NHS Resolution

Annual Report and Accounts 2025/26

Advise / Resolve / Learn

HC 421

NHS Resolution
Annual Report and Accounts

2025/26

For the period 1 April 2025 to 31 March 2026

Accounts presented to Parliament pursuant to Paragraph 29A of the National Health Service Act 2006.

Report presented to Parliament by Command of His Majesty.

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Performance overview

Chair and Chief Executive's welcome

Welcome to our Annual Report and Accounts for 2025/26. This reflects on the first year of our new three-year strategy, Resolution Through Collaboration[1], which focuses on delivering fairer resolution, using data to drive learning, and deepening our contribution to maternity and neonatal safety improvements.

It has been a year of strong performance, with the majority of our 2025/26 business plan objectives achieved across our core service areas as well as most of our key performance indicators being achieved or within tolerance, indicating consistent operational delivery. This is despite a continued increase in the volume and complexity in many areas of our work and significant operational transformation as a result of the next phase of the implementation of our new case management system, CaseHub.

Delivering fair resolution

We have seen a continuing increase in the number of new clinical claims received – which totalled 15,236 new claims in 2025/26 (up from 14,428 claims in 2024/25), a figure that may be impacted by increased NHS activity. Despite this increase, we continue to deliver against our strategic aim of reducing litigation and improving claimant experience – illustrated by the achievement of keeping a record 84% of claims out of formal processes.

It has also been a year of open engagement in important work by the National Audit Office (NAO) and the Public Accounts Committee (PAC) to consider the rising costs of clinical negligence. We welcome their reports[2] and endorse their findings, both of which included acknowledgement of our hard work in reducing the financial and emotional cost of clinical negligence by resolving claims faster and without litigation wherever possible.

We will continue to do everything we can within our remit to manage these costs, and work with ministers and officials across Government to tackle the wider issues raised by the reports, including supporting the work of David Lock KC.

There has also been an increase in requests for case advice made to our Practitioner Performance Advice service. We received 1,576 new and reopened requests for case advice in 2025/26, an 11% increase on 2024/25. The open case load at the end of the financial year stood at 1,242, an 8.5% increase when compared with 2024/25, reflecting the increasing complexity of these cases.

Similar increases in case volume and complexity, requiring careful management, are evident in our Primary Care Appeals service.

[1] https://resolution.nhs.uk/corporate-publications/resolution-through-collaboration-2025-28-strategy/
[2] See National Audit Office: Costs of clinical negligence (www.nao.org.uk/reports/costs-of-clinical-negligence/) and Committee of Public Accounts: Costs of clinical negligence (publications.parliament.uk/pa/cm5901/cmselect/cmpubacc/1234/report.html)

Our contribution to system learning and patient safety

We are proud to be a trusted source of data, learning, and practical tools for our partners across the NHS, and we hold a unique role in the patient safety landscape, something that's captured in our second strategic priority, which focuses on data and insights.

Throughout the year we have worked collaboratively to support the development and implementation of system-wide recommendations for improvement and to ensure the lessons held in our data continue to act as an enabler for new models of care.

We facilitated 1,029 engagements that provided opportunities to use claims data to support learning, with an estimated reach of more than 25,000 people. We also delivered 57 workshops to 880 delegates that promoted good practice in managing and resolving performance concerns to help build local capacity and capability.

In collaboration with national bodies, we also developed and shared insight products, thematic reviews, and practical tools to support improvement across the NHS. We worked with a range of partners to share our learning and to identify where our insights can support system priorities and the delivery of the 10 Year Health Plan for England[1], including in response to the new National Quality Strategy and the work of the National Quality Board.

We will continue to seek opportunities to maximise the impact of our learning outputs, translating insights from our Claims Management and Practitioner Performance Advice services into improvements in clinical practice and patient safety.

Contributing to improvement in maternity and neonatal safety

We recognise that avoidable errors in maternity and neonatal services still occur and that incidents have devastating consequences for the child, mother, and wider family, as well as the NHS staff involved.

Our Maternity (Perinatal) Incentive Scheme (MIS) is a financial incentive programme designed to enhance maternity and neonatal safety within NHS trusts. This year, 90% of trusts who provide these services were fully compliant with MIS standards, the highest compliance levels to date.

The Early Notification (EN) scheme continues to support families affected by specific brain injury at birth, enable earlier investigation, and reduce legal costs. It also allows us to accelerate learning, and we are exploring further opportunities to maximise how learning is shared more effectively with the wider system so that it translates into practical improvements.

