interventions on the fair management of concerns about the performance of doctors, dentists and pharmacists.

**Safety and Learning**
Supports the NHS, our members and beneficiaries to better understand their claims risk profiles, to target their safety activity while sharing learning across the system to improve patient care.

## Enabled by

**Finance and Corporate Planning**

**Digital, Data, and Technology, and Transformation**

**Policy, Strategy and Communications**

## Our values

**Professional**
We are dedicated to providing a professional, high quality service.

**Expert**
We bring unique skills, knowledge and expertise to everything we do.

**Ethical**
We are committed to acting with honesty, integrity and fairness.

**Respectful**
We treat people with consideration and respect and encourage supportive, collaborative and inclusive team working.

# Key highlights against our four strategic priorities[3]

## Resolution

- Reduced the volume of claims entering formal court proceedings (81% in 2023/24), thereby providing earlier resolution for patients and healthcare staff and saving costs.
- Expanded our dispute resolution options and resolved 16,834 claims for compensation.
- Managed a range of sensitive and precedent-setting cases to a conclusion, including in the appeal courts and established innovative compensation approaches to groups of claims.
- Brought our partners in legal, governance and clinical teams in the NHS together, to share how we respond when things go wrong and how we resolve compensation claims together, delivering 21 events.
- Resolved 276 primary care contracting appeals and disputes, many of which raised new issues. Our Primary Care Appeals service resolved the remaining Covid-19 payment disputes. While the overall number of payment disputes was low, the total value of the disputes amounted to £2.5 million.
- Dealt with 956 new requests for advice from healthcare organisations with concerns about the practice of individual practitioners as well as services.
- Delivered 46 education programmes across the NHS to improve how the service responds to performance concerns in the workforce.

## Maternity

- Strengthened how we connect with families who interact with our services, including appointing a family liaison and mediation lead, continuing the valuable work with our Maternity Voices Advisory Group and holding a parent focus group to help us improve how we communicate with families engaged with our Early Notification scheme.
- Led by our Practitioner Performance Advice service, we launched our new maternity team review aimed at the team-related issues that can affect performance in maternity services in England.
- Launched our eLearning module focused on safer maternity care. The module uses three illustrative case stories to support clinicians working in maternity services. Since its launch in June 2023, 904 people have accessed the module.
- Commenced the evaluation of our Early Notification scheme and Maternity Incentive Scheme.
- Worked with our Collaborative Advisory Group to develop the Maternity Incentive Scheme to respond to the current pressures on maternity services and further incentivise safety improvement. Supported and informed the work of national policy and inquiries into the safety of maternity services.

[3] This figure represents all clinical and non-clinical claims resolved in 2023/24.

## Insights

- Published five *Insights* papers relating to Practitioner Performance Advice.
- Held an in-person national emergency medicine conference, attended by 147 delegates, aimed at bringing together professionals working in emergency departments across England to share learning from compensation claims and on-the-ground experiences of how to improve care.
- Published updated claims scorecards, an interactive improvement tool to enable NHS trusts to extract and analyse information on high-value and high-volume claims.
- Launched our new podcast series with the first episode focusing on how insights from claims data can be used by emergency medicine teams to help improve safety.
- Worked with our legal panel firms, drawing on their collective expertise to inform current and future priorities for NHS Resolution and our partners in improving safety and the response to compensation claims.
- Delivered a range of claims webinars to almost 400 NHS delegates, focusing on topics such as compassion in claims management, working in the independent sector and LTPS claims. Of the delegates who attended the independent sector webinar, 82% said they learned something new or heard a new insight.
- Continued to operate, and continuously improve, our framework to manage concerns referred to our Significant Concerns Group including the addition of a specific process to manage and respond to immediate concerns.

## Investing in people and systems

- Shifted our entire Claims Management service to a regional model to align with NHS structures, strengthening the connection with local NHS services and our teams. This has enabled a deeper shared understanding of the challenges experienced by healthcare providers and of opportunities to learn from claims. In line with the achievement of a reduction in litigation, we have built on the opportunity this creates to save costs by progressing the first phase of our plan to undertake more claims work in-house.
- Implemented internally our new IT system, CaseHub, for our Advice service, applying learning from the early adopter model to the upcoming roll-out for the Claims Management service. Completed the first phase of a pilot of our Claims Support Service, which will drive efficiencies in claims management while making the most of our in-house expertise.
- Achieved Disability Confident Level 3 accreditation.

# Performance summary

Our services combine to be a driver for positive change across the healthcare system, reducing harm to patients, reducing the distress caused to both patients and healthcare staff when a claim or concern arises and, ultimately, reducing the cost of delivering fair resolution.

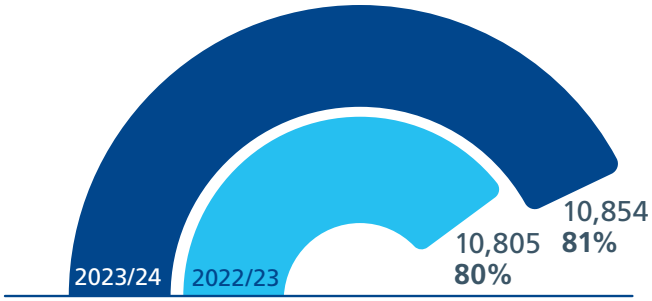
Our commitment to continuing to deliver on our purpose is underpinned by our three-year strategy, *Advise, resolve and learn: Our strategy to 2025*.

In this middle year of the strategy, and during a period of both external and internal change and challenge, we have continued to make good progress on its priorities.

## Delivering fair resolution

All of our services focus on achieving fair and timely resolution, wherever possible keeping patients and healthcare staff out of formal processes to minimise distress and cost.

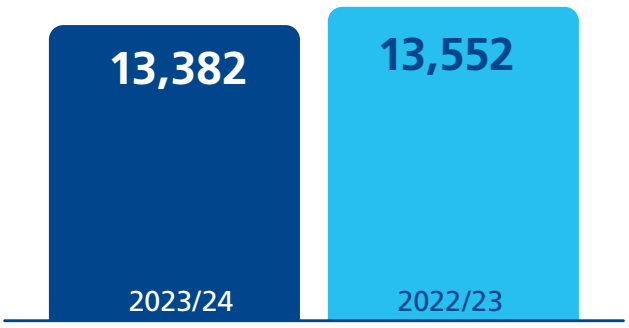
### Clinical claims resolved without entering court proceedings in 2023/24 compared with 2022/23




In 2023/24, the number of clinical claims resolved without entering court proceedings (10,854) is the highest ever, which is a major achievement of our strategy. We will always work to keep claims out of court proceedings where appropriate and are continuing to extend our use of dispute resolution options such as resolution meetings, mediation and stock takes when appropriate. However, we also recognise that this upward trend cannot continue indefinitely, and we expect this figure to stabilise over the next few years.

The number of claims we resolved in 2023/24 compared with 2022/23 decreased slightly. Our strategy to deliver fair resolution means we expect the volumes and values of cases resolved to fluctuate year on year, as the portfolio of cases we resolve will vary and depend on many factors within the wider health system, including the effects of the Covid-19 pandemic. Of the claims we resolved, 52% resulted in a payment of damages, compared with 51% in 2022/23, which reflects our strategy of delivering fair resolution, making damages payments where it is right to do so.

### Clinical claims resolved in 2023/24 compared with 2022/23



**Payments for resolving clinical claims in 2023/24 compared with 2022/23**

**£2,821.2m** 2023/24

**£2,641.7m** 2022/23

**Year-end provision in 2023/24 compared with 2022/23**


In relation to our accounts, year-end provision for future claims liabilities has decreased, primarily due to the change in HMT discount rates, a technical accounting feature affecting the provision. The change in the discount rate does not, however, in any way reflect changes in the main drivers of claims experience, such as the number of claims that result in damages being paid or the average cost of these claims. Trends over the longer term indicate that the assumptions underlying the provisions do continue to move in a favourable direction, that is, to reduce the value of the provision. The average cost assumptions for the highest-value claims have not grown as much as expected five years ago and the corresponding assumption for future claims inflation continues to fall. Despite this year's experience being slightly higher than assumed last year, the expected future claim numbers, including high-value claim numbers, have also reduced over time.

## What are His Majesty's Treasury (HMT) discount rates for general provisions and why does it matter?

One of the key assumptions used in calculating the provisions are the discount rates which are designed to recognise the value of money over time: generally speaking £1 in the future is worth less than £1 now, because of the interest that could be earned by investing £1 today. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings in today's terms. At a high level, it tells us how much it might cost to settle those obligations today or at the balance sheet date (31 March). In accordance with International Financial Reporting Standards (IFRSs), HMT has determined market rates which reflect the Government's cost of borrowing. NHS Resolution's provisions are particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities which is driven by the reporting and settlement delays as well as the fact that many high-value claims are settled as a periodical payment order (PPO) with payments provided over the remaining lifetime of the claimant. Further information about HMT's discount rates can be found in Note 7 to the financial statements on page 166.

However, it is important to recognise that the in-year cost of clinical negligence across the NHS continues to be significant.

Payments in respect of our clinical schemes in 2023/24 totalled £2,821 million. This includes damages paid to claimants of £2,107 million, claimant legal costs of £545 million and NHS legal costs of £169 million.

When we look at Clinical Negligence Scheme for Trusts (CNST), which is our biggest scheme and which represents the majority of claims by numbers, the estimated cost of harm in 2023/24 was £4,778 million (see Note 2.1 to the financial statements on page 162). This figure is lower than the previous year's figure of £6,278 million, mainly owing to increases in HMT discount rates, which has placed a lower value on projected claims costs.

**CNST claims and reported incidents across primary and secondary care in 2023/24 compared with 2022/23**

**10,834** 2023/24

**10,567** 2022/23

In terms of clinical negligence claims and incidents reported to us, we saw an increase of 3% (from 10,567 in 2022/23 to 10,834 in 2023/24) in CNST. It is important to note that numbers for 2022/23 may still have been impacted by the Covid-19 pandemic and wider system pressures, which saw reduced numbers of claims being made. When we take an average of claims in the five years immediately preceding the pandemic (2015/16 to 2019/20), the increase is 0.7%.

The top four categories of clinical claim numbers by specialty in 2023/24 were emergency medicine, obstetrics,[4] orthopaedic surgery and general surgery. Of these, obstetric claims accounted for 13% of clinical claims reported by volume (excluding General Practice Indemnity, (GPI)) but accounted for 57% of all clinical claims by value received in 2023/24 (compared with 64% in 2022/23 – see page 52 for more information on this change).

**Percentage of obstetric claims received by volume in 2023/24**

**12.8%** 2023/24

**Percentage of obstetric claims received by value in 2023/24**

**56.7%** 2023/24

All these numbers illustrate why it is so important that we continue to support work across Government to address the causes and cost of clinical negligence as described on page 30.

At the same time, we are awaiting the Ministry of Justice's personal injury discount rate (PIDR) reviews. These developments will necessarily involve changes to our day-to-day working processes and our Claims Management service is continuing to work hard to prepare for and manage these changes.

The healthcare system is still facing significant frontline pressures and continues to be the focus of a range of inquiries and reviews. We are starting to see the impact of these frontline pressures in relation to the complexity of both our Claims Management and Practitioner Performance Advice cases.

Our Practitioner Performance Advice service, as described on page 64, has seen a significant increase in demand for case advice in 2023/24 – around a 21% increase in new requests for advice when compared with the last financial year. Similarly, activity levels for our specialist assessment and remediation services are at their highest for more than five years, with high demand for assessments of practitioners' behaviours and action plans to help improve their performance and/or return to work after an absence from clinical duties. We see a clear focus on patient safety in these requests and assessments.

In 2023/24, our Primary Care Appeals service resolved the remaining Covid-19 payment disputes received following the Secretary of State for Health and Social Care Committee's directions to NHS Resolution to manage and resolve these cases. These disputes are in relation to the costs incurred by pharmacies for providing services during the Covid-19 pandemic against decisions taken by NHS Business Services Authority to either refuse to make payments or to recover past payments. While the overall number of payment disputes was low (23), the total value of the disputes amounted to £2.5 million. We have been monitoring the Health and Social Care Select Committee inquiry relating to pharmacy; this is an area in which our Primary Care Appeals service plays a key role in delivering fair resolution of disputes between contract holders and the commissioner.

For a full insight into our work in this area in 2023/24, see Strategic priority one: Deliver fair resolution on page 44.

[4] Obstetric care is defined as the care of women during pregnancy, childbirth and the period following delivery (typically 3–6 weeks).

# Sharing data and insights as a catalyst for improvement

Our second strategic priority demonstrates our commitment to using our data to derive useable insights that can be shared with our stakeholders and used to improve service delivery, identify emerging patient safety risks and support a greater understanding of the causes of incidents.

Against the current backdrop of system pressures, it is more important than ever to share those insights, but to do so in a way that respects time-pressed staff. In 2023/24 we have engaged with both managers and clinicians, attending external conferences and organising in-person and virtual events. We have also published research and insights that provide practical, actionable patient safety insights.

In 2023/24, our Safety and Learning service launched a pilot Recommendation to Implementation tool, consolidating the 21 recommendations from the three NHS Resolution emergency medicine thematic reviews. The tool aims to make it easier for NHS trusts to navigate the many recommendations that come from different sources in relation to the delivery of emergency care, generating learning which can be applied in other areas of clinical practice.

We have undertaken a significant piece of research to better understand the lived experience of ethnic minority and international medical graduate (IMG) practitioners who are the subject of performance concerns referred to us. The actions flowing from this research now sit within our broader programme of equality, diversity and inclusion (EDI) work and present an opportunity to consider how the research outcomes can be used to support improvement in our own service and to help effect change in the wider NHS.

For a full insight into our work in this area in 2023/24, see Strategic priority two: Share data and insights as a catalyst for improvement on page 66.

# Collaborating to improve maternity outcomes

We have built a reputation as a trusted partner in the maternity healthcare system and our third strategic priority is about bringing together key parties to see what more can be done to support the Government's maternity safety ambition to reduce harm.

Each incident can lead to heartbreaking consequences for a family. Although secondary to the human impact, errors can also result in a significant financial cost to the NHS.

It is for these reasons that we continue to focus so much of our resource on addressing the causes and management of incidences of brain injury sustained at birth, which can have a life-long and devastating impact.

In relation to our Early Notification (EN) scheme, our expert clinical staff draw learning from liability investigations in real time and work with the NHS to receive an assurance that steps are being taken to prevent the same avoidable errors happening again. We continue to work with our Maternity Voices Advisory Group to understand how we can better support families at an incredibly difficult time.

Our Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. Developed in partnership with the national maternity safety champions at the time and continuing to be delivered in partnership with a broad range of stakeholders, it rewards trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services. These actions are owned and developed by members of NHS Resolution's Collaborative Advisory Group, which is composed of DHSC, other arm's length bodies, the relevant royal colleges, Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK), and the Maternity and Newborn Safety Investigations (MNSI) programme, with the financial incentive delivered via the CNST.

We are in the process of evaluating both these schemes and plan to report on our findings in 2024/25.

In 2023/24 we also launched an eLearning module specifically designed to support clinicians working in maternity services. The module uses three illustrative case stories to support clinicians working in maternity services. Since its launch in June 2023, 904 users have accessed the module in order to enhance their professional development.

**Figure 3: NHS Resolution's eLearning module: Maternity insights, closing the loop, learning from harm (launch June 2023)**


For a full insight into our work in this area in 2023/24, see Strategic priority three: Collaborate to improve maternity outcomes on page 70.

# Investing in our people and systems to transform our business

The internal changes we are making enable us to develop as an organisation and are a necessary part of our evolution to ensure we can continue to deliver best value for public funds.

In 2023/24 we continued to deliver our key transformation programmes, CaseHub and the Claims Evolution Programme, both of which involve huge amounts of work behind the scenes.

CaseHub is a significant technology upgrade programme for NHS Resolution. It will replace legacy operational IT systems in addition to enabling efficiencies across all our functions, streamlining how we interact with the NHS and boosting our analytical capability. This will mean we can provide even better value for public funds and enhance our role in sharing insights for safety improvement. In March 2024, internally, we successfully rolled out the platform to our Practitioner Performance Advice service and we will continue to roll out the system to more functions within the organisation in 2024/25.

Our Claims Evolution Programme will bring more claims management in-house to NHS Resolution and reduce the money spent on external legal costs. This has resulted in planned growth which will ultimately enable us to build on our dispute resolution approach in pursuit of our ambition that no compensation claim against the NHS should go into court proceedings unless it is absolutely necessary.

As part of this programme, in 2023/24 we have shifted our entire Claims Management service to a regional model to align with NHS structures, strengthening the connection between local NHS services and our teams. This has enabled a deeper shared understanding of the challenges experienced by healthcare providers and of opportunities to learn from claims. We have built on the opportunity this creates to save costs by progressing the first phase of our plan to undertake more claims work in-house.

For a full insight into our work in this area in 2023/24, see Strategic priority four: Invest in our people and systems to transform our business on page 78.

# The year in numbers

### What is the difference between a resolved claim and a closed claim?

A claim is resolved when we have reached settlement about the payment or non-payment of damages. At this point, there may be claimant and NHS legal costs still to be agreed, so there will continue to be uncertainty over the total amount to be incurred on these claims. Also, in cases where a periodical payment order (PPO) is involved, the claim is referred to as resolved for the duration of the claimant's lifetime. Costs for these cases will be uncertain due to inflation factors and life expectancy. We refer to resolved claims as settled claims in our internal systems. We have also referred to settled claims in previous annual reports and accounts.

When all elements of a claim have been agreed and paid, or payments on a PPO have come to an end, the claim is closed.

## Table 1: The finance year in numbers

| Financial element | 2023/24 (£ million) | 2022/23 (£ million) | Change (£ million) | (%) | |
|---|---|---|---|---|---|
| **Funding for clinical schemes** | | | | | |
| Income from members | 2,664.2 | 2,431.1 | 233.1 | 9.6% | ^ |
| Funding from DHSC (budget) | 261.4 | 287.9 | (26.5) | (9.2%) | v |
| **Total clinical scheme funding** | **2,925.6** | **2,719.0** | **206.6** | **7.6%** | ^ |
| **Payments in respect of clinical schemes** | | | | | |
| Damages payments to claimants | 2,106.9 | 1,992.0 | 114.9 | 5.8% | ^ |
| Claimant legal costs | 545.3 | 490.9 | 54.4 | 11.1% | ^ |
| NHS legal costs | 169.0 | 158.8 | 10.2 | 6.4% | ^ |
| **Total clinical scheme payments** | **2,821.2** | **2,641.7** | **179.5** | **6.8%** | ^ |
| **Funding for non-clinical schemes** | | | | | |
| Income from members | 60.5 | 59.0 | 1.5 | 2.5% | ^ |
| Funding from DHSC (budget) | 7.2 | 9.3 | (2.1) | (22.6%) | v |
| **Total non-clinical scheme funding** | **67.7** | **68.3** | **(0.6)** | **(0.9%)** | v |
| **Payments in respect of non-clinical schemes** | | | | | |
| Damages payments to claimants | 26.2 | 26.8 | (0.6) | (2.2%) | v |
| Claimant legal costs | 16.6 | 16.3 | 0.3 | 1.8% | ^ |
| NHS legal costs | 7.1 | 6.1 | 1.0 | 16.4% | ^ |
| **Total non-clinical scheme payments** | **49.9** | **49.2** | **0.7** | **1.4%** | ^ |
| **NHS Resolution administration costs** | | | | | |
| Clinical schemes administration | 44.1 | 38.0 | 6.1 | 16.1% | ^ |
| Non-clinical schemes administration | 7.1 | 6.2 | 0.9 | 14.5% | ^ |
| Other activities | 7.7 | 7.9 | (0.2) | (2.5%) | v |
| **Total administration expenditure** | 58.9 | 52.1 | 6.8 | 13.1% | ^ |
| **Income** | 0.9 | 1.0 | (0.1) | (10.0%) | v |
| **Staff numbers (full time equivalent)** | 680 | 578 | 102 | 17.6% | ^ |
| **Claims provisions expenditure[5] of which:** | **(8,262.5)** | **(56,245.6)** | **47,983.1** | **85.3%** | ^ |
| • CNST incurred cost/cost of harm in the financial year | 4,777.8 | 6,278.5 | (1,500.7) | (23.9%) | v |
| • Other schemes incurred cost in the financial year | 339.4 | 335.8 | 3.6 | 1.1% | ^ |
| **Subtotal incurred cost/cost of harm in the financial year** | 5,117.2 | 6,614.3 | (1,497.1) | (22.6%) | v |
| Costs arising from previous financial years incidents and claims | (13,379.7) | (62,859.9) | 49,480.2 | 78.7% | ^ |
| | | | | | |
| **Provisions for claims** | **58,480.0** | **69,613.5** | **(11,133.5)** | **(16.0%)** | v |
| | | | | | |
| **Capital expenditure** | **3.5** | **5.5** | **(2.0)** | **(36.4%)** | v |

For a full insight into the year in numbers, see the Finance report on page 84.

[5] Total charge to Statement of Comprehensive Net Expenditure – see Notes 2.1 and 7.1 to the financial statements for the breakdown and the Finance report on page 84 for explanation. The increase in HMT long-term and very long-term discount rates has had the most significant impact in both 2022/23 and 2023/24.

## Table 2: The claims year in numbers

| Claims element | 2023/24 | 2022/23 | Change | (%) | |
|---|---|---|---|---|---|
| **Notified claims for clinical schemes** | | | | | |
| CNST | 10,834 | 10,567 | 267 | 2.5% | ^ |
| CNSGP | 2,382 | 2,180 | 202 | 9.3% | ^ |
| CNSC | 22 | 15 | 7 | 46.7% | ^ |
| ELSGP | 502 | 709 | (207) | (29.2%) | v |
| DHSC Funded Schemes | 44 | 40 | 4 | 10.0% | ^ |
| **Total clinical schemes** | **13,784** | **13,511** | **273** | **2.0%** | ^ |
| **Notified claims for non-clinical schemes** | | | | | |
| LTPS | 3,299 | 3,136 | 163 | 5.2% | ^ |
| DHSC Liabilities | 13 | 10 | 3 | 30.0% | ^ |
| PES | 47 | 46 | 1 | 2.2% | ^ |
| **Total non-clinical schemes** | **3,359** | **3,192** | **167** | **5.2%** | ^ |
| **Resolved for clinical schemes** | | | | | |
| CNST | 10,275 | 10,338 | (63) | (0.6%) | v |
| CNSGP | 2,089 | 1,729 | 360 | 20.8% | ^ |
| CNSC | 11 | 10 | 1 | 10.0% | ^ |
| ELSGP | 965 | 1,423 | (458) | (32.2%) | v |
| DHSC Funded Schemes | 42 | 52 | (10) | (19.2%) | v |
| **Total clinical schemes** | **13,382** | **13,552** | **(170)** | **(1.3%)** | v |
| **Resolved for non-clinical schemes** | | | | | |
| LTPS | 3,396 | 3,601 | (205) | (5.7%) | v |
| DHSC Liabilities | 18 | 15 | 3 | 20.0% | ^ |
| PES | 38 | 52 | (14) | (26.9%) | v |
| **Total non-clinical schemes** | **3,452** | **3,668** | **(216)** | **(5.9%)** | v |
| **Closed for clinical schemes** | | | | | |
| CNST | 10,658 | 11,047 | (389) | (3.5%) | v |
| CNSGP | 1,994 | 1,670 | 324 | 19.4% | ^ |
| CNSC | 14 | 21 | (7) | (33.3%) | v |
| ELSGP | 1,114 | 1,550 | (436) | (28.1%) | v |
| DHSC Funded Schemes | 53 | 51 | 2 | 3.9% | ^ |
| **Total clinical schemes** | **13,833** | **14,339** | **(506)** | **(3.5%)** | v |
| **Closed for non-clinical schemes** | | | | | |
| LTPS | 3,768 | 3,892 | (124) | (3.2%) | v |
| DHSC Liabilities | 19 | 14 | 5 | 35.7% | ^ |
| PES | 49 | 57 | (8) | 14.0% | ^ |
| **Total non-clinical schemes** | **3,836** | **3,963** | **(127)** | **(3.2%)** | v |

# The environment we work in

We work across two interrelated sectors, health and justice. We recognise the current pressures in each sector, but we also note that our work always relates to incidents that happened in the past. It means that while we can reflect on the landscape as we see it now, we won't know for several years how it will impact on the number and nature of claims we receive.

## Health

The NHS continues to face service pressures. A combination of increasing demand for care, workforce issues and recovery from the Covid-19 pandemic means that the number of people on waiting lists and waiting times across the service remain, in general, high.

Patient safety inquiries, referenced in the sections on Strategic priority one on page 44 and Strategic priority three on page 70 under Performance analysis in this report, demonstrate the continued concern of providers, patients and Government, and offer valuable conclusions on opportunities for improvement and enhanced ways of working.

The establishment of integrated care systems and strategies such as the NHS Long Term Workforce Plan are part of the series of interventions that will help address issues over the longer term, but we are aware of the impact of the current landscape on the here and now.

We rely on the expertise of NHS staff in delivering our services. Recognising the necessity of prioritising frontline care, we have liaised closely and sensitively with colleagues in the NHS when requesting their expertise.

## Justice

From 1 October 2023, the Government expanded fixed recoverable costs to a wider category of civil claims which impacts some of our clinical and non-clinical schemes.

The main objective is to provide faster resolution, with legal costs that are proportionate to the value of compensation. Around 50% of successful resolved clinical negligence claims are for matters with a damages value of £1,501 to £25,000, so this reform is likely to affect several thousand claims annually.

### What are damages?

Damages is another term for compensation and can include general damages and special damages. General damages is compensation for both the pain suffered and impact on quality of life (usually referred to as loss of amenity incurred). Special damages is compensation for any additional losses incurred such as loss of earnings, additional care requirements, medical expenses and funeral expenses.

## Our partnerships with stakeholders in the health and justice sectors

We have built effective relationships across the NHS, the wider patient safety landscape and in justice and the wider legal system. These relationships support shared objectives to improve healthcare for NHS patients.

A summary of our engagement with our key stakeholders and partners is outlined in the next section.

# How we have worked with our stakeholders

Our unique position at the intersection of health and justice, combined with our engagement with stakeholders at every level from frontline clinicians to legal teams and board members, gives us a valuable perspective. We contribute informed insight within our remit at local, regional, national and even international levels in order to drive continued improvements in patient safety.

As outlined in the Strategic priority two and Strategic priority three sections of our Performance analysis on pages 66 and 70 respectively, in 2023/24 we worked with our stakeholders in a number of ways.

1. Many of our virtual forums had a primary care focus to shine a spotlight on themes identified in our 2022 report on the first year of the Clinical Negligence Scheme for General Practice (CNSGP).

   We held an Implementing recommendations: shared insights to reduce claims in emergency medicine conference in October 2023. The day was attended by 147 delegates and 95% said they would recommend the conference to a colleague.

   Our Collaboration for safer and sustainable maternity care event held in January 2024 brought together NHS Resolution, panel legal firms and clinical teams in the south east of England and London to promote learning using a regional platform.

2. Our EN Maternity Voices Advisory Group (MVAG) provides external stakeholders, in particular families and their representatives, with a forum in which they can advise and support future service developments within the EN scheme.

   We share early intelligence in relation to maternity and neonatal services via the Collaborative Advisory Group (CAG), which we discuss in more detail in Continuing to support work to improve the safety of maternity services on page 76.

3. We remain an active partner with Getting It Right First Time (GIRFT), the programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting a data-driven evidence base to support change.

   At a national level, we have built on the Medical Workforce Race Equality Standard (MWRES) – A commitment to collaborate; The first five report, to which we were a co-signatory, publishing research into the lived experience of ethnic minority and international medical graduate practitioners with our service and their employers. This is covered in more detail in Helping to resolve concerns relating to healthcare staff on page 64.

4 Our Primary Care Appeals service engaged with the national dental and ophthalmic team, the national pharmacy team and the national medical team of NHS England (NHSE) as well as professional representative bodies such as Community Pharmacy England, continuing to allow us to share data and insights to help facilitate improvement.

5 To foster learning and strengthen relationships with our healthcare system partners we take part in external events where appropriate. In 2023/24, these events have included the Royal College of Nursing Congress, the Royal College of Obstetrics and Gynaecology World Congress, the Health Service Journal Patient Safety Congress, Baby Lifeline's National Maternity Safety Conference and the NHS Providers Annual Conference.

We also work collaboratively with organisations and bodies including NHSE, the Parliamentary and Health Service Ombudsman, the Patient Safety Commissioner, the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigations (MNSI) programme, the Health Services Safety Investigations Body (HSSIB), the Society of Clinical Injury Lawyers and the patient safety charity Action against Medical Accidents.

In addition to our regular interactions on operational matters, we have worked with these partners on joint initiatives such as the clinical negligence claims management agreement and a symposium considering how to remove inefficiency and friction from the claims management process to benefit patients and healthcare staff. We recognise that by sharing insights and viewpoints where it is appropriate and relevant to do so we can enhance the patient safety and claims management landscapes.

6 We continue to share our unique learning and insights to inquiries and consultations and provide data, technical and operational advice to DHSC whenever our expertise is required.

We are also keen to learn from and share best practice with other jurisdictions and engage bilaterally whenever appropriate. In 2023/24 we contributed to work being undertaken by international bodies including the Botswana High Commission, the Canadian Medical Protective Association and the Ministry of Health in Singapore.

As well as allowing us to support the system with informed insight, our continuous engagement with our stakeholders is a critical element in helping us to effectively manage the risks and issues we face. These are summarised in the next section.

# Key risks and issues

Like every organisation, we face risks and issues that, unless carefully managed, have the potential to impact our performance. In this section, we explore our key risks and issues and outline the steps we take to manage them.

## Responding to the policy environment

We operate in a dynamic policy environment, and it is important to identify emerging issues so we may consider their potential impact on our strategic objectives and delivery.

As described in The environment we work in on page 28, the Government has announced its intention to fix legal costs for lower damages clinical negligence claims alongside changes to processes which are designed to speed up resolution of claims. Because the reform is likely to affect several thousand claims annually, we are working rigorously to ensure we can secure the benefits in speed and cost that it offers.

In addition, a scheduled review of the PIDR will carry significant operational and financial implications for our work, together with a degree of uncertainty as to the outcome and market response. We will prepare and stand ready to respond to the announcement and the resulting impact.

## Maintaining operational delivery in a system under pressure

As an organisation that works closely with – and relies on the expertise of – multiple stakeholders and partners, we are indirectly affected by the pressures that affect them. We recognise the necessity of prioritising frontline care and are consistently mindful of the need to work with our NHS colleagues in a way that recognises the impact of system pressures.

Factors such as access to clinicians to progress claims have, over the course of 2023/24, had an impact on our time to resolution key performance indicator (KPI) (see page 39). However, we are pleased to note that, as of 31 March 2024, this KPI is back within tolerance.[6]

[6] We expect this KPI to fluctuate in tolerance due to various system pressures we have outlined, which have a direct impact on our ability to manage claims.

## Maintaining operational delivery during transformation

Our transformation plans are reaching critical junctures, with both CaseHub and our Claims Evolution Programme (discussed in the section on Strategic priority four on page 78) reaching their implementation phases.

Two key strategic programmes, the EN scheme and the MIS, are undergoing evaluation.

We are continuing to plan our resources to ensure we deliver our vital transformation programmes while maintaining business as usual activities.

## Raising concerns

As an NHS body, patient safety and public protection are of paramount concern to us. On occasion, the data we hold may indicate a significant concern.

However, there are challenges in identifying within our data where those concerns may exist. Indemnity scheme claims may take many years to be reported to us and may represent only a very small fraction of incidents that occur in the NHS. As a result, it may not become apparent for some time that there have been particular risks to patient safety from the data we hold.

As part of our three-year strategy, we are continuing to develop ways of deriving insight from the data we hold in relation to our operational functions. As part of this work, we operate a Significant Concerns Framework (see page 66). It acts as a guide when there is concern about serious harm, ensuring that confidential information relating to notifications is managed appropriately. It provides a tightly controlled governance framework and includes escalation arrangements when these are required. The framework encourages candour and openness in managing our Claims Management and Practitioner Performance Advice services. It also ensures that we can, in very occasional circumstances, refer our concerns to other NHS bodies.

## Data quality

Interest in clinical negligence is growing, and interest in our data is growing as a consequence. We ensure that the data we produce, sometimes at short notice, is accurate and adequately described, to avoid incorrect interpretation.

This is challenging given the complexity of data and nuances in the definitions, and we are continually developing our quality assurance framework to ensure we capture and maintain accurate and relevant data while adhering to the General Data Protection Regulation framework.

A significant part of our second strategic priority, Share data and insights as a catalyst for improvement (see page 66), is to develop the use of technology to make our data more easily manageable and accessible so that we can provide analysis and insight.

We are committed to transparency in our policy to publish data directly, such as the annual report statistics derived from our claims data, or indirectly via system partners such as GIRFT or the Model Hospital.

## Protecting our assets

The risks posed by increasing and evolving cyber security threats are a reality for every organisation.

To mitigate the risk to our systems, we continue to work on implementing proactive cyber security measures, some of which are outlined in Strategic priority four on page 78.

We have worked closely with stakeholders such as NHSE to devise KPIs to help measure the effectiveness of our controls. We have risk assessed our information assets and their importance to the business processes they support. This ensures our technical controls are appropriately aligned and tested to the value of our assets.

We have successfully maintained our Cyber Security Essentials Plus and ISO 27001 certifications. Our Board, as well as our Audit and Risk Committee (ARC), are kept informed of emerging threats and our approach to dealing with them.

## Fraud

The risk of fraud is ever-present. With support from our local counter-fraud specialist providers, and participation in DHSC's Counter Fraud Liaison Group, we continually review and monitor potential threats. We provide awareness training to staff and undertake proactive exercises to detect potential fraud and improve our control framework where there is evidence of a fabricated or exaggerated claim. For more information, see page 60.

For more information on our approach to managing risk, see the Capacity to handle risk section in our Governance statement on page 106.

# Going concern

The 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 and funders of schemes contribute sufficient funds to meet the liabilities required on a yearly basis rather than holding reserves for future settlements. Based on discussions with DHSC, the Board has a reasonable expectation that the provision of clinical and non-clinical negligence schemes to be managed in the public sector will continue for the foreseeable future. To this end there is a further reasonable expectation that the Government, via DHSC and the NHS, will continue to fund future liabilities, and therefore the Board is assured that it will be able to meet all liabilities falling due during the going concern assessment period.

Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements of 31 March 2024.

# Performance analysis

This section reports on our areas of focus and performance against our key performance indicators as outlined in our Business plan 2023/24.

# Key performance indicators

Our key performance indicators (KPIs) cover all areas of our operations and provide an objective assessment of our operational performance. At a high level, our KPIs provide assurance to our Board and to DHSC that we are conducting our business as intended and as we are funded for.

Our KPIs are reviewed and agreed annually by our Board and DHSC, a process that helps us continuously develop our services.

The target measures for some of our internal claims KPIs are confidential because publication could prejudice the effective management of claims.

The performance of our panel of legal firms, or legal panel, is also monitored closely under a range of KPIs. These KPIs are specified in our contracts with them in order to ensure a high-quality service at a competitive price. We hold regular performance meetings to address any issues or concerns raised and discuss continuous improvement.

Our Board and People Committee monitor a variety of workforce indicators, including establishment levels, employee turnover, recruitment, sickness absence, levels of pay, and equality and diversity statistics. This ensures that the associated human resources (HR) issues flowing from our business are properly managed.

We use a red, amber and green (RAG) rating to show which KPIs we failed to meet, came close to meeting (within 10% of target) and fully met. We provide further information where KPI targets have not been met.

In 2023/24 we reviewed our KPIs. Some KPIs were not tracked because they were no longer relevant or because they were completed, so the numbering is not always continuous. Other KPIs may not have a trend comparison from 2022/23.

More detailed information about the activities we have undertaken in 2023/24 can be found in this section of the report.

# Deliver fair resolution

| No. | KPI description/measure | Area | Target | 2022/23 RAG | 2023/24 RAG |
|---|---|---|---|---|---|
| 1 | Reduction in volume of cases that enter litigation before appropriate dispute resolution | Claims Management | Internally reported[7] | N/A | G |
| 2 | Time to resolution from claims decision to agreement of damages | Claims Management | Internally reported[8] | R | G |
| 3 | Volume of cases repudiated initially with a subsequent payment agreed | Claims Management | Internally reported[9] | G | G |
| 4 | The movement in financial reserves is managed within a target range | Claims Management | Internally reported[10] | G | G |
| 5 | Undertake scheduled contract performance meetings with legal and costs suppliers to review performance against their KPIs | Claims Management | Internally reported[11] | G | G |
| 6 | We can demonstrate we have obtained relevant stakeholder input to inform our external products, services and/or service improvements[12] | Safety and Learning | At least 80% | G | G |
| 7 | 90% of requests for advice responded to within two working days (or within an alternative timeframe requested by the employing/contracting organisation) | Practitioner Performance Advice | 90% | G | G |
| 8 | 100% of Healthcare Professional Alert Notices (HPANs) issued/ released or revoked (where justified) within seven working days | Practitioner Performance Advice | 100% | G | G |
| 9 | 90% of all exclusions/suspensions critically reviewed (where due) | Practitioner Performance Advice | 90% | A | A |
| 10 | 90% of assessment and other intervention reports produced/issued within target timeframe | Practitioner Performance Advice | 90% | G | G |
| 11a | 80% of pharmacy appeals where decision maker agrees with recommendation of case manager | Primary Care Appeals | 80% | G | G |
| 11b | 90% outcome of quality audits for appeals and dispute files | Primary Care Appeals | 90% | G | G |
| 12 | Before and after education metrics are applied to 100% of training events provided (including to primary care contracting commissioning teams) | Primary Care Appeals | 100% | G | G |

## Red or amber KPIs – explanatory notes

**KPI 9 –** the financial year 2023/24 ended on 83%, with 154 of 185 exclusions/suspensions reviewed within the required timescales. Where reviews did not take place within the required time this was predominantly due to the employing or contracting organisation not responding to the request for review discussions. The current process has undergone review and revised criteria for reviewing exclusions/suspensions has been developed. The new process will be implemented in 2024/25. It recognises that in some instances it is not practicable for a review to take place because of local factors that relate to the exclusion/suspension, for example where a practitioner is suspended from the register or if they are subject to court proceedings. At the end of this reporting period there were 43 exclusions ongoing, with a median length of 6.6 months. There was one ongoing exclusion lasting longer than 24 months.

[7] KPI 1 focuses on reducing the number of claims that enter litigation before appropriate dispute resolution options have been considered and recommended. The emphasis on dispute resolution at the pre-litigation stage supports the strategic priority to deliver fair resolution. During 2022/23 we worked on establishing a baseline for this KPI and implementing processes to support data capture which has enabled the full measurement of this KPI in 2023/24. The target is not reported externally due to commercial sensitivities.

[8,9,10,11] Target not reported externally due to commercial sensitivities.

[12] We have amended the measure from 'Obtained relevant stakeholder input to inform at least 80% of our external products, services and/or service improvements.'

# Share data and insights as a catalyst for improvement

| No. | KPI description/measure | Area | Target | 2022/23 RAG | 2023/24 RAG |
|---|---|---|---|---|---|
| 13a | Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative information | NHS Resolution[13] | 100% | G | G |
| 13b | Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed) | NHS Resolution[14] | 100% | G | G |
| 13c | Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way | NHS Resolution | 100% | A | N/A |
| 14 | Actively sought and obtained feedback for 100% of the eLearning modules launched in 2023/24 | Safety and Learning | 100% | G | G |
| 15 | Actively sought an update on progress from all national level stakeholders tasked with delivering actions arising from national thematic review recommendations | Safety and Learning | Achieved | G | G |
| 16 | Before and after metrics are applied to 100% of events related to compassionate conversations and non-executive director training | Practitioner Performance Advice | 100% | N/A | G |
| 17 | Publication of six Advice Insights products by the end of Q4 | Practitioner Performance Advice | 6 | G | A |

## Red or amber KPIs – explanatory notes

**KPI 13c –** we hold ourselves to a very high standard, aiming to achieve 100% of concerns raised to have appropriate steps taken in a timely way. Due to the low number of notifications (nine) that were raised through this framework during the reporting period, this has not been RAG rated. The three cases that missed the 'timely' measure in 2023/24 each had different factors leading to the delay. We are using the lessons learned from these cases to inform future handling.

**KPI 17 –** five of the six scheduled Insights were published in 2023/24 – for more information see figure 19 in Strategic priority two on page 68. One of the Insights published accompanied the lived experience research and covered Practitioner Performance Advice's response to the findings, which is described on page 67. We undertook extensive internal and external pre-publication engagement work in mid-2023, which was deemed necessary to gain approval for publication and to secure appropriate engagement with the learning from the lived experience research. The change in schedule meant the publication of a number of Insights was shifted to the end of 2023 and we later took a decision to space out the Insights to ensure each publication gained maximum possible engagement and interest from our target audiences.

[13,14] We have amended the area to be an organisation-wide KPI.

# Collaborate to improve maternity outcomes

| No. | KPI description/measure | Area | Target | 2022/23 RAG | 2023/24 RAG |
|---|---|---|---|---|---|
| 19 | Reduction in the time from notification to a liability decision on an EN case compared to a similar case received via the traditional claims route | Claims Management | ≤ to baseline figure at close of period 2022/23[15] | G | G |
| 20 | Percentage of contested applications for an interim payment on EN cases where we have refused to make one | Claims Management | Internally reported[16] | G | G |
| 21 | We will share 100% of concerns derived from EN and MIS cases with the national maternity safety group at least quarterly | Safety and Learning | 100% | G | G |

[15] We have amended the target from 'Year-on-year improvements on the baseline for future years'. As the scheme is still maturing, the new target is suitable and stretching.

[16] Target not reported externally due to commercial sensitivities.

# Invest in our people and systems to transform our business

| No. | KPI description/measure | Area | Target | 2022/23 RAG | 2023/24 RAG |
|---|---|---|---|---|---|
| 24 | Staff in Claims Management who have new working practices have been provided with the appropriate training to undertake the new ways of working[17] | Claims Management | 90% of staff have received the appropriate training | N/A | G |
| 25 | General Practice Indemnity and Clinical Negligence Scheme for Trust claims functionality developed in CaseHub by the end of the financial year[18] | Digital, Data and Technology, and Transformation (DDaTT) | Achieved | N/A | A |
| 26 | 90% of Freedom of Information Act data provided within five working days from the criteria being set | DDaTT | 90% | N/A | G |
| 27 | 80% of member requests solved within five working days from receipt | DDaTT | 80% | N/A | G |
| 28 | Staff have engaged with the annual performance and development review process[19] | Human Resources (HR) and Organisational Development (OD) | >95% | N/A | G |
| 29a | Improvement in our gender pay gap[20] | HR and OD | Improvement on the reported 2022 figures[21] | A | R |
| 29b | We can evidence an improvement in the diversity of our workforce by reference to improvements in Workforce Race Equality Standards reports[22] | HR and OD | Improvement on the reported 2022 figures[23] | A | A |
| 30 | We have actively sought and obtained formal feedback from our top strategic stakeholders (usually around 10–15 organisations) at least annually through a variety of methods | Policy Strategy and Communications | 10–15 organisations | G | G |
| 31 | Retention of our ISO 27001 accreditation | Corporate Governance | Achieved | G | G |
| 32 | Management of budgets within net Departmental Expenditure Limits (between 95 and 100% of the in-year target for indemnity scheme spend)[24] | Finance | 95% – 100% | G | G |
| 33 | 95% of undisputed invoices are paid within 30 days | Finance | 95% | R | A |
| 34 | Monthly vacancy rate reduced | HR and OD | <10% by year end | N/A | R |
| 35 | Employee retention rate increased | HR and OD | Target: >85% | N/A | G |

[17] This KPI was changed to reflect 2023/24 activity.
[18] This KPI was changed from 'First release of Core Systems Programme by Q4 2022/23' because this target was achieved in 2022/23. It was changed to reflect 2023/24 activity.
[19] We have amended the measure from '>90% of our staff will have accessed learning and development opportunities relevant to the individual and/or organisation's needs'. The new measure is a better metric to ensure the vast majority of staff have engaged with the performance appraisal process meaning they will have agreed objectives and personal development plans that will be tracked in year.
[20] We have amended the measure from 'We can evidence an improvement in the diversity of our workforce by reference to improvements in the gender pay gap (GPG)'.
[21,23] We have amended the target from 'Evidence of improvement'.
[22] We have amended the measure from 'We can evidence an improvement in the diversity of our workforce by reference to improvements in Workforce Race Equality Standards reports'.
[24] We have added 'net' to ensure income is taken into account.

## Red or amber KPIs – explanatory notes

**KPI 25 –** we completed technical development of our GPI scheme in CaseHub in Q4 of 2023/24. The CNST scheme will be released in 2024/25 as the second release, in line with the revised business case approved by DHSC in December 2023. In addition, we have changed our go-live approach and will be doing a combined business deployment of GPI and CNST as the first Claims release in 2024/25.

**KPI 29a –** our reported gender pay gap (GPG) figures, as detailed in Gender pay gap reporting on page 138, show a decline in both our mean and median rates. The full published GPG report notes the considered impacts on each of the reported figures and our intended actions to continue to address the gaps.

**KPI 29b –** For the year ending 31 March 2024, the associated Workforce Race Equality Standards (WRES) reporting period is 1 April 2022 to 31 March 2023. In relation to the WRES reporting period ending March 2023, when compared to the prior year's data (ending 31 March 2022) our overall workforce profile did see a slight reduction in the proportion of ethnic minority staff employed. A Board level appointment was made during the WRES reporting period; however, there was no change to the ethnicity profile of our Board.

In March 2024 a new non-executive director from an ethnic minority background was appointed to the Board. The resulting change to our Board profile will be reflected in the WRES reporting period ending March 2024, which will be reported in 2024/25.

An Equality, Diversity and Inclusion (EDI) working group consisting of directors and deputy directors has been established to support delivery of the EDI People Strategy pillar. Further details of our achievements throughout 2023/24 in line with our EDI strategy pillar are detailed in Equality, diversity and inclusion on page 138.

**KPI 33 –** the number of invoices paid within 30 days is 88%, below the target of 95%, for the year to 31 March 2024. Work is continuing to improve business processes to assist with achieving this target and raising awareness across the organisation. Implementation of improvements to the purchase to pay process took place towards the end of the financial year but will take some time to embed.

**KPI 34 –** all departments ended the financial year with actual full-time equivalent numbers lower than budget except for Practitioner Performance Advice and Policy, Strategy and Communications.[25] The organisation was not able to recover from the 2022/23 lag in recruitment which carried over into 2023/24.

[25] In June 2023, Policy and Strategy (P&S) integrated with the Membership and Stakeholder Engagement (MSE) team in order to better align activity. This was part of wider changes to the former Policy, Strategy and Transformation directorate. Since 2 October 2023, the newly integrated directorate has been known as Policy, Strategy and Communications (PSC), reflecting the core functions of the directorate as a whole.

# Strategic priority one: Deliver fair resolution

Our first strategic priority is to achieve fair and timely resolution, wherever possible keeping patients out of formal processes, helping to keep harmed patients, families and healthcare staff out of litigation and preserving taxpayer funds.

We are pleased to say that in 2023/24 we have, once again, kept a record number of claims out of formal processes. The increase reflects our commitment to using dispute resolution initiatives wherever possible and appropriate, as well as our collaborative approach to claims management, all of which help to minimise the distress and costs that formal processes cause to both patients and staff.

During the past few years, we have been operating in a landscape affected by the Covid-19 pandemic. In 2023/24, we started to see a landscape that is recovering from – but still in some ways affected by – the pandemic.

We explore all these points in the following section.

## Understanding the claims journey

For many reasons, the journey of a claim can be lengthy and complex.

On average, there are three years between a clinical incident occurring and a claim being reported to us. We refer to this as the time lag associated with our claims data.

It can take some time for patients to decide whether they wish to pursue a claim and seek legal advice. During this time, the healthcare provider's focus will rightly be on understanding why the harm was caused and dealing with the immediate concerns of patients, including ongoing care. The time lag between a clinical incident occurring and a claim being reported to us means that we do not have a 'live' picture of the state of clinical negligence in the NHS, including the financial costs incurred. Instead, our claims portfolio identifies the patterns and trends relating to the types of clinical negligence incidents that have occurred in previous years. This portfolio does not reflect all clinical incidents that have occurred across the NHS, only those that result in a claim. Our EN scheme, described in more detail on page 73, does however enable us to investigate potential eligibility for compensation earlier than a standard obstetric claim, as detailed in figure 4.

We are therefore able to improve our understanding of clinical negligence relating to obstetric care closer to the date at which the incident occurred or was reported.[26]

### Have the number of reported claims and incidents increased in the last 10 years?

Since we recorded a peak in 2013/14 CNST claims numbers have fallen slightly and since then have remained generally steady. CNSGP claims are growing as expected.

CNST is our largest scheme, and although membership is voluntary, all NHS trusts (including foundation trusts) in England currently belong to the scheme. From 1 April 2013, independent sector providers of NHS care have been able to join CNST. CNST also includes obstetric claims portfolio, which reflects a natural and expected volatility in high-value claim numbers. We will continue to monitor the figure closely.

[26] Note that for EN claims the reported year reflects the year in which the incident was identified as a claim, not the year in which the incident was reported.

Once a patient or family member decides to make a claim there are several procedural and investigative stages to be undertaken before a decision can be made on liability.

It may then also take some time to quantify and agree damages on a claim, particularly those high-value claims where brain damage has occurred at birth and where a full assessment cannot be undertaken until a child has reached developmental milestones.

We are aware that multiple factors have the potential to increase the time it takes to reach a resolution, including issues in the justice system and, in the healthcare system, the prioritisation of frontline care meaning the availability of clinicians to provide expert advice is constrained.

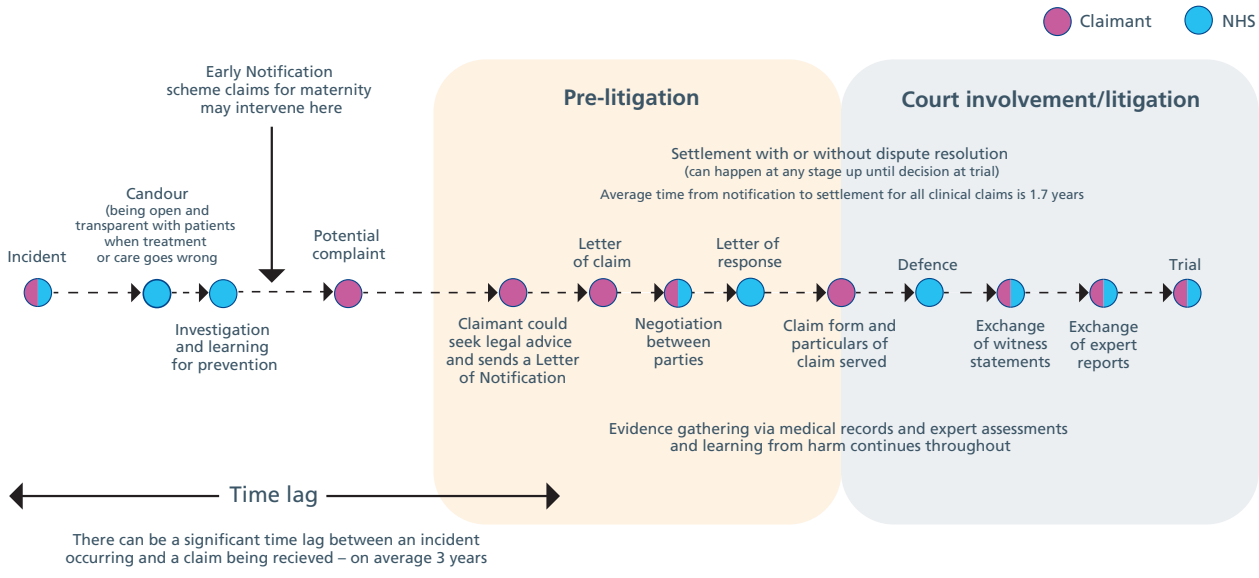
The claims journey is illustrated in figure 4: Clinical claims journey.

## What does liability mean?

Liability means legal responsibility. In clinical negligence, liability is established if treatment received falls below a reasonable standard of competence, resulting in an injury which is likely to have been avoided (or less severe) with appropriate care.

We also use liability when managing our finances. In accounting terms, a liability is a present obligation as a result of past events, the settlement of which is expected to result in an outflow of resources (payment).

### Figure 4: Clinical claims journey



## Reported claims and incidents

As figure 5 shows, the total number of new clinical negligence claims and reported incidents in 2023/24 totalled 13,784, an increase of 273 on 2022/23 (13,511).

As shown in figure 5, this number includes:

- 267 more CNST claims (10,834 in 2023/24 compared to 10,567 in 2022/23), an increase of 3% compared to 2022/23;
- 207 fewer ELSGP claims (502 in 2023/24 compared to 709 in 2022/23), a decrease of 29% compared to 2022/23; and
- 202 more CNSGP claims (2,382 in 2023/24 compared to 2,180 in 2022/23), an increase of 9% compared to 2022/23.

Looking at the increase in CNST claims, it is important to note that 2022/23's numbers may still have been impacted by the Covid-19 pandemic and wider system pressures, which saw reduced numbers of claims being made. When we take an average of claims in the five financial years immediately preceding the pandemic (2015/16 to 2019/20), the increase is 0.7%.

The reduction in ELSGP claims is in line with what we would expect. The scheme provides indemnity cover in respect of liabilities incurred before 1 April 2019 and so we expect numbers to reduce over time as fewer new claims for incidents before that date are reported. Reported numbers in 2021/22 were particularly high due to the bulk migration of 2,005 claims from the Medical Protection Society (as shown in figure 5).

In CNSGP claims, the 9% increase is lower than the 45% increase we saw in 2022/23. This is in line with what we would expect from a maturing scheme that covers clinical negligence liabilities in relation to incidents that occurred on or after 1 April 2019. The time lag between incident and reporting (as illustrated by figure 5) and the reduced ability for people to make a claim during the pandemic means that we are now more steadily receiving claims relating to incidents which occurred after the date the scheme began. We expect numbers to stabilise over time as the scheme reaches maturity.

Turning to LTPS, which covers non-clinical claims such as public and employers' liability, we received 163 more claims (3,299 in 2023/24 compared to 3,136 in 2022/23), an increase of 5%. However, the number remains lower than the average over the five financial years to 2019/20. This is likely to be due to the lower footfall in hospitals and healthcare settings throughout the pandemic.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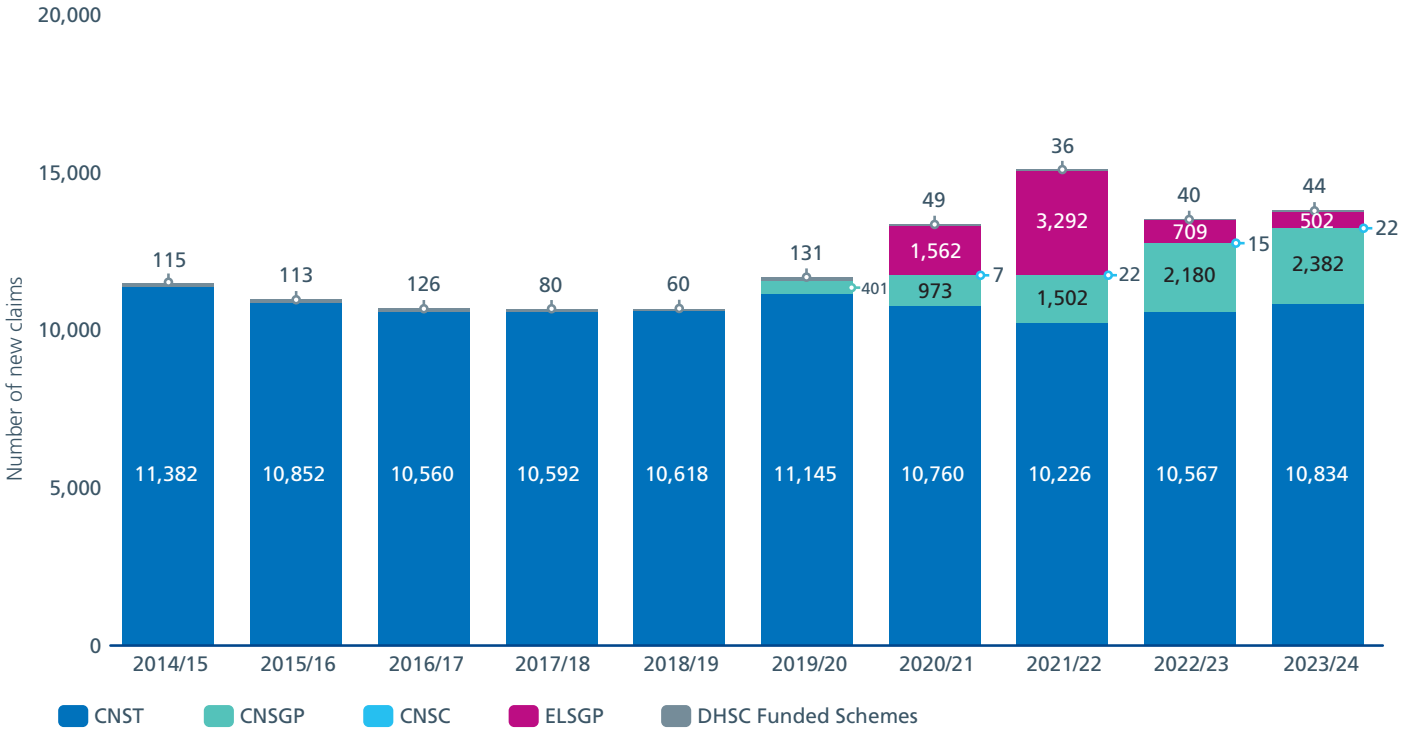
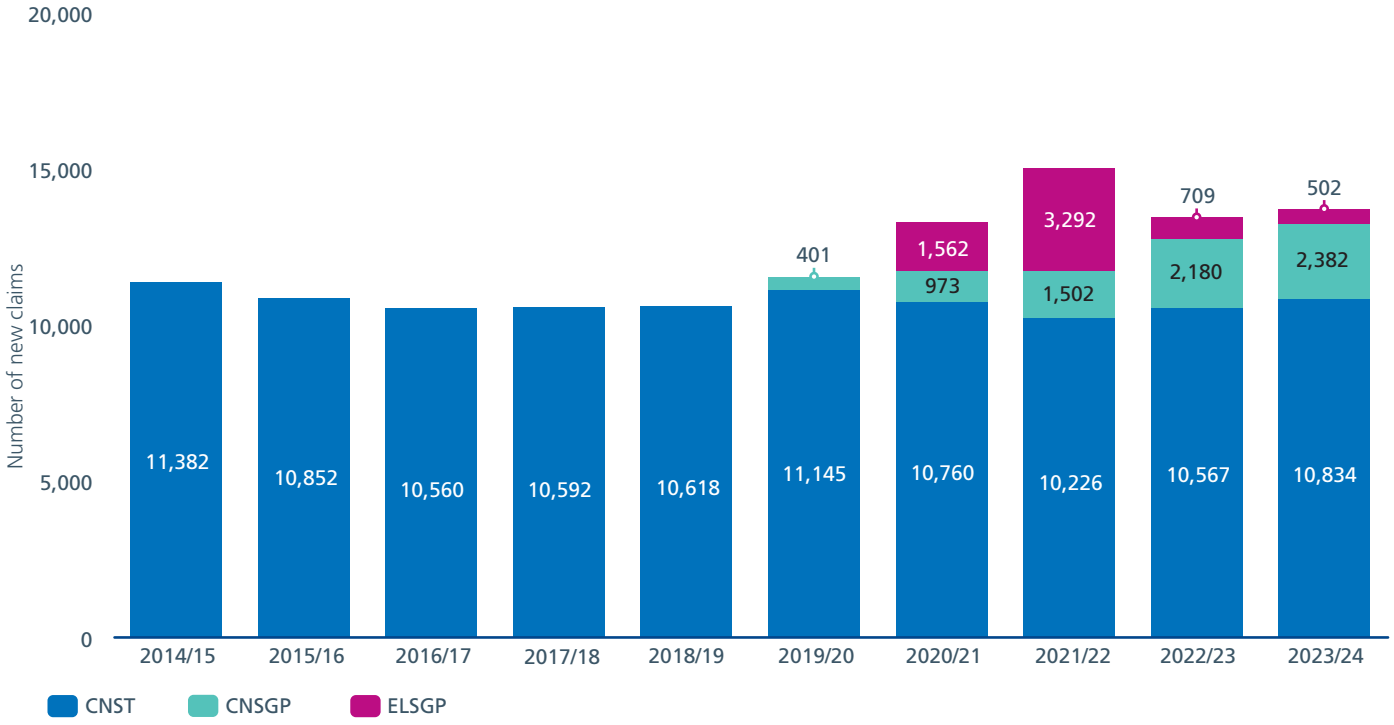
## Figure 5: The total number of new clinical claims and incidents reported in each financial year from 2014/15 to 2023/24



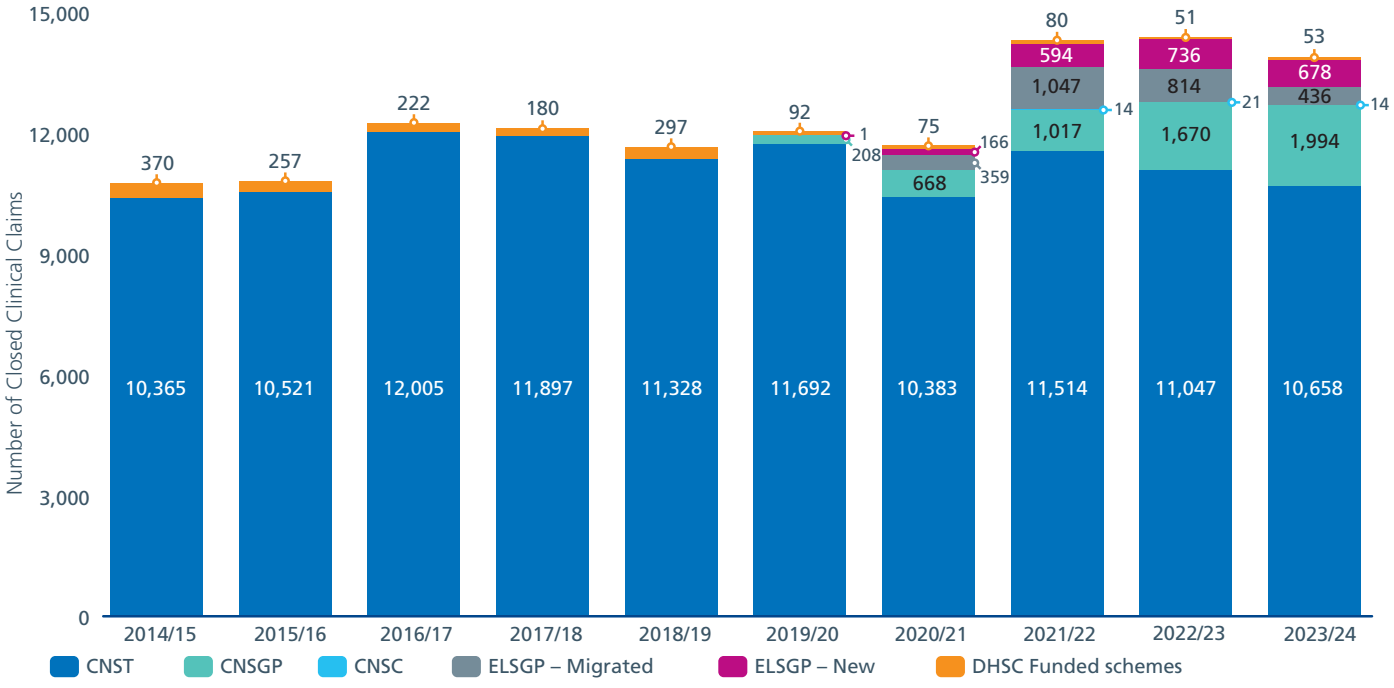

## Figure 6: The total number of new non-clinical claims and incidents reported in each financial year from 2014/15 to 2023/24

### Figure 7: The total number of new CNST, CNSGP and ELSGP claims and incidents reported in each financial year from 2014/15 to 2023/24[27]




## Claims closed

### Figure 8: The total number of clinical claims closed broken down by scheme in each financial year from 2014/15 to 2023/24[28]



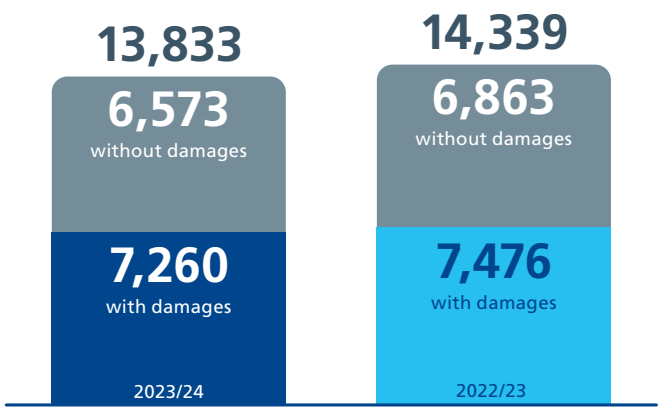

[27] Given that CNSGP and ELSGP were established on 1 April 2019 and 6 April 2020 respectively, data reporting for these schemes reflects these financial years onwards.

[28] CNSC refers to the Clinical Negligence Scheme for Coronavirus. Further information about the scheme can be found in Covid-19-related claims on page 53.

In 2023/24 we closed 13,833 clinical claims (compared to 14,339 in 2022/23), a small decrease of 4%.

In 2023/24 we closed 6,573 clinical claims without damages, a decrease of 4% (290 claims) on the previous year (6,863 in 2022/23). The estimated total value of claims we closed with no damages payment was £3.6 billion.[29]

### Clinical claims closed in 2023/24 compared with 2022/23




We closed 7,260 clinical claims with damages in 2023/24, a decrease of 3% (216 claims) on the previous year (7,476 in 2022/23).

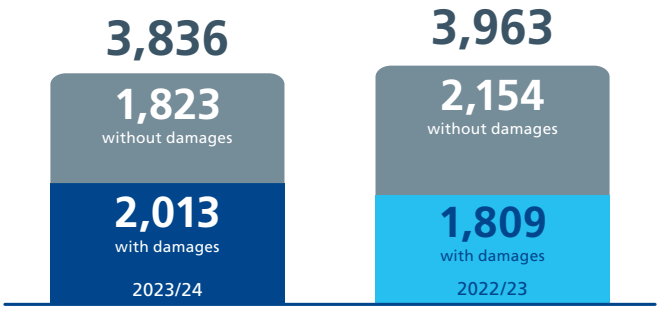
The rates of closure with and without damages paid have both decreased year on year but remain at a healthy level when compared to the average of the previous ten financial years.

In 2023/24, the percentage of clinical claims closed with damages was 52%. This compares to 52% in 2022/23, demonstrating our continued commitment to investigating claims robustly and fairly, making damages payments where the merits of the case warrant it.

Of our non-clinical claims, 1,823 were closed without damages in 2023/24, a decrease of 15% (331) on the previous year (2,154 in 2022/23). We also closed 2,013 non-clinical claims with damages in 2023/24, an increase of 11% (204) on the previous year (1,809 in 2022/23).[30]

We are committed to continually reviewing our processes and procedures so that we can continually optimise our approach and thus support our scheme members and beneficiaries as effectively as possible.

### Non-clinical claims closed in 2023/24 compared with 2022/23




We have reviewed and updated our Claims Management membership charter and launched our Claims Management beneficiary charter General Practice Indemnity. Both charters summarise the interactions between NHS Resolution, scheme members or beneficiaries and legal panel firms, along with our respective obligations under the scheme rules. This contributes to a streamlined claims management process in which every stakeholder has clarity about what is required of them.

We have also reprocured our panel of expert legal costs advisers using the Government's Crown Commercial Services framework. The panel's expertise is invaluable in costs discussions during settlement meetings with claimants and defendants, helping us to reach fair resolution in a more streamlined way.

We have begun to reflect on the lessons we can learn from our Covid-19 Clinical Negligence Protocol for claims management, which we launched in August 2020. The protocol outlines a best practice approach to claims handling agreed between the Society of Clinical Injury Lawyers, Action against Medical Accidents and NHS Resolution. It encourages a collaborative relationship between lawyers acting for patients and defendant organisations as well as removing barriers to resolution such as limitation periods. The protocol has improved co-operation between all parties, helping to support the resolution of more claims pre-action. We are working with stakeholders across the spectrum, including patient representatives, to understand how to formally embed these good practice approaches into our work.

[29] The estimated value of claims closed without damages is the highest reserve estimate for damages, NHS legal and claimant legal costs, less NHS legal costs incurred on these cases.

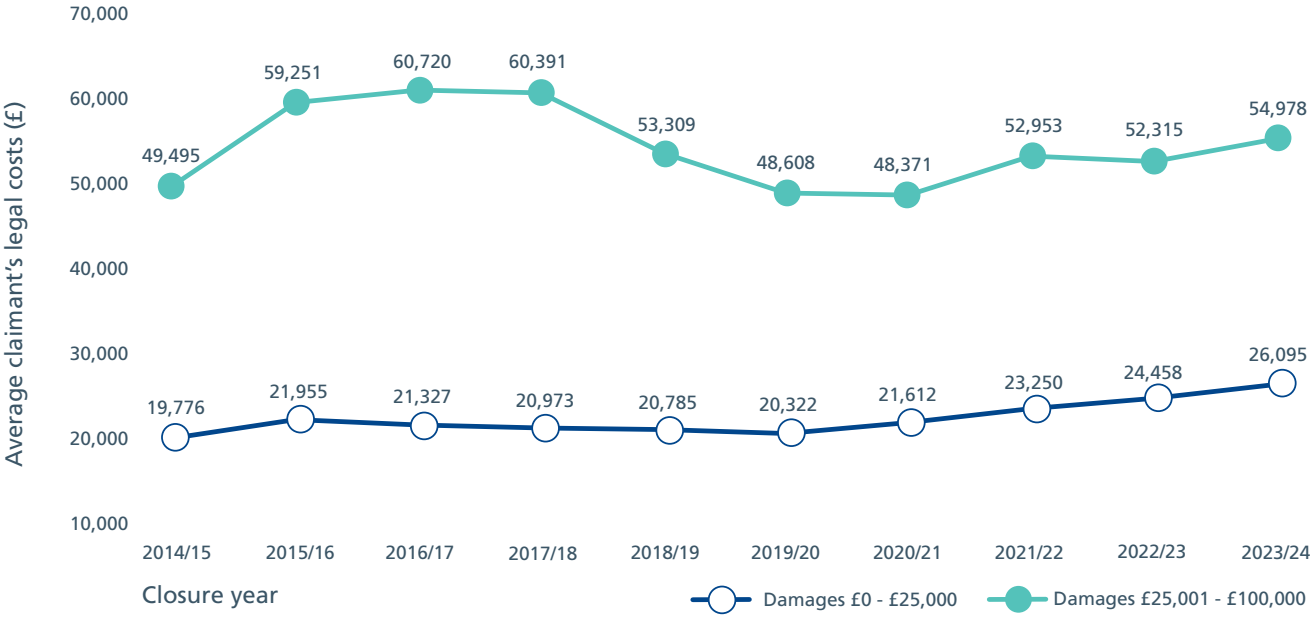
[30] The change in percentages in non-clinical claims can be more volatile than the changes in clinical claims because of the smaller volume of claims numbers involved.

## Legal costs

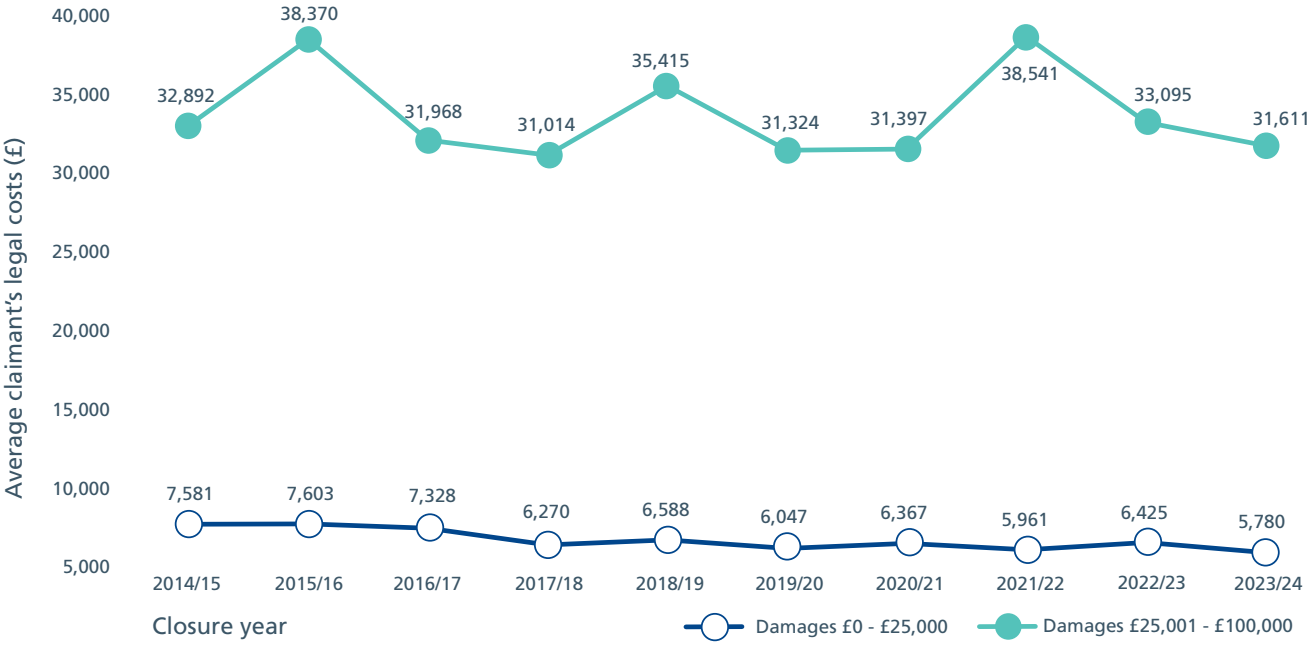
As shown in figure 9, of the clinical claims closed where damages were paid in the bracket £25,000 to £100,000, the average claimant legal costs awarded per claim were £54,978, a 5% increase on 2022/23's figure of £52,315.

For claims valued up to £25,000 the average claimant costs award increased from £24,458 to £26,095, an increase of 7%. The average legal costs on claims valued up to £25,000 has now exceeded the highest damages awarded in this cohort of claims.

### Figure 9: Average claimant's legal costs for clinical claims closed in each financial year from 2014/15 to 2023/24




### Figure 10: Average claimant's legal costs for non-clinical claims closed in each financial year from 2014/15 to 2023/24

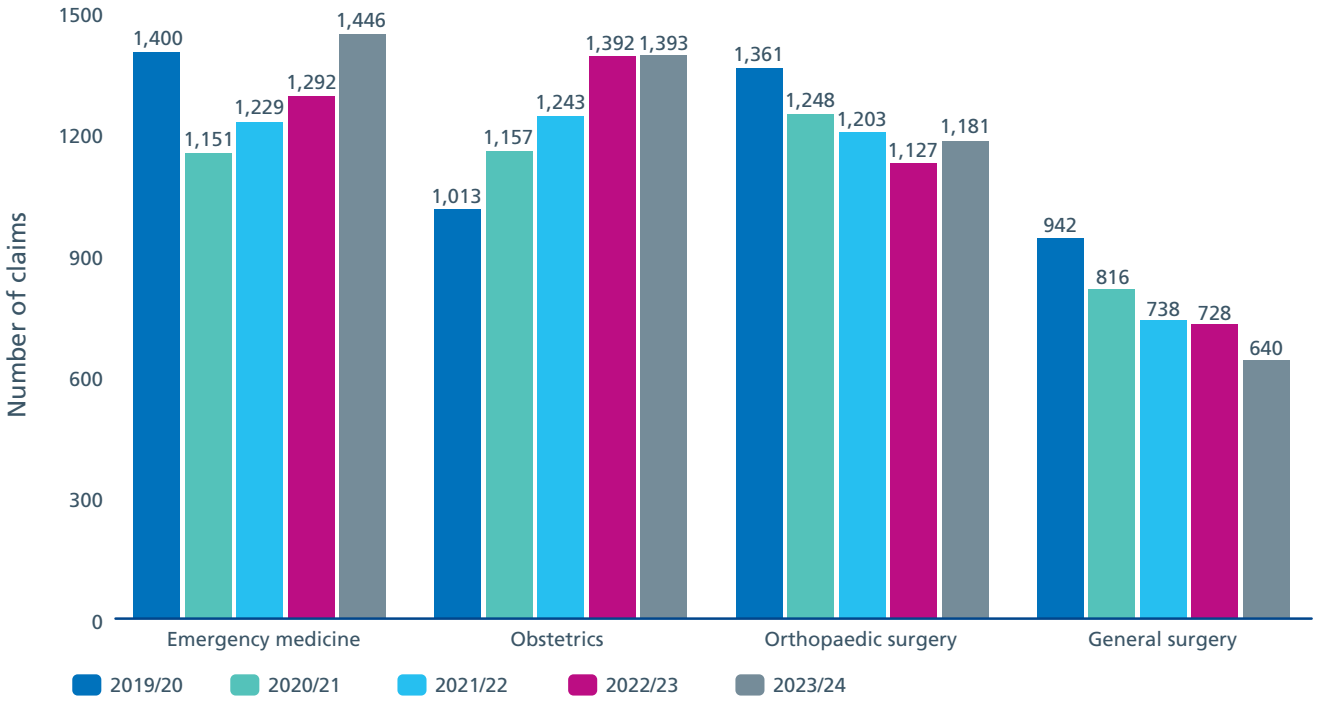


## Categories of clinical claim

Figure 11 shows the top four categories of clinical claim numbers by specialty in 2023/24: emergency medicine, obstetrics, orthopaedic surgery and general surgery. They remain the same four as in 2022/23, although emergency medicine is now the largest specialty by volume. Given the time lag between incidents occurring and being notified as a claim, the higher volumes of emergency medicine and obstetric claims could reflect the acute phases of the pandemic in which these services continued while elective procedures involved in orthopaedic and general surgery were reduced.

Since April 2017, when the EN scheme was first launched, we now receive notification of EN incidents earlier than would have been expected for such incidents prior to the scheme's launch. As expected, the volume of non-EN obstetric cerebral palsy/brain damage claims notified is lower now than prior to the launch of the EN scheme. For more information on EN claims in 2023/24, see Strategic priority three (page 70).

**Figure 11: The top four categories of clinical negligence claims reported in each financial year between 2019/20 and 2023/24[31]**




[31] This data is based on clinical claims notified in each financial year.

## Covid-19 related claims

In 2023/24 we received 281 clinical claims reported where there was a claim related to Covid-19 (excluding claims reported under CNSC, which is discussed below). This compares to 346 in 2022/23. As in previous financial years, most of these claims relate to indirect effects of the pandemic such as failures and/or delays in treatment or diagnosis. However, because claims are time lagged (as explained in figure 4: Clinical claims journey on page 45), we still only have an early picture of the claims profile for Covid-19, and we can't speculate on any trends or patterns at this stage.

Of the Covid-19 related clinical claims resolved in 2023/24, 67% were resolved without damages.

Under the non-clinical schemes, 36 claims were reported in 2023/24 compared with 64 in 2022/23. Of the non-clinical claims settled in 2023/24, 84% were resolved without damages.

The Clinical Negligence Scheme for Coronavirus (CNSC) was launched in April 2020. The Government introduced the additional indemnity cover under the Coronavirus Act 2020 to meet clinical negligence liabilities arising from NHS services provided in response to the coronavirus pandemic where no other indemnity or insurance arrangements were already in place to cover such liabilities.

We received 22 CNSC claims in 2023/24. This compares to 15 claims in 2022/23, 22 in 2021/22 and 7 in 2020/21.

We have received no claims under the Coronavirus Temporary Indemnity Scheme (CTIS), which was set up to cover non-clinical liabilities under certain arrangements.

## Vaginal mesh and sodium valproate claims

We offer simplified processes for vaginal mesh claims and sodium valproate claims to be reported to us by unrepresented claimants. The processes, often referred to as gateways, were established following the 2020 publication of *First do no harm*, and in response to a request by DHSC.

The aim of the gateways is to manage the procedure for reporting and investigating claims without the need for litigation, but it is not intended that our investigation processes into any claims should be substantively different to any other negligence claim. In 2023/24, we received 23 claims via the sodium valproate gateway and 48 via the vaginal mesh gateway.

A high proportion of the claims we have received via the gateways in 2023/24 came after the publication of The Hughes Report: Options for redress for those harmed by valproate and pelvic mesh. The increase could be due to the report contributing to an increased level of awareness of the gateways.

We await the Government's response to the report and decisions regarding a redress scheme that could impact claims submitted via the gateways. At the same time, we will continue to progress the claims that we receive in order to avoid the distress that would be caused to claimants by pausing their cases.

Claims in relation to sodium valproate and vaginal mesh have also been received and progressed through regular claims management arrangements during 2023/24.

## Payments

As illustrated in figure 12, payments against our clinical schemes in 2023/24 totalled £2,821.2 million. This includes:

- damages paid to claimants of £2,106.9 million;
- claimant legal costs of £545.3 million; and
- NHS legal costs of £169.0 million.

Damages payments across our clinical schemes increased by 6% in 2023/24 compared with 2022/23.

There has been an 11% increase in claimant costs in 2023/24 compared with 2022/23. This increase will be contributed to by an increase in cases resolved between around £250,000 and £4.75 million because settlements at these levels give rise to a liability to pay costs as well as damages. There has been a 6% increase in NHS legal costs.

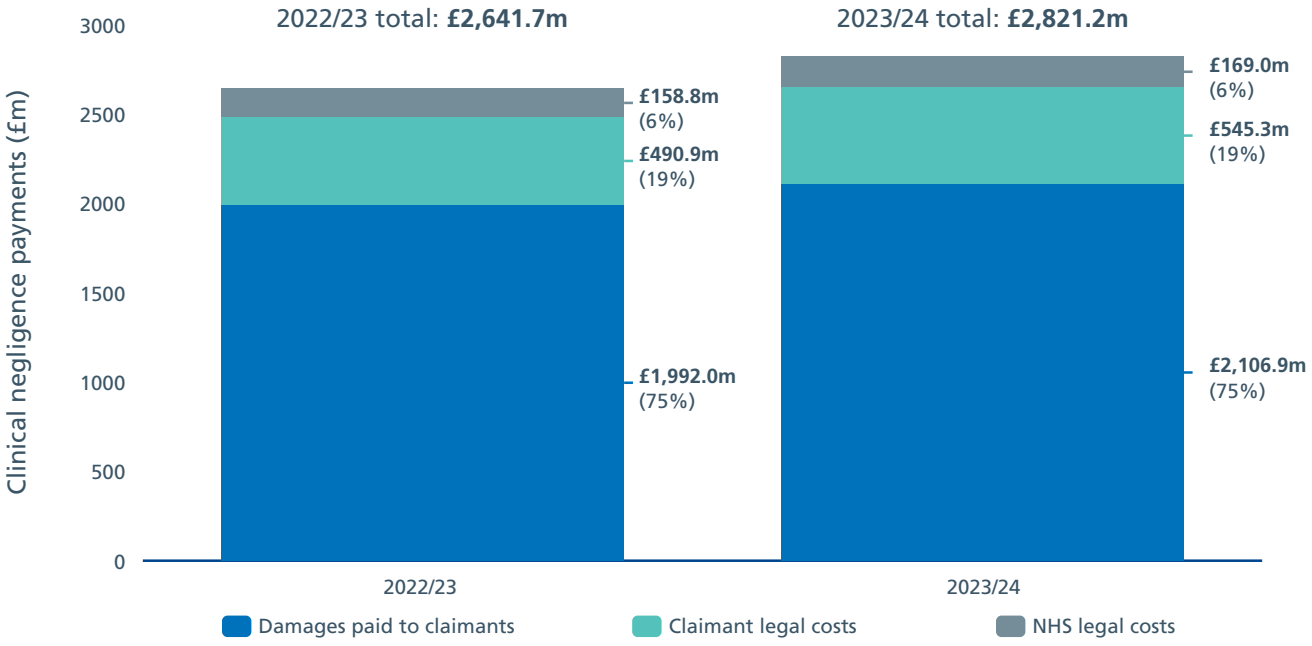
As figure 13 shows, payments against our non-clinical schemes in 2023/24 totalled £49.9 million. This includes:

- damages paid to claimants of £26.2 million;
- claimant legal costs of £16.6 million; and
- NHS legal costs of £7.1 million.

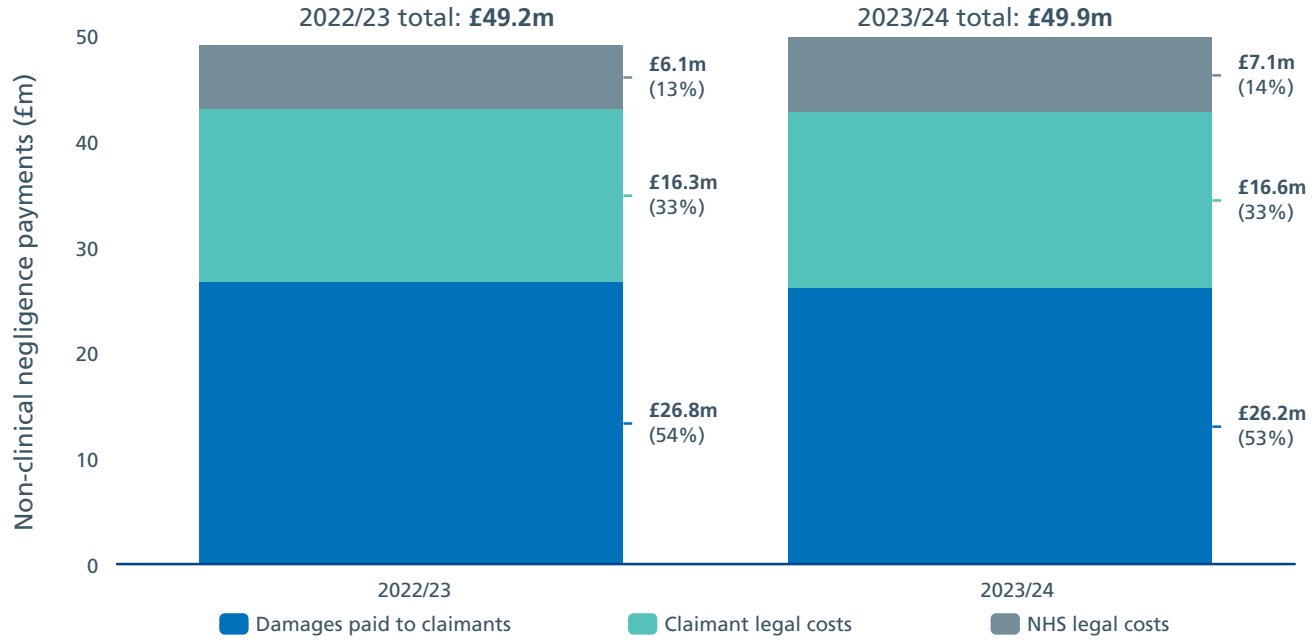
Damages payments across our non-clinical schemes decreased by 2% in 2023/24 compared with 2022/23. Claimant legal costs increased by 2% and NHS legal costs increased by 16%. These increases in costs are associated with an increase in both the volume and value of cases settling with damages between £50,000 and £250,000.

An overview of the financial performance across each scheme is described in the Finance report on page 84.

## Figure 12: Clinical negligence payments made in 2022/23 compared with 2023/24




## Figure 13: Non-clinical negligence payments made in 2022/23 compared with 2023/24



# Our approach to dispute resolution

## We are committed to a positive, less adversarial and more collaborative dispute resolution strategy.

Resolving matters without the need for court proceedings can reduce costs[32] and the pressure on courts. It can also minimise the stress and distress of the claims process for claimants and healthcare staff, as well as being a valuable approach where claimants might be seeking an outcome which litigation might not be able to provide.

To help ensure that litigation is always by choice, we offer an increasing range of alternatives, which are outlined in Dispute resolution options on page 59.

However, there will always be some claims where litigation is the right choice, for example, where a legal point is in issue (see Setting legal precedent on page 60) or where the court must approve a settlement in the best interests of a protected party.

[32] See National Audit Office: Managing the costs of clinical negligence in trusts.

## Litigation rate

As figure 15 illustrates, 81% of clinical claims were resolved without litigation (an increase of one percentage point on 2022/23), the highest volume ever achieved.

We recognise that this upward trend cannot continue indefinitely but, for the reasons outlined above, will always continue to promote dispute resolution over litigation.

The decision to take a case to trial is often finely balanced, requiring careful assessment of all evidence.

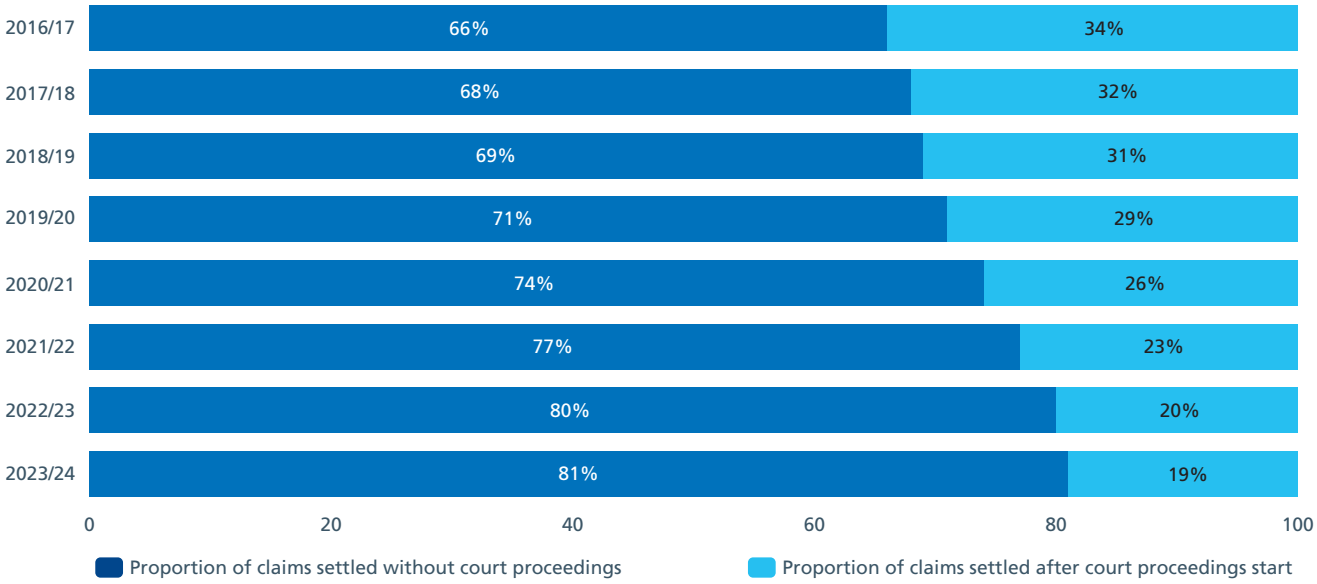
In 2023/24, 50 resolved claims across clinical and non-clinical were litigated to trial, with 17 (34%) resulting in an award of damages. This compares to 60 trials,[33] with 19 (32%)[34] resulting in award of damages in 2022/23.

In 66% of claims in 2023/24 the court agreed with our assessment on the merits of the claim and awarded no damages (compared to 68% in 2022/23). In all claims, seeking the input of the court was appropriate to ensure there was a fair outcome delivered for all parties.

As figure 15 shows, the total number of clinical claims that resolved in 2023/24 decreased to 13,382 from 13,552 in 2022/23 (a decrease of 1%).[36]

Of those, 52% of claims resulted in a payment of damages, compared with 51% in 2022/23, which reflects our strategy of delivering fair resolution, making damages payments where it is right to do so. Clinical claims settling pre-litigation (see figure 4: Clinical claims journey on page 45) and without payment of damages decreased by 1% (from 5,929[37] in 2022/23 to 5,864 in 2023/24). For claims in proceedings, the number resolved with no damages paid has decreased by 12% (from 701 in 2022/23 to 619 in 2023/24).