In 2025/26 we published the evaluation of the MIS. It will be followed by the evaluation of the EN scheme in 2026/27.

These evaluations provide vital insight, and we have used – and will use – their findings to help us to reform and evolve the schemes.

[1] www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future

Alongside the MIS and the EN scheme, we continued to play our part to support those affected by avoidable harm, working with the system to improve maternity and neonatal care and expanding the support for families with personalised communication resources. As part of our strong system-level role, we stand ready to support the work of the Maternity and Neonatal Taskforce[1] and will provide information and assistance wherever it is relevant to our role.

Operational transformation to support a service fit for the future

Our new case management system, CaseHub, represents a cornerstone of operational transformation. 2025/26 marked the next phase of its implementation, which included transitioning our legacy Claims Management System, the largest element of our largest function, to the new system.

Its implementation involved migrating tens of thousands of claims and millions of records. It also involved redesigning processes and providing extensive training to support staff as they transitioned to new ways of working.

As with any major transformation programme, the process was not without its challenges. We are grateful to colleagues across the organisation for their engagement in supporting the successful rollout of CaseHub.

There was a short-term impact in relation to the day-to-day management of claims while the system was bedding in. Throughout, our focus was on minimising the impact for patients and their families, and to ensuring payment of damages continued without delay.

In addition, as a result of regular monitoring of our budget, we achieved a year-end position within the 1% underspend tolerance set by the Department of Health and Social Care (DHSC) and maintained our budgets within Departmental Expenditure Limits (DEL) limits.

Progress is already evident and it is clear that, over time, CaseHub will bring robust data capture, enhanced case management capabilities, and better quality and more useable data, helping us to deliver more efficient and responsive services.

A year in summary

The endorsements in the NAO and PAC reports reflect the strength of our ability to innovate, evolve, and adapt, something that has been in evidence throughout our 30-year history, as described in infographic 1: 30 years of progress. As we look ahead to 2026/27, we will continue to deliver the hard work that was recognised by the NAO and PAC in reducing the costs and emotional distress of clinical negligence, including by expanding our innovative dispute resolution approaches. We will also continue to engage with stakeholders to tackle the wider issues involved.

What follows in the rest of this section of the report is a summary of our performance in 2025/26. It provides an overview of NHS Resolution and its purpose, the objectives we

[1] www.gov.uk/government/groups/national-maternity-and-neonatal-taskforce

set out to achieve and our performance against those objectives, and the impact and management of key risks.

Finally, we are grateful to our staff, partners and our sponsoring department, the Department of Health and Social Care (DHSC), who have worked with us throughout the year to resolve, learn, and improve for the benefit of patients, staff, and the NHS as a whole.

Sally Cheshire CBE
Chair

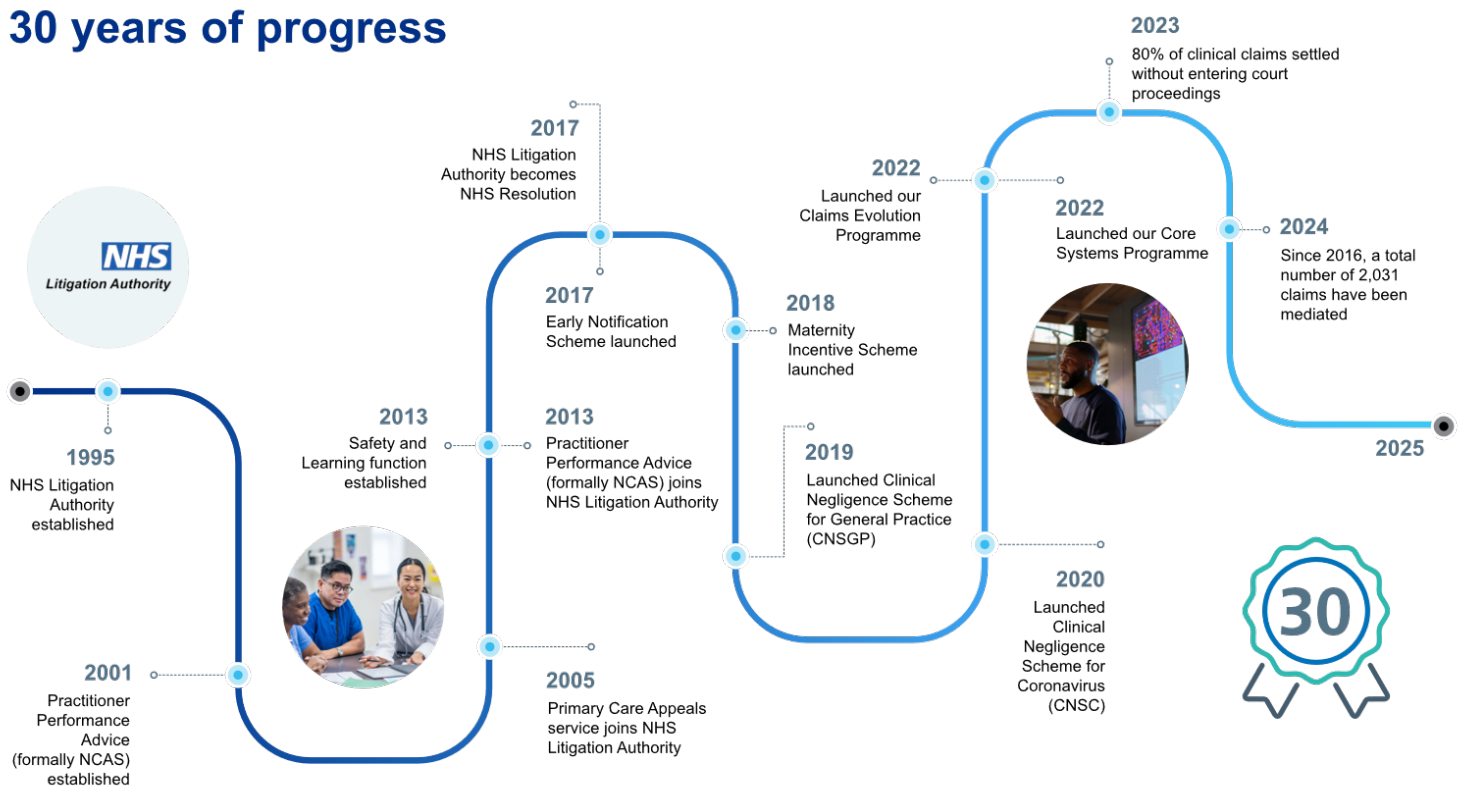
Helen Vernon
CEO

30 years of progress

2025 marked 30 years of NHS Resolution delivering reliable and comprehensive indemnity solutions for the NHS, and the start of our three-year strategy to 2028 Resolution Through Collaboration. Over those 30 years, our services have grown to encompass advice on practitioner performance and resolving disputes between commissioners and providers of primary care.

Infographic 1 highlights a few of our most significant milestones and innovations since 1995.

Infographic 1: 30 years of progress



Who we are and what we do

We are part of the NHS, operating at arm's length from the Department of Health and Social Care (DHSC).

Our services

We work across two interrelated sectors, health and justice, and are tasked with:

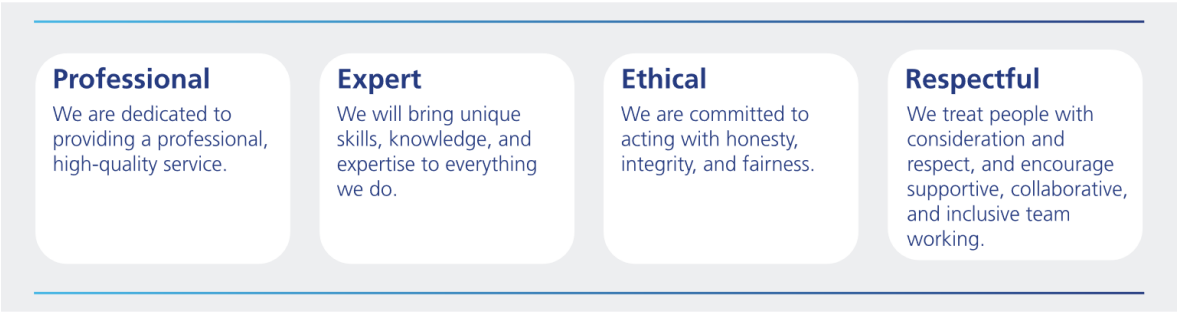
- Administering a range of **indemnity schemes** to cover the risks involved in delivering general practice and secondary healthcare services in England and handling associated compensation claims. More information on the indemnity schemes we administer is shown in the Appendix.
- Providing **expert 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.
- 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**.