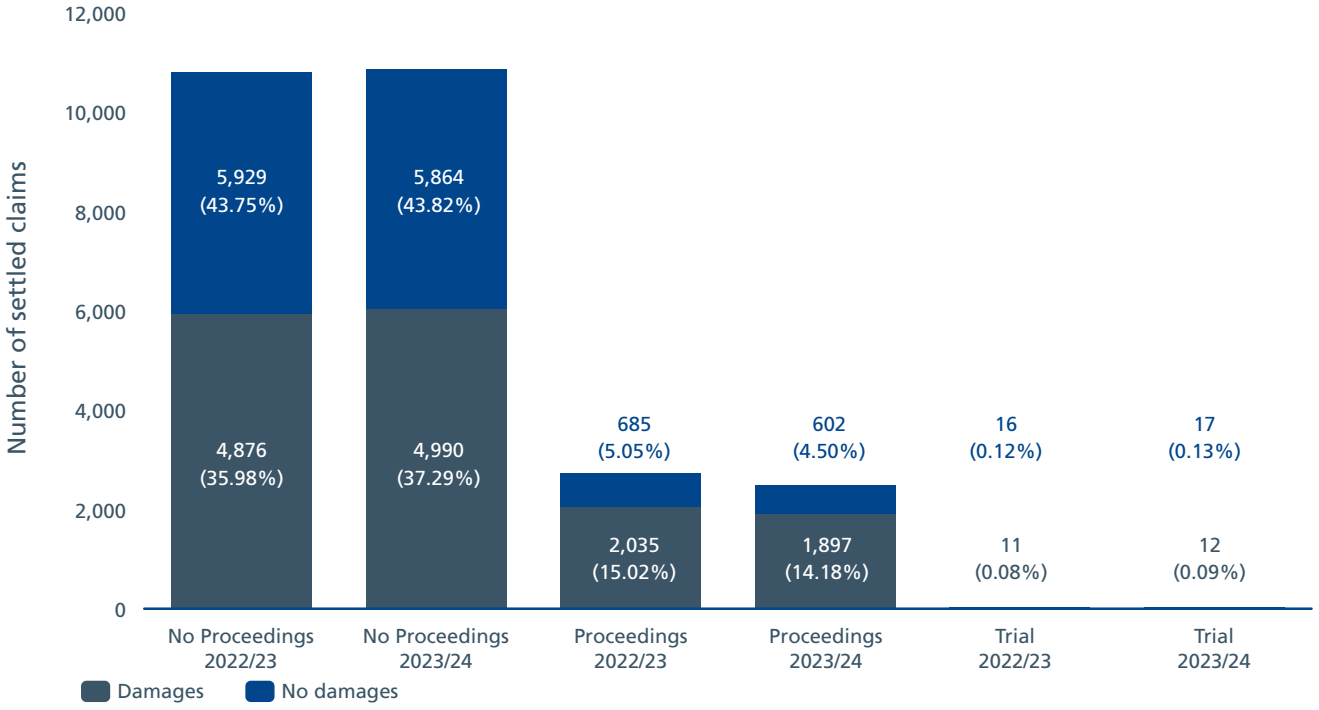
**Figure 14: Litigation rate for clinical claims for each financial year from 2016/17 to 2023/24[35]**



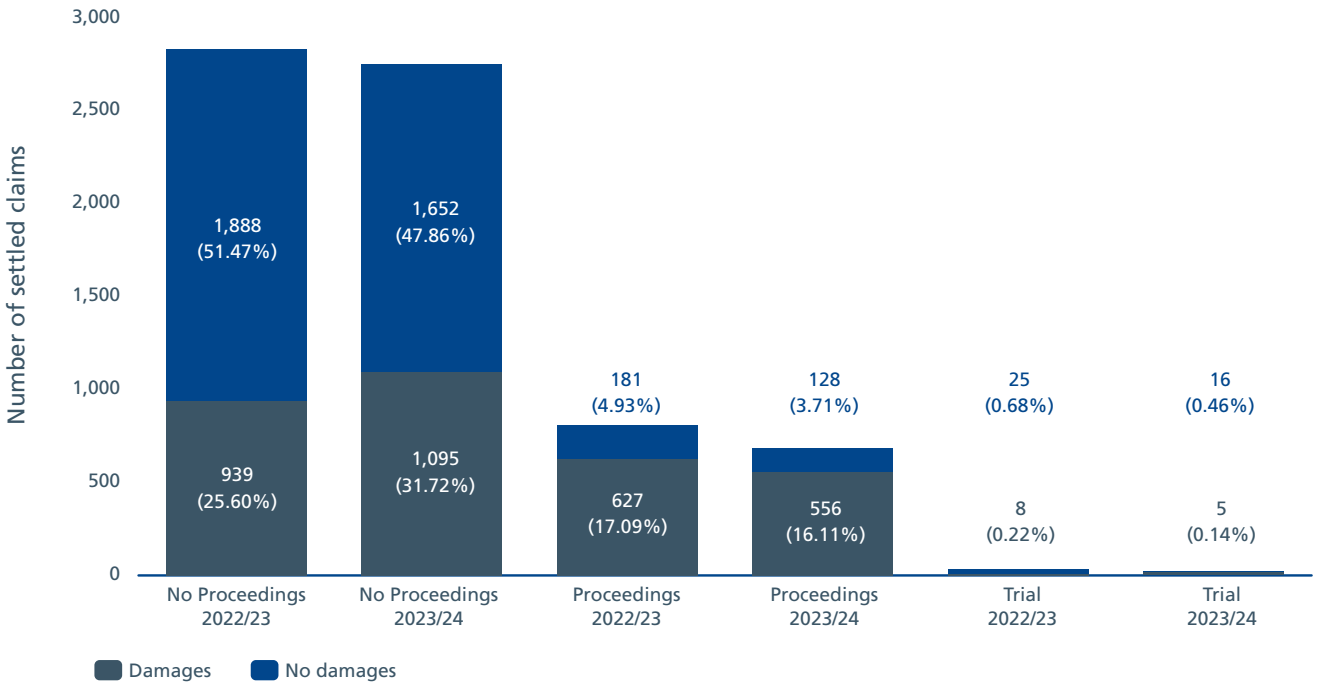

[33,34,36,37] We identified an issue in relation to the way data for a small number of closed cases was feeding into settled case data. This was resolved in 2023/24 and settled case numbers for previous years have been restated. Ninety-nine additional cases were identified as settled over the last five years.

[35] Data is provided from 2016/17 when monitoring of the litigation rate began using the current metrics.

## Figure 15: The number of clinical claims resolved in 2022/23 compared with 2023/24, by settlement type, and with or without damages




## Figure 16: The number of non-clinical claims resolved in 2022/23 compared with 2023/24, by settlement type, and with or without damages




As figure 16 shows, the total number of non-clinical claims that resolved in 2023/24 decreased to 3,452 from 3,668[38] in 2022/23 (6%).

Claims settling pre-litigation and without damages decreased by 13% (from 1,888 in 2022/23 to 1,652 in 2023/24).

Where claims had proceedings issued, the number resolved with no damages paid decreased by 30% (from 206 in 2022/23 to 144 in 2023/24).

The smaller numbers in the non-clinical portfolio mean average damages values are more susceptible to change related to a small number of very high-value or very low-value claims settling.

[38] We identified an issue in relation to the way data for a small number of closed cases was feeding into settled case data. This was resolved in 2023/24 and settled case numbers for previous years have been restated. Ninety-nine additional cases were identified as settled over the last five years.

## Dispute resolution options

We continue to extend our use of resolution meetings, mediation, stock takes and early neutral evaluation. These more empathetic methods of dispute resolution give us the opportunity to choose, in collaboration with the claimant, the most suitable course of action in each case, effectively addressing claimants' concerns and achieving satisfactory resolutions.

### Resolution meetings

Resolution meetings allow the parties to explain their respective positions and are a useful way to discuss the strength and prospects of a claim. The process is particularly suited to claims where the merits of the case have been investigated and the issues in question are capable of being resolved between the parties with an open and constructive dialogue, often supported by a peer review.

In 2023/24, 259 claims were discussed in resolution meetings. Of those claims, 105 were resolved. Twenty (19%) were resolved either on the day or within 28 days of the meeting and 85 went on to resolve after 28 days. The remaining 154 claims were not resolved. Of the claims that were discussed at a resolution meeting, only 7 (3%) went on to be litigated (as at 31 March 2024), demonstrating how this process can be an effective way of avoiding formal proceedings. In comparison, in 2022/23, 301 claims were discussed in resolution meetings with 191 being resolved (63%). Of the claims that were discussed at a resolution meeting, only 13 (7%) went on to be litigated. The lower number of resolution meetings this financial year is due to internal team changes which temporarily reduced our capacity to hold resolution meetings as well as a reduction in cases suitable for the process. The reduced numbers provided an opportunity to develop other methods of dispute resolution and collaborative case management such as early neutral evaluation.

### Mediation

We continue to promote the use of mediation in appropriate claims and our Claims Management service now considers mediation a routine part of our suite of dispute resolution options.[39] The service provides access to an independent and accredited mediator, selected from a panel drawn from a wide range of backgrounds, and provides a platform to claimants, patients and their families to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution. The forum also provides benefits to clinicians, allowing them to bring closure to historical concerns.

We contract with four providers[40] to deliver mediation. Since the start of the service in December 2016 to 31 March 2024, a total number of 2,031 claims have been mediated. In 2023/24 a total of 195 claims proceeded to mediation with 79% of the claims settling on the mediation day or within 28 days of the mediation.

### Stock takes

Stock take meetings allow us to work collaboratively, discuss the merits of claims with claimant firms and allow all parties to make better informed decisions about resolution.

Following the success of the pilot in 2022/23,[41] we have introduced stock take meetings across our Claims Management function.

In 2023/24 we held stock take meetings in relation to 45 claims. Of these claims, 39 went on to be resolved without the issue of formal proceedings and six were resolved after formal proceedings.

We will continue to work with lawyers acting for patients on stock take meetings in order to discuss case management, resolution opportunities and collaboration on medical evidence.

### Early neutral evaluation

In April 2023, working in partnership with two claimant law firms, we launched a pilot to test the benefits and effectiveness of early neutral evaluation. This process involves the parties appointing an independent evaluator with specialist knowledge of the subject matter to give an assessment of the merits of their respective claims. The evaluation is non-binding and without prejudice, so no reference can be made in any proceedings to what happened in the early neutral evaluation process unless otherwise agreed by the parties. The pilot continued throughout 2023/24 and is due to complete in 2024/25. Following its conclusion, we hope to share the outcomes in a thematic review.

[39] For more information, see NHS Resolution: Mediation in healthcare claims – an evaluation.

[40] The Centre for Effective Dispute Resolution (CEDR) and Trust Mediation Limited mediate disputes around personal injury and clinical negligence incidents and claims and St John's Buildings Limited and Costs-ADR mediate disputes relating to the recovery of legal costs.

[41] Our stock take pilot was discussed on page 45 of our Annual report and accounts 2022/23.

## Setting legal precedent

We focus on ensuring claims are properly investigated and resolved fairly at the earliest opportunity. However, it is sometimes appropriate to take claims to trial or to the higher courts because they are in areas of law that require certainty or need to be challenged in the broader interests of the NHS.

We publish the findings of such cases as cases of note on our website.

We recognise that the circumstances of such cases can be truly tragic and do not seek to diminish the trauma of those involved. However, an outcome can provide an opportunity for others to claim under similar circumstances or deter claims without merit. It can also provide our members, the legal profession and healthcare staff with valuable insights to learn from.

In 2023/24, one such case was Paul v. Royal Wolverhampton NHS Trust. In this case, the Supreme Court made a ruling on secondary victims (people who suffer psychological trauma as a result of witnessing the consequences of alleged negligence to a patient). The ruling significantly altered existing law, saying that secondary victims cannot normally recover damages in a clinical negligence context.

> "We are not able to accept that the responsibilities of a medical practitioner, and the purposes for which care is provided, extend to protecting members of the patient's close family from exposure to the traumatic experience of witnessing the death or manifestation of disease or injury in their relative."
>
> **Judgment: Paul and another (Appellants) v Royal Wolverhampton NHS Trust (Respondent); Polmear and another (Appellants) v Royal Cornwall Hospitals NHS Trust (Respondent); Purchase (Appellant) v Ahmed (Respondent), paragraph 138**

# Taking steps against exaggerated or false claims

Genuine claimants have nothing to fear.

However, as the following case shows, where there is evidence of a fabricated or exaggerated claim, we will always take steps to protect public funds.[42]

The claimant brought a claim for a delay in diagnosing cancer, as a result of which they had to undergo more extensive abdominal surgery than otherwise would have been necessary. They alleged that they suffered chronic, disabling pain as a result of the surgery.

The claimant alleged the condition had restricted their mobility and daily activities, essentially leaving them housebound. We agreed that some standards of care had not been met and that the claimant's treatment would have been less extensive with earlier diagnosis.

Following assessments, our medical experts noted some inconsistencies around the claimant's reported injuries. Social media posts also pointed to an inconsistent presentation, so we instructed surveillance agents to carry out a period of surveillance.

The surveillance showed the claimant walking unimpeded and carrying out heavy gardening work, with no obvious evidence of problems with mobility.

We raised allegations of fundamental dishonesty and withdrew previous offers. The claimant continued to specifically deny any dishonesty. Shortly before the trial date, their claim was struck out by the court for conduct likely to obstruct just disposal of proceedings.

[42] For other examples of actions, see NHS Resolution: Jail sentence for multi-million pound attempt to claim damages from NHS and NHS Resolution: Builder in dishonest NHS compensation case.

The claimant did not receive any of the £4.3 million damages they sought, and their solicitors did not receive any of the costs of bringing the claim. The claimant was ordered to pay the defendant's costs of the action and to repay the interim damages payments received before their claim was struck out in April 2023.

We do not take decisions to undertake surveillance or raise allegations of fundamental dishonesty lightly. However, given the extent of the damages sought by the claimant, it was felt appropriate.

By taking action in cases such as this one, we demonstrate to claimants the very serious consequences of submitting dishonest and exaggerated claims.

## Primary care contracting disputes

Through our Primary Care Appeals service, we offer an impartial resolution service for the fair handling of primary care contracting disputes. Our service ensures the prompt and fair resolution of appeals and disputes between primary care contractors or those wishing to provide primary care services and NHSE and/or ICBs.

The Primary Care Appeals contracting disputes journey is summarised in figure 17.

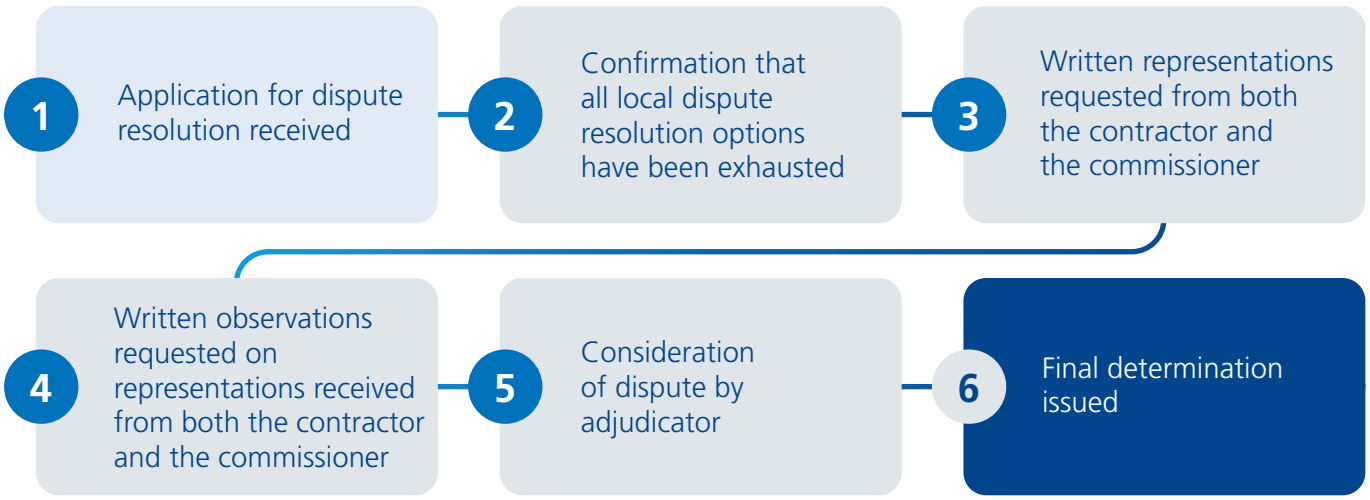
In 2023/24, Primary Care Appeals received 275 cases (a 60% increase on 2022/23) and closed 276 cases (a 76% increase on 2022/23). Figure 18 shows a breakdown of these cases by category.

The increase in activity is primarily due to 132 appeals from two NHS community pharmacy groups against decisions taken by one NHSE regional team to issue breach notices for unplanned temporary suspensions of services because pharmacist cover could not be found.

Based on the evidence provided we confirmed NHSE's decision to issue 126 breach notices on the basis that staffing levels of a pharmacy are not usually beyond the control of pharmacies.

In line with our commitment to openness, transparency and to share learning, these decisions have been published in the Primary Care Appeals decisions section of our website.

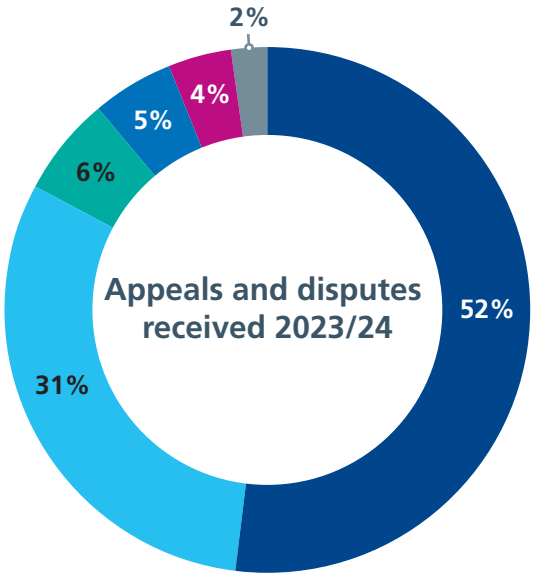
**Figure 17: Primary Care Appeals contracting disputes journey[43]**



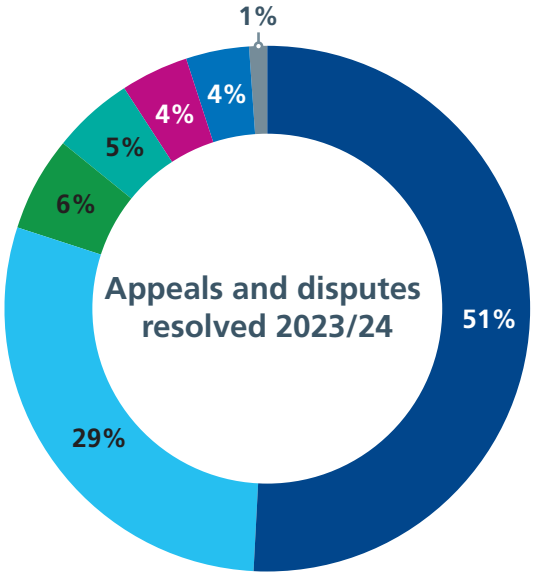

[43] Across all types of appeals and disputes, the parties involved are entitled to make submissions and to see and comment on what others have said before the matter is considered by the decision-maker.

In 2023/24 we also resolved the remaining Covid-19 payment disputes received following the Secretary of State for Health and Social Care's directions to NHS Resolution to manage and resolve these cases. These disputes are in relation to the costs incurred by pharmacies for providing services during the Covid-19 pandemic against decisions taken by NHS Business Services Authority to either refuse to make payments or to recover past payments. While the overall number of payment disputes was low (23), the total value of the disputes amounted to £2.5 million.

**Figure 18: Appeals and disputes received and resolved in 2023/24[44]**




- Pharmacy performance sanction appeals **144 (52%)**
- Pharmacy market entry and change of listing appeals **87 (31%)**
- Medical disputes **16 (6%)**
- Dental disputes **13 (5%)**
- Pharmacy overpayment appeals **10 (4%)**
- PLR suspension payment appeals/consent to withdraw **5 (2%)**




- Pharmacy performance sanction appeals **141 (51%)**
- Pharmacy market entry and change of listing appeals **81 (29%)**
- Pharmacy Covid-19 payment appeals **16 (6%)**
- Medical disputes **14 (5%)**
- Pharmacy overpayment appeals **11 (4%)**
- Dental disputes **10 (4%)**
- PLR suspension payment appeals/consent to withdraw **3 (1%)**

[44] For Covid-19 pharmacy payment appeals, the appeals window closed on 31 March 2023, so no cases were received in 2023/24. PLR refers to Performance Lists Regulations.

# Embedding a just and learning culture

Our first strategic priority includes a commitment to continue to promote the principles of a just and learning culture as the optimum environment in which resolution and learning can occur, as illustrated in figure 4: Clinical claims journey.

We set out the argument for organisations adopting a more reflective approach to learning from incidents and supporting staff in our *Being fair* report. *Being fair 2* encourages organisations to take an evidence-based, proactive approach to ensuring the behaviours underpinning a just and learning culture are embedded.

In 2023/24, we have been supporting members and beneficiaries to better understand how they can effectively implement the principles underpinning our *Being fair* reports. Our Safety and Learning service has facilitated over 870 events, sessions and engagements for clinicians and legal professionals.

*Being fair* and *Being fair 2*, as well as other NHS Resolution resources, are included in the curriculum content of the patient safety syllabus and training that forms part of the NHS Patient Safety Strategy. The training is required to be completed by the NHS's 900+ patient safety specialists by November 2024.

**What is a just and learning culture?**

A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability. It sits at the heart of a person-centred workplace that is compassionate, safe and fair.

It supports the NHS Patient Safety Strategy: Safer culture, safer systems, safer patients, which recognises the need for organisations to have a culture embedded within them that allows incidents to be examined openly without fear of inappropriate sanction and supports those who are affected.

**60%**

of attendees at the Psychological Safety in Primary Care webinar in September 2023 said they would take knowledge from the session to change their practice or leadership.

# Helping to resolve concerns relating to healthcare staff

Our Practitioner Performance Advice service provides impartial advice, assessment and intervention, training courses and other expert services to healthcare organisations to help them effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists.

The service has seen a significant increase in demand for case advice across 2023/24 – around a 21% increase in new requests for advice when compared with the last financial year. Similarly, activity levels for our specialist assessment and remediation services are at their highest for more than five years, with particularly high demand for assessments of practitioners' professional behaviours and action plans to help improve their performance and/or return to work after an absence from clinical duties. We see a clear focus on patient safety in these requests and assessments.

## Developing our activities to support healthcare organisations

We delivered 46 evidence-based workshops to a total of 711 participants to increase local capacity and capability in managing and resolving concerns, including through the promotion of compassionate responses to performance concerns.

We have continued our roll out of regional teams to handle interventions. The regional approach echoes the changes we are rolling out as part of our Claims Evolution Programme (discussed on page 78), which are all designed to better support ICBs.

## Sharing insights to support the management of concerns about practitioners

We have completed the roll out of organisational activity reports, a system of analysis and reporting that allows the organisations we work with to engage in a deep-dive, five-year analysis on the cases for advice opened and any associated activity. This allows organisations to reflect on themes and trends over time and consider any improvement action in relation to managing performance concerns and remediation.

We published five Insights, which are listed in figure 19. These publications share analysis and research that draw on our in-depth experience providing expert, impartial advice and interventions to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual healthcare practitioners.

Publications such as these rely on the data we hold. Maximising the value of this data to support healthcare organisations sits at the heart of our second strategic priority, which we discuss next.

# Strategic priority two: Share data and insights as a catalyst for improvement

Our second strategic priority recognises that our unique datasets reveal vital insights that can be used to improve service delivery. Against the current backdrop of system pressures, it is more important than ever to share those insights, but to do so in a way that respects time-pressed staff.

We use our data in two ways: to identify and advise on emerging patient safety risks and to share insights that improve service delivery. We give an overview of our work in these two areas in 2023/24 in this section.

## Identifying and advising on emerging patient safety risks

At times, the data we hold can indicate the potential for significant harm to be caused, or where significant ham has been caused, in relation to:

- a patient;
- a healthcare practitioner or other employee;
- a service; or
- an organisation.

To ensure that we appropriately identify and respond to concerns we use our Significant Concerns Framework. It allows us to consider sharing information externally where we see evidence of harm or potential harm (for example, unsafe clinical practice). We may share information with other NHS bodies or those with responsibility for regulation in the healthcare system (for example, the General Medical Council). Our paramount consideration in these circumstances is always patient safety and public protection.[45]

The Framework is overseen by our Significant Concerns Group. In 2023/24 it designed and implemented an enhanced process for implementing our response to handling concerns which may require an urgent response. These changes were made as a result of a case notified to the Significant Concerns Group which identified potential safety concerns, indicating an urgent need to act.

Our approach in this complex and sensitive area continues to develop. We recognise that healthcare organisations are best placed to take the lead on identifying and responding to patient harm concerns, but that we can support them with the expert and tailored support we offer through our services.

## Sharing insights to improve service delivery

Our Safety and Learning service shares learning across the system to support improvements in service delivery. In 2023/24 we have engaged with both managers and clinicians, attending external conferences and organising in-person and virtual events. We have also published research and insights that provide practical, actionable patient safety insights.

[45] To read an example of how our rapid and coordinated action across our services helped to reduce the risk of avoidable harm, see the case study on page 53 of our Annual report and accounts 2022/23.

## Recommendation to Implementation pilot

Our Recommendation to Implementation emergency medicine tool was developed in collaboration with the Safer Care Committee at the Royal College of Emergency Medicine. The tool was designed to provide practical support to staff in aligning and prioritising safety recommendations from external bodies such as NHS Resolution alongside existing work. It consolidates the 21 recommendations from the three NHS Resolution emergency medicine thematic reviews and provides a one-window overview of recommendations, enabling clinicians and clinical leaders to simplify the decision-making process of prioritisation, tracking implementation and managing risk for recommendations. The tool was piloted with ten emergency care departments, with feedback showing it saved time in compiling and representing information, serving as a valuable information platform for sharing and aiding discussions with other services and trust boards.

## Research on the lived experience of ethnic minority and international medical graduate practitioners

We commissioned research into the lived experience of ethnic minority and international medical graduate (IMG) practitioners with our service and their employers to produce practical suggestions to provide a fair, consistent service to all where there are performance concerns.

The findings provided a mixed picture in terms of whether practitioners felt they had been treated fairly by Practitioner Performance Advice and their employer. Most participants described feeling discriminated against and long-term impacts included trauma, stress and anxiety.

We have responded to the research by developing an initial internal action plan rooted in these experiences. We have established an Equality, Diversity and Inclusion working group and we are working collaboratively with other organisations, including practitioner representative bodies, to share this research widely to maximise learning and identify areas for collaboration to improve the experiences for all practitioners.

We published the findings of the research in our Insight publication Experiences of ethnic minority and IMG practitioners: Research to improve fairness in the management of concerns.

The work complements the quantitative analysis from our Insight publication Demographics, professions and concerns: What are the patterns in Practitioner Performance Advice cases?, which demonstrates that practitioners from ethnic minority groups and doctors who qualified outside the UK and EEA have higher rates of cases than white or UK qualified practitioners respectively.

> "BAPIO is delighted to collaborate with NHS Resolution on this important piece of work. It is essential that concerns about the performance of any medical practitioners are handled in a sensitive manner, with equal attention given to the viewpoints of all parties involved. This is particularly important in the case of complaints against international medical graduates / ethnic minority doctors, where there is frequently an element of systemic bias against the doctors involved."
>
> **Dr Ramesh Mehta, President, British Association of Physicians of Indian Origin (BAPIO)**

## Insights from claims involving people with a learning disability

In June 2023, a multi-agency advisory group (consisting of arm's length bodies including NHS Resolution, health providers, regulators, royal colleges, subject matter experts and advocates from patient organisations) identified several areas where our data can help to strengthen established training programmes and national quality standards in relation to people with learning disabilities. A further recommendation from the group led to the commissioning and publication of a new easy- read version of the process for making a claim.

## Evaluating our impact

Throughout the last twelve months, our Safety and Learning service has implemented an improvement programme including enhancing our approach to supporting individual members to learn from claims. Of the 36 members and beneficiaries who subsequently responded to a request for feedback following an engagement with them, 78% said they planned to discuss the points raised during the engagement with local teams, 67% said they intended to feed claims insights into their quality improvement workstreams and 31% said they were considering making changes to local pathways or processes.

Figure 19 outlines some of the products we developed to share insights in 2023/24. These publications and training and learning modules are complemented by the insights we share with our stakeholders through ongoing engagement and collaboration.

**Figure 19: A selection of the products developed in 2023/24 in order to share our insights**

### Managers

#### In person events

- Two panel conferences
- Seven claims regional member events

#### Virtual events

- A member webinar on compassion in claims
- A member webinar on LTPS claims
- A webinar on NHS Resolution's service offer to Independent Sector Members

#### Publications

- Insights:
  - Demographics, professions and concerns: What are the patterns in Practitioner Performance Advice cases?
  - Exclusion trends and evaluation of NHS Resolution resources to manage exclusions
  - Insights from five years of supporting the management of Medical and Dental Performers List suspensions
  - Specialities in Practitioner Performance Advice cases: Key themes and use of our services
  - Experiences of ethnic minority and IMG practitioners: Research to improve fairness in the management of concerns

### Clinicians

#### In person events

- Collaboration for safer and sustainable maternity care
- Implementing recommendations: shared insights to reduce claims in emergency medicine

#### Virtual resources

- Learning from emergency department claims podcast
- NHS Resolution's service offer to Independent Sector Members webinar
- Virtual Forums:
  - Psychological Safety in Primary Care
  - Learning from venous thromboembolism (VTE) claims in Primary Care
  - Dermatology in Primary Care
  - Fundamental Dishonesty
  - Patient safety in remote consultations
  - Perspectives on delivering health in the prison and justice system
- Maternity insights: closing the loop, learning from harm eLearning module

#### Publications

- Claims scorecards for our CNST and LTSP schemes for each of our 217 member trusts
- Case stories:
  - Navigating an Early Notification scheme liability investigation
  - Recognising and avoiding significant maternal and neonatal hyponatraemia

A number of other developments in 2023/24 will further support and enhance our ability to share insights with the system. A few examples follow.

## Optimising the quality and management of our information

Activities such as our newly formed Research Governance Group and our Knowledge and Records Management strategy, which is largely complete ahead of its scheduled completion date of December 2024, are designed to help us make use of the information and insights we have in our organisation in the most efficient and effective ways possible.

## Understanding the opportunities and implications of artificial intelligence

Our Practitioner Performance Advice service has started to explore the use of artificial intelligence (AI) search functionality in its work to understand how it could drive greater efficiency and insight.

To better understand the potential impact of the use of AI in the NHS on claims risks and mitigation, and for regulatory policy, we ran a project with the NHS AI Lab. The project's findings will be used to advise members of our schemes.

# Strategic priority three: Collaborate to improve maternity outcomes

Our third strategic priority emphasises the importance of playing our part to improve maternity outcomes and using our data to support the Government's maternity safety ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2025.

NHSE and Government reviews and reports including the independent review into the quality and safety of care at Nottingham University Hospitals maternity services that is currently underway, the Government's response in July 2023 to the independent review into maternity failings at East Kent Hospitals NHS Trust and the Women and Equalities Committee report in June 2023 on Black maternal health reinforce the need for ongoing concern around avoidable error and disparity of outcomes in maternity care.

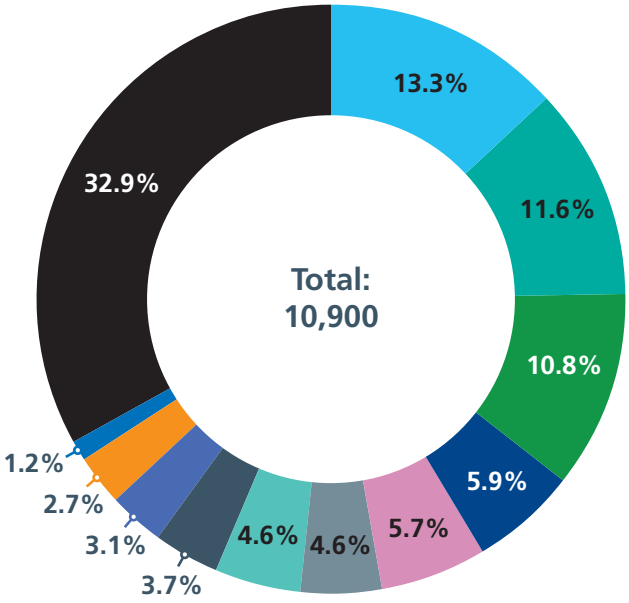
Such incidents can cause devastating consequences for the child, parents and wider family, as well as the NHS staff involved. Reports of the lived experience make the stress, grief and trauma of those affected desperately apparent.

Although secondary to the human impact, errors can also result in a significant financial cost to the NHS, something that we report on in this section.

We can never reverse the damage that these incidents cause. However, we can play our part to support those affected by them and use our insights to help improve maternity care in the future. Some of our work in these areas is also covered in this section.

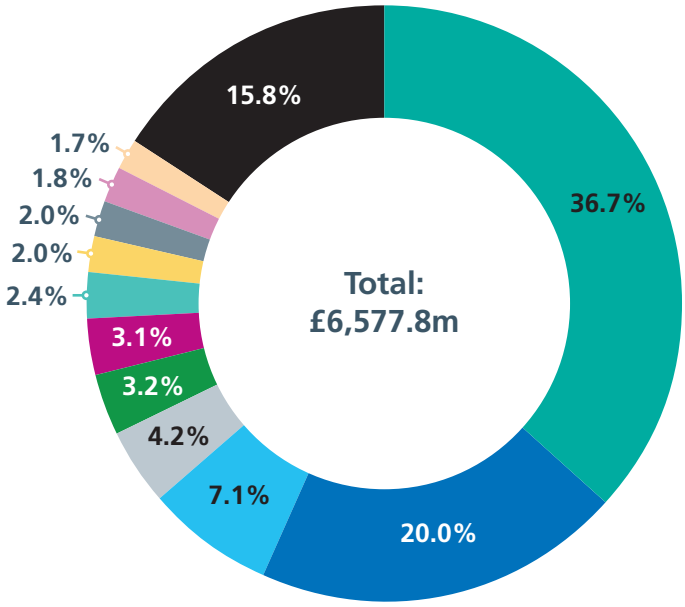
As figures 19 and 20 highlight, obstetric claims accounted for 13% of clinical claims reported by volume (excluding GPI) but accounted for 57% of all clinical claims by value received in 2023/24 (compared with 64% in 2022/23). These include claims reported under our EN scheme on page 74. The reduction in the value of claims received has been impacted by the reduction in the number of high-value obstetric EN claims. This reflects a natural and expected volatility in high-value claim numbers and we will continue to monitor the figure closely. A breakdown of the financial value of obstetric claims is shown in figure 22.

## Figure 20: Total number of clinical claims received in 2023/24 by specialty[46]




| | |
|---|---|
| 13.3% | Emergency medicine |
| 11.6% | Obstetrics – Non-Early Notification |
| 10.8% | Orthopaedic surgery |
| 5.9% | General surgery |
| 5.7% | Gynaecology |
| 4.6% | Radiology |
| 4.6% | General medicine |
| 3.7% | Psychiatry/mental health |
| 3.1% | Gastroenterology |
| 2.7% | Opthalmology |
| 1.2% | Obstetrics – Early Notification |
| 32.9% | Other |

## Figure 21: Total value of clinical claims received in 2023/24 by specialty[47]

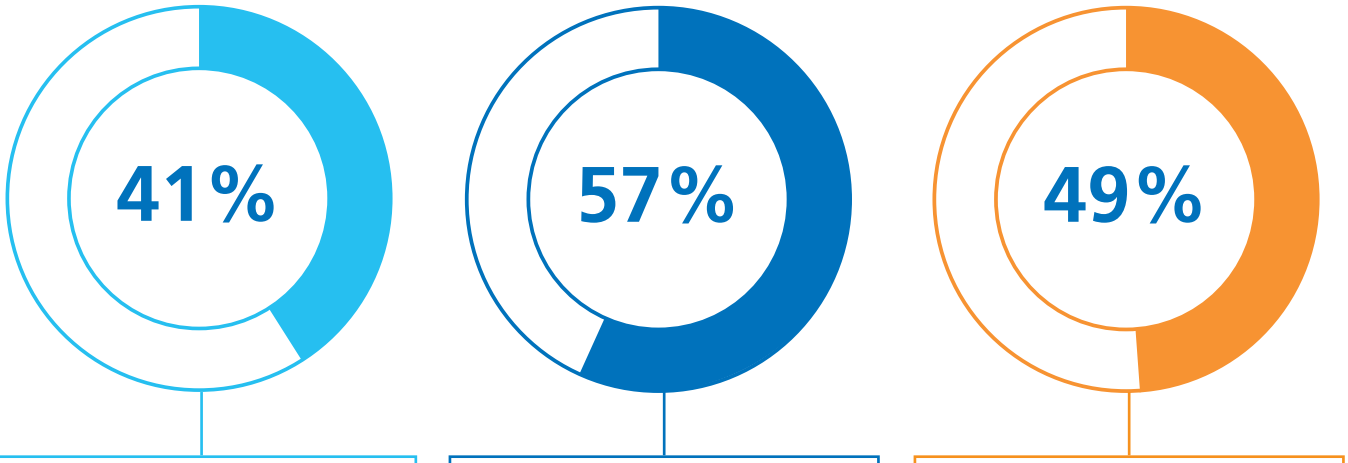


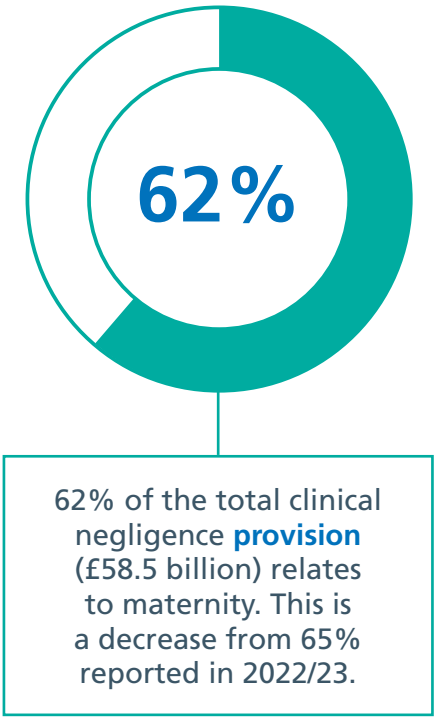

| | |
|---|---|
| 36.7% | Obstetrics – Non-Early Notification |
| 20.0% | Obstetrics – Early Notification |
| 7.1% | Emergency medicine |
| 4.2% | Neonatology |
| 3.2% | Orthopaedic surgery |
| 3.1% | Paediatrics |
| 2.4% | Neurology |
| 2.0% | Neurosurgery |
| 2.0% | Radiology |
| 1.8% | Gynaecology |
| 1.7% | Ambulance |
| 15.8% | Other |

[46] Figure 20 includes all claims received against our CNSC, CNST, DHSC clinical and ELS schemes. It does not include claims received against our GPI scheme. Obstetric care is defined as the care of women during pregnancy, childbirth and the period following delivery (typically 3–6 weeks).

[47] Figure 21 includes all claims received against our CNSC, CNST, DHSC clinical and ELS schemes. It does not include claims received against our GPI scheme.

**Figure 22: The financial value of obstetric claims as of 31 March 2024[48]**




[48] This figure uses data from across all our clinical schemes. In relation to the cost of harm, the figure reported in the 2022/23 accounts was 63% which was incorrect, and has now been updated to 52%.

# Working to improve the experiences of patients and their families

## The Early Notification scheme

We launched the Early Notification (EN) scheme in 2017 to proactively support the National Maternity Safety Ambition to halve maternal and neonatal deaths and reduce significant harm.

The EN scheme proactively investigates specific brain injuries at birth for the purposes of determining whether negligence has caused harm. We do this by requiring our CNST members to notify us of maternity incidents which meet a certain clinical definition. It is designed to speed up investigations into whether or not a baby is entitled to receive compensation by investigating early and to help ensure that steps are taken to learn from things that have gone wrong to improve maternity care closer to the incident.

You can see where our EN scheme intervenes before notification in our claims in figure 4: Clinical claims journey.

For parents whose children have experienced significant brain injuries, we know that navigating a complex and often lengthy legal process can add further distress to an already challenging situation, and that each family will feel the impact of the injury in different ways and at different times. Damages awards for maternity claims are often made by way of a periodical payment order (PPO), meaning a lump sum is paid out upon settlement and then annual payments made for the remainder of the child's life. Earlier admissions via our EN scheme allow earlier support to be provided to families with an interim payment before a final settlement. This provides the security of regular payments for care packages and other assistance that might be required (including therapies or counselling).

The EN scheme is achieving reductions in the time between an incident occurring and an admission of liability being made, monitored as one of our Collaborate to improve maternity outcomes KPIs (see page 41). It has also enhanced our ability to provide financial support to families when they need it the most.

Figures 23 and 24 provide an overview of the year-on-year movement in the volume and value[49] of cerebral palsy/brain damage claims over the last ten financial years. Since the introduction of the EN scheme, the number of non-EN scheme cerebral palsy/brain damage claims being notified is lower, as expected.

### Why can the legal process for obstetric cerebral palsy/brain damage claims take a long time?

In addition to the time taken from the incident occurring to the notification of a claim, for maternity claims involving harm to a baby it may take many years to assess the full extent of the harm caused, as the needs of the child cannot be fully assessed until developmental milestones have been reached. Claims also require court approval of the award of damages. For this reason, the average time between notification of an obstetric cerebral palsy/brain damage claim and settlement with payment of damages is approximately 6.5 years, 4.7 years longer than the average clinical negligence claim.

[49] This can result in changes in the reported total value of all cerebral palsy/brain damage claims from the year that they are reported to the year they are settled.

The figures for 2023/24 (as shown in figure 23) show a reduction in the number of obstetric cerebral palsy/brain damage claims identified compared to the previous financial year. We consider this to reflect a natural and expected volatility in claim numbers, possibly impacted by pandemic and system pressures, materialising in these more complex cases some years later. As discussed in The environment we work in on page 28, the prioritisation of frontline care means the reduced availability of clinicians to provide expert advice may also have contributed to the reduction in EN claims. These factors, however, have not had a significant impact on us meeting our KPIs.

**Figure 23: The total number of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2014/15 and 2023/24[50]**

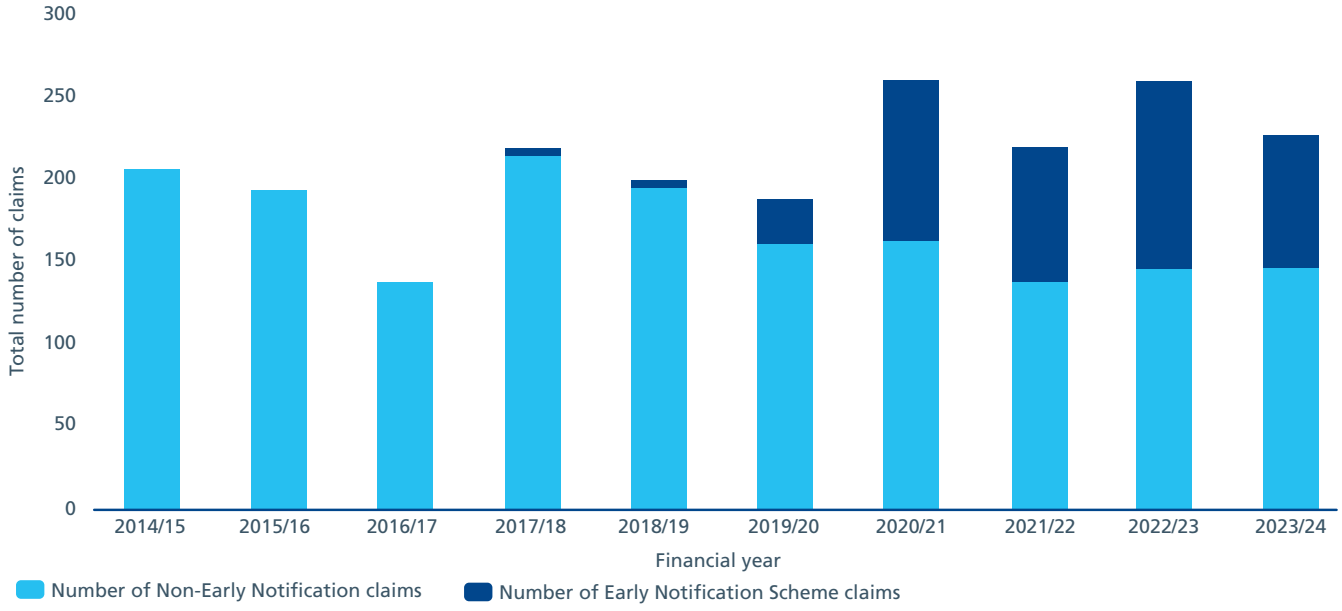
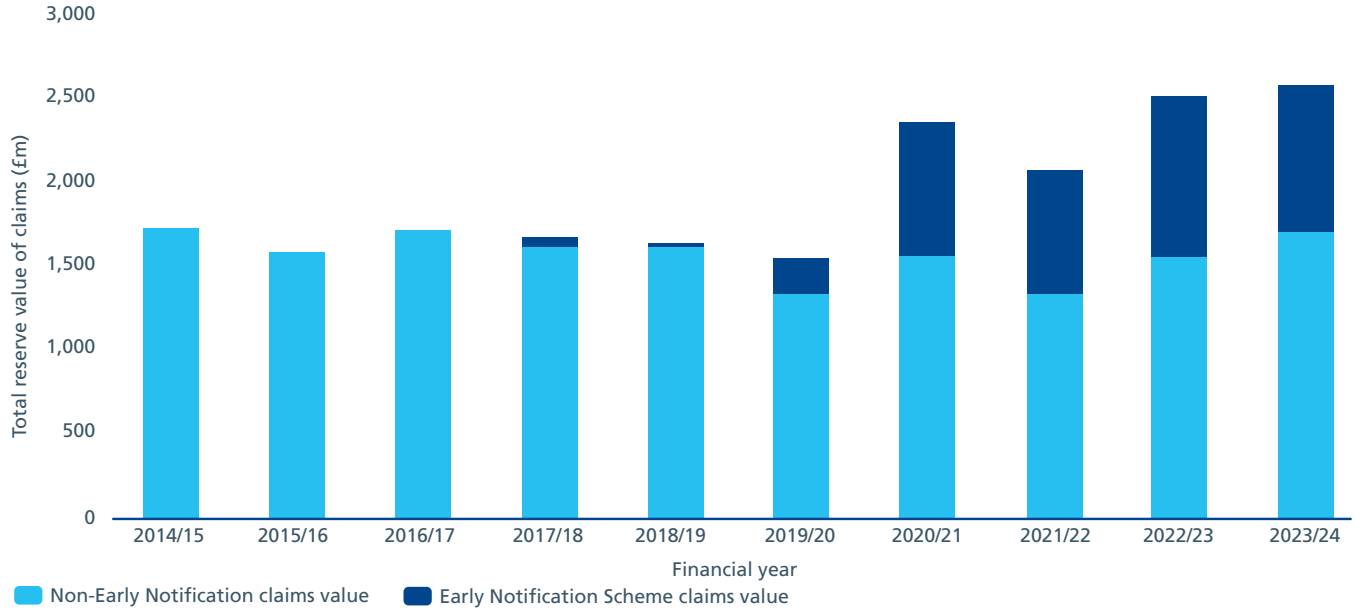



**Figure 24: Total reserve value for obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2014/15 and 2023/24**




[50] Given that the EN scheme started in 2017, data reporting reflects 2017/18 onwards. Note that for EN claims the reported year reflects the year in which the incident was identified as a claim and not the year the incident was reported. Note also that not all EN claims will have a cerebral palsy/brain damage learning code as these are only added once diagnosis is confirmed, which may be some years later. Those cases that pre-date the clinical definition/narrowing of the criteria in particular may not have a confirmed cerebral palsy or brain damage learning code.

## Listening to families' voices

The EN Maternity Voices Advisory Group (MVAG) was established in February 2021 to provide external stakeholders, in particular families and their representatives, with a forum in which they can advise and support future service developments within the EN scheme. The group forms part of our response to the ambition set out in the National Patient Safety Strategy, which encourages organisations and service users to work in partnership to improve quality and safety.

This year, as part of MVAG's work, we hosted two parents' focus groups to hear about their experiences of the EN scheme and understand how we can better support them at an incredibly difficult time.

We made improvements to our webpages, in particular the family-facing pages and pages to support trusts and clinicians. We also made improvements to the correspondence we send to families following feedback.

To support families whose cases are reported to the EN scheme and who do not speak or read English, we started work to procure professional language services.

We also appointed a family liaison and mediation lead to ensure consistent contact once a case is accepted onto the EN scheme. Trusts will retain their duty of candour obligations,[51] and our EN team will collaborate with trusts to inform families of outcomes and next steps.

Alongside these enhancements, we are continuing to work closely with families and with our legal panel firms to ensure we are consistent in our approach and that families are compensated appropriately in accordance with the legal framework.

Our approach in this area builds on the principles and approaches outlined in our publications *Saying sorry*, *Being fair* and *Being fair 2*, ensuring the process to obtain compensation is not a barrier to openness, candour and learning.

## Evaluating the EN scheme

To assess the effectiveness of the EN scheme against its objectives, we have launched an evaluation into the scheme. The process is supported by an academic partner to ensure it has independent rigour and to give assurance to stakeholders that they are providing their feedback in a safe and supportive environment. We intend to report on the findings of the review in 2024/25.

[51] The statutory duty of candour is laid out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It puts an overarching legal duty on healthcare and social care providers to be open and transparent with people using services, and their families, in relation to their treatment or care. It is overseen by the Care Quality Commission.

# Continuing to support work to improve the safety of maternity services

## The Maternity Incentive Scheme

The Maternity Safety Strategy set out DHSC's ambition to reward those who have taken action to improve maternity safety. We support this work through our Maternity Incentive Scheme (MIS).

The MIS is an incentive fund that charges trusts an additional 10% of their maternity contribution to the CNST indemnity scheme. Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services recover their 10% contribution and also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions do not recover their contribution but may be eligible for a smaller discretionary payment to help them make progress against any actions they have not achieved. Trust submissions are checked against Care Quality Commission (CQC) findings in addition to a range of other external verification points.

The MIS's work is supported by our Collaborative Advisory Group (CAG), which brings together other arm's length bodies and the royal colleges. Members of the group include DHSC, NHSE, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Neonatal Clinical Reference Group, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists, the Care Quality Commission and the Maternity and Newborn Safety Investigations (MNSI) programme.

In year five of the MIS 120 trusts participated. This represents all but one of the NHS hospital trusts delivering maternity care in England. The one remaining trust only resumed maternity services part way through the scheme and, while they did follow the guidance, they did not formally participate with the incentive element.

Trusts reported difficulties in complying with the multidisciplinary aspects of the safety actions in year five, in particular around training and perinatal mortality reporting elements (within strict timeframes) as a result of service pressures. To reflect these difficulties and with the agreement of our CAG, compliance requirements were amended for some aspects. We will continue to be mindful of these pressures while balancing them against the need to continue to drive patient safety within maternity care.

Seventy-seven percent of trusts were found to be fully compliant with all elements of the scheme (or granted equivalent status following CAG recommendation). This is an increase on the compliance rate for year four of the scheme, which was 52%.

For those trusts unable to achieve all ten safety actions this year, more safety improvement funding has been made available under the terms of the MIS to support them on their improvement journey.

## Evaluating the MIS

During August 2023, we undertook an early stakeholder engagement exercise to capture a snapshot of feedback on the MIS to provide insights for consideration in year six of the scheme and also to inform the full evaluation of the MIS, which is underway. Like the full evaluation of the EN scheme, it will be supported by an academic partner to ensure it has independent rigour, and we intend to report on its findings in 2024/25.

## Sharing insights to support learning from harm

We share early intelligence in relation to maternity and neonatal services via our CAG. We also develop resources to support learning from harm.

In June 2023 we launched our first eLearning module, called Maternity insights: closing the loop, learning from harm. This innovative and free tool focuses on learning from the significant avoidable harm that can occur during the antenatal and postnatal care of mothers and their babies and that is seen in the cases notified to our EN scheme. Up to 31 March 2024, the module has been accessed by 904 learners. The module is also available in the Royal College of Obstetricians and Gynaecologists' wellbeing resources hub.

In November 2023, we launched a maternity team review offering which recognises that teamwork, cooperation and positive working relationships have been identified as key features of safety in maternity units. Reviews can be commissioned at the request of employing/contracting organisations to provide a better understanding of the barriers to resolving behavioural issues within the team and to suggest options for improving professional relationships.

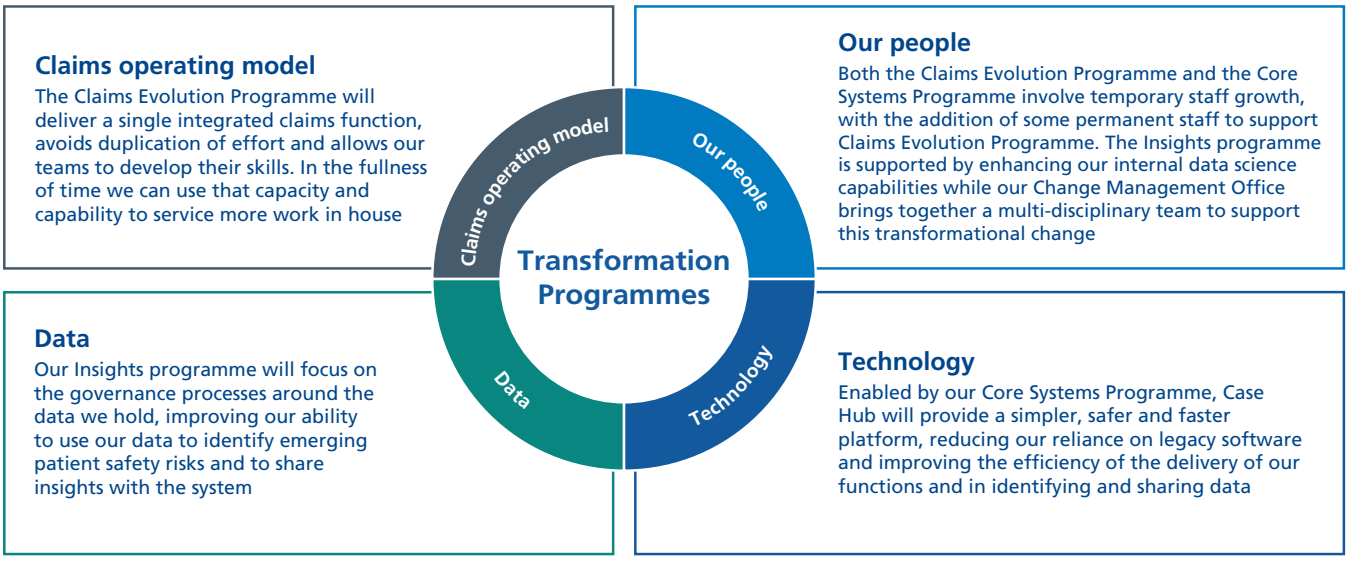
We published two new case stories in 2023/24, which are listed in figure 19. Like all our illustrative case stories, their aim is that by learning from the experience of others, maternity unit staff will be able to change their approach to care.

# Strategic priority four: Invest in our people and systems to transform our business

Our fourth strategic priority focuses on developing our people, systems and services so that we can simultaneously realise the ambitions of priorities one, two and three, and continue to deliver best value for public funds. While recognising the clear value of such transformations, we continue to take a pragmatic and paced approach which acknowledges that our key areas of focus must always be delivering against our first three strategic priorities.

As part of our transformation, we are rolling out two change programmes that will enhance our ability to deliver an efficient, effective and modern public service.

**Figure 25: Transformation programmes**




## Claims Evolution Programme

The Claims Evolution Programme (CEP) is a four-year programme designed to deliver a new operating model. The new model will help us provide an optimal claims management service to the NHS, improve the financial and operational efficiencies to all stakeholders we interact with and allow teams to develop their skills.

As part of the programme, we have moved to a regional model by creating regional-facing Claims Management services supported by regionally aligned legal panel firms.[52] This way of working aligns with the NHS's approach to regionalised working, allowing us to engage more effectively with our stakeholders and opening up opportunities to learn from claims.

[52] For more information, see NHS Resolution: Legal firms appointed to NHS Resolution legal panel.

It also aligns our work across all our services to improve the sharing of insights and identification of potential patient safety risks via our Significant Concerns Framework, which is discussed on page 66.

In line with our commitment to reducing litigation, we have also progressed the first phase of our plan to undertake more claims work in-house, helping us to save costs while continuing to undertake high-quality claims investigations.

Our Claims Support Service, which was created in January 2023, is helping to streamline and improve our claims handling process by handling the more process-driven and administrative-focused tasks that occur during the journey of a claim.

We intend to report in more detail on the realised benefits of the programme in our Annual report and Accounts 2024/25 when we have robust data available.

## CaseHub

CaseHub will replace our legacy case management systems with a single cloud-based system. Over time, the new system will enhance our ability to use the data we hold to gain insights into the healthcare system and increase the efficiency of our day-to-day operations. We will report on these benefits in future annual reports and accounts.

In March 2024, we successfully rolled out the platform to our Practitioner Performance Advice service. Throughout 2024, in line with improvements brought about through the CEP and using learnings from the Practitioner Performance Advice roll-out, we will continue to implement the system for more functions within the organisation.

## The enablers that underpin our transformation projects

Our transformation programmes are underpinned by three core enablers – people, data and technology. Together, they support us to collaboratively change the way we work for the better, and ultimately improve our workplace practices, processes and culture.

### Supporting and developing our people

Reflecting our continued focus on equality, diversity and inclusion, we have been awarded the Disability Confident Leader Level 3 award. This is the highest level of accreditation on the Government's Disability Confident scheme. We remain committed to continuing to improve further and fostering disability awareness throughout the organisation and among partners in the health sector.

As we cover in detail in our Remuneration and Staff report on page 114, we have continued to progress our People Strategy, which is designed to allow us to continue to focus on our people priorities and ensure we have a competent, capable, diverse and well-supported workforce equipped with the knowledge, skills and ambition to deliver on our strategy.

To support our staff and ensure we are equipped to handle and embrace the new ways of working being rolled out as part of the CEP and CaseHub, we have developed and embedded relevant communication, training and engagement activities.

### Enhancing our use of data

In 2023/24, we have started to look ahead at how to make best use of the data insights that will become available to us as CaseHub rolls out. We have laid the foundations for a modern data platform and data science environment that will allow us to interrogate our data more effectively and efficiently. We have also started to consider how best to share data insights with our stakeholders.

### Using technology to streamline internal processes

As well as continuing to progress CaseHub, we have continued to make increased use of digital products to improve how we deliver services internally and to modernise our underlying technology platforms.

To protect our systems from cyber attacks, we have reviewed our security to ensure we align with National Cyber Security Centre guidelines and integrated the NHSE Cyber Security Operations Centre. We have also successfully maintained our Cyber Security Essentials Plus and ISO 27001 certifications.

# Sustainability report

NHS Resolution reports on climate-related financial disclosures consistent with HMT's Task Force on Climate-related Financial Disclosures (TCFD) aligned disclosure application guidance which interprets and adapts the framework for the UK public sector. We have complied with the TCFD recommendations and recommended disclosures in line with the implementation timetable.

It should be noted that NHS Resolution is an office-based organisation, occupying shared office space in line with Government recommendations and this office space is owned and managed by third parties (the Government Property Agency, GPA, and His Majesty's Revenue and Customs, HMRC). As such, NHS Resolution have limited control over the majority of our carbon emissions, which relate to building energy consumption and waste, although we do monitor this on a regular basis. Where NHS Resolution can exercise control, in areas such as policy, asset use and disposal, this is done by our dedicated facilities management team with input from the employee-driven Sustainability Network.

We provide regular quarterly reporting on our carbon emissions via the Greening Government Commitments (GGC) template and annually, along with other sustainability metrics, via the Sustainability report in the Annual report and Accounts. This Sustainability report has been reviewed and signed off by the NHS Resolution management team and Board.

Our contribution to the GGC to reduce greenhouse gas and emissions continues to support the Estates and Operations strategy set by DHSC and the GPA's Net-Zero Estates Strategy.

Our main activities operate from two Government Hubs: 10 South Colonnade, London (Head Office) and 7&8 Wellington Place, Leeds. Both offices are leased as serviced offices, with both landlords (GPA and HMRC respectively) taking primary responsibility for providing gas, electricity, and water and waste services. Although we are not directly responsible for the management of these services, our operational activities have an impact on their net-zero initiatives and GGC targets.

A combination of our Hub Network Strategy, hybrid working, and the estates sustainability initiative programme have all been contributing factors towards improving our environmental performance, which also further align our operational targets with the Government's 25 Year Environment Plan.

We have continued to house our IT systems in data centres that are compliant with the Environmental Management System Standard (ISO 14001) and are the UK's most efficient. They also run on 100% renewable energy and emit minimal emissions, which helps to maintain a lower carbon footprint.

IT asset recycling continues to be used through a reputable supplier, which ensures zero waste goes to landfill, and we will repurpose and recondition some of our oldest endpoint estate equipment, where possible, to remain reusable and compatible with Windows 11.

10 South Colonnade's action plan is owned by the GPA and continues to focus on improving building energy efficiency and performance, sourcing sustainable supply chains and waste streams. There are ongoing projects to look at ways to reduce the electricity and gas use in the building. This includes upgrades to the Building Management System, surveying of submeters, feasibility studies for solar panels and switching gas heat pumps to electricity. As mentioned in our 2022/23 Annual report and Accounts, the biodiversity projects which were being discussed with Canary Wharf Management were not able to be taken forward. The GPA is currently in active discussions regarding other options.

The Leeds Hub is under the management of HMRC, which has provided figures for 2023/24; however, prior years are not available.

Our staff-led Sustainability Network continues to look at opportunities to encourage staff to reduce their carbon footprint, producing regular articles on the staff intranet.

# Data published for the financial years 2021/22 to 2023/24[53]

Electricity, gas and water consumption are calculated per building tenant as a percentage of total consumption for both 10 South Colonnade and 7&8 Wellington Place. Consumption has increased this financial year; however, it should be noted that both properties are managed by third parties and our occupancy represents a very small percentage of the overall property (part occupancy of floors representing around 4% and 7% respectively of the estate). Therefore, the level of control that NHS Resolution can exert over consumption is limited. The overall level of building occupancy also affects the proportion of costs apportioned to individual tenants.

**Table 3: Greenhouse gas emission in each financial year from 2021/22 to 2023/24[54]**

| Greenhouse gas emissions (tonnes $CO_2$)[55] | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|
| Gross emissions for scope 1 Gas | 1.5 | 1.9 | 43 |
| Gross emissions for scope 2 Electricity | 116.4 | 117.3 | 133 |
| Gross emissions for scope 3 Business Travel | 5 | 20 | 20.17 |

The data shows a sharp increase in $CO_2$ emissions which is due, in the main, to the inclusion of 7&8 Wellington Place in 2023/24 (prior year data is not available) – the like-for-like figure for 10 South Colonnade shows only a small increase.

It should be noted that, in 2023/24, 10 South Colonnade switched to a 100% renewable energy tariff for electricity; however, GGC reporting requirements mean this is not reflected in the emissions calculation.

**Table 4: 10 South Colonnade energy consumption in each financial year from 2021/22 to 2023/24**

| Building energy consumption | | 2021/22[56] | 2022/23[57] | 2023/24 |
|---|---|---|---|---|
| Electricity | Quantity (KWh) | 293,261 | 360,814 | 365,232 |
| | Cost (£) | 49,308 | 49,075 | 92,267 |
| Natural gas | Quantity (KWh) | 8,266 | 10,413 | 11,759 |
| | Cost (£) | 1,260 | 449 | 551 |

[53] Sourced from GPA and external suppliers. All figures (including for prior years) have been stated in KWh (where applicable) to align with GGC reporting.

[54] All prior years updated from our Annual report and accounts 2022/23 to reflect updated GGC standards to include all in scope emissions (previously 10 South Colonnade only). Note this excludes data centre emissions.

[55] Reporting in line with GGC standards, see description of scope 1, 2 and 3 carbon emissions.

[56] NHS Resolution moved into 10 South Colonnade part way through 2021 so figures are July 2021 onwards.

[57] Updated from our Annual report and accounts 2022/23 to include 2022/23 Q4 figures (which had not been provided by GPA at the time of original publication).

The data shows an increase in consumption this financial year; however, this is in line with the adjusted tenant allocation due to changes in building occupancy (3.53% in 2022/23 increasing to 4.17% in 2023/24).

**Table 5: 7&8 Wellington Place energy consumption for 2023/24**

| Building energy consumption | | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| Electricity | Quantity (KWh) | Not available | Not available | 226,164 |
| | Cost (£) | NA | NA | 70,015 |
| Natural gas | Quantity (KWh) | Not available | Not available | 181,874 |
| | Cost (£) | NA | NA | 10,677 |

This is the first year of reporting figures for 7&8 Wellington Place and therefore this will be monitored going forward. We have noted that the gas consumption for the building is very high, relatively speaking; however, HMRC have not advised on any measures they are taking to address this at this time.

**Table 6: Data centre electrical energy consumption in each financial year from 2021/2022 to 2023/24**

| Data centre energy consumption | | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| Data centre 1 | Quantity (KWh) | 147,305[58] | 124,658 | 126,314 |
| Secondary data centre 2 | Quantity (KWh) | 63,139 | 70,402 | 66,349 |

Our off-site electricity has remained broadly consistent with consumption over prior reporting periods. We recently completed a project to decommission our secondary data centre so we expect a reduction in the next financial year.

**Table 7: Mileage and cost for road, air and rail travel in each financial year from 2021/22 to 2023/24**

| Travel | | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| Road | Miles | 8,080 | 15,792 | 21,449 |
| | Cost (£) | 4,976 | 8,843 | 12,519 |
| Air | Miles | 0 | 54,332 | 6,291 |
| | Cost (£) | 0 | 5,443 | 1,741 |
| Rail | Miles | 39,817 | 142,544[59] | 327,496 |
| | Cost (£) | 15,049 | 76,487 | 149,716 |
| Total mileage | | 47,897 | 212,668 | 355,236 |

[58] Financial year 2021/22 Data centre 1 consumption was recorded incorrectly in our Annual report and accounts 2022/23.
[59] Updated with financial year 2022/23 Q4 figures.

Travel has seen a notable increase in the overall mileage figures compared to 2022/23. This is primarily attributed to a rise in road and rail travel. Approximately 60% of the rail travel relates to meetings (both internal and team meetings) and this is an area for focus for the upcoming year, balancing the benefits of in-person working against virtual working. Air miles recorded for 2023/24 have reduced as no offshore CaseHub development centre trip was required.

**Table 8: Recycled waste quantity and cost in each financial year from 2021/22 to 2023/24**

| Waste | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|
| Quantity (tonnes) | 6.0 | 6.5 | 4 |
| Cost (£) | £702 | £2,972 | £1,565 |

10 South Colonnade's gross waste has decreased, and since 2020/21 we have continued to achieve 100% diversion from landfill, noting that the cost of this service has increased. Therefore, the figures recorded from 2020 onwards are associated with recycling waste streams only. We have not been provided with figures from HMRC for 7&8 Wellington Place.

**Table 9: Use of finite resources in terms of water consumption and paper in each financial year from 2021/22 to 2023/24**

| Use of finite resources | | 2021/22 | 2022/23 | 2023/24 |
|---|---|---|---|---|
| 10 South Colonnade water consumption ($m^3$) | Usage | 367 | 693[60] | 945 |
| | Cost (£) | 934 | 1,655 | 2,253 |
| 7&8 Wellington Place water consumption ($m^3$) | Usage | NA | NA | 1,048[61] |
| | Cost (£) | NA | NA | 3,171 |
| Paper (reams) | Usage | 20 | 60 | 140 |
| | Cost (£) | 49 | 208 | 665.80 |

Water consumption and paper usage have increased since the last financial year. Water consumption is calculated per building tenant as a percentage of total consumption across 10 South Colonnade and, as such, has increased due to changes in building occupancy levels (as reported above). The 7&8 Wellington Place costs are relatively high compared to the consumption and HMRC have advised this is because different water suppliers apply different charges.

Paper consumption has also increased, due to increased levels of office printing. We will be asking the Sustainability Network to address this with staff in the coming financial year.

[60] Updated from our Annual report and accounts 2022/23 to include 2022/23 Q4 figures (which had not been provided by GPA at the time of original publication).

[61] Includes estimated figures for March 2024.

# Finance report

## Headlines in numbers

The two key aspects to our financial activities are the provision for liabilities arising from incidents which have already happened and in-year budgetary performance, which includes both scheme payments and our administration costs. Further information about our financial activity is provided in the following sections.

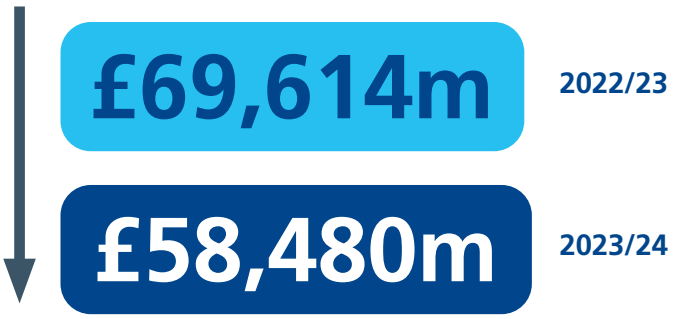
- As at 31 March 2024, the provision for the liabilities arising from claims has decreased by £11,134 million (16%) from £69,614 million at 31 March 2023 to £58,480 million. This is primarily due to the change in HMT discount rates, a technical accounting feature affecting the provision.
- The total estimated cost of clinical negligence claims under CNST incurred as a result of incidents in 2023/24 was £4,778 million, down from £6,278 million the previous year. The change in the discount rates set by HMT has significantly affected this value. The expected value would have been £6,137 million if discount rates had stayed the same as in 2022/23.
- Payments made in relation to claims in 2023/24 increased by £180 million (7%), to £2,871 million.
- Administration costs increased by £6.8 million (13%) to £58.9 million.
- Budget position:
  - Departmental Expenditure Limit (DEL): expenditure was £72 million (2%) under budgeted income and funding.
  - Annually Managed Expenditure (AME): £6,579 million (144%) under budget.

## Year-end provisions

The provision is the value of liabilities arising from incidents that occurred before 31 March 2024, both in relation to claims received and our estimate of claims that we are likely to receive in the future but have yet to be reported as claims (incurred but not reported, IBNR). Figure 26 on page 86 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

The provision has decreased by £11,134 million (16%) to £58,480 million. The most significant factor, accounting for a £14,553 million reduction, is the increase in the discount rates set by HMT. (The discount rate is explained in the Performance summary on page 18).

**The provision for the liabilities arising from claims in 2023/24 compared to 2022/23**



A significant proportion of the provision relates to claims expected to be settled over the longer term. Consequently, increases in the long-term and very long-term discount rates have had a considerable impact on the value of the provision. However, this is an accounting estimate that does not change the underlying future payments that will be incurred in meeting the obligations arising from claims when they fall due in the short term. In other words, the change in the discount rates does not in any way reflect changes in the fundamental drivers of clinical negligence, such as the number of claims that result in damages being paid, the cost of paying these claims, the legal costs involved in handling them and the rate that any payments might increase in the future.

This significant reduction has been partially offset by an increase in the provision arising from another year's worth of activity. Relative to the assumptions that we made last year, reported claims numbers are also slightly higher than expected. However, on the whole, there is a net decrease in the impact of changes in assumptions affecting the provision:

- average claims costs have grown at a lower rate than previously assumed;
- we have made a further small reduction in the long-term claims inflation assumption for periodical payment orders (PPOs); and
- the provision for Covid-19 continues to fall.

It is important to recognise that the in-year cost[62] of clinical negligence across the NHS continues to be significant. The estimated cost of harm in 2023/24 covered by CNST was £4,778 million (see Note 2.1 to the financial statements on page 162). This figure is lower than the previous year's figure of £6,278 million owing to increases in HMT discount rates, which has placed a lower value on projected claims costs.

If HMT discount rate changes for 2023/24 were not applied, the equivalent cost of harm for CNST for 2023/24 would have been £6,137 million. This figure is slightly lower than the corresponding 2022/23 cost of harm figure of £6,278 million. The decrease is mainly due to the average cost assumptions being slightly lower than implied by last year's assumptions and a reduction in the long-term claims inflation assumption for PPO claims.

Indeed, trends over the longer term indicate that the assumptions underlying the provisions do continue to move in a favourable direction. PPO damages average cost assumptions have not grown as much as expected five years ago and the corresponding assumption for future claims inflation continues to fall. Despite this year's experience being slightly higher than assumed last year, the expected future claim numbers, including PPO claim numbers, have also reduced over time. These trends act to reduce the provision over the longer term.

## What is the provision for claims?

A provision is a liability of uncertain timing or amount. The provision in the NHS Resolution accounts is for claims arising from incidents up to and including the balance sheet date (31 March). This includes claims that we have already received, and those that we expect to receive in the future because of the length of time it can take for a claim to come forward after an incident.

As it is expected that payments to settle the liabilities will be made for many years into the future, these are discounted to give a value for the provision at current prices.

A helpful way to understand the provision is to think of it as the amount of money needed to settle all liabilities from claims arising from incidents up to the balance sheet date if they had to be settled on that date.

[62] This is the cost recognised in the Statement of Comprehensive Net Expenditure in the financial year; it is not the value of payments made to resolve claims during the year.

# The estimated financial impact of Covid-19 on provision

The estimated impact of Covid-19 on the provision continues to be relatively limited because the majority (60%) of the IBNR provision relates to maternity claims and we continue to have no evidence to suggest that the pandemic has altered the number or cost of these claims. The net impact of Covid-19 on total IBNR provisions across all NHS Resolution schemes is £0.9 billion for 2023/24, which is an overall decrease of £0.6 billion from the provision of £1.5 billion in 2022/23. Although there has been an increase in the total number of Covid-19 claims received during 2023/24, the increase on the known claims provision is small and lower than previously assumed. The provision for these claims within the known claims remains below £0.1 billion.

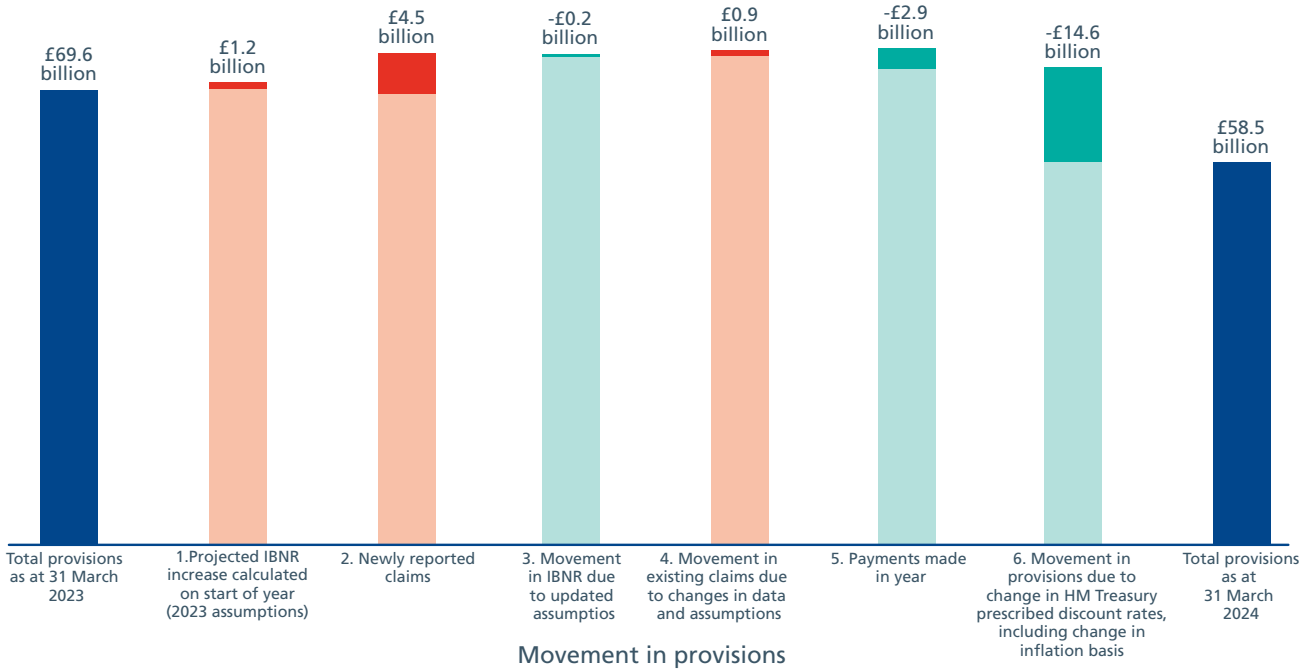
These movements reflect a further year of evidence that Covid-19 isn't leading to a significant increase in claims. That said, the IBNR provision continues to allow for the possibility of further claims arising in the future. The main impacts of Covid-19 on the IBNR provisions include the following:

- We continue to allow for the possibility of risks and potential claims that would not have materialised before the pandemic – for example in relation to the treatment of Covid-19. Generally, the number of reported claims has been towards the lower end of the ranges previously considered, which acts to reduce the provision. This is offset by potential claims from exposure to a further year of such risks arising from clinical activity over the last year. Overall, this update decreases the IBNR provisions by £0.3 billion.
- We also continue to allow for additional potential claims arising from delays, cancellations and misdiagnosis. Again, the number of reported claims has been towards the lower end of the ranges previously considered. Updates to such provisions this year have decreased by £0.2 billion.
- A small additional provision is held for other potential Covid-19 related claims, including employee liability and claims arising from the administration of vaccines. These elements account for less than £0.1 billion of the overall provision, which is broadly unchanged from last year.

The high-level approach adopted to quantifying the impact of Covid-19 on the provisions is discussed in Note 7.2 and Note 7.3 to the financial statements on pages 172 and 176 respectively. The following pages provide an overview of the change in provision for all schemes in 2023/24.

# Change in provision for all schemes in 2023/24

**Figure 26: The change in NHS Resolution's provisions for all schemes from 31 March 2023 to 31 March 2024**




Note: figures may not sum due to rounding

**Items 1 and 2:** Liabilities from another year's worth of activity in 2023/24 for all schemes for all incident years are £5.7 billion.

**Item 3:** shows a decrease of £0.2 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease are in the CNST IBNR, which is the most material component, including:

- An increase of £1.1 billion in respect of claim number projections. Reported claim numbers are slightly higher than expected for a number of incident years for claims likely to settle with PPO damage payments. These claims make up the majority of the IBNR provision.
- A decrease of £0.7 billion for average cost assumptions. In general, the average cost of claims has risen by slightly less than expected, based on the inflation and average cost assumptions that were made last year.
- A decrease of £0.6 billion in respect of Covid-19 related provisions. While the IBNR provision continues to allow for the possibility of further claims arising in the future, this reduction reflects reported claims experience being towards the lower end of the ranges considered in previous years.
- A decrease of £0.3 billion following an update to the long-term inflation assumptions. This reduction is particularly driven by a lowering of the long-term inflation assumption in respect of PPO damages, supported by recent trends in settled claim costs.
- An increase of £0.2 billion following updates to the probability assumptions for paying damages.
- An increase of £0.1 billion in respect of lag and payment patterns and updated mortality assumptions in respect of potential PPO claims.

**Item 4:** The liability has increased by £0.9 billion in respect of changes in data (such as reserve values and other data held for individual claims) and assumptions affecting known claims. The known claims provision is impacted by the changes in inflation and Annual Survey of Hours and Earnings (ASHE) assumptions.

**Item 5:** £2.9 billion was paid out during the financial year in relation to claims. This is lower than the amount we receive in claims from another year's worth of activity (items 1 and 2) partly because we generally settle high-value cases where ongoing care is a feature with a PPO. This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2018/19 financial year), the number of PPOs in payment was 2,192 with £248 million paid out that year, and a whole life value of £18.8 billion (23% of the total provision of £83 billion). At the end of this financial year (2023/24), the equivalent figures were 2,757, £437 million and £13.8 billion respectively (24%).

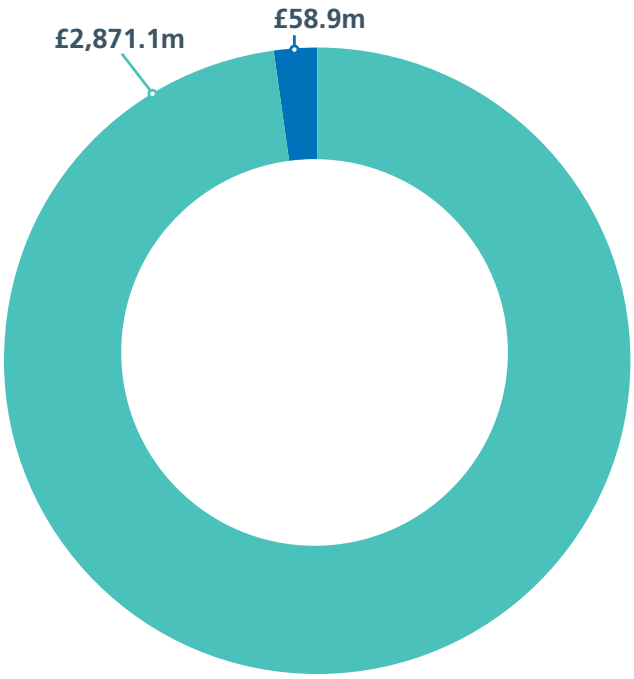
**Item 6:** There is a significant decrease in the provision of £14.6 billion due to increases in the discount rates specified for use by HMT.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the legal 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 as well as changes to discount rates reflecting the financial/market environment, as described above, can have significant impacts on the provision from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail in Note 7.2 to the financial statements section of this report, on page 172.

# 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 healthcare, integrated care boards and other DHSC arm's length bodies) and financing from DHSC. GPI costs are funded out of the budget held by NHSE for the NHS, via DHSC financing.

**A breakdown of NHS Resolution's total expenditure budget for 2023/24**




**£2,871.1m**

Resolving claims

**£58.9m**

Administration costs

DHSC sets a budget in respect of this financing on a DEL basis. The public sector funding regime does not require us to have sufficient assets to cover the long-term liabilities, as these will be financed by Government at the time they become due for settlement. Therefore, we only collect the cash needed to settle claims in the financial year in question.

## What is the Departmental Expenditure Limit (DEL)?

The DEL is a HMT budgetary control, 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. HMT Consolidated Budgeting Guidance can be found at Consolidated budgeting guidance 2023 to 2024 - GOV.UK (www.gov.uk)

## Indemnity schemes in-year financial position

### Table 10: Clinical schemes financial performance

| Clinical schemes | 2023/24 Income/ budget (£ million) | 2023/24 Expenditure (£ million) | 2023/24 Under/ (over) spend (£ million) | 2023/24 Under/ (over) spend Percentage | 2022/23 Expenditure (£ million) |
|---|---|---|---|---|---|
| Member funded – CNST | 2,664 | 2,614 | 50 | 2% | 2,409 |
| DHSC funded schemes | 119 | 101 | 18 | 15% | 130 |
| GPI | 142 | 149 | (7) | (5%) | 140 |
| CNSC | 0 | 0 | 0 | 53% | 1 |
| **Total clinical schemes** | **2,925** | **2,864** | **61** | **2%** | **2,680** |

CNST is our largest scheme and has the majority of the underspend against budget.

Payments on CNST claims and scheme administration increased year on year by £205 million (9%), following on from a £172 million (8%) increase in 2022/23. Expenditure was within 2% of income collected from members. Income from members has been increased by £201 million (8%) to £2,865 million in 2024/25 in the expectation of a continued trend in increasing claims costs.

£140 million of the year-on-year increase in CNST costs relates to damages payments. Just over half of the increase was for lump sum payments on claims with a reserve value of £1 million to £3.5 million, not the highest value group as has been reported in previous years. Annual payments on PPOs increased by £46 million (15%). These costs will continue to rise as we add around 150 of newly settled claims of this nature every year.

Claimant legal costs increased by £49 million (11%), while NHS legal costs increased by £10 million (7%). Cost increases were generally spread across claims of all values.

The EN scheme within CNST is still at a relatively early stage of its development. Spending on these claims was broadly in line with 2022/23 levels.

Expenditure on GPI schemes increased by £9 million to £149 million compared to the previous year. Almost all of the growth is in the CNSGP scheme which provides cover for incidents from April 2019, and is still maturing. The ELSGP scheme covers historic incidents prior to that date, and it is expected that new claims and settlements will reduce over time. The budget for GPI schemes was overspent due to the relatively short time NHS Resolution has been operating these schemes and their relative maturity, making it difficult to establish firmer information to support forecasting.

The budget for DHSC schemes anticipated a higher number of high value claims being settled in the year than actually occurred, hence the underspend of £18 million (15%). There was a significant drop in payments against claims with a value of over £3.5 million compared to 2022/23.

There were 23 new claims received for CNSC during the year. £0.2 million has been spent on dealing with claims.

### Table 11: Non-clinical schemes financial performance

| Non-clinical schemes | 2023/24 Income/ budget (£ million) | 2023/24 Expenditure (£ million) | 2023/24 Under/ (over) spend (£ million) | 2023/24 Under/ (over) spend Percentage | 2022/23 Expenditure (£ million) |
|---|---|---|---|---|---|
| Member funded – LTPS | 53 | 46 | 7 | 13% | 41 |
| Member funded – PES | 8 | 4 | 4 | 50% | 8 |
| DHSC funded scheme | 7 | 7 | 0 | 0% | 6 |
| CTIS | 0 | 0 | 0 | 90% | 0 |
| **Total non-clinical schemes** | **68** | **57** | **11** | **16%** | **55** |

As table 11 shows, expenditure on LTPS has increased by £5 million (12%) compared to 2022/23, concentrated in lower value claims (under £250,000).

Expenditure on the Property Expenses Scheme (PES) is volatile and it is difficult to predict due to the nature of claims received under this scheme. No claims have been received for the Coronavirus Temporary Indemnity Scheme (CTIS), and £15,000 has been spent on administration (primarily in relation to meeting financial reporting needs).

We also have a budget for Annually Managed Expenditure in respect of the net movement in provisions for all the indemnity schemes, such as the change in the provision less any provisions settled in the year. The budget is set 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 HMT.

## What is Annually Managed Expenditure (AME)?

AME is a budget to cover expenditure on volatile or difficult-to-manage budget items, and is set on an annual basis.

As detailed in table 12, a negative expenditure budget of £4,555 million was set as HMT discount rates were published in advance of the forecast being submitted to DHSC. It was therefore possible to provide an estimate of the significant reduction they were likely to generate. However, some contingency for activity in the final few months of the year, and for adverse movements in key assumptions which could have increased the provision, was allowed for in the budget. This was because the work on updating the key assumptions had not commenced when the final forecast for the year was required for the Parliamentary Supply Estimate process.

In the event, that contingency was not required, the provision reduced by more than was allowed for in the budget, and this resulted in a lower level of AME against the budget of £6,579 million.

**Table 12: Annually Managed Expenditure**

| Annually Managed Expenditure | £ million | £ million |
|---|---|---|
| Budget | | (4,555) |
| Expenditure | | |
| Net cost of claims provision | 6,290 | |
| Change in discount rates | (14,553) | |
| Settlement of provisions | (2,871) | |
| **Total expenditure** | **(11,134)** | |
| **Under / (overspend)** | | **6,579** |

## Administration costs in-year financial performance

Administration costs for all our activities (including the costs of administering member-funded schemes and GPI arrangements which have been allocated to the scheme DEL budgets above) have increased by £6.8 million (13%) to £58.9 million. This is 2% of our total DEL expenditure. The increase primarily relates to staffing costs, as average full-time equivalent staff numbers have increased by 97 (18%) to 653. The costs of a further 27 full-time equivalent staff were charged to the capital budget for CaseHub, bringing our total to 680 full-time equivalent staff members.

In addition, this year we have generated £888k (£981k in 2022/23) of income from commercial activity in respect of activities and services to NHS bodies and other national governments delivered by our Practitioner Performance Advice service. These activities were reduced during the year as staff resource was focused on implementing the new IT operational system, and made a small loss of £24k (3%) during the year (£16k/2% loss in 2022/23).

The Claims Management service has continued to expand as the team has been implementing the next phase of the Claims Evolution Programme, which is discussed in Strategic priority four of the Performance report on page 78.

The volume of claims being received from the maturing CNSGP have also continued to increase, which requires ongoing expansion of our workforce. GPI scheme claims require more activity from our staff compared to claims against secondary care providers as the latter have legal services to support with the administration of the claim.

During 2023/24, there was a significant amount of activity involved in the design and development phase of the programme to replace our IT operational systems, which has required considerable input from subject matter experts from across the business, as well as technical change and ongoing infrastructure support. This has also resulted in growth in staff numbers, some of which will be temporary for the implementation process which will continue into 2024/25.

## Capital

There was £3.5 million in capital additions in the year, an underspend of £1.6 million against the budget of £5.1 million. The majority of the £3.5 million of capital expenditure is for CaseHub, set up to replace our main operational IT systems.

## Cash

The balance has increased by £79.7 million to £685.5 million by the end of the year due to the in-year underspend on our indemnity schemes. While all cash balances are held in Government Banking Service accounts, we continue to discuss with DHSC the options for using cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. Funding for member-funded schemes is provided through the NHS finance regime, and any underspends incurred by NHS Resolution contribute to the management of the overall DHSC group financial position.

# Expected future performance

For the coming year, our focus will be on the next phase of modernisation and change. The next phase of our Claims Evolution Programme in 2024/25 will bring more claims management in-house to NHS Resolution and reduce the money spent on external legal costs. This will enable us to build on our dispute resolution approach in pursuit of our ambition that no compensation claim against the NHS should be litigated unless it is absolutely necessary.

At the same time, we will be moving to the next and final stage of the development and roll-out of CaseHub across the business. This is a significant technology programme for NHS Resolution to replace legacy operational IT systems, and will be our main priority for 2024/25.

In parallel, we will need to be ready to respond to expected changes in the legal environment.

The scheduled review of the personal injury discount rate (PIDR) will carry significant operational and financial implications for our work, together with a degree of uncertainty as to the outcome and market response. We will prepare and stand ready to respond to the announcement and the impact that follows.

Safety in maternity services remains a key focus and we will report on the evaluations of our Maternity Incentive Scheme and Early Notification scheme to ensure that their future development enables them to reach their maximum potential in terms of benefits for patient safety and how we respond to harm.

It will be challenging to deliver our core services alongside our transformation programmes, but the changes are necessary in order to become a forward-facing organisation equipped to navigate the increasingly complex environment that we, along with many of our NHS partners, face.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2023/24.

**Helen Vernon**
Chief Executive and Accounting Officer

Date: Wednesday 17 July 2024

Image credit: https://en.wikipedia.org/wiki/File:Reuters_and_10_South_Colonnade,_Canary_Wharf.jpg

# Accountability report

## Corporate governance report

The corporate governance report provides an explanation of how NHS Resolution is governed, how this supports our objectives and how we make sure that there is a sound system of internal control allowing us to fulfil our purpose and role.

# Directors' report

## NHS Resolution's Board

This report primarily provides information about the composition of the Board[63] of NHS Resolution. The Board had authority or responsibility for directing or controlling the major activities of the entity during the year and has responsibility for setting the strategic direction and risk appetite of the organisation. It is collectively accountable, through the Chair, to the Secretary of State for Health and Social Care for ensuring a sound system of internal control including implementing arrangements for securing assurance about the effectiveness of the organisation's governance.[64] Details of the Board's activities are given in Board activities on page 100.

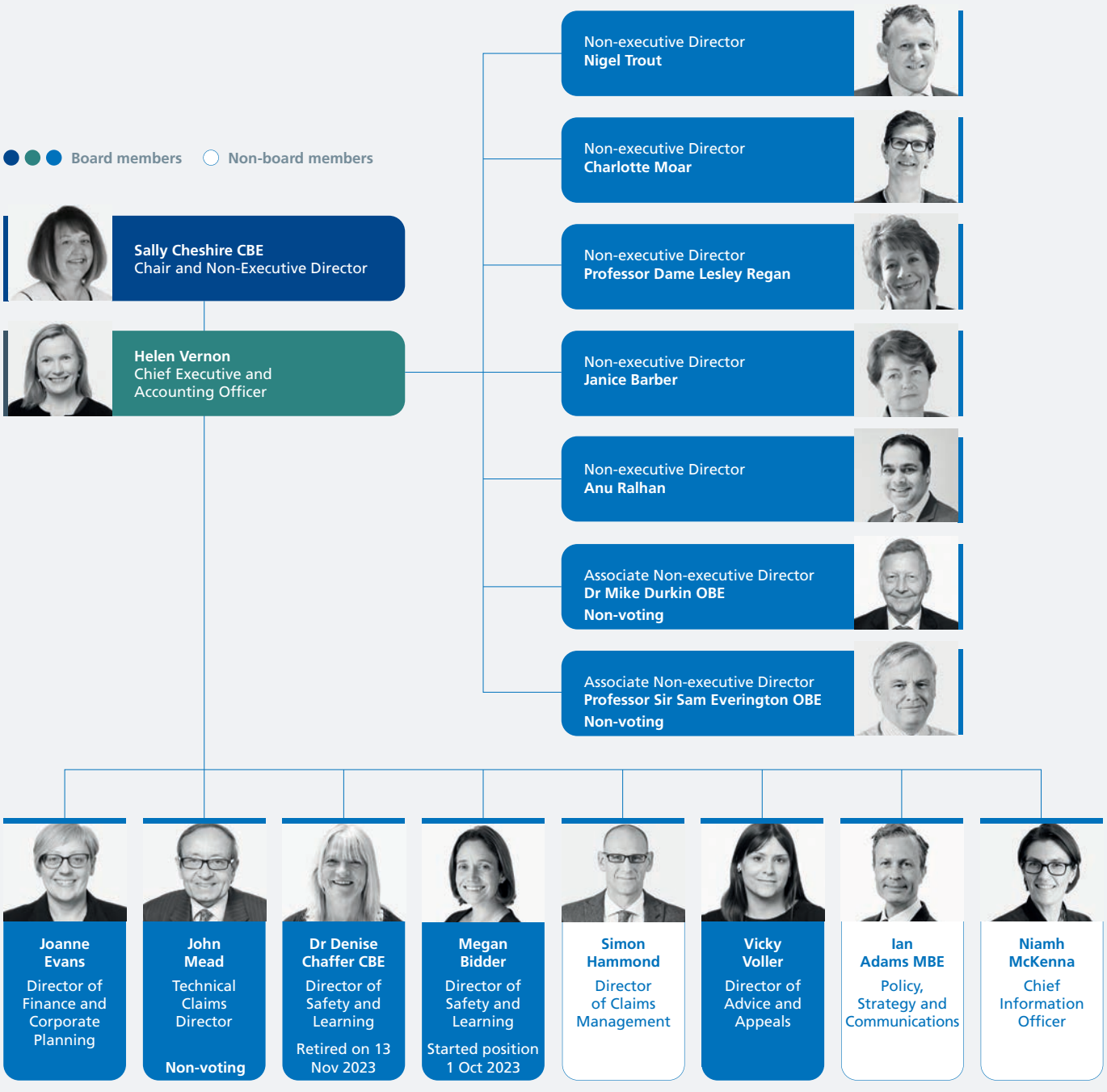
## Board composition

As of 31 March 2024, the Board consisted of a non-executive chair, five non-executive members and four executive members. There are also two associate non-executive directors and one associate executive director. The Board can consist of between three and five non-executive directors and between three and five executive directors.

[63] A register of interests of each of our Board members can be found on our website at resolution.nhs.uk/leadership.

[64] Further information about our Board and governance structures can be found on our website at resolution.nhs.uk/about/governance/governance-structures.

## Figure 27: NHS Resolution's Board in operation from 1 April 2023 to 31 March 2024[65]




[65] On 1 April 2024 Simon Hammond became an executive director. Anu Ralhan's appointment as non-executive director started on 1 March 2024.

# 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 (FReM) 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 judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the FReM 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 are fair, balanced and understandable and take personal responsibility for the Annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accounting Officer of DHSC has designated me, 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 HMT.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as Accounting Officer of NHS Resolution. 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 are fair, balanced and understandable.

**Helen Vernon**

Chief Executive and Accounting Officer

# Governance statement

## Scope of responsibility

As Chief Executive and Accounting Officer of NHS Resolution I am responsible for maintaining a sound system of internal controls that supports compliance with our policies and the achievement of our objectives while safeguarding public funds and our assets in accordance with HMT's guidance *Managing Public Money*.[66]

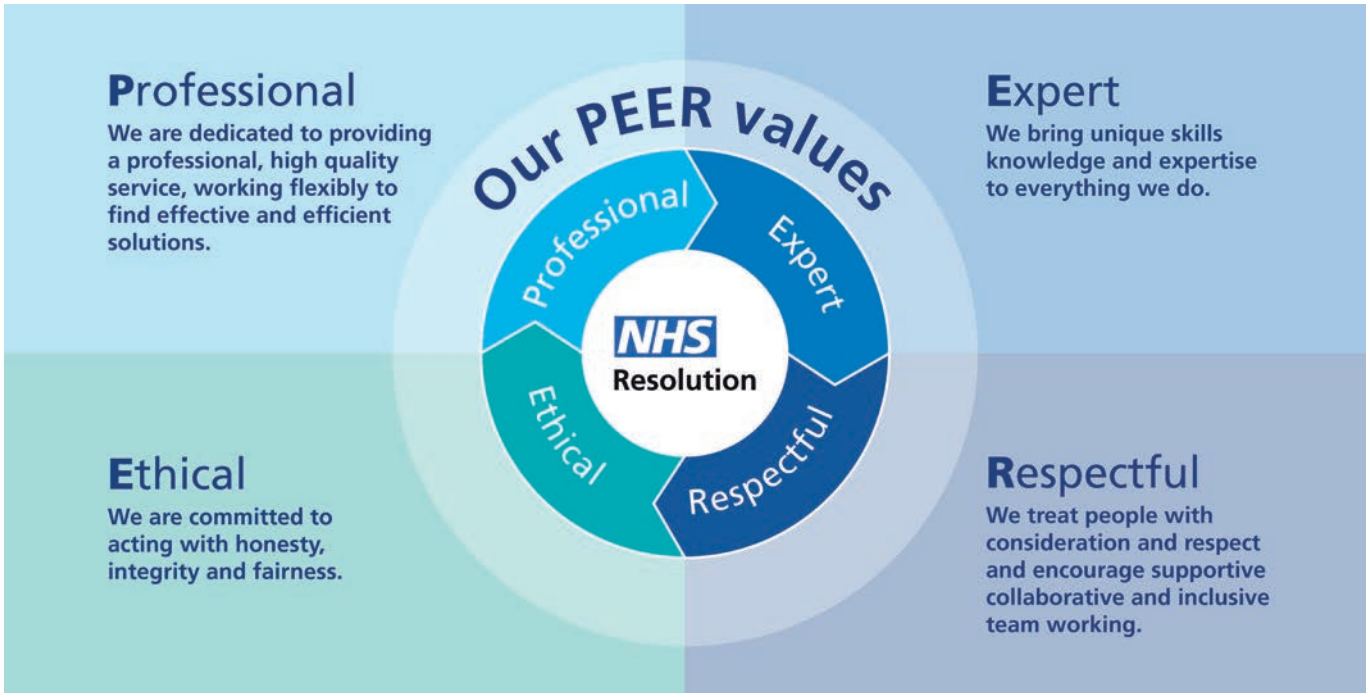
I have responsibility for the delivery of NHS Resolution's strategic aims and objectives within our legislative and regulatory parameters, as directed by DHSC and in conjunction with the Board through development of strategy and effective governance arrangements.

I am responsible for:

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

As Accounting Officer, I am supported by our senior management team (SMT), internal audit and the 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 our values, as outlined in figure 29, in everything we do.

**Figure 28: Our PEER values**



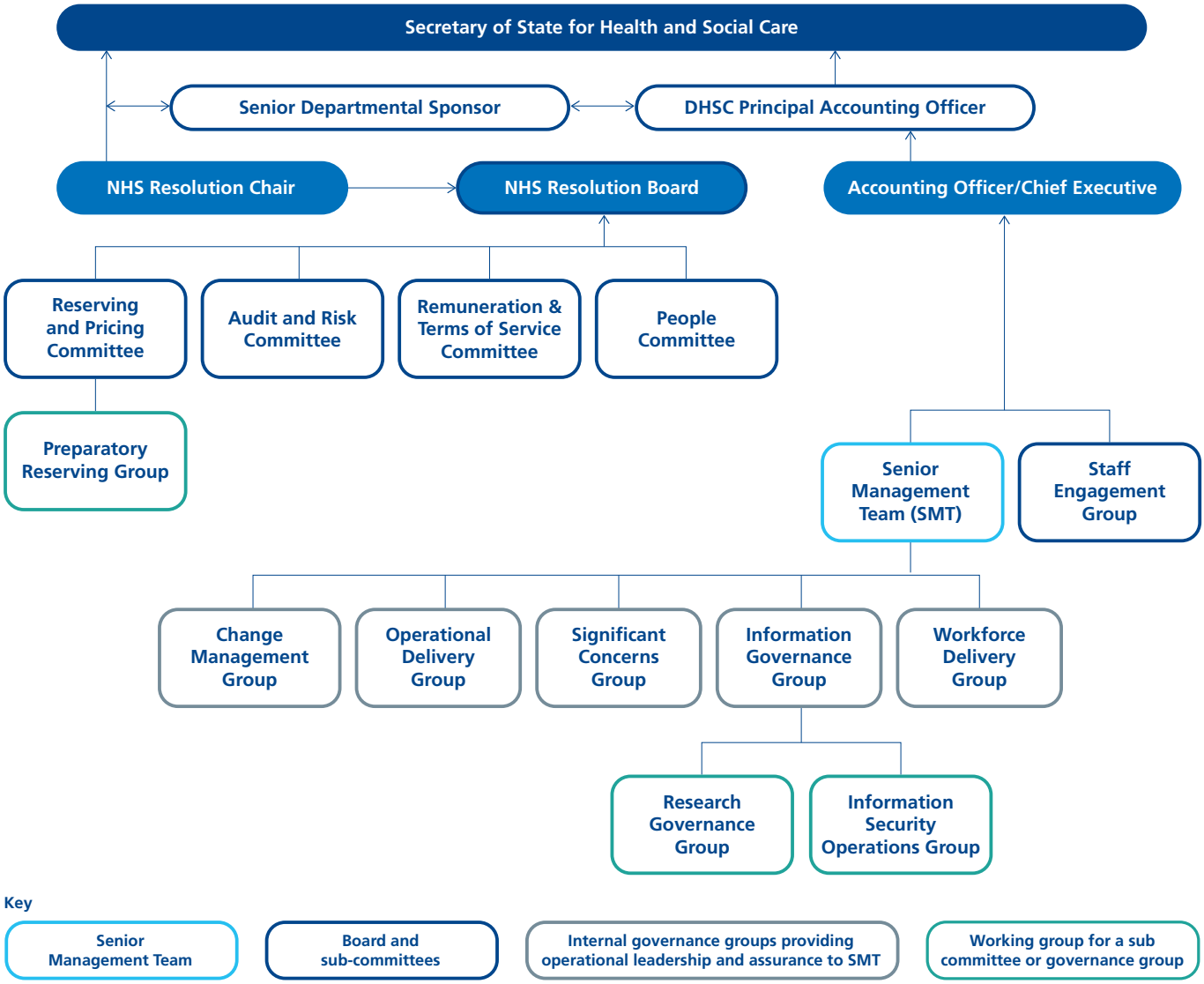

I delegate day-to-day operational responsibility for our financial systems and internal risk management arrangements to the Director of Finance and Corporate Planning, who also acts as the Senior Information Risk Owner for NHS Resolution.

[66] HMT: Managing Public Money, May 2023.

## The governance framework and structures

Figure 29 outlines our governance and risk management structure, with the following sections describing the role of our Board and committees, the SMT and its sub-groups.

**Figure 29: NHS Resolution governance structure in operation from 1 April 2023 to 31 March 2024**




## The NHS Resolution Board

### Board activities

As NHS Resolution's Accounting Officer, I am supported by the SMT, internal audit and ARC to provide assurance to the Board on matters as they relate to effective governance. I provide reports on the organisation's performance to the Board and to DHSC on a regular basis in accordance with the Framework Agreement with DHSC.

The Board regularly considers these reports to ensure it remains satisfied regarding the quality of information, ensuring that it is relevant and sufficient to inform the business of the Board.

Consideration of the strategic objectives, business plan and associated risks is also given at the Board meetings.

During the period from 1 April 2023 to 31 March 2024 the Board met on six occasions. Table 13 provides further information on the attendance of the Board at these meetings and table 14 provides an overview of the key matters considered at these meetings.

## Table 13: NHS Resolution Board meeting attendance from 1 April 2023 to 31 March 2024

| Name | Post | Meetings attended |
|---|---|---|
| Sally Cheshire CBE | NHS Resolution Chair | 6/6 |
| Charlotte Moar | Non-executive Director | 6/6 |
| Nigel Trout | Non-executive Director | 6/6 |
| Professor Dame Lesley Regan | Non-executive Director | 6/6 |
| Janice Barber | Non-executive Director | 6/6 |
| Anu Ralhan[67] | Non-executive Director | 1/1 |
| Helen Vernon | Chief Executive | 6/6 |
| Joanne Evans | Director of Finance and Corporate Planning | 5/6 |
| Dr Denise Chaffer CBE[68] | Director of Safety and Learning | 3/3 |
| Megan Bidder[69] | Director of Safety and Learning | 3/3 |
| Vicky Voller | Director of Advice and Appeals | 6/6 |
| Dr Mike Durkin OBE | Associate Non-executive Director | 6/6 |
| Sir Sam Everington OBE | Associate Non-executive Director | 5/6 |
| John Mead | Associate Board Member | 6/6 |

## Table 14: Frequency of key matters discussed at Board meetings from 1 April 2023 to 31 March 2024

| Matter | Number of meetings discussed |
|---|---|
| **Chief Executive's report** | |
| The Board considered reports from the Chief Executive which provided updates on key matters related to the work of NHS Resolution and its operating environment. | 6/6 |
| **Performance and activity** | |
| **Performance report:** Considered the performance and activity across NHS Resolution in line with the NHS Resolution business plan and strategy. | 6/6 |
| **Risk and assurance:** Regularly considered the risks related to performance, business delivery and the strategy. | 6/6 |
| **Transformation:** Discussed the portfolio and the key programme and portfolio risks/issues and the mitigating actions. | 5/6 |
| **Annual report and accounts:** Considered the drafting and endorsement of the Annual report and Accounts for Accounting Officer signing. | 3/6 |
| **Business plan:** Discussed the development of and approved the 2024/25 business plan. | 3/6 |
| **Complaints report:** Considered the complaints reports and discussed themes and learning from complaints. | 2/6 |
| **Strategic priorities** | |
| Discussed opportunities and risks associated with key areas of the NHS Resolution strategy. | 3/6 |
| **Administrative approvals** | |
| **Risk appetite statement:** Considered and approved the risk appetite statement in line with the current internal and external risk environment. | 2/6 |
| **Policies:** Considered and approved polices as retained by the Board. | 5/6 |

[67] First meeting: March 2024.
[68] Last meeting: September 2023.
[69] First meeting: November 2023.

## Compliance with the corporate governance code

While we are not required to comply with the UK Code of Corporate Governance, the Board and its committees have due regard to the principles set out in the Code with effectiveness reviews of the Board and ARC also taking the Code into account.

## Board and subcommittee effectiveness

In 2022/23 the NHS Resolution Chair commissioned an independent effectiveness review of the Board and its subcommittees which included ARC, the People Committee and the Reserving and Pricing Committee (RPC). The effectiveness review concluded that the organisation is well run. There was recognition of the transition from being the NHS Litigation Authority to NHS Resolution, particularly in the context of the changing landscape in which NHS Resolution operates.

Through 2023/24 the Board took forward actions in line with recommendations made including:

- agreeing a single private meeting of the Board with a single set of papers, which enabled effective and efficient use of the meetings;
- agreeing that summaries of the Board meetings should be published on the NHS Resolution website, and actioning as such; and
- continuing to receive improved quality of papers to enable Board discussions to focus on insights and assurance related to any concerns or risks and mitigations to manage those.

## Committees of the Board

The Board is supported by four subcommittees which have been 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. Following the independent effectiveness review, the Board's subcommittees took forward actions including:

- reviewing their terms of reference and annual work plans to ensure their work is aligned to the strategic objectives and business plan and, where appropriate, to provide assurance on the management of associated risk and mitigations; and
- providing reports to the Board which include key matters for the Board to consider.

Each committee considered their performance in 2023 as satisfactory and each concluded it had discharged its obligations as set out in the terms of reference. The committees also considered that their terms of reference remain appropriate and fit for their purpose.

### Audit and Risk Committee

The Audit and Risk Committee (ARC) supports the Board and me in our responsibilities for reviewing the comprehensiveness and reliability of our assurances on governance, risk management, the control environment and the integrity of financial statements as well as the Annual report and accounts. The ARC is also supported by internal and external auditors.

The ARC is chaired by a non-executive director and also has two independent members. During this reporting period the committee met on four occasions, The Chair of DHSC's ARC attended an ARC meeting held in May 2023. Table 15 provides further information on the attendance of ARC at these meetings.

**Table 15: NHS Resolution ARC meeting attendance from 1 April 2023 to 31 March 2024**

| Name | Post | Meetings attended |
|---|---|---|
| Charlotte Moar | Non-executive Director and Chair of ARC | 4/4 |
| Marcus Hine | Independent Member | 4/4 |
| Kafui Tay | Independent Member | 4/4 |

During the year the ARC particularly focused on:

- progress on actions agreed from internal audit recommendations;
- assurance reports on health, safety and wellbeing, business continuity, cyber security and information governance, including progress towards achieving and sustaining ISO 27001 certification, as well as actions taken and lessons learned;
- oversight of the arrangements for countering fraud including fraud risk assessments, progress against the annual action plan and metrics as well as receiving reports on proactive exercises;
- receiving independent assurance reviews of the CaseHub programme;
- NHS Resolution compliance with relevant Government Functional Standards;
- the plan to improve forecasting around the cash flow and AME;
- assurance around freedom to speak up arrangements;
- a briefing from NHS Resolution's actuarial advisers on the development of assumptions affecting the key estimate in the accounts as approved by RPC, the provision for claims liabilities; and
- outcomes and progress of actions from the Known Claims Advisory Review.

### Renumeration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee and is chaired by the Chair of NHS Resolution. It considers risk and provides assurance to the Board on recruitment, appraisal and performance management of senior personnel, together with succession planning. The Committee meets as required but at least twice yearly.

### People Committee

The People Committee provides assurance to me, as the Accounting Officer, and the Board on matters related to people, risks, our organisational development strategies and associated workstreams.

The Committee is chaired by a non-executive director with membership comprising two directors and one independent member.

In 2023/24 the People Committee met on three occasions.

During the year the Committee focused on:

- HR performance reporting;
- assurance on transformation programme processes, the potential impacts on staff and the development of a Change Management Office;
- significant workforce and people-related risks;
- an update on progress against each of the five People Strategy pillars; and
- our talent management and succession planning strategy.

### Reserving and Pricing Committee

I chair the Reserving and Pricing Committee (RPC) with membership comprising the Director of Finance and Corporate Planning, the Director of Claims, a non-executive director and an independent member.

The Committee's purpose is to:

- determine, on the basis of the evidence and advice available, the most appropriate methodology and practice, modelling assumptions and outputs to be used in reserving and pricing; and
- provide assurance to the Board that these are appropriate, escalating to the Board any areas of significance.

Key matters considered in 2023/24 included an ongoing focus on known claims methodology and assumptions due to the issue arising in the audit of the 2021/22 accounts concerning assessing the time to settlement of claims. This includes greater attention to the assurance framework for the known claims data and models.

The RPC is supported by the Preparatory Reserving Group (PRG), a forum which brings the organisation and our actuaries together to consider emerging experiences that could influence and impact the reserving assumptions.

I, Dave Johnston, am an Actuarial Director at the Government Actuary Department (GAD) and a Fellow of the Institute and Faculty of Actuaries.

I have calculated the IBNR provisions to be £23,758 million for all schemes combined as at 31 March 2024 using the method and assumptions selected by NHS Resolution.

Bearing in mind the purpose of the calculation and taking into account discussions held with the working groups and NHS Resolution's Reserving and Pricing Committee:

- in my opinion the actuarial assumptions that were selected by NHS Resolution's Reserving and Pricing Committee for both the IBNR and known claims provisions have been selected on a best estimate basis, with no explicit adjustment for risk and uncertainty;
- in my opinion the IBNR provisions for NHS Resolution as at 31 March 2024 that I have calculated, and are to be included in NHS Resolution's Annual report and accounts, have been determined using an appropriate actuarial methodology and assumptions that are within a reasonable range, given the range of uncertainty; and
- in my opinion and based on my understanding of the approach taken by NHS Resolution's finance team, the known claims and settled PPO provisions for NHS Resolution as at 31 March 2024 have been determined using an appropriate actuarial methodology and assumptions that are within a reasonable range, given the range of uncertainty.

This opinion statement should be considered in the context of:

- my advice to the Reserving and Pricing Committee; and
- GAD's role in determining the known claims provision – which is more limited in comparison to the IBNR.

There are a number of uncertainties underlying the 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 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 senior management team (SMT) includes the directors of each of the business areas. 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 our strategy and business plan. The SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which the SMT has oversight of or approval is required. This includes resource management, planning, governance arrangements, complaints and stakeholder management. The SMT reviews particular areas of our activity or areas of development and considers any changes in the internal and the external environment that may have an impact on NHS Resolution and its services.

There are regular risk review sessions to ensure we have controls and treatments in place to mitigate risks and bring them within appetite.

During 2023/24, the SMT worked closely with the Operational Delivery Group (ODG) to consider the delivery of our business plan and the associated resource requirements.

### SMT governance sub-groups

We have established internal governance groups that provide operational leadership on matters related to business plan delivery. These groups, described in table 16, provide assurance to the SMT through regular reporting and the escalation of any risks or issues that could impact our business objectives.

**Table 16: SMT sub-groups in operation from 1 April 2023 to 31 March 2024**

| SMT sub-group | Function |
|---|---|
| Change Management Group (CMG) | • Oversees the governance, commissioning and implementation of projects and programmes to enable delivery of the business plan.<br>• Ensures value for money and benefit realisation.<br>• Ensures that best change management practice is identified and shared within the organisation. |
| Operational Delivery Group (ODG) | • Monitors the delivery of business plan objectives and identifies associated risks and issues.<br>• Reviews operational performance and ensures improvement plans are implemented.<br>• Ensures compliance with the policies approval process and assesses key changes to operational policies. |
| Information Governance Group (IG) | • Provides expertise to enable the production, oversight and maintenance of key information governance policies and protocols in line with legal and organisational requirements.<br>• Has operational oversight of the maintenance of ISO 27001 certification. |
| Significant Concerns Group (SCG) | • Supports the prompt and effective management of significant concerns identified by individual NHS services. |
| Workforce Delivery Group (WDG) | • Provides dedicated focus on workforce development and management (both the HR and OD aspects).<br>• Ensures NHS Resolution has an effective organisational culture, workforce plan and consistent application of HR policies that support delivery of organisational objectives.<br>• Ensures compliance with relevant legislation and DHSC/wider government directives. |

## The control environment

Confidence in our ability to deliver core business is key to maintaining our position as a trusted and effective organisation. Our system of internal control is designed to support effective mitigation of risk rather than the elimination of risk. As such, it can only provide reasonable, and not absolute, assurance of effectiveness.

### Capacity to handle risk

Effective risk management supports the delivery of our strategic priorities and business plan objectives. Through 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, developing plans to bring those risks within appetite. Risk reporting and escalation is set out in our *Risk management policy and procedure*, which is published on our website.

The Board actively considers at its meetings the key strategic and operational risks facing NHS Resolution in carrying out its statutory and other functions. The Chair and Chief Executive ensure that appropriate issues are discussed by the Board in a timely manner with a reporting process against key performance indicators (KPIs) to assure the Board of delivery against its strategy and business plan, together with associated risks and how they are being managed. The Board sets the organisation's risk appetite and ensures that the framework of governance, risk management and control is in place to manage risk.

The Board receives regular risk reports which provide assurances that risks have been identified and assessed, and that all reasonable steps are being taken to manage the risks effectively and appropriately. The Board also discusses any risks that are outside of risk appetite and considers the advice of the ARC on remedial actions.

The SMT maintains and updates a strategic risk register which reflects those risks that could have an impact on the delivery of our strategy. The ODG is charged with the review and escalation of corporate operational risks that may impact the delivery of our business plan as well as business as usual matters.

Overall, we aim to ensure the risk registers are integrated and dynamic, and that all teams across the organisation support risk management and mitigation.

Regular reports are provided to ARC, which considers the application of the risk management framework and as such the current controls and required treatment plans to mitigate risk. In relation to those risks which are outside the risk appetite of the organization, ARC recommends appropriate action to the Board.

## Risk appetite

The Board has developed a risk appetite statement which is reviewed and updated annually.

The Board's approach is to minimise its exposure to risk in relation to the delivery of its strategy and operations as well as ensure compliance with good standards of governance. The risk appetite statement is designed to provide a framework or point of reference to managers when considering their approach to a risk area, courses of action or taking decisions (subject to delegated authorities), and the level of priority, resource and investment to be allocated to the mitigating actions. The Board expects that NHS Resolution's management will plan for and appropriately resource these initiatives, while ensuring that the health and wellbeing of our staff and core operations are not compromised.

## Internal audit

An internal audit plan is developed in conjunction with management and the ARC to focus on the areas of risk, and to provide insight, advice and assurance on the internal control framework. Internal Audit carried out nine reviews in the financial year.

| Audit title | Audit opinion |
|---|---|
| Procurement | Reasonable |
| Data Quality | Reasonable |
| Data Security Protection Toolkit | Reasonable |
| Governance and Performance | Reasonable |
| Payments | Substantial |
| Cyber | Reasonable |
| Risk Management | Advisory |
| Annual Follow Up | Advisory |

## Audit opinion key

**Substantial**
Controls upon which the organisation relies to manage the risks are suitably designed, consistently applied and effective.

**Reasonable**
Controls upon which the organisation relies to manage the risks are suitably designed, consistently applied and effective. Further actions have been identified to enhance the control framework.

**Partial**
Action required to strengthen the control framework.

**Minimal**
Urgent action required to strengthen the control framework.

**Advisory**
Intended to add value and improve an organisation's governance, risk management and control processes. Advisory reviews do not include an internal audit assurance opinion but do provide a conclusion of the findings of the work undertaken. Advisory reviews are often delivered at the request of management and the audit committee.

The Head of Internal Audit concluded NHS Resolution has **Adequate and Effective** systems of control, governance and risk management in place for the reporting year 2023/24.

## Management assurance

Our assurance arrangements bring together governance and quality linked to our strategic objectives. These arrangements ensure that systems and information are available to provide assurance on identified strategic risks and that such risks are being controlled and objectives achieved.

## Anti-fraud, bribery and corruption

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 stance towards fraud and bribery. Through 2023/24 we developed an internal counter-fraud strategy and associated action plans to ensure we take forward improvements and as such comply with the Government Counter Fraud Functional Standard GovS013.

We have established controls in place to mitigate the risk of fraud as far as possible, including an up-to-date *Anti-fraud, bribery and corruption policy and procedure*, as well as annual mandatory training. These provide guidance for all staff, enabling them to recognise and deal with potential instances of fraud and bribery.

Where potential incidents of fraud could occur, we ensure systems are in place to investigate, establish cause and ensure lessons are learnt to enable us to enhance controls where required.

Counter fraud services are provided by the Government Internal Audit Agency (GIAA).

We continue our membership of 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.

## Business continuity

We have business continuity plans and policies to ensure we can respond to and recover from major operating disruptions which would seriously impact our ability to conduct critical business operations for a significant period of time. We carried out a thorough review of our departmental business impact assessments, which take into account the changing external, as well as our own internal, operating environment. We took forward our plans to train those charged with business continuity and the testing of our plans, which ensures they are fit for purpose.

## Data quality

We have designed our systems to ensure the controls and assurances we have in place include:

- exception reports and management review;
- quality assurance through the Business Intelligence Service; and
- internal audit of data both from the claims function and third-party Internal Audit provider.

Work is ongoing to document and enhance the assurance framework on data and model quality in relation to the inputs required for calculating the provision for claims liabilities.

## Performance and financial controls

NHS Resolution's financial and operational performance is reported regularly to the SMT, the Board and to me. Our financial position, together with operational KPIs, are reported quarterly to DHSC to demonstrate that performance is being managed in line with expectations.

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 assurances to management and the Board. Governance arrangements through the RPC for the valuing of provisions for claims and forecasting budgetary requirements for indemnity schemes are set out earlier in this statement.

## Procurement and contracting

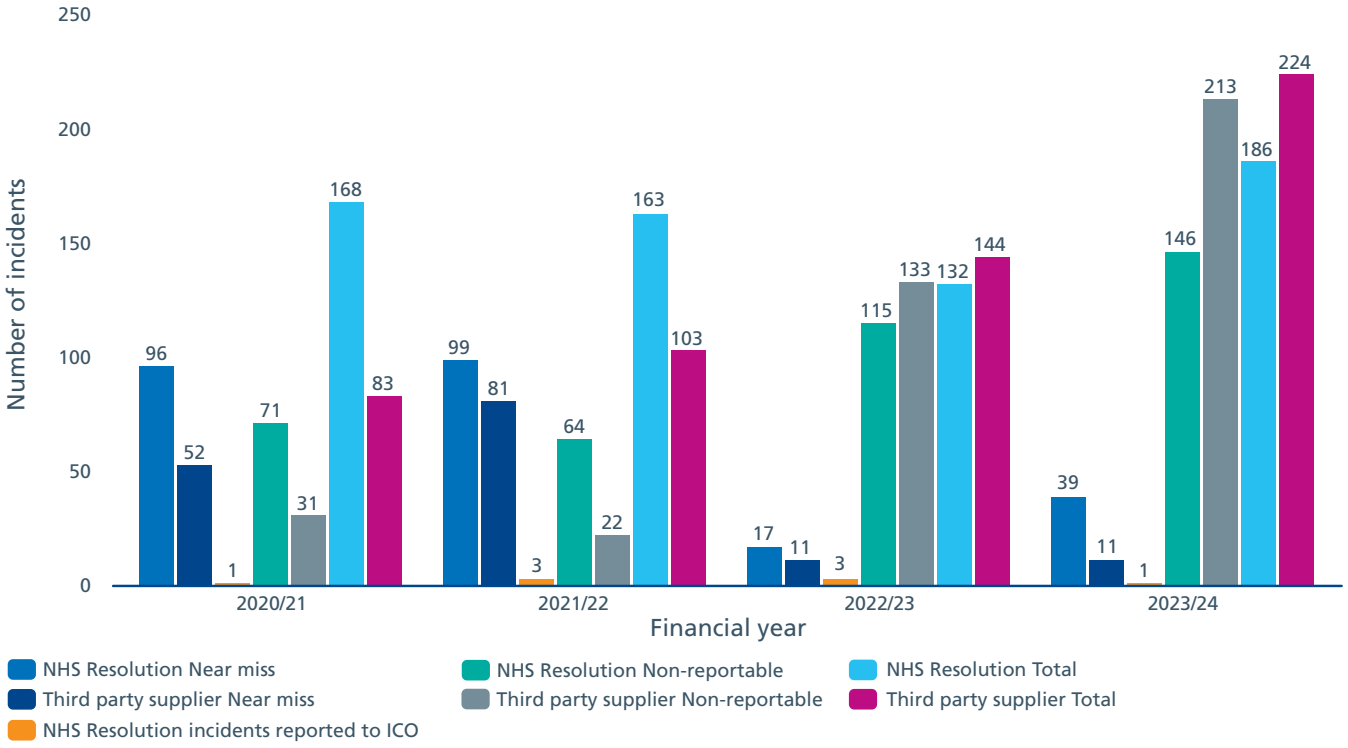
We ensure our procurement processes are compliant with regulation, Cabinet Office and DHSC requirements. We have pipeline plans in place to ensure that acquisitions for goods and services provide value for money and that we are transparent in our procurement approach.

We are committed to ensuring our tenders include matters related to the Public Services (Social Value) Act 2012 and as such have included this as an evaluation criterion in appropriate tenders. 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.

## Information governance and security

NHS Resolution has maintained ISO 27001 Information Security certification, demonstrating that we have an effective information security management system. The recertification audit in January 2024 reviewed a range of governance and technical security controls against the ISO standards. We also continue to maintain Cyber Essentials Plus certification, which is a UK Government scheme of good practice in information security.

**Figure 30: Information governance incidents reported in each financial year between 2020/21 and 2023/24[70]**




During 2023/24, as figure 30 shows, a total of 410 incidents and 'near misses' were recorded. Of this total, 50 were 'near misses'.[71] The difference in our reporting numbers from previous years is largely as a result of organisational growth, accessibility for incident reporting via a digital form and increasing engagement with suppliers to raise incidents so that we can understand and take swift action to mitigate any impacts to NHS Resolution.

During this reporting period there was one report to the Information Commissioner's Office (ICO), which was directed through the Data Security Reporting Toolkit. While we continue to learn from any incidents and address any gaps in our internal controls, the ICO concluded that no further action was required on the reported incident.

Following learning from previous incident investigations we have updated our incident policy and procedure to include a process for stepping up an incident oversight group. An incident oversight group is set up where a serious incident is reported with an impact score of three or above in line with our risk matrix, involves multiple teams and requires active team co-ordination to achieve quick resolution and learning.

We continue to review our incident reporting framework to enhance the reporting on incidents and derive more insight and any associated learning.

[70] Incidents that are categorised as 'non-reportable' are those that are reported but do not meet the criteria for onward reporting to the ICO.

[71] A 'near miss' is defined as an incident that did not lead to harm, loss or damage, but could have done, and is reported in order that we can learn from the near miss occurrence.

## Responding to members of the public

Effective processes were in place throughout the year to ensure we responded to all public enquiries, correspondence, parliamentary questions, issues raised under freedom of information (FOI) requests and Data Protection Act (DPA) legislation and complaints.

In 2023/24 we received 335 FOI requests (a 23% increase compared to the 272 received in 2022/23), of which 84% were completed within the statutory timescale of 20 working days. We improved our compliance with the legal deadline compared to 2022/23 (69% compliance in 2022/23).

We had one complaint made to the ICO related to the timeliness of a FOI response. The ICO did not take any further action.

There continues to be a growing interest in the work of NHS Resolution and we note that a popular area of interest continues to be our claims data and particularly maternity claims (costs, causes of claims and injuries suffered). We have continued to publish responses on our disclosure log and update our factsheets and our publication scheme to assist the public to find information about our organisation and our activities.

We seek to be open and in the majority of responses we do provide disclosure of information in full. Where we do not, it is because doing so would be to increase the risk of identifying claimants or others who trust us with their sensitive health information.

## Data protection requests

NHS Resolution receives two types of request under the DPA. The first type, subject access requests (SARs), gives individuals the right to request any information held about themselves.

In 2023/24 150 SARs were received, which is an increase of 19 (15%) on the previous year. Of these, 134 (89%) were responded to within the statutory deadline of one calendar month. This is an improvement compared to the compliance for 2022/23, which was 86%. Where these were not responded to within the specified time, we advised the requestor of the reasons for the delay, such as complexity or volume of information in scope of the request.

The second type of requests are third party requests for information for personal data relating to activities for the prevention and detection of crime. Such requests can be made by the police, regulators and, in respect of our claim function, other insurance bodies who are members of the CUE.

## Complaints and feedback

In 2023/24 we received 21 complaints, which were reviewed via our formal complaints policy. Of the 21 complaints received, 47% were completed within the 25-working-day deadline. This performance is explained by an increase in complaints where there were complex matters to address, and consequently took longer to respond to fully. Where we have exceeded the 25-working-day deadline we always engage with the requestor to explain any delay.

We also have a claims management framework for recording concerns and queries relating to claims, and these are addressed through our Claims Management service. This process provides our service users with a route by which their concerns can be addressed, whereas previously the complaints policy was the only route and that does not encompass complaints about claims decisions because of the legal framework within which claims operate. There is a dedicated Complaints and Learning Manager within the Claims Management service, who has been able to resolve these concerns and ensure they are addressed promptly.

These numbers remain small relative to the volume of activity across the organisation. We are, however, always keen to learn from complaints.

There was only one complaint referred to our Chair during 2023/24, which was not upheld. There have been no complaints referred to the Parliamentary and Health Service Ombudsman (PHSO).

We have taken learning forward from our complaints by including themes from complaints in our reporting and have in place steps to address any issues identified.

We are engaged with the PHSO to ensure that our policy is aligned to the principles of the complaints standard framework.

## Freedom to speak up

We have a *Raising concerns policy* and have in place four Freedom to Speak Up guardians as well as a Board lead (a non-executive director) and SMT lead. The guardians continue to work within the organisation to influence change and drive improvement arising from concerns raised, which for this year has included:

- Regular meetings with the Human Resources/ Organisational Development (HR/OD) team to consider themes from issues raised and remedial actions that can be put in place, and to review corporate policies, taking account of examples of inconsistency or inequity. Promoting greater visibility and accessibility of the HR team as a valuable source of advice and support for managers and staff. Identifying training or policy and procedures knowledge gaps that may exist across the organisation;
- Regular meetings with teams to discuss concerns raised by their team members and providing intelligence to prompt earlier management intervention where possible; and
- Participating in corporate induction sessions to promote the commitment to speaking up and how that facilitates change in the organisation.

## Health, safety and wellbeing

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures with staff required to participate in training to ensure they are aware of these. We have ensured that all staff have complete display screen equipment assessments to make sure they are working safely both in the office and at home. We have also undertaken an individual risk assessment with all staff to identify those who may need extra support. To ensure all our staff are supported we have continued to provide an Employee Assistance Programme, various health and wellbeing tools, and the assistance of mental health first aiders. Further information about the support we provide can be found in Maximising employee health and wellbeing on page 140.

## Respect for human rights

We are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to ensure this include the following:

### People

- We confirm the identities of all new employees and their right to work in the United Kingdom and pay all our employees above the National Living Wage.
- Our *Raising concerns policy* provides a platform for our employees to raise concerns about poor working practices.

### Procurement and our supply chain

Our procurement approach is in line with the Cabinet Office Guidance: *Tackling Modern Slavery in Government Supply Chains*[72] and as such includes a mandatory exclusion question regarding the Modern Slavery Act 2015.

## NHS Pension scheme regulations

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

## Statutory functions

We maintain a register of the relevant directions and statutory functions for NHS Resolution which ensures we are operating as we should be.

This gives me, as Accounting Officer, the assurance that we have a clear view of those functions and regulations we should be working to.

[72] Cabinet Office: PPN 02/23 - Tackling Modern Slavery in Government Supply Chains - Guidance, March 2024.

## Government Functional Standards

As of 31 March 2024, we were compliant with the mandatory elements of the relevant Government Functional Standards with one exception. We are considering a matter related to the Standard GovS 014: Debt and the requirement of a Debt Strategy which will take into account the context of the debts recognised by NHS Resolution, as referred to in Note 1.8 to the financial statements, on page 159.

We will continue to enhance our assurance framework in line with the relevant Government Functional Standards, by adopting best practice where applicable.

## Accounting Officer's conclusion

The governance arrangements detailed in the statement aim to support NHS Resolution to maximise our 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.

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 2023/24.

# 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 service of all posts covered by the Pay Framework for Executive and Senior Managers (ESMs). The Committee, established by NHS Resolution's Board, which also approves its terms of reference, met three times during the 2023/24 financial year. All meetings were quorate with the attendance of members shown in table 17.

**Table 17: Remuneration and Terms of Service Committee meeting attendance from 1 April 2023 to 31 March 2024**

| Name | Post | Meetings attended |
|---|---|---|
| Sally Cheshire CBE | Chair | 3/3 |
| Charlotte Moar | Non-executive Director | 3/3 |
| Nigel Trout | Non-executive Director | 3/3 |
| Janice Barber | Non-executive Director | 3/3 |
| Professor Dame Lesley Regan | Non-executive Director | 2/3 |
| Anu Ralhan[73] | Non-executive Director | 1/1 |

In May 2023 the Committee received an update on the appraisals discussions that had been held with each of the ESMs as presented by the CEO. They considered the application of local recruitment and retention premia and provided the CEO the authority to manage existing arrangements where necessary. In addition, the Committee approved the extension of the two associate non-executive director positions from July 2023.

In September 2023 the 2023/24 annual pay award and performance related payments were determined by the Committee based on guidance provided by DHSC and approved. The Committee considered a further update from the CEO on the performance of each of the ESMs, including the assigned performance ratings.

In March 2024 the Committee considered and noted the updated succession plans for each of the Directors as presented by the Chief Executive, who was in attendance. In addition, the Committee approved the extension of the two associate non-executive director positions with effect from July 2024.

The Committee considered its performance in 2023 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 and fit for their purpose.

[73] Anu Ralhan's appointment as non-executive director started on 1 March 2024.

# 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 the DHSC pay framework for very senior managers in arm's length bodies, all staff are paid in accordance with Agenda for Change. Where necessary, NHS Resolution also makes use of the national medical and dental pay, and terms and conditions of service for those positions which are deemed necessary to have a current licence to practise and/or professional membership with an appropriate body. We currently have three staff members employed under the medical and dental terms and conditions of service.

Full details on the Agenda for Change, 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 that supports modernised working practices. Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system that supports NHS service modernisation and meets the reasonable aspirations of staff. Full detail on the medical and dental pay and terms and conditions of service can be found on the NHS Employers website.

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 *NHS 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 premia, 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 executive and non-executive directors who had control over the major activities of NHS Resolution during 2023/24, except for the associate executive directors who have no voting rights on the Board. Tables 18, 19 and 20 are subject to audit. There were two changes in Board membership during 2023/24. A new non-executive director, Anu Ralhan, started his term of office on 1 March 2024. Megan Bidder, Director of Safety and Learning, commenced in post from 1 October 2023, replacing Dr Denise Chaffer CBE.

## Table 18: Executive and non-executive director salaries and allowances[73] for 2023/24

| Name and title | Salary (bands of £5,000) £000 | Expense payments (taxable) total to nearest £100 |
|---|---|---|
| **Sally Cheshire CBE** (Chair) | 60–65 | 8,200 |
| **Helen Vernon**[76] (Chief Executive) | 165–170 | 0 |
| **Joanne Evans** (Director of Finance and Corporate Planning) | 130–135 | 5,900 |
| **Vicky Voller**[77] (Director of Advice and Appeals) | 125–130 | 0 |
| **John Mead** (Technical Claims Director) | 105–110 | 5,900 |
| **Dr Denise Chaffer CBE** (Director of Safety and Learning) | 60–65 | 0 |
| **Megan Bidder**[78] (Director of Safety and Learning) | 45–50 | 0 |
| **Charlotte Moar**[79] (Non-executive Member) | 10–15 | 3,300 |
| **Nigel Trout** (Non-executive Member) | 5–10 | 100 |
| **Janice Barber** (Non-executive Member) | 5–10 | 0 |
| **Professor Dame Lesley Regan** (Non-executive Member) | 5–10 | 0 |
| **Anu Ralhan**[80] (Non-executive Member) | 0–5 | 0 |
| **Dr Mike Durkin OBE**[81] (Associate Non-executive Member) | 5–10 | 600 |
| **Sir Sam Everington OBE**[82] (Associate Non-executive Member) | 5–10 | 0 |

[74] The executive and non-executive directors do not receive any non-cash benefits other than travel costs for journeys to locations approved under NHS Resolution's travel expenses and reimbursement policy. The gross value of this benefit and any taxable expenses reimbursed are included in the expense payments column of this table.

[75] The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decrease due to a transfer of pension rights.

[76] Helen Vernon is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

[77] Vicky Voller is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

| Performance pay and bonuses (bands of £5,000) £000 | All pension-related benefits[75] total to nearest £1,000 | Total (bands of £5,000) £000 |
|---|---|---|
| N/A | N/A | 70–75 |
| 5–10 | 0 | 175–180 |
| 0 | 36,000 | 175–180 |
| 0 | 0 | 125–130 |
| 0 | 0 | 115–120 |
| 5–10 | N/A | 65–70 |
| 0 | 13,000 | 60–65 |
| N/A | N/A | 15–20 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |
| N/A | N/A | 0–5 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |

[78] Megan Bidder's appointment as Director of Safety and Learning commenced on 1 October 2023. The Director of Safety and Learning full year equivalent salary is in the band of £95–100k.

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

[80] Anu Ralhan's appointment as non-executive director commenced on 1 March 2024. The non-executive director full year equivalent salary is in the band of £5–10k.

[81] Dr Mike Durkin OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2023.

[82] Professor Sir Sam Everington OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2023.

## Table 19: Executive and non-executive director salaries and allowances[83] for 2022/23

| Name and title | Salary (bands of £5,000) £000 | Expense payments (taxable) total to nearest £100 |
|---|---|---|
| **Mike Pinkerton**[85] (Interim Chair) | 30–35 | 1,400 |
| **Sally Cheshire CBE**[86] (Chair) | 30–35 | 3,300 |
| **Helen Vernon** (Chief Executive) | 165–170 | 0 |
| **Joanne Evans** (Director of Finance and Corporate Planning) | 125–130 | 10,700 |
| **Dr Denise Chaffer CBE** (Director of Safety and Learning) | 115–120 | 0 |
| **Vicky Voller** (Director of Advice and Appeals) | 115–120 | 0 |
| **Charlotte Moar**[87] (Non-executive Member) | 10–15 | 3,000 |
| **Mike Pinkerton**[88] (Non-executive Member) | 0–5 | 800 |
| **Nigel Trout** (Non-executive Member) | 5–10 | 0 |
| **Janice Barber** (Non-executive Member) | 5–10 | 0 |
| **Professor Dame Lesley Regan** (Non-executive Member) | 5–10 | 0 |
| **Dr Mike Durkin OBE**[89] (Associate Non-executive Member) | 5–10 | 0 |
| **Sir Sam Everington OBE**[90] (Associate Non-executive Member) | 5–10 | 0 |

[83] The executive and non-executive directors do not receive any non-cash benefits other than travel costs booked through the corporate booking company for journeys to locations approved under NHS Resolution's Travel expenses and reimbursement policy. The gross value of this benefit and any taxable expenses reimbursed are included in the expense payments column of this table.

[84] The value of pension benefits accrued during the year is calculated as (the real increase in pension multiplied by 20) plus (the real increase in any lump sum) less (the contributions made by the individual). The real increases exclude increases due to inflation or any increase or decreases due to a transfer of pension rights.

[85] Mike Pinkerton's term of office as Interim Chair ended on 18 September 2022. The Interim Chair full year equivalent salary is in the band £60–65k. Mike Pinkerton's non-executive director appointment ended on 15 January 2023. The non-executive director full year equivalent salary is in the band £5–10k.

| Performance pay and bonuses (bands of £5,000) £000 | All pension-related benefits[84] total to nearest £1,000 | Total (bands of £5,000) £000 |
|---|---|---|
| N/A | N/A | 30–35 |
| N/A | N/A | 35–40 |
| 5–10 | 44,000 | 215–220 |
| 0 | 34,000 | 170–175 |
| 0 | N/A | 115–120 |
| 5–10 | 32,000 | 155–160 |
| N/A | N/A | 15–20 |
| N/A | N/A | 0–5 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |
| N/A | N/A | 5–10 |

[86] Sally Cheshire CBE's term of office as Chair started on 19 September 2022. The Chair's full year equivalent salary is in the band £60–65k.

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

[88] Mike Pinkerton's term of office as Interim Chair ended on 18 September 2022. The Interim Chair full year equivalent salary is in the band £60–65k. Mike Pinkerton's non-executive director appointment ended on 15 January 2023. The non-executive director full year equivalent salary is in the band £5–10k.

[89] Dr Mike Durkin OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2022.

[90] Professor Sir Sam Everington OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2022. Sir Sam was on a sabbatical for the period 3 June 2022 to 31 August 2022. Sir Sam's full year equivalent salary is in the band of £5–£10k.

## Pension entitlements for executive directors

### Table 20: Pension entitlements for executive directors

| Name and title | Real increase in pension at pension age (bands of £2,500) £000 | Real increase in pension lump sum at pension age (bands of £2,500) £000 | Total accrued pension at pension age at 31 March 2024 (bands of £5,000) £000 |
|---|---|---|---|
| **Helen Vernon**[91] (Chief Executive) | 0 | 30–32.5 | 50–55 |
| **Joanne Evans** (Director of Finance and Corporate Planning) | 2.5–5 | 0 | 20–25 |
| **Vicky Voller**[92] (Director of Advice and Appeals) | 0 | 27.5–30 | 30–35 |
| **Megan Bidder** (Director of Safety and Learning) | 0–2.5 | 0 | 0–5 |
| **John Mead** (Director of Technical Claims) | 0–2.5 | 0 | 35–40 |

## Cash equivalent transfer values

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2024. HMT published updated guidance on 27 April 2023; this guidance has been used in the calculation of 2023/24 CETV figures.

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 or past senior managers. This is subject to audit.

[91] Helen Vernon is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

[92] Vicky Voller is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

| Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000) £000 | Cash equivalent transfer value at 31 March 2024 £000 | Cash equivalent transfer value at 31 March 2023 £000 | Real increase in cash equivalent transfer value £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|
| 130–135 | 1,112 | 945 | 49 | 0 |
| 0 | 366 | 261 | 61 | 0 |
| 80–85 | 641 | 461 | 117 | 0 |
| 0 | 11 | 0 | 5 | 0 |
| 95–100 | 0 | 0 | 0 | 0 |

## Fair pay disclosure

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest-paid director/member in NHS Resolution in the financial year 2023/24 was £175,000–£180,000 (£170,000–£175,000 in 2022/23).

The relationship to the remuneration of the organisation's workforce is disclosed in the following table.

| | | 25th percentile | Median | 75th percentile |
|---|---|---|---|---|
| 2023/24 | Total remuneration | £42,618 | £53,741 | £65,094 |
| | Pay ratio – total renumeration | 4.16:1 | 3.30:1 | 2.73:1 |
| | Salary component of total remuneration | £42,618 | £53,741 | £65,094 |
| | Pay ratio – salary component | 3.93:1 | 3.12:1 | 2.57:1 |
| 2022/23 | Total remuneration | £42,750 | £53,409 | £64,438 |
| | Pay ratio – total remuneration | 4.04:1 | 3.23:1 | 2.68:1 |
| Restated | Salary component of total remuneration* | £40,588 | £51,183 | £61,996 |
| | Pay ratio – salary component | 4.13:1 | 3.27:1 | 2.70:1 |

*The salary component for the prior year has been restated as it did not include allowances and has been restated to include these amounts.

In 2023/24 no employee (2022/23 no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £20,834 to £177,760 (2022/23 £22,142 to £174,528).

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 total banded remuneration of the highest-paid director has increased by 2.9% from 2022/23 as a result of the pay award.

The basic pay of the highest-paid director in NHS Resolution in the financial year 2023/24 was £165,000–£170,000 (2022/23 £165,000–£170,000), which is equal to the banding for 2022/23. The performance and bonus pay of the highest-paid director for 2023/24 was £5,000–£10,000 which was the same range as the prior year (£5,000–£10,000).

The average percentage change in total remuneration of employees taken as a whole (excluding the highest-paid director), was a 0.2% decrease (2022/23 5.1% increase), with the percentage change in pay and allowances (salary component) being a 3.6% increase (2022/23 0.3% decrease).

The increase in pay and allowances that can be seen in the median and 75th percentiles is as a result of the NHS Agenda for Change pay award of 5%. In addition, the average workforce grew by 102 full-time equivalent at an average remuneration lying between the median and the upper quartile.

However, the total remuneration across the workforce has seen a marginal decrease of 0.2% on average. This is mostly due to the effects of changes to workforce location where there has been a concerted effort to recruit outside of London (where the Higher Cost Area Supplement for the London area does not apply).

No adjustments have been made in the calculation of remuneration of the workforce as a result of restructuring, downsizing or outsourcing.

The fair pay disclosures are subject to audit.

# Staff report

During the 2023/24 year there has been an increase in average full-time equivalent (FTE) staff, up from 578 in 2022/23 to 680. The increase in budgeted establishment continues to reflect our requirements to successfully operate the CNSGP, Claims Evolution Programme and CaseHub, including the corporate support required for the ongoing increase in remit and establishment. While increasing our budgeted establishment and headcount in 2023/24 we have seen a decrease in our annual staff turnover, down to 8% compared to 10% in 2022/23. Our voluntary staff turnover rate for 2023/24 was 6%.

The SMT and the Board receive regular reports on staffing levels by directorate, with attention drawn to where there may be risks from high vacancy rates.

During 2023/24 the People Committee, a subcommittee of the Board, met on three occasions. The role of the People Committee is to support the Board and the Accounting Officer by reviewing the comprehensiveness and reliability of assurances in relation to its people strategies, risks and activities. The Committee members provide advice on the adequacy of the organisation's people, plans and strategies. They provide support and recommend which issues/matters should be escalated to the Board for further discussion. We also made an appointment of an independent member to the People Committee.

The purpose of the independent member is to use their experience as a senior people leader to provide guidance and advice in regard to the organisation on its management of its people. They also provide strategic support to the HR and OD teams on matters arising from the Committee.

Throughout 2023/24 we have continued to support our workforce in a range of professional development opportunities both internally and externally. As referenced previously, our ongoing commitment to high standards of people management has been recognised by achieving Investors in People Gold, following the reaccreditation process in early 2023. Tables 21 and 22 set out staff costs and average staff numbers, which are subject to audit.

**Table 21: Staff costs 1 April 2023 to 31 March 2024 compared to 1 April 2022 to 31 March 2023**

| Staff costs | Permanently employed staff £000 | Other[93] £000 | 2023/24 Total £000 | 2022/23 Total £000 |
|---|---|---|---|---|
| Salaries and wages | 34,583 | 1,018 | 35,601 | 30,514 |
| Social security costs | 3,985 | – | 3,985 | 3,431 |
| Employer contributions to NHS Pensions | 6,035 | – | 6,035 | 4,830 |
| NEST pension contributions | 7 | – | 7 | 6 |
| Apprenticeship levy | 174 | – | 174 | 123 |
| **Total** | **44,784** | **1,018** | **45,802** | **38,904** |

[93] Other is seconded/agency staff.

### Table 22: The average full-time equivalent staff employed broken down by related costs 1 April 2023 to 31 March 2024 compared to 1 April 2022 to 31 March 2023

| Average number of persons employed/staff numbers and related costs | Permanently employed staff | Other[94] | 2023/24 Total | 2022/23 Total |
|---|---|---|---|---|
| Core department | 641 | 12 | 653 | 556 |
| Capital projects | 26 | 1 | 27 | 22 |
| **Total** | **667** | **13** | **680** | **578** |

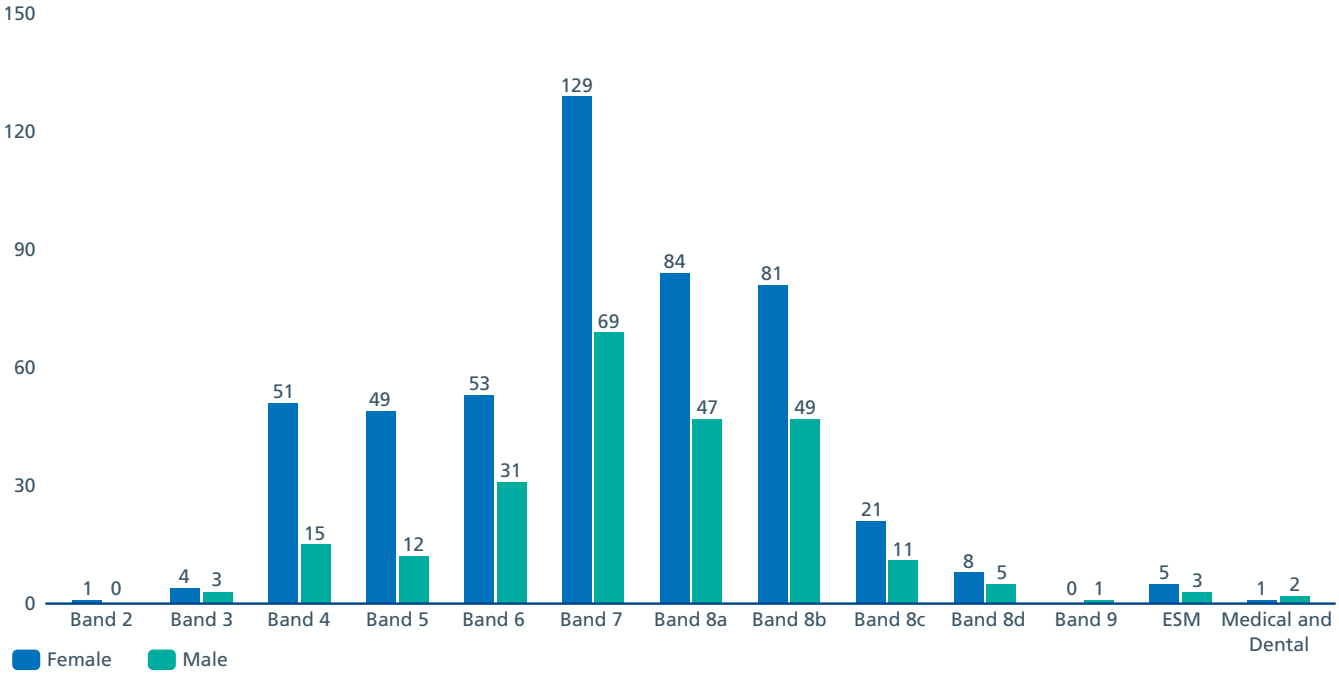
As at 31 March 2024, of the eight executive and senior managers, three were male (38%) and five were female (63%). The organisation's gender split ratio for all employees remained unchanged from 2023 at 34% male and 66% female. We regularly report to the People Committee the details of our workforce gender by pay band including executive and senior managers.

Figures 32 to 38 detail how the organisation's workforce is made up in respect of the other monitored characteristics that are included under the Equality Act 2010.

The overall proportions of staff against each of the monitored characteristics have remained broadly comparable to the proportions reported in 2022/23. There are some changes to the regional ethnicity profile information and ethnicity profiles across the pay bands shown in figures 35, 36 and 37.

Equality, diversity and inclusion (EDI) remains a core pillar of our People Strategy. The graphs and narrative below set out our actions taken to date and intended future actions in tackling barriers to improving diversity in our workforce.

### Figure 31: Staff headcount broken down by gender and banding from 1 April 2023 to 31 March 2024




[94] Other is seconded/agency staff.

Our gender pay gap (GPG) report for the twelve-month period ending 31 March 2024 showed that we appointed 1.8 times more females into senior roles than males, up from 1.7 times in 2022/23. Bands 7 to 8b and our ESMs are largely reflective of the organisation's gender profile; in 2023/24 there has been an upwards trend in employing more female staff at bands 4 and 5. Further information about our GPG can be found in Gender pay gap (GPG) reporting on page 138.

There has been an increase in the proportion of staff disclosing their sexual orientation when compared to 2022/23. The number of staff who do not wish to disclose their sexual orientation has reduced to 14% compared to 21% in 2022/23.

**Figure 32: Sexual orientation of staff**

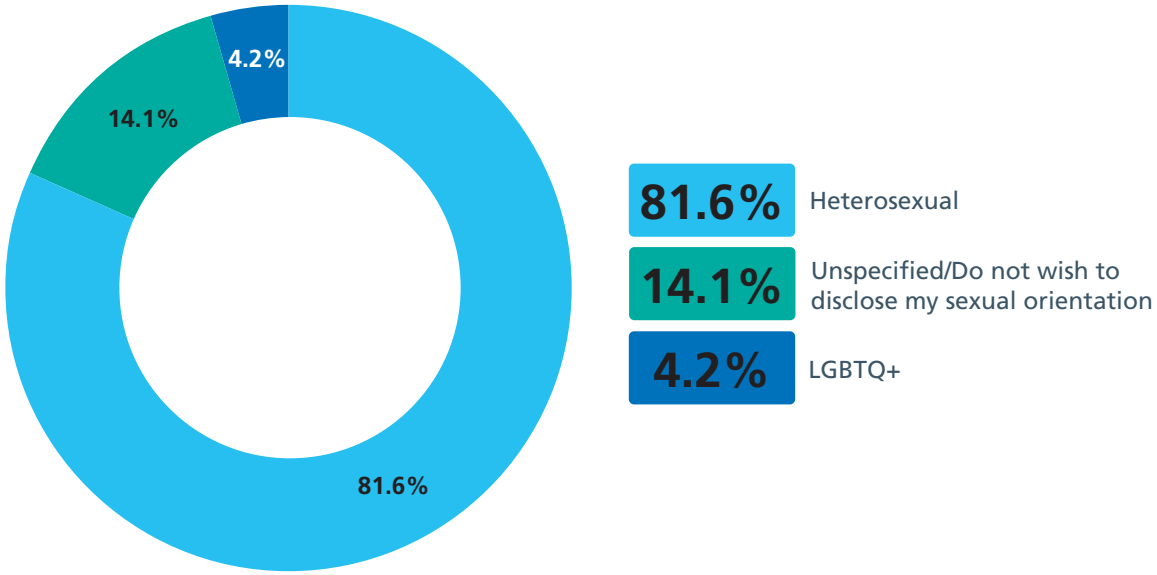
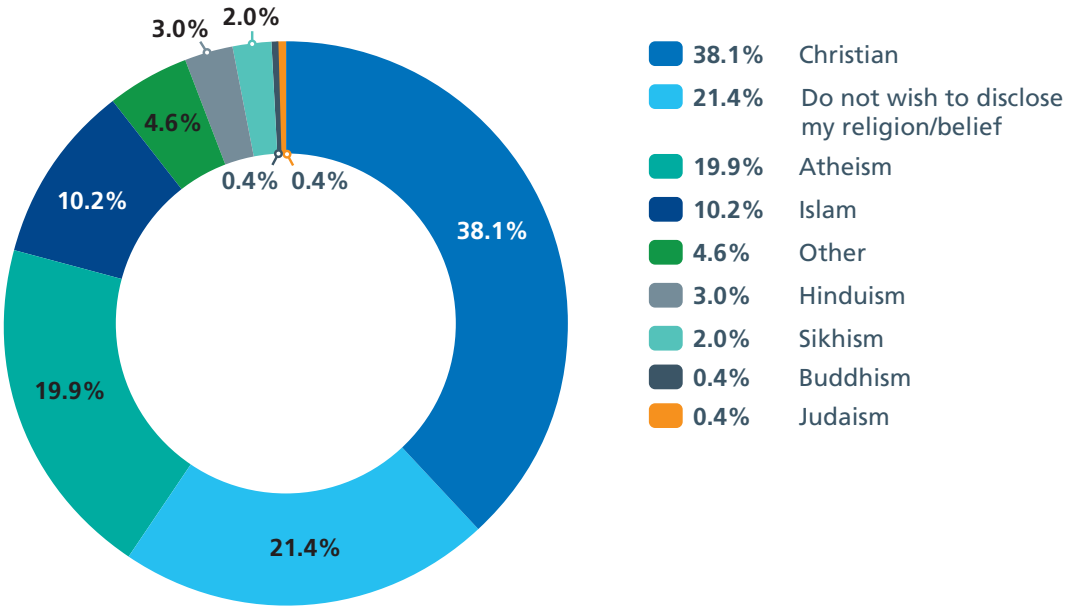



**Figure 33: Religion and/or belief of staff**



## Disability

In July 2023 NHS Resolution was awarded Disability Confident Leader Level 3. This scheme is a Government initiative to support employers in becoming more inclusive and diverse in their workforce. This achievement reflects our ongoing commitment to create a workplace that embraces diversity, empowers our staff and delivers excellence in the services we provide.

Our staff-led Disability Network has continued to meet throughout 2023/24. The purpose of this group is to:

- create an active forum to promote the awareness of disability and inclusion in a supportive and non-judgemental environment;
- be central to the visions and values at NHS Resolution, and encourage staff engagement and staff empowerment;
- assist in making NHS Resolution an employer of choice for people with a disability; and
- assist in ensuring disabled people and those with long-term health conditions have equal access to jobs and are able to fulfil their potential at NHS Resolution.

Table 23 shows the percentage of applications that were shortlisted and the percentage of appointments made from those who consider themselves as having a disability, those who do not consider themselves as having a disability and those who do not wish to disclose this information. It also provides a comparison to 2022/23.

**Table 23: A comparison of the proportion of job candidates shortlisted and appointed to role at NHS Resolution in 2022/23 and 2023/24 with and without a disclosed disability**

| Application category | % Shortlisted 2023/24 | % Shortlisted 2022/23 | % Appointed from shortlisting 2023/24 | % Appointed from shortlisting 2022/23 |
|---|---|---|---|---|
| Disabled | 28.6 | 39.5 | 25.7 | 9.9 |
| Not disabled | 15.4 | 38.0 | 39.1 | 16.0 |
| Not disclosed | 14.5 | 35.1 | 47.6 | 112.1[95] |
| All applications | 16.3 | 38.0 | 24.9 | 18.9 |

The above figures exclude appointments made via agencies

Overall, we shortlisted fewer candidates across all categories in 2023/24, down from 932 in 2022/23 to 725 in 2023/24. The number of appointments made in 2023/24 decreased slightly from 186 in 2022/23 to 165.

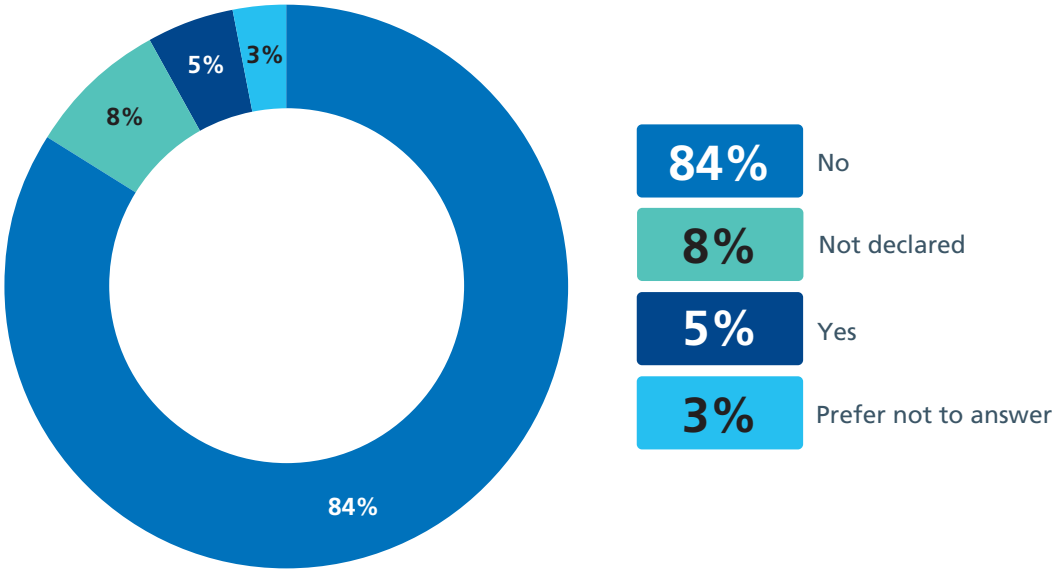
Although the percentage of applicants who were shortlisted decreased for all categories in 2023/24, the data shows that there was an overall rise in the percentage of shortlisted applicants who were appointed to roles with NHS Resolution, increasing from 19% in 2022/23 to 25% in 2023/24.

This year we also appointed more individuals with a declared disability than we did in 2022/23.

[95] Monitoring information is captured at the application stage and again as part of the new joiners' process. Individuals may choose to answer differently at each stage which is why the 2022/23 appointments for the 'not disclosed' category is greater than 100%.

There has been an increase in the proportion of staff disclosing their disability status when compared to 2022/23. The number of staff who do not wish to disclose their disability status has reduced to 11% compared to 18% in 2022/23.

**Figure 34: Proportion of staff declaring a disability**




## Ethnicity

In 2023/24, the proportion of ethnic minority employees has remained at 33%. During this year we continued to grow our workforce in Leeds as well as seeing a number of staff moving to 100% home working. Figure 36 shows the current workforce profile compared to the regional profile information derived from the 2021 census data for our two main office bases.

**Figure 35: Ethnicity of staff (organisational profile)**

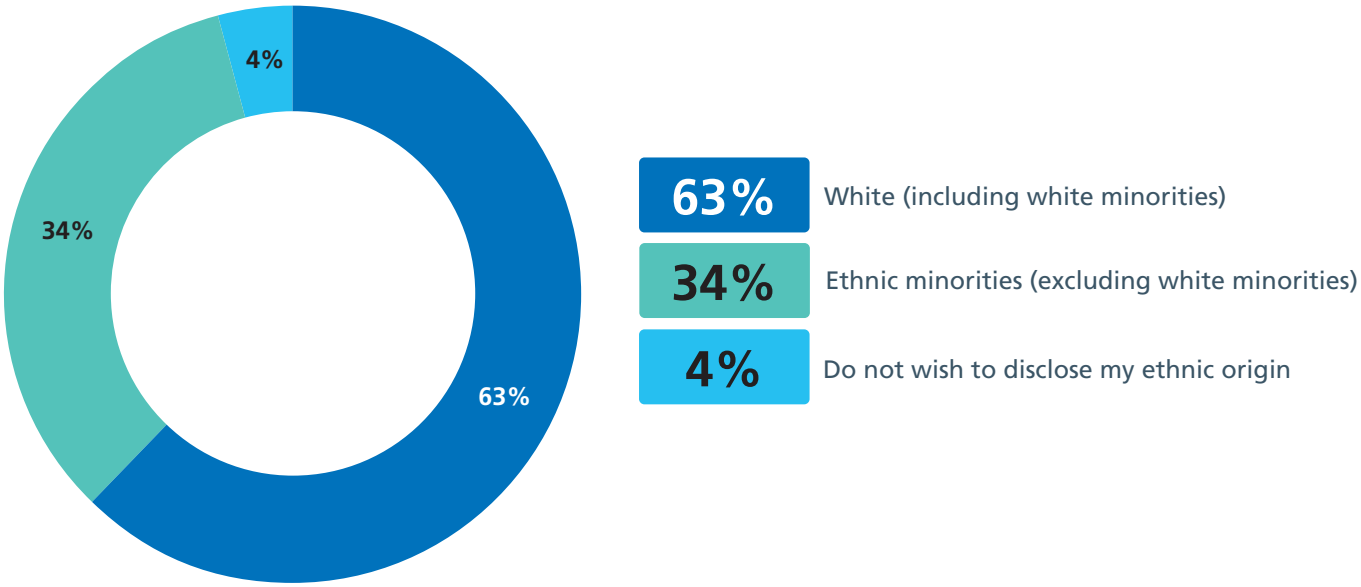
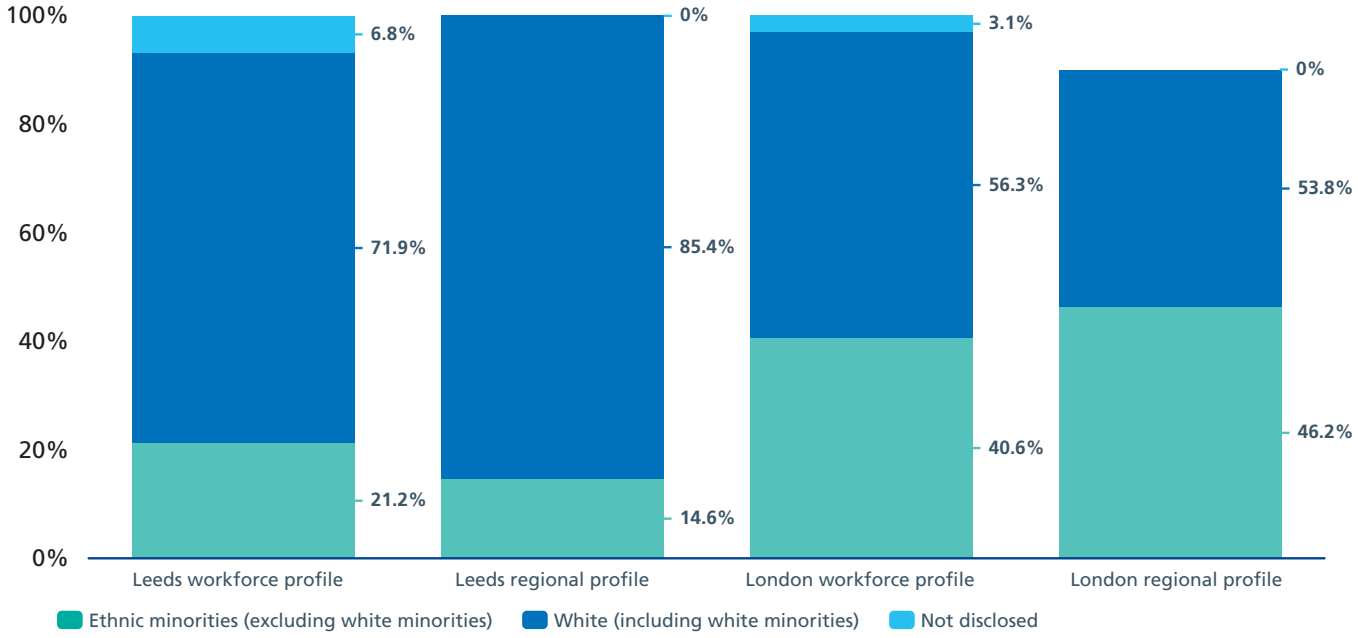


**Figure 36: Ethnicity of staff based at NHS Resolution's London and Leeds offices compared to regional ethnicity data[96]**




The number of London-based staff from an ethnic minority background (excluding white minorities) has increased to 40.6% compared to 38% in 2022/23. The regional profile for London has seen an increase in ethnic minority groups, up from 40% in the 2011 census to 46.2% in 2021. Our workforce profile (excluding full-time home workers) has previously been closely aligned to the regional figures for London; however, with the updated regional data now available, this does show an underrepresentation of ethnic minority groups.

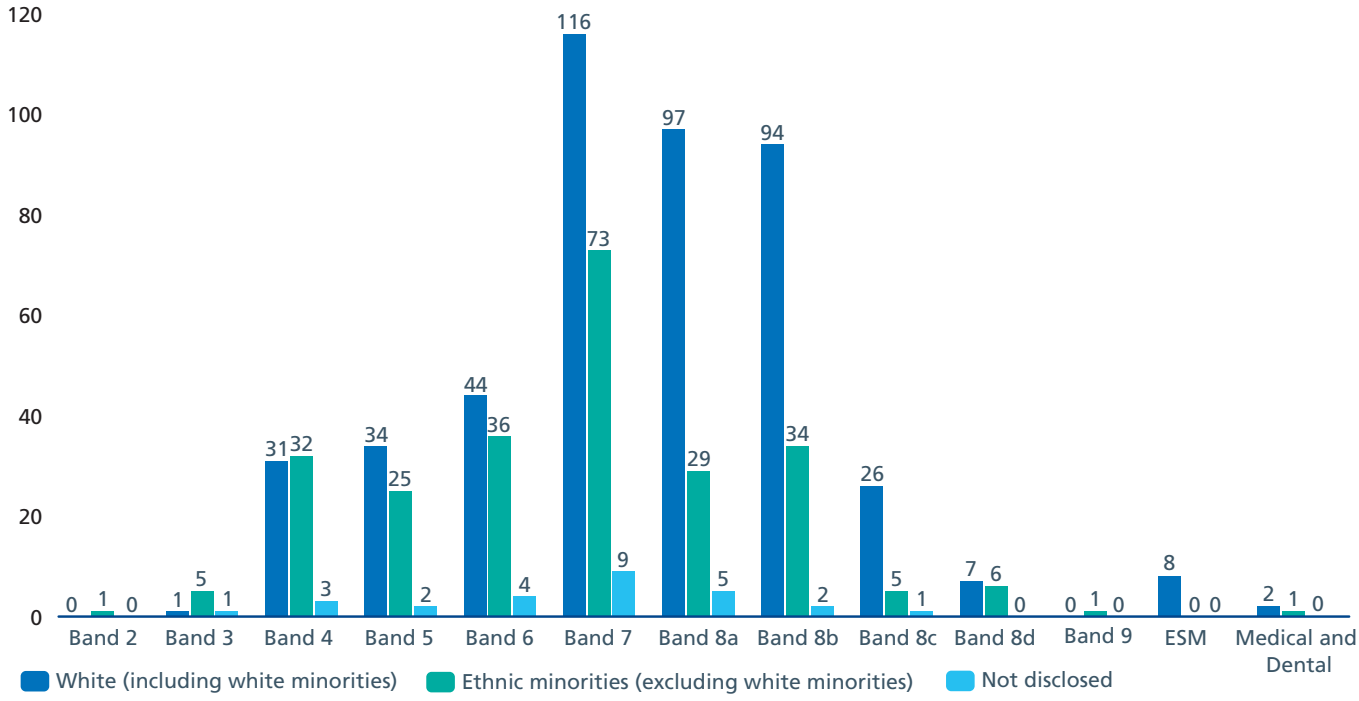
While the number of Leeds-based staff who are from an ethnic minority background has decreased to 21.2% compared to 22.1% in 2022/23, the organisation continues to employ a higher proportion of ethnic minority groups in Leeds when compared to the regional figures.

The regional profile for Leeds (Yorkshire and the Humber region) has also seen an increase in ethnic minority groups, up from 10.4% in the 2011 census to 14.6% in 2021. The main category of ethnic minority staff in Leeds remains those from Asian groups, with an underrepresentation of staff from Black African/Caribbean/British backgrounds in comparison to the regional profile.

Figure 37 shows some areas of underrepresentation and overrepresentation across pay grades. While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is an underrepresentation of ethnic minority staff at the ESM level and across pay bands 8a to 8c. This is consistent with the national data around the underrepresentation of ethnic minority staff at senior level within the NHS. The information also shows that there is an overrepresentation of ethnic minority staff within the lower pay bands. As detailed in Equality, diversity and inclusion (EDI) on page 138, we continue to take steps to address these issues. As detailed above, we continue to provide regular reports to our People Committee, detailing the workforce ethnicity by pay band including senior managers.

[96] Leeds location reflects Yorkshire and the Humber. Regional ethnicity data is derived from the data published in the 2021 census.

### Figure 37: Headcount by ethnicity from 1 April 2023 to 31 March 2024




## Sickness absence

The following figures are based on the 2023 calendar year. DHSC considers the resulting figures to be a reasonable proxy for financial year equivalents.

| Figures converted by DHSC to best estimates of required data Items | | Statistics produced by NHS Digital from ESR Data Warehouse | | |
|---|---|---|---|---|
| **Average FTE 2023** | **Adjusted FTE days lost to Cabinet Office definitions** | **FTE days available** | **FTE days lost to sickness absence** | **Average sick days per FTE** |
| 648 | 2,655 | 236,683 | 4,307 | 4.1 |

### Table notes

**Source:** NHS Digital:Sickness Absence and Workforce Publications – based on data from the ESR Data Warehouse.

**Data items:** ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual report and accounts the following figures are used:

- The number of FTE days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
- The number of FTE days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
- The average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

## Off-payroll engagements

As of 31 March 2024, NHS Resolution has seven off-payroll appointments costing more than £245 per day. One of these appointments is likely to last longer than six months. However, at the time of reporting, all seven appointments have existed for less than one year. The appropriate pre-placement checks were completed for these and for 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.[97]

### Table 24: All off-payroll engagements as of 31 March 2024, for more than £245 per day

| Off-payroll engagements as of 31 March 2024 | |
|---|---|
| No. of existing engagements as of 31 March 2024 | 7 |
| Of which: | |
| No. that have existed for less than one year at time of reporting | 7 |
| No. that have existed for between one and two years at time of reporting | – |
| No. that have existed for between two and three years at time of reporting | – |
| No. that have existed for between three and four years at time of reporting | – |
| No. that have existed for four or more years at time of reporting | – |

### Table 25: All off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245 per day

| Off-payroll engagements between 1 April 2023 and 31 March 2024 | |
|---|---|
| No. of temporary workers engaged between 1 April 2023 and 31 March 2024 | 16 |
| Of which: | |
| No. not subject to off-payroll legislation | – |
| No. subject to off-payroll legislation and determined as in scope of IR35 | – |
| No. subject to off-payroll legislation and determined as out of scope of IR35 | 16 |
| No. of engagements reassessed for compliance or assurance purposes during the year | – |
| No. of engagements that saw a change to IR35 status following the review | – |

### Table 26: Any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2023 and 31 March 2024

| Off-payroll engagements of Board members and/or senior officials | |
|---|---|
| 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 | 12 |

[97] IR35 is tax legislation 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.

## Exit packages

### Table 27: Exit packages

| Exit package cost band (including any special payment element) | Number of compulsory redundancies | Cost of compulsory redundancies £000s | Number of other departures agreed |
|---|---|---|---|
| Less than £10,000 | – | – | 1 |
| £10,000–£25,000 | – | – | – |
| £25,001–£50,000 | – | – | – |
| £50,001–£100,000 | – | – | – |
| £100,001–£150,000 | – | – | – |
| £150,001–£200,000 | – | – | – |
| >£200,000 | – | – | – |
| **Total** | – | – | **1** |

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period. There were no exit packages and costs in 2022/23.

### Table 28: Analysis of other departures

| Type of other departures | Agreements number | Total value of agreements £000s |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | – | – |
| Mutually agreed resignations (MARS) contractual costs | – | – |
| Early retirements in the efficiency of the service contractual costs | – | – |
| Contractual payments in lieu of notice | 1 | 6 |
| Exit payments following employment tribunals or court orders | – | – |
| Non-contractual payments requiring HMT approval | – | – |
| **Total** | **1** | **6** |

As a single exit package can be made up of several components, each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in table 27, which will be the number of individuals.

Where appropriate, the Remuneration report includes disclosure of exit payments payable to individuals named in that report.

## 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. This covers the period 1 April 2023 to 31 March 2024.

### Table 29: Relevant union officials from 1 April 2023 to 31 March 2024

| Number of employees who were relevant union officials during 2023/24 | Full-time equivalent employee number |
|---|---|
| 2 | 2 |

| Cost of other departures agreed £000s | Total number of exit packages | Total cost of exit packages £000s | Number of departures where special payments have been made | Cost of special payment element included in exit packages £000s |
|---|---|---|---|---|
| 6 | 1 | 6 | – | – |
| – | – | – | – | – |
| – | – | – | – | – |
| – | – | – | – | – |
| – | – | – | – | – |
| – | – | – | – | – |
| – | – | – | – | – |
| **6** | **1** | **6** | – | – |

### Table 30: Percentage of time spent on facility time from 1 April 2023 to 31 March 2024

| Percentage of time | Number of employees |
|---|---|
| 0% | – |
| 1–50% | 2 |
| 51–99% | – |
| 100% | – |

### Table 31: Percentage of pay bill spent on facility time from 1 April 2023 to 31 March 2024

| Percentage of pay bill | |
|---|---|
| Total cost of facility time | £4,784.21 |
| Total pay bill | £44,798,993 |
| Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 | 0.01% |

### Table 32: Paid trade union activities from 1 April 2023 to 31 March 2024

| Paid activities[98] | |
|---|---|
| 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 | 12.1% |

[98] We note an increase in the paid trade union activities as a percentage of total paid facility time hours in 2023/24. This can be attributed to an increase of in-person UNISON meetings/conferences compared to years when these were less active due to the Covid-19 pandemic. Additionally, NHS Resolution has had one union official for the majority of the 2023/24 financial year and thus the increase could also be attributed to union officials reporting less time spent on union duties in total and for the reasons above, increased time on union activities.

# People

Our *Being fair* charter, described in Embedding a just and learning culture on page 63, does not just apply to those delivering healthcare, it applies to us too. We recognise that when staff are supported and listened to they will continue to put every effort into helping to deliver value-for-money services and improve patient safety. Our approach to compassionate leadership is reflected in our Investors in People Gold accreditation awarded in early 2023.

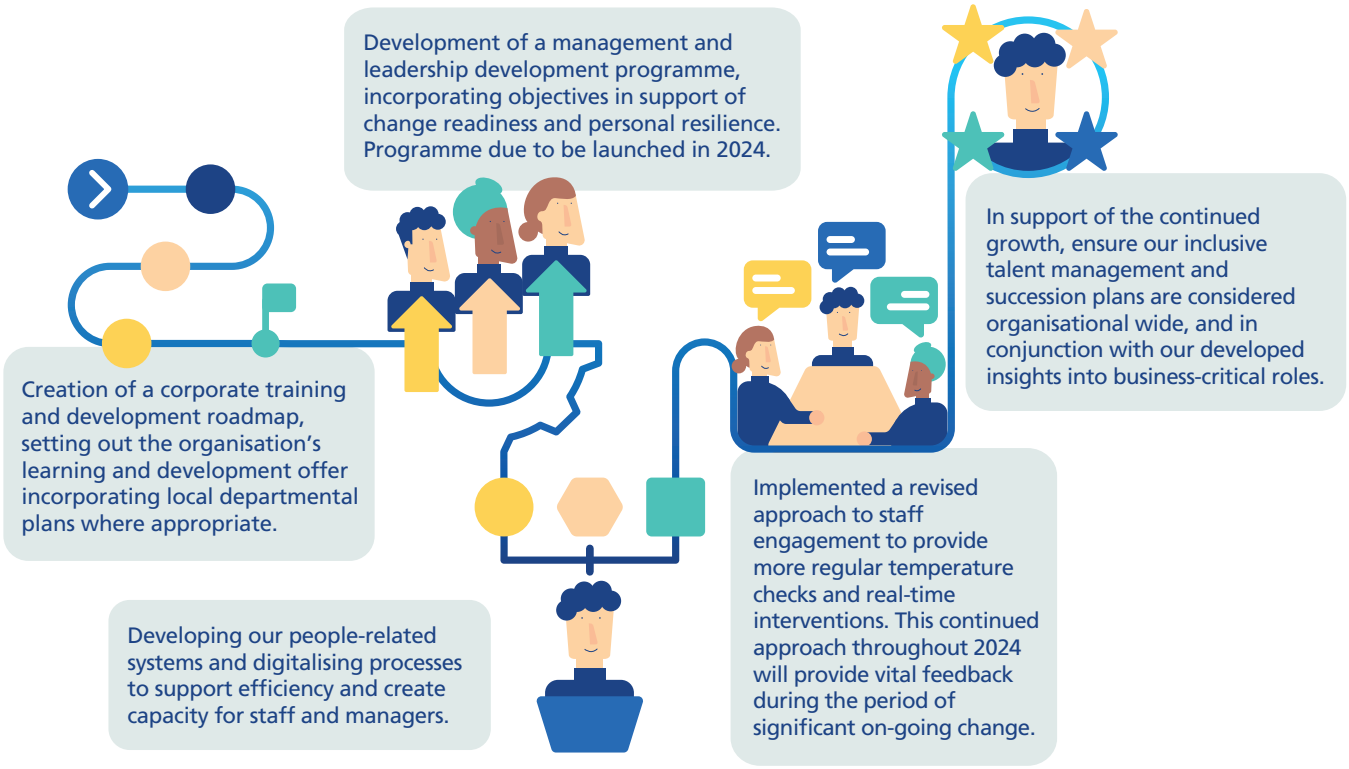
As illustrated in figure 38, our People Strategy, which supports the implementation of our strategy to 2025, remained a focus for our workforce related activities during 2023/24.

**Figure 38: NHS Resolution's People Strategy**


Given the continued pace of change within the organisation, a corporate training and development roadmap setting out the organisation's learning and development offer was put together to sequence activity, to ensure sufficient capacity to deliver priority actions for the organisation and to identify and remove any duplication.

Figure 39 shows some of the headline activities undertaken to support staff during 2023/24.

**Figure 39: Activities undertaken to support staff during 2023/24**



# Equality, diversity and inclusion

Our aim is to create an environment where staff respect and value each other's diversity. We have a set of intended actions which are captured in our equality, diversity and inclusion (EDI) people pillar. The key achievements for 2023/24 are set out below.

- We developed an implementation plan to roll out our inclusive talent management strategy. This has enabled us to develop succession plans for business-critical roles, provide workforce opportunities and improve cost efficiencies by reducing agency spend.
- In July 2023, we conducted a pulse survey to ask staff for their views on how they experience working at NHS Resolution, using questions aligned to the Workforce Race Equality Standard and Workforce Disability Equality Standard. The results of the survey were shared with staff in October 2023 and the EDI people pillar has been revised to reflect the findings and provide a focus.
- We revisited and updated the approach to ensure all new staff are inducted in principles of EDI at corporate induction.
- We developed a dedicated page on our intranet to promote our equality and diversity ambitions and inclusion policy.
- In July 2023, NHS Resolution was awarded Disability Confident Leader Level 3. This scheme is a Government initiative to support employers in becoming more inclusive and diverse in their workforce.
- We established an EDI working group consisting of directors and deputy directors to support delivery of the EDI people pillar. The first meeting took place in April 2024, and the group will continue to meet on a quarterly basis.

## Gender pay gap reporting

In March 2024, in accordance with the requirements under the Equality Act 2010, we published our 2023 gender pay gap (GPG) report.

### What are the key findings of the 2023 GPG report?

- Our 2023 mean GPG has increased from 7.9% in 2022 to 9.8% in 2023.
- Our median GPG has increased from 10.4% in 2022 to 12.3% in 2023.
- Our GPG remains lower than the current UK GPG of 14.3%.
- In common with the wider NHS, our workforce is predominantly female; 66% of our workforce is female. While pay bands 6 to 8b and our ESM grade are generally reflective of the organisation's profile, there is an upwards trend in employing more female staff in bands 4 and 5. See figure 31 Staff headcount broken down by gender and banding from 1 April 2023 to 31 March 2024.
- Over the twelve-month reporting period, we appointed 1.8 times more females into senior roles than males, up from 1.7 times in 2022.
- We reported a higher turnover of female employees in senior pay bands with most leaving NHS Resolution due to promotional opportunities.

## What are we going to do?

We remain committed to closing our GPG, ensuring that the right approach and actions are taken to appropriately address the areas where female staff are underrepresented. This approach can be challenging and does not always provide an immediate improvement in the reported figures. It does, however, ensure that we are closing the gap positively and ensuring longevity in terms of the diversity of our future workforce. We want female employees to be proportionately represented across all pay grades. We have already identified and are working towards a number of actions as part of the EDI pillar of our People Strategy, which will support our aim to close the GPG further.

### Workforce Race Equality Standard, Workforce Disability Equality Standard and ethnicity pay gap reporting

We continued to assess our workforce data in accordance with the national Workforce Race Equality Standard (WRES) indicators. For the first time in 2023 we considered our workforce data in line with the national Workforce Disability Equality Standard (WDES) indicators and looked more in-depth at our ethnicity pay gap (EPG) data. The output from these areas were collated alongside our GPG data, and we produced a combined staff inclusion report. The outputs from the staff inclusion report and subsequent required actions will be taken forward by the recently established EDI working group noted on page 138.

## Recruitment and retention

In support of our growth, we have continued to develop our internal resourcing expertise to ensure we are best placed to attract, recruit and retain staff. In collaboration with various parts of the organisation we are evolving our employer brand and employee value proposition. This will continue to support our recruitment activities and the ability to attract high-calibre candidates.

Where appropriate, we have used LinkedIn for direct sourcing of talent. This has resulted in a number of successful appointments, including for roles which are considered difficult or hard to fill. As a result of our internal expertise and making the best use of our available routes to market, we have seen a reduction in our recruitment spend of circa £100,000 throughout 2023/24.

With a focus on continuous service improvement, we have made some positive progress in relation to digitalising our recruitment and on-boarding activities. We are in the process of procuring a new applicant tracking system (ATS) which will provide a modern, reportable and easy-to-use system for candidates, hiring managers and the resourcing team. The implementation of the new ATS will reduce administrative time and the risk of errors occurring and will provide a consistent and appropriate manner of communication in all our resourcing work.

The ATS will assist and support the organisation in attracting and recruiting the best and most diverse range of candidates while ensuring we keep up to date with technology changes and demands in workforce requirements, and ensure a rich and simple experience for all users. It will allow us to build career pages, target and measure specific job boards, use modern technology to support unbiased adverts and provide us with an end-to-end candidate environment, including links for approval and onboarding to our staff records system.

In response to our increasingly flexible and agile working approach, in 2023 we introduced an online platform for identity checking and verifications. This provides more timely pre-employment checks and minimises risks in relation to individuals' right to work and residency status.

We are committed to supporting the Government's Places for Growth agenda by continuing to increase our presence outside of London. We have benefited from a nationwide approach to recruitment, and our current strategy is, wherever possible, to recruit to Leeds or home working arrangements by default.

## Maximising employee health and wellbeing

Throughout the year, we continued to support staff health and wellbeing through a range of initiatives making best use of our Mental Health First Aiders and our Employee Assistance Programme. We have a group of 20 Mental Health First Aiders who are trained/certificated via Mental Health First Aid England and who are all compliant with recent changes announced by the Health and Safety Executive. During the period April 2023 to March 2024 there were 16 contacts. Themes are managed and fed into our wellbeing offer.

Our health and wellbeing toolkit, supported by informal lunchtime sessions and our Employee Assistance Programme, provides staff with details of a range of resources and support for many different areas of health and wellbeing. This is further supported by an intranet page providing additional resources and guidance for staff and line managers.

In December 2023 we went live with a new occupational health provider, to ensure that we are offering our staff access to the most appropriate support on an ongoing basis.

## Talent management and succession planning

Following approval of our talent management strategy, director and deputy director talent conversations have taken place throughout 2023/24, in line with the agreed approach. The intention is for further talent reviews to be rolled out in the autumn of 2024. Talent management will form an integral part of the performance and development review process going forward; meanwhile, a guide to talent conversations has been developed, which provides helpful insights on how to facilitate an effective talent conversation.

The current Performance Appraisal Development Review (PADR) process cycle for all substantive staff runs from April to June each year. The organisation reported 96% compliance in 2023. A survey to evaluate the effectiveness of the PADR process was conducted in September 2023, with recommendations made to improve the process for 2024. Recommendations included:

- a refresh of the paperwork, including the associated 1:1 guidance;
- a continued drive to progress to a more cyclical, person-centred approach; and
- recording activity on our Electronic Staff Record (ESR) and Oracle Learning Management (OLM) system.

A formal leadership and management development programme has been developed to support our People Strategy and current business plan, which is expected to start in the autumn of 2024. In the interim, a dedicated page on our intranet has been developed with a range of products and interventions to suit different learning needs and styles.

We continue to use the apprenticeship levy to support a range of courses across the organisation. Apprenticeships are open to all staff at every level. The courses are funded through an apprenticeship levy at no cost to the learner and provide ongoing development opportunities. As of April 2024, there are 31 apprentices studying seven qualifications. These include Insurance Practitioner, Team Leader/Supervisor, Coaching, Professional and Public Relations, and Communications Assistant. Since January 2023 we have celebrated the success of 11 apprentices and look forward to welcoming many more in the coming months through the recently launched Team Leader/Supervisor apprenticeship and Operations/Departmental Manager apprenticeship.

Our coaching and mentoring offer continues to evolve. All coaches are required to have an accredited coaching qualification in line with best practice.

# Organisation change and transformation

## HR and OD digitalisation

We have made significant advances over the past twelve months in relation to our systems and digitalisation ambitions. In addition to the new ATS mentioned on page 139, we have enhanced our approach to capturing Mandatory and Statutory Training (MAST) data by moving away from manual recording to using ESR and OLM. These involve less resource-intensive processes and allow our staff to spend their time on more value-adding activities. It is also beneficial for line managers and enables them to view their team's compliance data at any given time.

The HR and OD team has been working with finance colleagues and heads of directorates on a recent project to improve alignment of our ESR work structures and corporate hierarchy to ensure they reflect the establishment within NHS Resolution. This will result in accurate outputs of any organisation-based workforce, financial and compliance reports in terms of directorates, divisions and teams to support business planning and decision making.

For the 2023/24 year we also introduced online annual leave management via ESR, providing staff and managers with quicker and easier management and oversight of leave allocation. In 2024 we intend to extend this further to incorporate sickness absence management.

In early 2024 we launched our People Portal, a single unified platform with an inbuilt streamlined process for HR and OD to respond to transactional requests and provide appropriate support to managers and staff in a managed way. The benefits for staff include:

- a user friendly and familiar online system;
- accessibility by all staff at any time, which will improve service delivery;
- automatic email notification as soon as a ticket is raised;
- responses within defined timescales which should increase satisfaction levels;
- prioritisation of enquiries to ensure that matters requiring urgent attention receive timely responses; and
- streamlined communications and improved overall efficiency.

# Parliamentary accountability and audit report

The following disclosures are subject to audit except where specified.

## Losses and special payments

We had losses of £28,417 in 2023/24. In 2022/23 we had losses of £112,242.

## 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 in Note 1.3 to the financial statements on page 157. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the financial statements on page 163.

## Expenditure on consultancy

Expenditure incurred on consultancy in 2023/24 was nil. In 2022/23 the expenditure on consultancy was nil.

## Regularity of expenditure – gifts

We have not received or made any gifts where the value exceeded £300,000. Staff are required to declare gifts in line with NHS Resolution's *Conflict of Interest Policy including hospitality and gifts (CG06)*, which states that staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

## Indemnity scheme cover for NHS Resolution (not subject to audit)

For 2023/24, NHS Resolution was covered under both LTPS and PES.

## Use of Government Functional Standards (not subject to audit)

Our update on the use of Government Functional Standards is included in the Governance report on page 113.

## Remote contingent liabilities

There is no recognition of potential change in the value of liabilities arising from events that, at this point in time, are too uncertain or remote to include, such as from policy developments or from efforts to improve safety in the NHS (other than through experience reflected in current and past claims).

Disclosures in relation to liabilities arising from the Covid-19 pandemic have been made in Notes 7 and 8 to the financial statements.

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2023/24.

**Helen Vernon**

Chief Executive and Accounting Officer

Date: Wednesday 17 July 2024

# The Certificate and Report of the Comptroller and Auditor General to the House of Commons

## Opinion on financial statements

I certify that I have audited the financial statements of the NHS Litigation Authority (herein referred to as NHS Resolution) for the year ended 31 March 2024 under the National Health Service Act 2006.

The financial statements comprise NHS Resolution's:

- Statement of Financial Position as at 31 March 2024;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK-adopted international accounting standards.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2024 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

## 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 for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2022)*. 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 2019*. I am independent of NHS Resolution in accordance with the ethical requirements that are relevant to my audit of 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.

## Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

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 that are different from the current assumptions adopted by NHS Resolution. My opinion is not modified in respect of this matter.

## Conclusions relating to going concern

In auditing the financial statements, I have concluded that NHS Resolution's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS Resolution's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS Resolution is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which requires entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

## Other information

The other information comprises information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report thereon. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

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 I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. 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 part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006.

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Performance and Accountability Reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

## Matters on which I report by exception

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 material misstatements in the Performance and Accountability Reports.

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 by NHS Resolution or returns adequate for my audit have not been received from branches not visited by my staff; or
- I have not received all of the information and explanations I require for my audit; or
- the financial statements and the parts of the Accountability Report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited are not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

## 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:

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS Resolution from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- preparing financial statements which give a true and fair view and are in accordance with Secretary of State directions made under the National Health Service Act 2006;
- ensuring that the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;
- assessing NHS Resolution's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS Resolution will not continue to be provided in the future.

## 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.

My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue a certificate that includes my opinion. 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.

## Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

## Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, I:

- considered the nature of the sector, control environment and operational performance including the design of NHS Resolution's accounting policies;
- inquired of management, NHS Resolution's head of internal audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Resolution's policies and procedures on:
  - identifying, evaluating and complying with laws and regulations;
  - detecting and responding to the risks of fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS Resolution's controls relating to NHS Resolution's compliance with the National Health Service Act 2006 and Managing Public Money;
- inquired of management, NHS Resolution's head of internal audit and those charged with governance whether:
  - they were aware of any instances of non-compliance with laws and regulations;
  - they had knowledge of any actual, suspected, or alleged fraud.
- discussed with the engagement team and the relevant specialists, including where relevant actuarial specialists, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS Resolution for fraud and identified the greatest potential for fraud in the following areas: revenue, posting of unusual journals, complex transactions, and bias in management estimates. In common with all audits under ISAs (UK), I am required to perform specific procedures to respond to the risk of management override of controls.

I obtained an understanding of NHS Resolution's framework of authority and other legal and regulatory frameworks in which NHS Resolution operates. I focused on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS Resolution. The key laws and regulations I considered in this context included the National Health Service Litigation Authority (Establishment and Constitution) Order 1995, the National Health Service Litigation Authority Regulations 1995, the National Health Service Act 2006 and *Managing Public Money*.

## Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

- I reviewed the financial statement disclosures and testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described above as having direct effect on the financial statements;
- I enquired of management and the Audit and Risk Committee concerning actual and potential litigation and claims;
- I reviewed minutes of meetings of those charged with governance and the Board; and internal audit reports; and
- in addressing the risk of fraud through management override of controls, I tested the appropriateness of journal entries and other adjustments; assessed whether the judgements on estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members including where relevant internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

## Other auditor's responsibilities

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

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 I identify during my audit.

## Report

I have no observations to make on these financial statements.

**Gareth Davies**
Comptroller and Auditor General

Date: 18 July 2024

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 2024

| Comprehensive net expenditure | Notes | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|---|
| Other operating income | 3 | **(2,725,562)** | (2,491,070) |
| **Total operating income** | | **(2,725,562)** | **(2,491,070)** |
| Staff costs | 2 | **45,802** | 38,904 |
| Purchase of goods and services | 2 | **7,691** | 7,466 |
| Depreciation and impairment charges | 2 | **1,878** | 2,005 |
| Provision (release)/expense | 7/7.1 | **(9,147,447)** | (56,497,075) |
| Other operating expenditure | 2 | **3,404** | 3,703 |
| **Total operating expenditure** | | **(9,088,672)** | (56,444,997) |
| **Net operating expenditure** | | **(11,814,234)** | (58,936,067) |
| Finance costs – interest on lease liability | 2/9 | **87** | 71 |
| Finance costs – claims | 7 | **884,985** | 251,419 |
| **Net expenditure for the year** | | **(10,929,162)** | (58,684,577) |
| **Comprehensive net expenditure for the year** | | **(10,929,162)** | (58,684,577) |

The Notes on pages 156 – 192 form part of these financial statements.

## Statement of financial position as at 31 March 2024

| Statement of financial position | Notes | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Property, plant and equipment | | 857 | 915 |
| Intangible assets | | 10,829 | 8,159 |
| Right of use assets | | 8,394 | 9,428 |
| **Total non-current assets** | | **20,080** | 18,502 |
| **Current assets** | | | |
| Trade and other receivables | 4 | 26,666 | 19,669 |
| Cash and cash equivalents | 5 | 685,452 | 605,728 |
| **Total current assets** | | **712,118** | 625,397 |
| **Total assets** | | **732,198** | 643,899 |
| **Current liabilities** | | | |
| Trade and other payables | 6 | (61,945) | (66,443) |
| Lease liability – short term | 9 | (948) | (923) |
| Provisions for liabilities and charges – known claims | 7 | (3,686,649) | (3,351,058) |
| **Total current liabilities** | | **(3,749,542)** | (3,418,424) |
| **Total assets less current liabilities** | | **(3,017,344)** | (2,774,525) |
| **Non-current liabilities** | | | |
| Lease liabilities | 9 | (7,673) | (8,621) |
| Provisions for liabilities and charges – known claims | 7 | (31,035,322) | (37,723,455) |
| Provisions for liabilities and charges – IBNR | 7 | (23,758,000) | (28,539,000) |
| **Total non-current liabilities** | | **(54,800,995)** | (66,271,076) |
| **Total assets less liabilities** | | **(57,818,339)** | (69,045,601) |
| **Taxpayers' equity** | | | |
| General Fund | | **36,291** | 33,594 |
| Ex-RHA reserve | | **(35,328)** | (43,701) |
| ELS reserve | | **(655,757)** | (833,763) |
| CNST reserve | | **(53,529,293)** | (64,030,919) |
| DHSC clinical reserve | | **(1,711,315)** | (2,213,692) |
| ELSGP reserve | | **(576,000)** | (731,589) |
| CNSGP reserve | | **(1,089,997)** | (912,928) |
| CNSC reserve | | **(26,133)** | (36,414) |
| CTIS reserve | | **(100)** | (2,240) |
| DHSC non-clinical reserve | | **(83,325)** | (97,075) |
| PES reserve | | **7,064** | 3,835 |
| LTPS reserve | | **(154,446)** | (180,709) |
| **Total taxpayers' equity** | | **(57,818,339)** | (69,045,601) |

The Notes on pages 156 – 192 form part of these financial statements.

The General Fund and individual scheme reserves are used to account for all financial resources. See figure 1: Our indemnity schemes on page 14 for a brief description of each scheme to which the reserves relate.

The Board approved a recommendation on Thursday 27 June 2024 that the financial statements from page 148 should be signed by the Accounting Officer and these were signed by Helen Vernon on Wednesday 17 July 2024. The Notes on pages 156 – 192 form part of these financial statements.

**Helen Vernon**
Chief Executive and Accounting Officer

Date: Wednesday 17 July 2024

## Statement of cash flows for the year ended 31 March 2024

| Cash flows | Notes | 31 March 2024 £000 | 31 March 2023 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Net income/(expenditure) | | 10,929,162 | 58,684,577 |
| Net finance cost – IFRS 16 | | 87 | 71 |
| Other cash flow adjustments | 2 | 1,878 | 2,005 |
| (Increase) in receivables | 4 | (6,997) | (1,552) |
| (Decrease)/increase in payables | 6 | (4,498) | 5,932 |
| (Decrease) in provisions | 7 | (11,133,542) | (58,936,538) |
| **Net cash (outflow) from operating activities** | | **(213,910)** | (245,505) |
| **Cash flows from investing activities** | | | |
| Purchase of property, plant and equipment | | (302) | (529) |
| Purchase of intangible assets | | (3,153) | (4,938) |
| **Net cash (outflow) from investing activities** | | **(3,455)** | (5,467) |
| **Cash flows from financing activities** | | | |
| Net Parliamentary funding | | 298,100 | 309,022 |
| Repayment of lease liability – capital | 9 | (924) | (920) |
| Repayment of lease liability – interest | 9 | (87) | (71) |
| **Net financing** | | **297,089** | 308,031 |
| **Net increase in cash and cash equivalents** | | 79,724 | 57,059 |
| Cash and cash equivalents at the beginning of the period | | 605,728 | 548,669 |
| **Cash and cash equivalents at the end of the period** | **5** | **685,452** | 605,728 |

The Notes on pages 156 – 192 form part of these financial statements.

## Statement of changes in taxpayers' equity for the year ended 31 March 2024

| Changes in taxpayers' equity | Notes | General Fund £000 | Ex-RHA Reserve £000 | ELS Reserve £000 | CNST Reserve £000 | DHSC Clinical Reserve £000 |
|---|---|---|---|---|---|---|
| **Balance at 31 March 2022** | | 16,764 | (76,013) | (1,536,350) | (120,007,174) | (4,124,538) |
| **Total recognised income and expense as at 2022/23** | | (6,955) | 30,684 | 662,045 | 55,976,257 | 1,808,161 |
| Net Parliamentary funding | | 23,784 | 1,628 | 40,542 | – | 102,685 |
| **Balance at 31 March 2023** | | **33,593** | **(43,701)** | **(833,763)** | **(64,030,917)** | **(2,213,692)** |
| **Changes in taxpayers' equity for 2023/24** | | | | | | |
| **Expenditure** | | | | | | |
| Authority and claims administration | 2 | (7,695) | (4) | (46) | (32,504) | (307) |
| (Increase)/decrease in provision for known claims | 7 | – | 6,861 | 143,196 | 3,186,977 | 330,694 |
| (Increase)/decrease in the provision for IBNR | 7 | – | – | 12,000 | 4,683,000 | 90,000 |
| | | **(7,695)** | **6,857** | **155,150** | **7,837,473** | **420,387** |
| **Income** | | | | | | |
| Scheme and other income | 3 | 888 | – | – | 2,664,151 | – |
| **Total recognised income and expense for 2023/24** | | **(6,807)** | **6,857** | **155,150** | **10,501,624** | **420,387** |
| Net Parliamentary funding[99] | | 9,505 | 1,516 | 22,856 | – | 81,990 |
| **Balance at 31 March 2024** | | **36,291** | **(35,328)** | **(655,757)** | **(53,529,293)** | **(1,711,315)** |

[99] The net Parliamentary funding represents the cash drawdown of £298.1 million in 2023/24 for DHSC-funded indemnity schemes and administration costs. The Notes on pages 156 – 192 form part of these financial statements.

| ELSGP Reserve £000 | CNSGP Reserve £000 | CNSC Reserve £000 | CTIS Reserve £000 | DHSC Non-Clinical Reserve £000 | PES Reserve £000 | LTPS Reserve £000 | Total Reserves £000 |
|---|---|---|---|---|---|---|---|
| (1,100,864) | (821,279) | (92,362) | (2,085) | (132,741) | 3,007 | (165,565) | (128,039,200) |
| 243,529 | (95,902) | 54,710 | (155) | 26,521 | 828 | (15,146) | 58,684,577 |
| 125,746 | 4,254 | 1,238 | – | 9,145 | – | – | 309,022 |
| **(731,589)** | **(912,927)** | **(36,414)** | **(2,240)** | **(97,075)** | **3,835** | **(180,711)** | **(69,045,601)** |
| | | | | | | | |
| (6,624) | (4,512) | (44) | (15) | (122) | (133) | (6,856) | (58,862) |
| (3,767) | (126,767) | (3,364) | – | (7,328) | (5,638) | (39,402) | 3,481,462 |
| 20,000 | (75,000) | 13,000 | 2,000 | 15,000 | 1,000 | 20,000 | 4,781,000 |
| **9,609** | **(206,279)** | **9,592** | **1,985** | **7,550** | **(4,771)** | **(26,258)** | **8,203,600** |
| | | | | | | | |
| – | – | – | – | – | 8,000 | 52,523 | 2,725,562 |
| **9,609** | **(206,279)** | **9,592** | **1,985** | **7,550** | **3,229** | **26,265** | **10,929,162** |
| 145,980 | 29,209 | 689 | 155 | 6,200 | – | – | 298,100 |
| **(576,000)** | **(1,089,997)** | **(26,133)** | **(100)** | **(83,325)** | **7,064** | **(154,446)** | **(57,818,339)** |

# Notes to the financial statements

## 1. Accounting policies

The financial statements have been prepared in accordance with the 2023/24 Government Financial Reporting Manual (FReM) issued by HM Treasury (HMT). 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 that is judged most appropriate to the particular circumstances of NHS Resolution for giving a true and fair view has been selected. The particular policies adopted by NHS Resolution are described in the following text. 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. The functional currency of NHS Resolution is pounds sterling.

### 1.1 Accounting conventions

These accounts are 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 HMT.

### 1.2 New adoption of standards, amendments and interpretations

#### New standards effective and adopted in these accounts

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. These are effective for financial statements after this accounting period.

The following have not been adopted early in these accounts:

#### IFRS 17 Insurance Contracts

The effective date is for accounting periods beginning on or after 1 January 2023, but has not yet been adopted by the FReM, with a confirmed adoption date of 1 April 2025. NHS Resolution are in the process of considering the impact that IFRS17 will have on the risk-pooling indemnity schemes. NHS Resolution considers the indemnity schemes to be outside of the scope of IFRS4 which is the standard being replaced by IFRS17 but they acknowledge that IFRS17 has a wider scope than IFRS4.

#### IFRS 14 Regulatory Deferral Accounts

The effective date for first time adopters of IFRS 14 was for accounting periods beginning on or after 1 January 2016. However, this standard has not been endorsed by the UK and has not been adopted within FReM. DHSC have confirmed that this standard is not applicable to DHSC group bodies for 2023/24. In addition, NHS Resolution's assessment is that this standard would not be applicable to our business and therefore is not anticipated to have any impact on the accounts.

### IFRS 18 Presentation and Disclosure in Financial Statements

IFRS 18 was published in April 2024. The effective date for first time adopters of IFRS 18 is for accounting periods beginning on or after 1 January 2027. However, this standard has not yet been adopted within FReM. DHSC have confirmed that this standard is not applicable to DHSC group bodies for 2023/24.

### IFRS 19 Subsidiaries without Public Accountability: Disclosures

IFRS 19 was published in May 2024. The effective date for first time adopters of IFRS 19 is for accounting periods beginning on or after 1 January 2027. However, this standard has not yet been adopted within FReM. DHSC have confirmed that this standard is not applicable to DHSC group bodies for 2023/24. In addition, NHS Resolution's assessment is that this standard would not be applicable to our business and therefore is not anticipated to have any impact on the accounts.

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

A source of funding for NHS Resolution as a Special Health Authority is a Parliamentary grant from DHSC within an approved cash limit, which is reported within the Statement of Changes in Taxpayers' Equity. This funds the ELS, Ex-RHA, DHSC clinical, DHSC liabilities schemes, CNSC and CTIS (the Covid-19 schemes created in 2020/21), and some administration costs. In addition, from 1 April 2019, NHS Resolution received funding from NHSE/I via DHSC for the administration of general practice indemnity arrangements, as directed by the Secretary of State. Parliamentary funding is recognised in the financial period in which it is received.

The operating income disclosed in Note 3 to the financial statements 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 has been assessed against the requirements of IFRS 15 Revenue Recognition:

- 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. The authorising legislation for these schemes gives the right to collect these contributions. This is deemed, per the FReM adaptation of IFRS 15, 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 ten months and monthly. Revenue is recognised in our accounts in equal monthly instalments over the term of the yearly contract, as and when 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 contract. Regardless of the timing on raising invoices for payment, we recognise revenue in equal instalments over the accounting year, as and when performance obligations are fulfilled.
- Revenue from contracts in relation to training courses: We recognise revenue in this category only once the training has taken place, that being the point at which NHS Resolution's performance obligations are fulfilled.

NHS Resolution introduced the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST.

NHS trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. Trusts unable to demonstrate achievement of the ten actions may be able to recover a lesser sum from the fund to help them achieve the actions.

As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, 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.

Since the scheme relaunched for 2022/23 compliance with the ten safety actions was assessed in 2023/24. The contributions to the MIS were collected and distributed against achievement of the actions in the 2023/24 financial year.

## 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 Pensions

NHS Resolution offers two pension schemes to staff, the NHS Pension scheme and the National Employment Savings Trust (NEST).

### NHS Pension scheme

Past and present employees are covered by the provisions of the NHS Pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover 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. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

#### a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 2024, is based on valuation data as at 31 March 2023, updated to 31 March 2024 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 HMT have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from the Stationery Office.

#### b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

### 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 is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2023/24 were £6,240 up to £50,270. Total contributions are 9%, with employee contributions at 5%, employer contributions at 3% and Government contributions (basic tax relief) at 1%. More details on NEST can be found on the NEST website: www.nestpensions.org.uk/schemeweb/nest/my-nest-pension/contributions-and-fees.

## 1.6 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.

## 1.7 Provisions and contingent liabilities

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 cash flows are discounted using HMT's nominal discount rate.

Nominal discount rates are applied to general provisions, in accordance with the Financial Reporting Advisory Board (FRAB) recommendation in 2017.

The ELS, Ex-RHA, CNSC, CTIS 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.

NHS Resolution does not consider that any of our indemnity schemes fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because significant insurance risk is passed back to the members of risk-pooling schemes through annual contributions, to the GP Contract funding held by NHSE transferred via DHSC as provision of financing, or directly to DHSC through the provision of financing.

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 8.

The methodology with key assumptions, uncertainties and sensitivities in determining the various provisions are detailed in Note 7.

## 1.8 Financial assets

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 not recognised any expected credit loss (nil in 2022/23).

## 1.9 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.

## 1.10 Critical judgements and key sources of estimation uncertainty

In the application of NHS Resolution's accounting policies, which are described elsewhere in Note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities. The key accounting estimates relate to the calculation of the provision for known claims and for IBNR as disclosed in Note 7. There are no critical accounting judgements relevant to the accounts.

## 1.11 IFRS 8 – operating segments

NHS Resolution has one reportable segment under IFRS 8: income and expenditure are separated into different scheme types in the Statement of Changes in Taxpayers' Equity.

## 1.12 IFRS 16 – leases

NHS Resolution adopted IFRS 16 in line with FReM adoption effective 1 April 2022. The adoption of the standard had no material impact on the financial statements.

The transition to IFRS 16 was completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application and therefore there is no prior year adjustment.

Hindsight was used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease. Upon review of the leases, it was determined that at initial application there were four leases that fell under the scope of IFRS 16, the two main leases being the London and Leeds offices. The London lease is for ten years, and the Leeds lease is for twenty years with five-year break clauses. Management took the decision to recognise both leases for a ten-year period, as this was their best current estimate of the expected life of both property leases. Management will review again when appropriate.

On initial application NHS Resolution measured the right of use assets for leases previously classified as operating leases, at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

The right-of-use assets are depreciated on a straight-line basis over the term of lease recognised and the depreciation is charged to the Statement of Comprehensive Net Expenditure.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

### Short-term leases of low-value assets

NHS Resolution has elected not to recognise right-of-use assets and lease liabilities for short-term leases of machinery that have a lease term of twelve months or less and of low-value assets (less than £5,000). NHS Resolution recognises the lease payments associated with these leases as an expense on a straight-line basis over the lease term.

# 2. Expenditure

| Expenditure | Notes | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|
| Non-executive members' remuneration[100] | | **127** | 142 |
| **Other salaries and wages[101]** | | | |
| Salaries and wages | | **35,601** | 30,514 |
| Social security costs | | **3,985** | 3,431 |
| Pension costs | | **6,042** | 4,836 |
| Apprenticeship levy | | **174** | 123 |
| Education, training and conferences | | **196** | 188 |
| Establishment expenses | | **902** | 1,193 |
| **Low-value and short-term leases** | | | |
| Land and buildings | | **63** | 57 |
| Lease cars | | **5** | 5 |
| Photocopiers and franking machine | | **(7)** | 2 |
| Insurance | | **135** | 176 |
| Transport (business travel) | | **187** | 109 |
| Premises and fixed plant | | **5,482** | 5,194 |
| **External contractors** | | | |
| Actuary's advice | | **1,771** | 1,433 |
| Appeals advisory expenditure | | **46** | 26 |
| External corporate legal fees[102] | | **365** | 183 |
| Practitioner Performance Advice assessment expenditure | | **277** | 144 |
| Advice professional services | | **–** | 5 |
| Other[103] | | **1,172** | 1,941 |
| Auditor's remuneration: audit fees[104] | | **295** | 265 |
| Internal audit fees | | **68** | 94 |
| Bank charges and interest | | **11** | 12 |
| | | **56,897** | 50,073 |
| Depreciation | | **379** | 471 |
| Depreciation – right of use assets | | **1,034** | 1,036 |
| Amortisation | | **465** | 498 |
| **Total depreciation and amortisation** | | **1,878** | 2,005 |
| **Total expenditure before provisions and finance costs[105]** | | **58,775** | 52,078 |
| Finance costs – unwinding of discount | 7 | **884,985** | 251,419 |
| Increase in provision for known claims (excl. unwinding of discounts and change in the discount rates) | 7 | **4,452,329** | 17,116,295 |
| Change in the discount rates[106] | 7 | **(14,552,776)** | (74,604,370) |
| Increase in the provision for IBNR | 7 | **953,000** | 991,000 |
| **Total provision (release)/expense** | **2.1/7.1** | **(8,262,462)** | (56,245,656) |
| Finance costs – interest on lease liability | | **87** | 71 |
| **Total provision (release)/expense and finance costs** | | **(8,262,375)** | (56,245,585) |
| **Total (income)/expenditure** | | **(8,203,600)** | (56,193,507) |

[100] Additional explanations can be found in the Remuneration and staff report in the Accountability report section.
[101] Additional explanations can be found in the Remuneration and staff report in the Accountability report section.
[102] External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included in Note 7: Provisions.
[103] Other external contractor costs have decreased primarily due to lower spend in professional services on IT projects.
[104] NHS Resolution did not make any payments to its auditors for non-audit work.
[105] Of the £58.9 million total expenditure for 2023/24, £5.5 million is shown as administration expenditure in DHSC consolidated group accounts.
[106] The discount rates used are mandated by HMT and are set out in Note 7.3 to the financial statements.

## 2.1 Analysis of the provision expense

| 2023/24 | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| **2023/24 incidents** | | | | | |
| Known claims | – | – | 20,685 | – | – |
| IBNR | – | – | 4,757,121 | – | – |
| **Total 2023/24** | **–** | **–** | **4,777,806** | **–** | **–** |
| **Prior year incidents** | | | | | |
| Known claims | (6,861) | (143,196) | (3,207,662) | (330,694) | 3,767 |
| IBNR | – | (12,000) | (9,440,121) | (90,000) | (20,000) |
| **Total prior years** | **(6,861)** | **(155,196)** | **(12,647,783)** | **(420,694)** | **(16,233)** |
| **Total** | **(6,861)** | **(155,196)** | **(7,869,977)** | **(420,694)** | **(16,233)** |

| 2022/23 | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| **2022/23 incidents** | | | | | |
| Known claims | – | – | 40,321 | – | – |
| IBNR | – | – | 6,238,130 | – | – |
| **Total 2022/23** | **–** | **–** | **6,278,451** | **–** | **–** |
| **Prior year incidents** | | | | | |
| Known claims | (30,687) | (549,094) | (18,650,389) | (1,357,486) | (103,402) |
| IBNR | – | (113,000) | (41,200,130) | (451,000) | (147,000) |
| **Total prior years** | **(30,687)** | **(662,094)** | **(59,850,519)** | **(1,808,486)** | **(250,402)** |
| **Total** | **(30,687)** | **(662,094)** | **(53,572,068)** | **(1,808,486)** | **(250,402)** |

### Explanatory note

Note 2.1 provides an analysis of the provision expense charged to the Statement of Net Comprehensive Expenditure in the reporting year. The cost of claims arising from incidents occurring in 2023/24 (cost of harm, or cost incurred in the financial year) totals £5,117 million across all schemes. This compares to £6,614 million in 2022/23.

The estimated cost of harm arising from the clinical activity in 2023/24 covered by the largest scheme, CNST, was £4,778 million. This figure is lower than the £6,278 million reported in 2022/23, reflecting the change in HMT long-term discount rates, which has placed a lower value on projected claims costs. If the 2022/23 discount rates were applied for the reporting year, the equivalent cost of harm figure would have been £6,137 million.

The small decrease is mainly due to the average cost assumptions being slightly lower than implied in the 2022/23 assumptions, and a reduction in the long-term claims inflation assumption for PPO claims.

The prior year's incidents figures show the changes in provisions that have been recognised in previous reporting years. In 2023/24 the total release of the provision to the Statement of Comprehensive Net Expenditure was £8,262 million. The factors affecting change in the provision are described in the report on pages 155 – 194.

The approach taken to valuing the provision is shown in Note 7.2 on page 172.

| CNSGP £000 | CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Total £000 |
|---|---|---|---|---|---|---|
| | | | | | | |
| 1,282 | – | – | – | 4,866 | 8,017 | **34,850** |
| 271,866 | – | – | 114 | 2,309 | 50,983 | **5,082,393** |
| **273,148** | **–** | **–** | **114** | **7,175** | **59,000** | **5,117,243** |
| | | | | | | |
| 125,485 | 3,363 | – | 7,329 | 772 | 31,385 | **(3,516,312)** |
| (196,866) | (13,000) | (2,000) | (15,114) | (3,309) | (70,983) | **(9,863,393)** |
| **(71,381)** | **(9,637)** | **(2,000)** | **(7,785)** | **(2,537)** | **(39,598)** | (13,379,705) |
| **201,767** | **(9,637)** | **(2,000)** | **(7,671)** | **4,638** | **19,402** | (8,262,462) |

| CNSGP £000 | CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Total £000 |
|---|---|---|---|---|---|---|
| | | | | | | |
| 1,778 | – | – | 14 | 2,089 | 7,060 | **51,262** |
| 276,508 | 300 | 856 | – | 2,730 | 44,490 | **6,563,014** |
| **278,286** | **300** | **856** | **14** | **4,819** | **51,550** | **6,614,276** |
| | | | | | | |
| 89,883 | 826 | – | 2,323 | 5,021 | 45,087 | **(20,547,918)** |
| (275,508) | (56,300) | (856) | (29,000) | (2,730) | (36,490) | **(42,312,014)** |
| **(185,625)** | **(55,474)** | **(856)** | **(26,677)** | **2,291** | **8,597** | (62,859,932) |
| **92,661** | **(55,174)** | **–** | **(26,663)** | **7,110** | **60,147** | (56,245,656) |

# 3. Operating income

| Operating income | 2023/24 £000 | 2022/23 £000 |
|---|---|---|
| CNST contributions | **2,664,151** | 2,431,108 |
| LTPS contributions | **52,523** | 50,936 |
| PES contributions | **8,000** | 8,045 |
| Practitioner Performance Advice | **888** | 981 |
| **Total** | **2,725,562** | 2,491,070 |

# 4. Receivables

| Receivables | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 | CNSGP £000 |
|---|---|---|---|---|---|---|
| NHS receivables – revenue | – | – | 21 | – | – | – |
| Accrued income | – | – | 1,888 | 1 | 6 | 7 |
| Prepayments | 50 | 804 | 1,295 | 1,843 | – | – |
| VAT | – | 21 | 6,998 | 54 | 333 | 273 |
| Other receivables | – | 137 | 6,294 | 524 | 1,845 | 1 |
| | **50** | **962** | **16,496** | **2,422** | **2,184** | **281** |

# 5. Cash and cash equivalents

| Cash and cash equivalents | Ex-RHA £000 | ELS £000 | CNST £000 | ELSGP £000 | CNSGP £000 |
|---|---|---|---|---|---|
| At 1 April 2023 | 1,199 | 71,307 | 365,741 | 61,152 | 1,099 |
| Change during the year | (32) | (1,474) | 8,242 | 59,882 | 412 |
| At 31 March 2024[107] | **1,167** | **69,833** | **373,983** | **121,034** | **1,511** |

# 6. Trade payables and other current liabilities

| Trade payables | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 | CNSGP £000 | CNSC £000 |
|---|---|---|---|---|---|---|---|
| NHS payables – revenue | – | – | – | – | – | – | – |
| Prepaid income | – | – | 12,142 | 1,060 | – | – | – |
| Accruals | – | 10 | 16,804 | 524 | 412 | 361 | 8 |
| Other payables | – | 219 | 24,695 | 438 | 445 | 174 | – |
| | **–** | **229** | **53,641** | **2,022** | **857** | **535** | **8** |

[107] All cash balances are held in Government Banking Service accounts.

| CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Administration £000 | Total 31 March 2024 £000 | Total 31 March 2023 £000 |
|---|---|---|---|---|---|---|---|
| – | – | – | 29 | 1,148 | 155 | **1,353** | 2,218 |
| – | – | – | – | 10 | 138 | **2,050** | 2,502 |
| – | – | – | – | – | 1,795 | **5,787** | 5,502 |
| 3 | – | 35 | 4 | 368 | 350 | **8,439** | 4,613 |
| – | – | – | – | 2 | 234 | **9,037** | 4,834 |
| **3** | **–** | **35** | **33** | **1,528** | **2,672** | **26,666** | 19,669 |

| PES £000 | LTPS £000 | Administration £000 | Total 31 March 2024 £000 | Total 31 March 2023 £000 |
|---|---|---|---|---|
| 15,866 | 77,731 | 11,633 | **605,728** | 548,669 |
| 4,150 | 14,452 | (5,908) | **79,724** | 57,059 |
| **20,016** | **92,183** | **5,725** | **685,452** | 605,728 |

| CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Administration £000 | Total 31 March 2024 £000 | Total 31 March 2023 £000 |
|---|---|---|---|---|---|---|
| – | – | 4 | 123 | – | **127** | 1,585 |
| – | – | – | – | 48 | **13,250** | 14,010 |
| – | 18 | 24 | 364 | 2,184 | **20,709** | 24,209 |
| – | 169 | (1) | 150 | 1,570 | **27,859** | 26,639 |
| **–** | **187** | **27** | **637** | **3,802** | **61,945** | 66,443 |

# 7. Provisions for liabilities and charges

| Provisions | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| Opening provision for known claims | 43,262 | 801,869 | 37,323,913 | 2,087,050 | 541,042 |
| Opening provisions for IBNR | – | 67,000 | 27,081,000 | 196,000 | 191,000 |
| **Total provisions as at 1 April 2023** | **43,262** | **868,869** | **64,404,913** | **2,283,050** | **732,042** |
| **Movement in known claims** | | | | | |
| Provided in the year | 1,149 | 37,529 | 7,857,403 | 96,497 | 169,627 |
| Provision not required written back | (141) | (29,099) | (3,675,786) | (75,760) | (123,475) |
| Unwinding of discount | 1,427 | 25,627 | 775,602 | 63,986 | 11,011 |
| Change in discount rates | (9,296) | (177,253) | (8,144,196) | (415,417) | (53,396) |
| Provisions utilised in the year | (1,487) | (22,899) | (2,581,803) | (76,813) | (115,391) |
| **Movement in known claims** | **(8,348)** | **(166,095)** | **(5,768,780)** | **(407,507)** | **(111,624)** |
| **Movement in IBNR** | | | | | |
| Change in discount rates | – | (15,000) | (5,606,000) | (41,000) | (14,000) |
| Increase/(decrease) in provision for IBNR | – | 3,000 | 923,000 | (49,000) | (6,000) |
| **Movement in IBNR** | **–** | **(12,000)** | **(4,683,000)** | **(90,000)** | **(20,000)** |
| Closing provision for known claims | 34,914 | 635,774 | 31,555,133 | 1,679,543 | 429,418 |
| Closing provision for IBNR | – | 55,000 | 22,398,000 | 106,000 | 171,000 |
| **Total provision as at 31 March 2024** | **34,914** | **690,774** | **53,953,133** | **1,785,543** | **600,418** |
| **Analysis of expected timing of discounted cash flows[108]** | | | | | |
| Not later than one year[109] | 1,502 | 25,974 | 3,352,753 | 101,442 | 99,174 |
| Later than one year and not later than five years | 7,079 | 120,623 | 11,195,088 | 360,785 | 214,071 |
| Later than five years | 26,333 | 544,177 | 39,405,292 | 1,323,316 | 287,173 |
| **Total provision as at 31 March 2024** | **34,914** | **690,774** | **53,953,133** | **1,785,543** | **600,418** |

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

[108] 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.

[109] The one-year projected cash flow figures shown above reflect an updated view of 2024/25 cash flow based on the latest provisioning exercise. As well as using the most up-to-date data and assumptions, the provisioning exercise more generally focuses on long-term (rather than short-term) view. This leads to differences in projected cash flows from those budgeted for 2024/25 as part of the 2024/25 cash flow projection exercise that was performed during the summer of 2023, where the emphasis was on short-term cash flows and assumptions that materially impact the short-term view. Both results are considered equally valid for their respective purposes.

| CNSGP £000 | CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Total £000 |
|---|---|---|---|---|---|---|
| 149,869 | 713 | – | 13,067 | 10,335 | 103,393 | **41,074,513** |
| 746,000 | 36,000 | 2,000 | 91,000 | 4,000 | 125,000 | **28,539,000** |
| **895,869** | **36,713** | **2,000** | **104,067** | **14,335** | **228,393** | 69,613,513 |
| | | | | | | |
| 174,679 | 3,808 | – | 10,691 | 8,127 | 73,947 | **8,433,457** |
| (35,156) | (358) | – | (3,292) | (2,592) | (35,469) | **(3,981,128)** |
| 3,873 | 21 | – | 90 | 252 | 3,096 | **884,985** |
| (16,629) | (108) | – | (160) | (149) | (2,172) | **(8,818,776)** |
| (22,602) | (172) | – | (7,067) | (3,906) | (38,940) | **(2,871,080)** |
| **104,165** | **3,191** | – | **262** | **1,732** | **462** | (6,352,542) |
| | | | | | | |
| (40,000) | (5,000) | – | (9,000) | - | (4,000) | **(5,734,000)** |
| 115,000 | (8,000) | (2,000) | (6,000) | (1,000) | (16,000) | **953,000** |
| **75,000** | **(13,000)** | **(2,000)** | **(15,000)** | **(1,000)** | **(20,000)** | (4,781,000) |
| 254,034 | 3,904 | – | 13,329 | 12,067 | 103,855 | **34,721,971** |
| 821,000 | 23,000 | – | 76,000 | 3,000 | 105,000 | **23,758,000** |
| **1,075,034** | **26,904** | – | **89,329** | **15,067** | **208,855** | 58,479,971 |
| | | | | | | |
| 45,836 | 1,027 | – | 14,414 | 7,238 | 37,289 | **3,686,649** |
| 386,628 | 5,855 | – | 21,523 | 7,119 | 118,163 | **12,436,934** |
| 642,570 | 20,022 | – | 53,392 | 710 | 53,403 | **42,356,388** |
| **1,075,034** | **26,904** | – | **89,329** | **15,067** | **208,855** | 58,479,971 |

## Provisions for liabilities and charges (prior year)

| Provisions | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| Opening provision for known claims | 75,325 | 1,380,007 | 58,315,683 | 3,544,243 | 762,387 |
| Opening provisions for IBNR | – | 180,000 | 62,043,000 | 647,000 | 338,000 |
| **Total provisions as at 1 April 2022** | **75,325** | **1,560,007** | **120,358,683** | **4,191,243** | **1,100,387** |
| **Movement in known claims** | | | | | |
| Provided in the year | 4,009 | 156,462 | 20,270,314 | 393,608 | 307,635 |
| Provision not required written back | – | (21,601) | (3,946,717) | (108,208) | (144,805) |
| Unwinding of discount | 598 | 10,516 | 215,841 | 23,740 | 587 |
| Change in discount rates | (35,294) | (694,471) | (35,149,506) | (1,666,626) | (266,819) |
| Provisions utilised in the year | (1,376) | (29,044) | (2,381,702) | (99,707) | (117,943) |
| **Movement in known claims** | **(32,063)** | **(578,138)** | **(20,991,770)** | **(1,457,193)** | **(221,345)** |
| **Movement in IBNR** | | | | | |
| Change in discount rates | – | (67,000) | (35,994,000) | (287,000) | (91,000) |
| Increase/(decrease) in provision for IBNR | – | (46,000) | 1,032,000 | (164,000) | (56,000) |
| **Movement in IBNR** | **–** | **(113,000)** | **(34,962,000)** | **(451,000)** | **(147,000)** |
| Closing provision for known claims | 43,262 | 801,869 | 37,323,913 | 2,087,050 | 541,042 |
| Closing provision for IBNR | – | 67,000 | 27,081,000 | 196,000 | 191,000 |
| **Total provision as at 31 March 2023** | **43,262** | **868,869** | **64,404,913** | **2,283,050** | **732,042** |
| **Analysis of expected timing of discounted cash flows[110]** | | | | | |
| Not later than one year[111] | 1,432 | 25,938 | 3,017,187 | 97,003 | 124,410 |
| Later than one year and not later than five years | 7,043 | 123,038 | 11,274,450 | 370,582 | 342,219 |
| Later than five years | 34,787 | 719,893 | 50,113,276 | 1,815,465 | 265,413 |
| **Total provision as at 31 March 2023** | **43,262** | **868,869** | **64,404,913** | **2,283,050** | **732,042** |

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

| Reconciliation of Note 7 to Statement of comprehensive net expenditure | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| **Unwinding of discount/finance charge** | **1,427** | **25,627** | **775,602** | **63,986** | **11,011** |
| Increase in known claims provision | 1,149 | 37,529 | 7,857,403 | 96,497 | 169,627 |
| Provision not required written back | (141) | (29,099) | (3,675,786) | (75,760) | (123,475) |
| Change in discount rates (known claims and IBNR) | (9,296) | (192,253) | (13,750,196) | (456,417) | (67,396) |
| Increase/(decrease) in provision for IBNR | – | 3,000 | 923,000 | (49,000) | (6,000) |
| **Provision expense charged to Statement of comprehensive net expenditure** | **(8,288)** | **(180,823)** | **(8,645,579)** | **(484,680)** | **(27,244)** |
| **Total charge to Statement of comprehensive net expenditure** | **(6,861)** | **(155,196)** | **(7,869,977)** | **(420,694)** | **(16,233)** |

[110] 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.

[111] The one-year projected cash flow figures shown above reflect an updated view of 2023/24 cash flow based on the latest provisioning exercise. As well as using the most up-to-date data and assumptions, the provisioning exercise more generally focuses on long-term (rather than short-term) view. This leads to differences in projected cash flows from those budgeted for 2023/24 as part of the 2023/24 cash flow projection exercise that was performed during the summer of 2022, where the emphasis was on short-term cash flows and assumptions that materially impact the short-term view. Both results are considered equally valid for their respective purposes.

| CNSGP £000 | CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Total £000 |
|---|---|---|---|---|---|---|
| 69,923 | 100 | – | 16,930 | 11,033 | 86,420 | **64,262,051** |
| 745,000 | 92,000 | 2,000 | 120,000 | 4,000 | 117,000 | **64,288,000** |
| **814,923** | **92,100** | **2,000** | **136,930** | **15,033** | **203,420** | **128,550,051** |
| | | | | | | |
| 165,229 | 927 | – | 8,734 | 8,514 | 80,841 | **21,396,273** |
| (29,678) | (46) | – | (6,064) | (1,012) | (21,847) | **(4,279,978)** |
| 61 | – | – | 29 | – | 47 | **251,419** |
| (43,951) | (55) | – | (362) | (392) | (6,894) | **(37,864,370)** |
| (11,715) | (213) | – | (6,200) | (7,808) | (35,174) | **(2,690,882)** |
| **79,946** | **613** | **–** | **(3,863)** | **(698)** | **16,973** | **(23,187,538)** |
| | | | | | | |
| (220,000) | (27,000) | – | (35,000) | – | (19,000) | **(36,740,000)** |
| 221,000 | (29,000) | – | 6,000 | – | 27,000 | **991,000** |
| **1,000** | **(56,000)** | **–** | **(29,000)** | **–** | **8,000** | **(35,749,000)** |
| 149,869 | 713 | – | 13,067 | 10,335 | 103,393 | **41,074,513** |
| 746,000 | 36,000 | 2,000 | 91,000 | 4,000 | 125,000 | **28,539,000** |
| **895,869** | **36,713** | **2,000** | **104,067** | **14,335** | **228,393** | **69,613,513** |
| | | | | | | |
| 27,568 | 169 | – | 13,352 | 6,143 | 37,856 | **3,351,058** |
| 336,044 | 5,022 | 1,000 | 23,009 | 7,542 | 127,850 | **12,617,799** |
| 532,257 | 31,522 | 1,000 | 67,706 | 650 | 62,687 | **53,644,656** |
| **895,869** | **36,713** | **2,000** | **104,067** | **14,335** | **228,393** | **69,613,513** |

| CNSGP £000 | CNSC £000 | CTIS £000 | DHSC Non-Clinical £000 | PES £000 | LTPS £000 | Total 2023/24 £000 | Total 2022/23 £000 |
|---|---|---|---|---|---|---|---|
| **3,873** | **21** | **–** | **90** | **252** | **3,096** | **884,985** | **251,419** |
| 174,679 | 3,808 | – | 10,691 | 8,127 | 73,947 | **8,433,457** | **21,396,273** |
| (35,156) | (358) | – | (3,292) | (2,592) | (35,469) | **(3,981,128)** | **(4,279,978)** |
| (56,629) | (5,108) | – | (9,160) | (149) | (6,172) | **(14,552,776)** | **(74,604,370)** |
| 115,000 | (8,000) | (2,000) | (6,000) | (1,000) | (16,000) | **953,000** | **991,000** |
| **197,894** | **(9,658)** | **(2,000)** | **(7,761)** | **4,386** | **16,306** | **(9,147,447)** | **(56,497,075)** |
| **201,767** | **(9,637)** | **(2,000)** | **(7,671)** | **4,638** | **19,402** | **(8,262,462)** | **(56,245,656)** |

## 7. 2 Explanatory notes

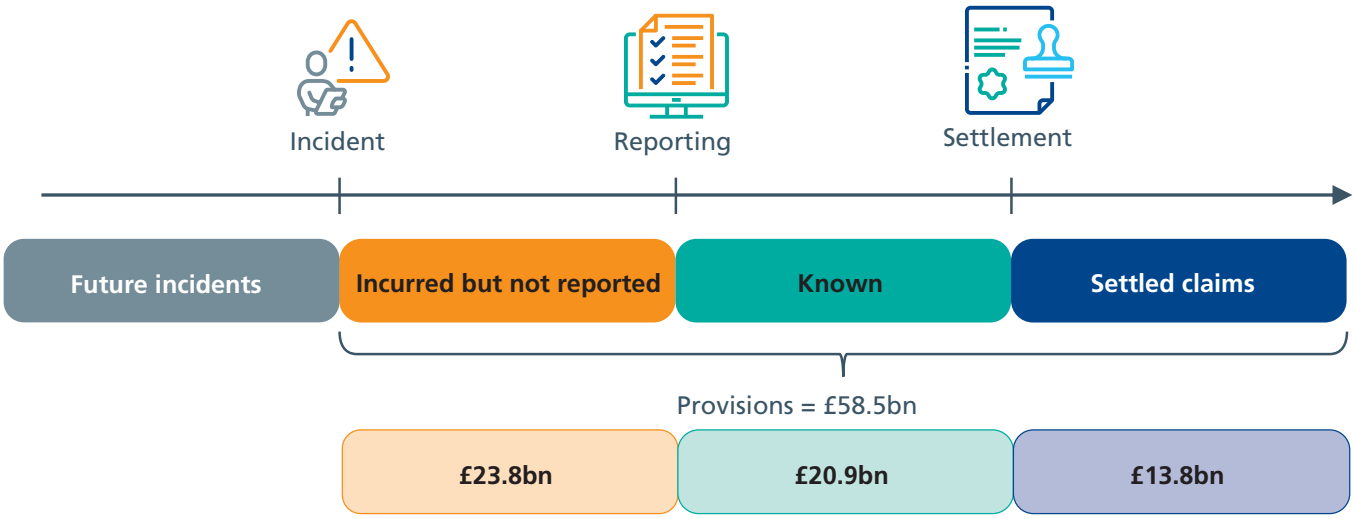
### Nature and scope of the obligation

NHS Resolution administers indemnity cover for clinical negligence and non-clinical claims under twelve schemes or arrangements. Provisions are calculated in accordance with IAS 37 and relate to liabilities arising from incidents covered by these arrangements. The three key elements of NHS Resolution's provisions are:

- **Known claims** – provisions for claims received by NHS Resolution but not yet settled;
- **Settled Periodical Payment Orders (PPOs)** – where the past settlement of a claim involves ongoing payments to the claimant into the future, generally for their lifetime; and
- **Incurred but not reported (IBNR)** – provision for claims that 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.

The different parts of the provision and their link to the claims journey is shown in figure 40 below.

**Figure 40: Provision and the claims journey**




The schemes we administer are shown in Who we are and what we do on page 12.

## Developments over the year affecting the provisions

### Discount rates

One of the key assumptions used in calculating the provisions are the discount rates used to place a present value on projected future cash flows. These rates are prescribed by HMT.

NHS Resolution's provisions are particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities, which is driven by the reporting and settlement delays, as well as the fact that many high-value claims are settled as a PPO with payments provided over the remaining lifetime of the claimant.

This year, there was a significant increase in the discount rates prescribed by HMT, across all durations. These rates are used to convert future payments into a present value, as outlined in the Chair and Chief Executive's Welcome on page 8. This update has decreased the provision by £14.6 billion (21%). Although the change in discount rates prescribed by HMT has a material effect on the value of the provisions, it does not alter the cost of settling claims, which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (e.g. the personal injury discount rate, PIDR). As such, the £14.6 billion decrease in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

### Short-term inflation

In determining the value of the provisions value as at 31 March 2024, we allowed for higher inflation expectations in the short term, assuming that a higher cost of living in the general economic environment would lead to higher claim settlement costs. While cost of living pressures in the general economic environment have eased, the general expectations are that Consumer Price Index (CPI) inflation will continue to exceed the Bank of England's 2% for longer than was assumed last year. This year's provisions include updated forecasts for short-term inflation expectations, which assume that claims inflation will be slightly higher than the long-term assumptions in the next year, falling (below the long-term average) the following year, before returning to the long-term view thereafter. The impact on the CNST IBNR provision is shown in table 33: Key assumptions in the CNST IBNR provision on page 178.

### Long-term claims inflation trends

Average settlement costs have generally grown at a lower rate than previously assumed. For PPO damages, recent trends in settled claim costs have continued and supported another slight reduction in the long-term view of inflation. See table 33: Key assumptions in the CNST IBNR provision on page 178 for details of the impact of the changes to the claims inflation assumption on CNST IBNR.

### Early notification

The majority of the CNST provision is as a result of claims arising from maternity activities, such as babies brain damaged at birth following negligent care.

A baby born with serious brain injury which meets the criteria for a Maternity and Newborn Safety Investigations (MNSI) investigation will be reported to MNSI by the trust. If MNSI accept the case and an investigation is commenced, the trust must also report the incident to NHS Resolution. After the MNSI investigation is complete the trust will share the final MNSI report with NHS Resolution. NHS Resolution's Early Notification (EN) team will triage the matter based on our internal clinical definition and where there are potential concerns about the care provided that may have caused injury, NHS Resolution will proceed to a full liability investigation. For babies born after 1 October 2023, NHS Resolution will seek the family's permission before proceeding.

The EN scheme has significantly altered the pace at which claims are opened. However, since the scheme was only launched in 2017 and it takes a number of years for higher-value claims to settle, there is relatively little settled claims experience to fully quantify the impact of the scheme.

Within the IBNR provision, we continue to separately model claims reported under the EN scheme and those expected to be reported outside of EN, but still within CNST. In arriving at our assumed number of claims, we have considered the rate at which EN cases have been opened to date while assuming that the overall level of risk in relation to brain damage at birth is broadly similar to the period before EN. Hence, we assume that the overall number of successful high-value claims after the introduction of EN will be similar to the period before, reflecting that EN only alters the reporting and claim settlement process, rather than the exposure to risk. Since only a very small number of high-value EN claims have been settled so far, other assumptions in respect of claim costs and settlement lags are set with reference to standard maternity claims.

### Indemnity arrangements for coronavirus

The coronavirus pandemic has had a significant impact on the NHS over the last four years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes that were established for 2020/21 (CNSC and CTIS), the liabilities covered under the arrangements that were already in place (i.e. through CNST, CNSGP and LTPS) have also been affected owing to changes in healthcare provision.

As was the case last year, the estimated effect on the NHS Resolution provision is fairly limited (£0.9 billion on the IBNR and £0.1 billion on the known claims). This is because a large proportion (62% for 2023/24 compared to 65% in 2022/23) of the total provision (across all clinical schemes) is as a result of claims arising from maternity activity. Although there were some changes to maternity activities during the pandemic, activities generally continued and we assume that there will be a similar level of claims as in previous years. The estimated value of CNST IBNR PPO claims, which mainly relate to maternity, for incidents in 2023/24 is approximately £3.3 billion.

Our approach to determining the impact of Covid-19 on the provisions is similar to that adopted in 2022/23, where we have separately considered:

- the direct impacts that might arise from new activities related to responding to the pandemic – for example in relation to testing, diagnosis, treating and caring for Covid-19 patients and administering vaccines; and
- the indirect impacts across all other factors that might influence claims and costs – for example in relation to lags between incidents, claims and settlement, the economic impact and delays, cancellations and misdiagnosis claims.

Although we continue to allow for the possibility of new risks and potential claims arising from Covid-19, these have been towards the lower end of the ranges that we have previously considered.

Note that since being established in 2020/21, the CTIS has not received a single claim and this year we have assumed a nil IBNR provision for this scheme.

### Risk and uncertainty

The risk and uncertainty in the provision continues to be demonstrated via presentation of sensitivity analysis and the uncertainty range (formerly described as the 'reasonable range'). Two uncertainty ranges have been shown – one illustrating the range of outcomes for the provision using plausible alternative assumptions, while the other illustrates the range of outcomes for the provision using alternative assumptions that reflect the wider observed variation in historical experience.

### Assumption of liabilities upon cessation

The NHS Act 2006 Section 70 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 has entered into a Memorandum of Understanding with the Government Actuary's Department, to assist with the preparation of financial statements through actuarial 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 (RPC) is responsible for making decisions on the key judgements and estimates. This is supported by the advice of the actuaries alongside the Preparatory Reserving Group, which reports into the RPC and brings together colleagues from across the organisation to scrutinise the analysis.

In addition to the discount rates, 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 RPC keeps all 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.

### Methodologies

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;
  - expected future claims inflation to settlement, based on an actuarial view of the expected timing of settlement of the provision;
  - the likelihood that they will go on to settle under a periodical payment regime, with part of the claim paid over the life of the claimant as a regular stream of compensation income rather than purely as a lump sum; and
  - the difference in 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 HMT-prescribed rates) to give a present value at the accounting date.

- **Settled PPOs** – The provision is determined on an individual claim-by-claim basis and then aggregated across all settled PPOs. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation). A probability of survival is then applied to each projected payment, based on the individual's life expectancy and the relevant mortality tables. This provides a weighting that allows for the relative probability of each payment being made. This forms the cash flows which are then discounted using HMT-prescribed discount rates to calculate a present value of the liability.
- **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 HMT-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 cost for different types of claims. Adjustments are made to these assumed claim costs 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 HMT-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.

These steps are applied across all schemes, noting the following differences:

- For CNST, ELS and DHSC clinical liabilities, calculations are carried out separately for damages, NHS legal costs and claimant costs, and for PPO and non-PPO type claims. We continue to set separate assumptions for the maternity claims reported under the EN scheme within the IBNR provision.
- For ELSGP, the reserving assumptions are based upon the combined historical claims experience from periods where claims were handled by the Medical and Dental Defence Union of Scotland (MDDUS) and/or the Medical Protection Society (MPS), and also more recently where claims have been handled by NHS Resolution.
- For CNSGP, the assumptions used to determine the provisions are based mainly on ELSGP experience, scaled up to allow for the fact that CNSGP has wider exposure coverage. CNSGP experience is used where appropriate.
- For CNSC and other coronavirus liabilities, approximate methods have been used based on levels of activity and assumed claim frequency and severity based on similar clinical risks.

## 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 the case for:

- the CNST, ELS and DHSC clinical schemes, given the long-term nature of the liabilities;
- the GPI schemes, given the recent changes in these arrangements with the take-on of claims from two medical defence organisations (MDOs); and
- the CNSC scheme and Covid-19 liabilities covered by the other schemes, given the novel nature of the liabilities and limited claims experience.

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, making adjustments for emerging risks and changes where relevant. In particular, the provisions are calculated on the basis of the current legal and claims environment, including the current personal injury discount rate (PIDR). There is also uncertainty in the IBNR for the CNST scheme in relation to the impact of the EN scheme given the innovative nature of the scheme.

### Key areas of uncertainty in the estimation of the claims provision

- **The number of clinical claims reported to NHS Resolution and lag patterns:** Despite this year's experience being slightly higher than assumed last year, the number of claims reported to NHS Resolution's long-established schemes has generally reduced over the last couple of years, excluding claims reported under the EN scheme. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in past claim trends. Covid-19 has reduced the number of claims being received from activity in 2020/21; however, clinical activity appears to have recovered to pre-pandemic levels.

Estimating the ultimate number of claims is complicated by the fact that 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, the introduction of the EN scheme (leading to earlier reporting of incidents and claims), increased awareness of the availability of compensation, potential disruptions owing to Covid-19 and the growth in waiting lists, increase the uncertainty in this assumption.

- **Claims settling as PPOs:** PPOs remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. 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.
- **Claims inflation:** 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 been much higher 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 Swift v. Carpenter in 2020) 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 HMT Public Expenditure System (PES) discount rate note from December 2023 (which specifies the financial assumptions to be used for valuing provisions at March 2024) 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 40 of Annex B of the HMT PES note PES (2023) 10.

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 RPC.

**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 assumptions for price inflation.

As a result, the claims inflation assumptions are derived by:

- first, looking at nominal increases in average claim costs over past years by reserving segment; and
- then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past.

The majority of PPOs have payments linked to the Retail Prices 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. Further, the reforms announced to the RPI will result in a change in the way that the RPI is determined in 2030.

- **Life expectancy:** 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 an individual claimant may differ significantly from this estimate. Furthermore, it is difficult to determine whether the life expectancies estimated by medical experts, in aggregate, 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).
- **Covid-19:** As with last year's provisions, there are additional assumptions made, and hence uncertainties in the provision, as a result of the impact of Covid-19. Among other risks, the provision continues to allow for clinical negligence claims resulting from the treatment of Covid-19.
- **Legal environment:** The provisions have been valued using the current PIDR of minus 0.25%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR. The next review is scheduled for 2024. However, as there is no certainty on the outcomes of future reviews, no adjustments have been made to the IBNR or known claims provisions for the potential effects of such changes at this stage.
- **Judicial College guidelines:** Updated Judicial College guidelines take effect from 5 April 2024. The latest edition of this guidance includes an above inflationary rise to general damages awards. In reality, this increase is already factored into more recent settlement values, so the impact on the provisions is expected to be limited.
- **Scheme developments:** There is additionally some uncertainty in relation to the impact of the EN scheme, which impacts some maternity incidents that occurred on or after 1 April 2017, on claims costs and reporting trends. We continue to set separate assumptions for claims reported under the EN scheme and those reported outside of the scheme. Assumptions have been set based on EN experience to date and we have assumed that the overall level of risk of brain damage to babies at birth is similar to that seen in previous years, but that EN brings forward the reporting of those claims. It will take several more years to ascertain fully what the impact of EN may be.

## Key assumptions

Table 33 shows a summary of the key assumptions used to determine the CNST IBNR provision. The CNST IBNR provision is the largest single element of the total provision, 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 as 'high', 'medium' or 'low'. These categories are colour coded in the table, with red shading to highlight the areas of greatest uncertainty and sensitivity, and green shading to highlight the areas where uncertainty and sensitivity is relatively low. Where appropriate the same assumptions are used for the CNST settled PPOs and known claims provisions.

The impacts of the various assumptions can be found detailed in figure 43 under CNST sensitivities as at 31 March 2024 (page 187)..

### Table 33: Key assumptions in the CNST IBNR provision

| Assumption | Approach | Degree of uncertainty |
|---|---|---|
| Nominal discount rates | HMT prescribed | **Prescribed** |
| Ultimate number of claims and propensity to settle as PPO | Derived from past claim numbers and development patterns and assumptions that the level of risk will be similar to previous years, adjusted for levels of activity | **Medium** |
| | Value threshold derived from recent years' settled claims data | **Medium** |
| Average cost per claim | Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs | **High** |
| Claims inflation | Long-term claims inflation: derived from past settled claims<br>Short-term claims inflation: derived from short-term HMT prescribed CPI forecasts | **High** |
| Probability of paying damages | Derived from past settled claims, adjusted for incomplete development | **Medium** |
| Creation to payment lags | Derived from past settled claims | **Low** |
| Life expectancy for PPO payments | Based on analysis of past settled PPO claims | **Medium** |
| ASHE 6115 (80th percentile) | Based on earnings increases relative to CPI over the longer term | **Medium** |

| | Sensitivity to changes | Change in assumption between 31 March 2023 and 31 March 2024 | YoY effect of change (CNST IBNR) |
|---|---|---|---|
| | **High** | All discount rates have been updated. Short- and medium-term rates have increased by 0.99 percentage points and 0.83 percentage points respectively. The long-term and very long-term rates have increased by 1.21 percentage points and 1.40 percentage points respectively. | –£6.5 billion |
| | **High** | The EN scheme has accelerated the reporting of potential PPO claims. We allow for this by specifying separate assumptions for claims that are expected to be reported under the EN scheme.<br>The number of non-EN potential PPO claims reported is slightly higher than expected for incident years 2019/20 and 2020/2021. The projections for non-EN potential PPO claims are now weighted towards actual experience for these two incident years, which leads to an increase in the assumed number of total claims and the IBNR provision.<br>The expected number of future non-PPO claims is similar to last year. | +£1.1 billion |
| | **Medium** | A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has increased from £4.25 million to £4.75 million. | |
| | **High** | The average cost per claim assumptions have increased at a slightly lower rate than previously assumed.<br>The assumed average cost for PPOs depends on the HMT discount rate used to place a present value on structured settlement payments. An increase to these rates has resulted in a decrease to the average cost assumption for PPO damages. This has been accounted for under the nominal discount rate impact shown above. | –£0.7 billion |
| | **High** | The long-term inflation assumption for PPO damages has decreased by 0.25 percentage points per annum from the previous year. | –£0.3 billion |
| | | We are assuming that the higher short-term inflationary environment will feed through to higher short-term claims inflation and persist for longer than was assumed last year. | +£0.9 billion |
| | **Medium** | This year the probability of paying damages for non-EN PPOs has increased slightly (+1%) for all incident years.<br>For EN PPOs the assumptions are unchanged from last year apart from the 2019/20 incident year, where the probability has increased slightly (+1%). | +£0.2 billion |
| | **Medium (for PPOs)** | Lag range from 2.8 to 7.3 years, unchanged at the higher end and decreasing by 0.1 years at the lower end of the range. | – |
| | **Low** | The mortality assumptions have been updated based on the latest available data from ONS. Separate assumptions are specified for EN claims (42 years) and non-EN claims (39 years). | +£0.1 billion |
| | **High** | The ASHE assumption is unchanged at CPI+1.75%. | – |

## Sensitivities as at 31 March 2024

The provisions are sensitive to the assumptions used to varying degrees. The following demonstrates the sensitivity to these assumptions by showing:

- Sensitivity of the total provisions (known claims, settled PPOs and IBNR) to changes in the following key assumptions:
  - HMT discount rates;
  - ASHE assumption;
  - claims inflation;
  - life expectancy; and
  - payment pattern.
- For CNST, which represents the largest scheme and the single most uncertain element of the total provision, sensitivity of the total provisions to other assumptions and uncertainty ranges.

## Sensitivity of provision to key assumptions

The following tables show the effect on the valuation of the total provisions if different rates and assumptions were applied for HMT discount rates, the differential between CPI and ASHE, claims inflation, life expectancy and payment patterns. The ranges of the sensitivity tests that follow 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 plausibly occur. Each change is shown separately, but in practice combinations are possible, as different assumptions can be correlated.

The tables show the separate impact on:

- The **known claims** provision. This represents 36% of total provisions.
- The **settled PPO** provision. This represents 23% of total provisions. They are typically high-value claims, and their long-term nature means they are highly sensitive to changes in key assumptions.
- The **IBNR** provision. This represents 41% of total provisions.

Note that the tables that follow show the sensitivity of the total provision across all schemes. However, the provision, and sensitivity of the provision, is dominated by CNST, which accounts for 92% of the total provisions.

Historically, the IBNR provision represented over 50% of the total provision, exceeding the provision for known claims and settled PPOs. However, as per 2022/23 financial year, this is no longer the case because:

- much of the known claims provision is driven by a growing book of settled PPOs that are particularly exposed to claims inflation due to the long-term nature of structured settlement payments;
- the EN scheme has accelerated the movement of claims from IBNR into the known claims; and
- due to potentially lengthy delays between claim incident, reporting and settlement, the IBNR is heavily discounted and sensitive to the discount rate. This reduces the IBNR provision, particularly when the discount rates are relatively high.

## Sensitivity to HMT tiered nominal discount rates

Since 2018/19, HMT specifies discount rates in nominal terms. These rates have increased this year across all durations, which has led to decreases in the provision across all schemes.

Due to the long-term nature of the liabilities, claims that have settled, or are expected to settle as a PPO are very sensitive to changes in HMT-prescribed discount rates, especially the long-term and very long-term discount rates.

| Discount rates term | 31 March 2023 nominal rates (%pa) | 31 March 2024 nominal rates (%pa) | Change |
|---|---|---|---|
| Short-term (<5 years) | 3.27% | 4.26% | +0.99% |
| Medium-term (5–10 years) | 3.20% | 4.03% | +0.83% |
| Long-term (10–40 years) | 3.51% | 4.72% | +1.21% |
| Very long-term (over 40 years) | 3.00% | 4.40% | +1.40% |

As shown in the following material, the relationship between the value of the total provision and the effect of changes in the discount rates is not a symmetrical one, due to the impacts of compound discounting. The table below is based on adjusting the nominal discount rates by +1% and -1%. A reduction of 1% in the discount rates will increase the total provision by 20%, but a 1% increase will reduce the provision by 14%.

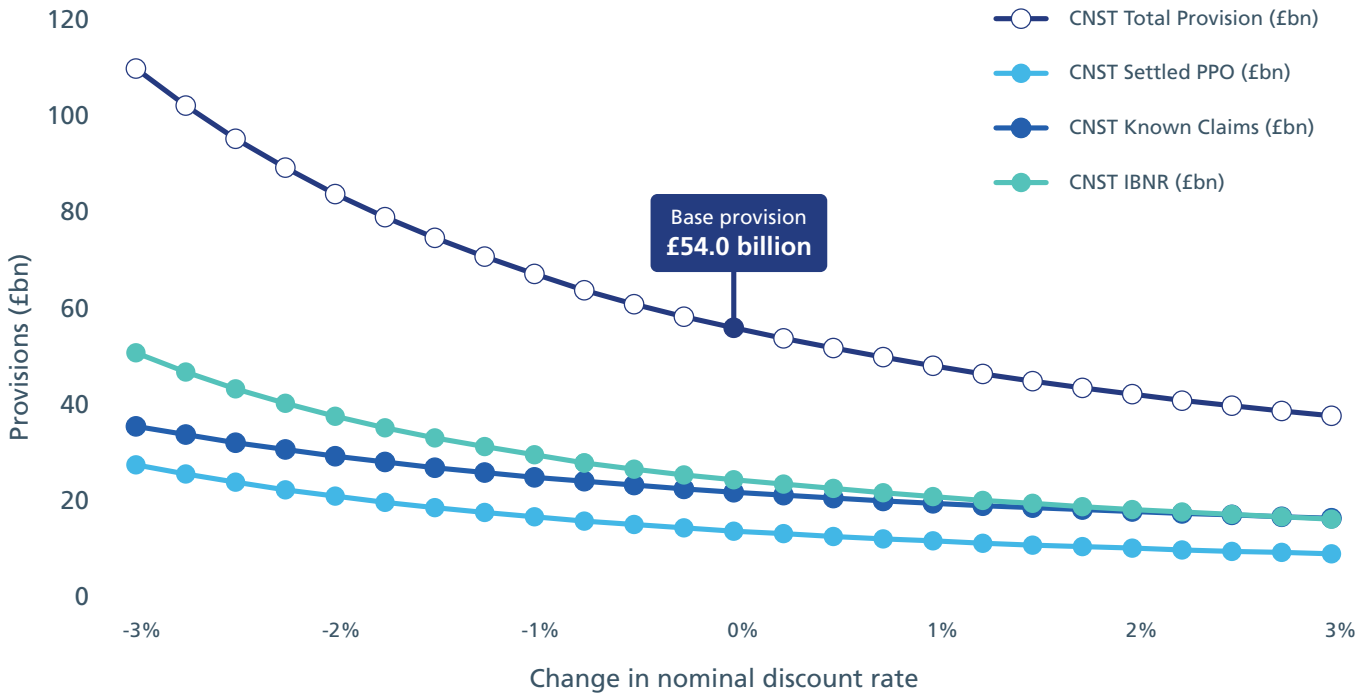
**Sensitivity of total provisions to HMT discount rates (£m)**

| Provisions | All rates reduced by | | Base assumptions | All rates increased by | |
|---|---|---|---|---|---|
| | 1.0% pa | % | | 1.0% pa | % |
| Known claims | 24,113 | +15% | **20,892** | 18,519 | -11% |
| Settled PPOs | 17,184 | +24% | **13,830** | 11,441 | -17% |
| IBNR | 29,104 | +23% | **23,758** | 20,120 | -15% |
| **Total provisions** | **70,401** | **+20%** | **58,480** | **50,080** | **-14%** |

For the clinical schemes, the changes in discount rates in 2023/24 have had a materially large impact on the IBNR provisions. This is because a large proportion (by value) of the provisions are expected to be paid in more than ten years' time, and so are subject to a large degree of discounting.

Figure 41 is based on adjusting the nominal discount rate by the increments shown for the CNST scheme only (as it is the most significant scheme) to show the non-linear effect of changes in this factor on the value of the provision. A change in the nominal discount rate of +1% would represent short-, medium-, long-term and very long-term nominal discount rates of 5.26%, 5.03%, 5.72% and 5.40% respectively.

**Figure 41: Sensitivity to changes in the nominal discount rate**




## Sensitivity to differential between ASHE and CPI

The ASHE index, used in the calculation of damages in PPO claims 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 1.75% higher than CPI price inflation each year.

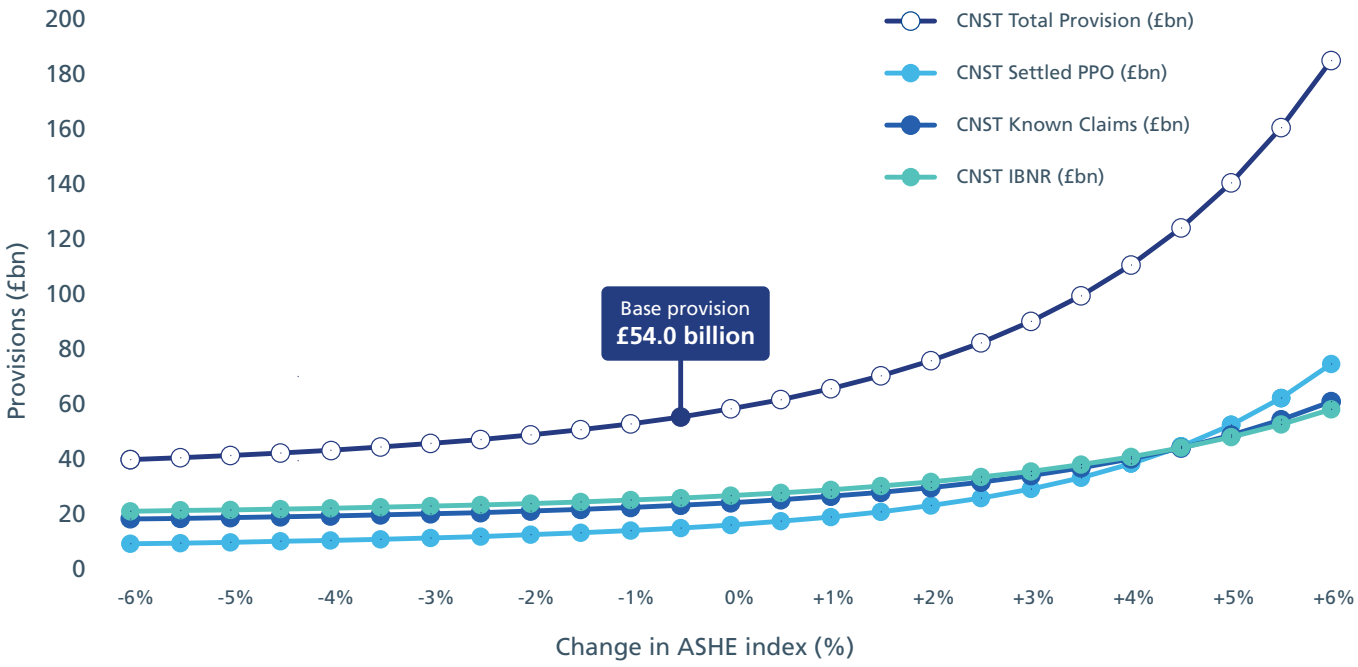
The table that follows shows the effect on the value of the provision where this differential is varied. An additional +/- 1.0% difference between ASHE and CPI will either increase the provision by 13% or decrease it by 10% respectively.

**Sensitivity of total provisions to ASHE assumptions (£m)**

| Provisions | All rates reduced by | | Base assumptions | All rates increased by | |
|---|---|---|---|---|---|
| | 1.0% pa | % | | 1.0% pa | % |
| Known claims | 19,105 | -9% | **20,892** | 23,294 | +11% |
| Settled PPOs | 11,503 | -17% | **13,830** | 17,061 | +23% |
| IBNR | 22,127 | -7% | **23,758** | 25,913 | +9% |
| **Total provisions** | **52,735** | **-10%** | **58,480** | **66,268** | **+13%** |

Figure 42 shows the non-linear relationship between this assumption and the value of the CNST provision (as the most significant scheme). The impact is also more pronounced for the book of settled PPOs as this provision relates to structured settlement payments only (which are fully exposed to changes in ASHE).

**Figure 42: Sensitivity to differential between ASHE and CPI**




## Claims inflation

The following table shows the effect on the value of the provisions of a +/- 1.5% change to the claims inflation assumptions. An addition of +/- 1.5% to the claims inflation assumptions will increase the provision by 8% or reduce it by 7% respectively. The effect of changes in the rate of claims inflation is not a symmetrical one, due to the impacts of compound inflation and discounting.

**Sensitivity of provisions to claims inflation (£m)**

| Provisions | All rates reduced by | | Base assumptions | All rates increased by | |
|---|---|---|---|---|---|
| | 1.5% pa | % | | 1.5% pa | % |
| Known claims | 19,846 | -5% | **20,892** | 22,029 | +5% |
| Settled PPOs | 13,830 | 0% | **13,830** | 13,830 | 0% |
| IBNR | 20,861 | -12% | **23,758** | 27,227 | +15% |
| **Total provisions** | **54,537** | **-7%** | **58,480** | **63,086** | **+8%** |

## Life expectancy

The provisions in respect of PPOs are sensitive to the assumed life expectancy of claimants. The following table shows the effect on the value of the provisions of a 30% adjustment to the assumed life expectancy of claimants. Reducing life expectancy by 30% reduces the provision by 17%, while increasing life expectancy by 30% increases the provision by 16%.

**Sensitivity of total provisions to life expectancy (£m)**

| Provisions | All life expectancies reduced by 30% | All life expectancies reduced by % | Base assumptions | All life expectancies increased by 30% | All life expectancies increased by % |
|---|---|---|---|---|---|
| Known claims | 18,176 | -13% | **20,892** | 23,500 | +12% |
| Settled PPOs | 9,366 | -32% | **13,830** | 17,958 | +30% |
| IBNR | 21,165 | -11% | **23,758** | 26,293 | +11% |
| **Total provisions** | **48,707** | **-17%** | **58,480** | **67,751** | **+16%** |

## Payment pattern

Payment patterns are used to express the timing of when a claim is expected to be paid, defining the lag between the claim being reported and the claim paying out. The following table shows the effect on the value of the provisions of a +/- 1 year adjustment to the claims payment pattern. Lengthening the assumed payment dates by 1 year will increase the provision by 1%, while shortening the payment pattern by 1 year reduces the provision by 1%.

**Sensitivity of total provisions to payment pattern (£m)**

| Provisions | Creation to payment lag reduced by 1 year | Creation to payment lag reduced by % | Base assumptions | Creation to payment lag increased by +1 year | Creation to payment lag increased by % |
|---|---|---|---|---|---|
| Known claims | 20,783 | -1% | **20,892** | 21,043 | +1% |
| Settled PPOs | 13,830 | 0% | **13,830** | 13,830 | 0% |
| IBNR | 23,466 | -1% | **23,758** | 24,050 | +1% |
| **Total provisions** | **58,079** | **-1%** | **58,480** | **58,923** | **+1%** |

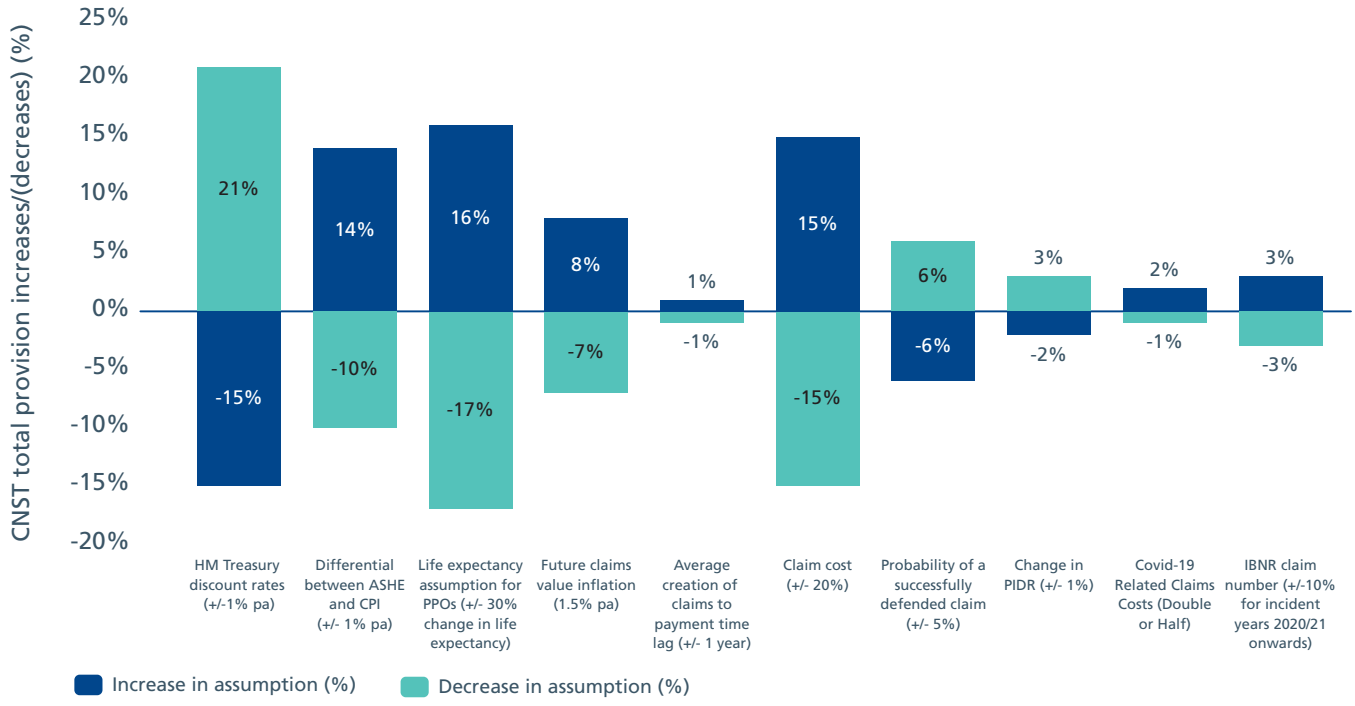
## CNST: sensitivity of provision to other assumptions

The sensitivity analysis that follows indicates how wider variations in individual assumptions would affect the CNST total provision. This demonstrates the extent to which plausible differences between the assumptions chosen and actual future experience could affect future years' provisions and the ultimate costs of settling claims.

The ranges of the sensitivity tests that follow 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 plausibly occur. Each change is shown separately, but in practice combinations are possible, as different assumptions can be correlated.

## CNST sensitivities as at 31 March 2024

**Figure 43: The value and percentage impact of variations in the key assumptions within the CNST estimate**




The sensitivities around the key assumptions are explained earlier in this note.

## CNST: uncertainty range

The CNST 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 CNST IBNR and known claims provisions in the accounts are 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. To illustrate this, an uncertainty range (formerly referred to as 'reasonable range') is set out below to demonstrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision.

Two separate ranges are considered:

- **Range 1 (plausible alternative assumptions)** – this illustrates the range of outcomes for the provision using plausible alternative assumptions. These assumptions reflect the range of values that could reasonably have been selected based on the same analysis of past data, focusing on the assumptions that are the most material and subjective.
- **Range 2 (broader plausible alternative assumptions)** – this illustrates the range of outcomes for the provision using alternative assumptions that represent a broader range of possible values that reflect the wider variation in the observed historical and/or potential future experience.

It should be noted that neither uncertainty range include variations in the discount rate as this is prescribed by HMT.

It should also be noted that the presentation of the uncertainty ranges does not in itself 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. Therefore, the ranges reported do not cover all possible outcomes.

The uncertainty ranges have been derived by varying the assumptions for both the IBNR and known claims (excluding settled PPOs). For the assessment, a number of assumptions are varied together.

| CNST uncertainty range | | Baseline provision £m | Upper range £m | Difference to accounts estimate | Lower range £m | Difference to accounts estimate |
|---|---|---|---|---|---|---|
| Range 1: plausible alternative assumptions | IBNR | 22,398 | 23,729 | 6% | 21,185 | -5% |
| | Known claims | 19,818 | 20,995 | 6% | 18,675 | -6% |
| | Settled PPOs | 11,737 | 11,737 | 0% | 11,737 | 0% |
| **Total** | | **53,953** | **56,461** | **5%** | **51,597** | **-4%** |
| Range 2: range of possible outcomes | IBNR | 22,398 | 27,567 | 23% | 17,889 | -20% |
| | Known claims | 19,818 | 22,366 | 13% | 17,478 | -12% |
| | Settled PPOs | 11,737 | 11,737 | 0% | 11,737 | 0% |
| **Total** | | **53,953** | **61,670** | **14%** | **47,104** | **-13%** |

The plausible alternative assumptions range (Range 1) was derived by varying the following assumptions, all of which could have reasonably been applied:

- For IBNR claims:
  - the estimate for numbers of PPO damages claims for the incident years 2017/18 onwards;
  - the average cost for PPO damages; and
  - PPO damages claims inflation.
- For known claims (excluding settled PPOs):
  - case estimates in respect of each known claim;
  - the probability of a claim being successful; and
  - PPO damages claims inflation.

The assumptions listed above were also varied (but to a greater extent) for the range of possible outcomes (Range 2). In addition, the following assumptions were also varied:

- For IBNR claims:
  - the probability of defence for PPO-type claims;
  - the creation to settlement lag for PPO claims; and
  - the Covid-19 related claims costs.
- For known claims (excluding settled PPOs):
  - The creation to settlement lag for PPO claims.

In summary, the provision in the accounts for CNST could have been set at a value between £51.6 billion and £56.5 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 £54.0 billion provision in the accounts.

This uncertainty range of £4.9 billion demonstrates the sensitivity of the provision to relatively small changes in the assumptions, as summarised in figure 43. The range is mainly driven by the IBNR (£2.5 billion), which is the most uncertain element of the provision as these claims are yet to be reported. The change in the estimate for the numbers of PPO damages claims has the largest impact on the IBNR uncertainty range calculation. This is further compounded by the sensitivity of the other factors. The remainder of the inner range (£2.3 billion) is driven by the known claims provision, where claims have been reported and there are fewer uncertainties, but judgement is still required as to the timing and cost of settlement.

Range 2 shows a variation of between £47.1 billion and £61.7 billion and reflects the range of possible outcomes if the assumptions chosen reflect variation in the observed historical and/or potential future experience.

This range of £14.6 billion is quite wide, illustrating the sensitivity of the provision to relatively small changes in the assumptions, the uncertainty of the assumptions underlying the provisioning estimate and the range of possible outcomes if experience deviates from current expectations.

Note that last year's accounts disclosed a 'reasonable range' of -16.3% to +17.4%. This is broadly comparable to the range of possible outcomes (Range 2) shown above.

# 8. Contingent liabilities

NHS Resolution makes a provision in its accounts for the likely value of future claims payments and records contingent liabilities that represent possible claims payments additional 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 through the payment of damages is not deemed likely.

The contingent liability represents an estimation of the additional provision NHS Resolution would recognise in its accounts if damage payments were awarded on all claims, rather than taking into account the probability of damages being paid (i.e. reflecting that typically many claims settle at nil). The known claims provision is calculated as the sum of outstanding reserve values (i.e. total claim value less payments) multiplied by the probability of damages being paid, inflated and discounted to provide a present value of the claim based on the expected settlement dates. The IBNR provisions calculation also includes probabilities of a claim being paid for each of the schemes. The contingent liability is then the difference between the total valuation of IBNR and known claims (including estimations on claims which are ultimately expected to settle at nil) and the main valuation of known claims and IBNR (which excludes claims expected to settle at nil). This does not include the full range of possible outcomes and there remains uncertainty in the amounts calculated due to the uncertainty in the number and type of claim and the costs of the claims (as described in Note 7).

| Contingent liabilities | Ex-RHA £000 | ELS £000 | CNST £000 | DHSC Clinical £000 | ELSGP £000 |
|---|---|---|---|---|---|
| Contingent liability as at 31 March 2024 | – | 95,648 | 23,394,831 | 185,337 | 268,731 |
| Contingent liability as at 31 March 2023 | – | 179,660 | 30,827,013 | 305,460 | 346,776 |

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. While no claim of this nature is currently provided for, any valid claims arising from the activities of those organisations will be dealt with by NHS Resolution and funded in full by DHSC.

We have not determined a separate and additional contingent liability for Covid-19 risks because we have included explicit provisions for the material and quantifiable risks.

| CNSGP £000 | CNSC £000 | DHSC Non-Clinical £000 | CTIS £000 | PES £000 | LTPS £000 | Total £000 |
|---|---|---|---|---|---|---|
| 592,842 | 16,460 | 57,862 | - | 9,732 | 159,336 | 24,780,779 |
| 496,474 | 21,574 | 74,626 | 2,000 | 8,632 | 179,370 | 32,441,585 |

# 9. Lease liabilities

The total future minimum lease payments under lease liabilities payable in each of the following periods are as below.

| Maturity analysis – contractual undiscounted cash flows lease liabilities | Leased from DHSC | Leased from other government bodies | Leased from bodies external to government | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|---|---|
| Within 1 year | 181 | 839 | 6 | **1,026** | 1,011 |
| Between 1 and 5 years | 762 | 3,526 | – | **4,288** | 4,209 |
| After 5 years | 587 | 3,079 | – | **3,666** | 4,770 |
| **Total undiscounted lease liabilities at 31 March** | **1,530** | **7,444** | **6** | **8,980** | 9,990 |

| Lease liabilities included in the statement of financial position at 31 March | Leased from DHSC | Leased from other government bodies | Leased from bodies external to government | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|---|---|
| Current | 168 | 774 | 6 | **948** | 923 |
| Non-current | 1,303 | 6,370 | – | **7,673** | 8,621 |
| | **1,471** | **7,144** | **6** | **8,621** | 9,544 |

| Amounts recognised in profit and loss | Leased from DHSC | Leased from other government bodies | Leased from bodies external to government | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|---|---|
| Interest on lease liabilities | 15 | 72 | – | **87** | 71 |
| Expenses related to low-value assets | – | – | 61 | **61** | 64 |

| Amounts recognised in the statement of cash flows | Leased from DHSC | Leased from other government bodies | Leased from bodies external to government | 2023/24 £000 | 2022/23 £000 |
|---|---|---|---|---|---|
| Repayment of lease liability – capital | 163 | 750 | 11 | **924** | 920 |
| Repayment of lease liability – interest | 15 | 72 | – | **87** | 71 |
| | **178** | **822** | **11** | **1,011** | 991 |

# 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
- All integrated care boards
- Care Quality Commission
- NHS Digital[112]
- Health Education England[113]
- Health Research Authority
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS England[114]
- NHS Property Services Limited
- NHS Trust Development Authority
- Public Health England
- NHS Counter Fraud Authority

[112,113,114] NHS Digital merged with NHS England on 1 February 2023; this was followed by the integration of Health Education England into NHS England on 1 April 2023. NHS England has now assumed responsibility for all activities previously undertaken by Health Education England.

## 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 in the following material. 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) | Reciepts from related organisation (£000) | Amount owed to related organisation (£000) | Amount due from related organisation (£000) |
|---|---|---|---|---|---|---|
| **Sally Cheshire CBE** Chair | Audit & Risk Assurance Committee of Department of Work and Pensions | Committee Member | 35,718 | – | 182 | – |
| **Mike Durkin** Associate Non-executive Member | Health Services Safety Investigations Body (HSSIB) | Non-executive Director | – | 2 | – | – |
| **Professor Sir Sam Everington OBE** Associate Non-executive Director | East London Foundation Trust | Non-executive Director | 30 | 1,868 | – | – |
| **Niamh McKenna** Chief Information Officer | NHS BT Audit and Risk Committee | Independent Member | 1 | 844 | – | 23 |
| **Helen Vernon** Chief Executive Officer | Tameside and Glossop Integrated Care NHS Foundation Trust | Clinical Director & Consultant (family member) | – | 9,395 | – | – |
| | Mid Cheshire Hospitals NHS Foundation Trust | Non-executive Director (family member) | 686 | 9,872 | – | – |
| **DHSC**[115] | Hodge Jones & Allen LLP | Related party to DHSC | 11,778 | – | – | – |
| **DHSC**[116] | Milton Keynes University Hospital NHS Trust | Related party to DHSC | 1,086 | 11,752 | – | 11 |
| **DHSC**[117] | NHS Confederation | Related party to DHSC | 6 | – | – | – |
| **DHSC**[118] | NHS England | Related party to DHSC | 5 | 8,568 | – | 60 |

[115, 116, 117, 118] DHSC have provided us with a list of individuals and entities which are deemed to be related parties of theirs for this financial year. These entities are deemed to be related parties of NHS Resolution for the purposes of IAS 24 Related Party Disclosures.

# 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. In addition, 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. Financial assets and liabilities are generated by day-to-day operational activities, rather than being held to changes within 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 twelve 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

These financial statements were authorised for issue on the date that the Comptroller and Auditor General certified the accounts.

Judicial College guidelines were updated effective from 5 April 2024. This latest (17th) edition of the guidance includes an increase of approximately 22% to general damages awards. This impacts heads of loss payments in respect of general damages only. Analysis of the change has been undertaken and if the revised rates had been applied to the provision at 31 March 2024, it is estimated that the clinical negligence provision would have increased by between 0.2% and 0.6% therefore the impact is not expected to be material. The change is a non-adjusting event as the change is effective after the balance sheet date.

# Glossary

An online glossary is available to support this document.

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