Infographic 2 sets these services out in graphical format, infographic 3 gives our strategic priorities, and infographic 4 sets out the values that guide us.

Infographic 2: Our services

Infographic 3: Our strategic priorities

Infographic 4: Our values



How we define success

We define success by the experience and outcomes our work enables for patients, families, healthcare staff, and the wider system, rather than by activity or volume alone. Success is defined by:

- **Fair outcomes and better experience** – providing fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost. We will continue to improve and innovate our processes to deliver fair, compassionate, and efficient resolution.

- **Learning, insight and system improvement** – making effective use of our unique data and insights so that learning from harm and the response to harm is used to support system-wide improvement and safer care.

- **Maternity and neonatal safety** – strengthening support for families by improving processes for obtaining compensation, and contributing insights and analysis that support greater assurance, consistency, learning and improvement in maternity and neonatal care.

Underpinning this, we also ensure our services are delivering value for money through strong financial stewardship, transparency, and effective governance, while continuing to build the systems, skills, and partnerships needed to support delivery now and in the future.

The risks we face

During the year, our risk profile changed in response to external policy developments, the delivery of transformation programmes, and emerging areas of uncertainty. While transformation activity introduces short-term operational and performance risks, it is a necessary component of delivering our strategy and improving services over the longer term. We have experience of delivering change and managing associated risks, supported by established governance, oversight and organisational learning.

Some risks increased in significance or required enhanced oversight during the year, particularly those linked to transformation and the external environment, while others are expected to reduce as planned mitigations take effect. Across all areas, risks are actively identified, monitored and managed through established governance arrangements to support delivery of our strategic objectives.

The Board sets our risk appetite and oversees the management of principal risks through established governance arrangements. Further detail on our risk management framework and system of internal control is set out in the 'Governance statement' within the 'Corporate governance report'.

External policy and regulatory environment

There is a risk that changes in the national policy and regulatory environment could change our organisational priorities, delivery plans, and resource allocation.

We operate within a dynamic national policy and regulatory environment, shaped by the cost of clinical negligence (as detailed below), and ongoing focus on patient safety, quality, and accountability across the health and care system.

We actively manage this risk through proactive horizon scanning, close engagement with system partners, and structured oversight through our governance arrangements. We maintain a close working relationship with DHSC, providing technical advice and constructive challenge where appropriate, and ensuring we are well-placed to anticipate, influence, and respond to policy developments.

This remains an area of ongoing change requiring continued attention as the external environment evolves.

Clinical negligence costs

There is a risk that clinical negligence claims could continue to rise.

As discussed in the Chair and Chief Executive's welcome, the cost of resolving clinical negligence claims remains substantial and continues to increase, reflecting long-term trends across the system.

This creates ongoing pressure on scheme expenditure, forecasting, and the level of provisions held, increasing the importance of rigorous financial governance and oversight.

We work to ensure claims are resolved fairly and in line with the legal framework, while maintaining rigorous oversight of expenditure to support value for money.

We actively identify and pursue opportunities within our direct control to manage cost pressures, supported by strong financial governance, regular monitoring, and escalation where required.

During 2025/26, the transition to CaseHub temporarily increased operational complexity (as detailed below). This was mitigated through enhanced management attention and staff resilience. As CaseHub continues to stabilise and embed, we expect this risk to reduce over time.

Operational disruption during business transformation

As with any transformation programme, there is a risk that the transition to new ways of working could affect operational efficiency and our ability to maintain service performance during periods of change.

In 2025/26 this resulted in short-term pressures and operational challenges as we moved our Claims Management System to CaseHub.

We actively manage the risk through structured programme governance, clear accountability, and ongoing oversight by the Senior Management Team and the Board. Transformation activity is carefully sequenced to maintain service stability, and while some implementation related risks are expected to reduce as programmes move into business as usual, ongoing risks remain during the period of system stabilisation and embedding, requiring continued oversight and management.

Identification and escalation of patient safety concerns

There is a risk that limitations in the timeliness, completeness, and nature of the information available to us could delay the identification and escalation of significant patient safety or public protection concerns.

In particular, indemnity scheme claims may take many years to be reported to us and will represent only a fraction of incidents that occur across the NHS. As a result, it may not become apparent for some time that there are emerging or systemic risks to patient safety or public protection.

We actively manage this risk through established frameworks and controls, including the Significant Concerns Framework, which supports the appropriate identification, handling, and escalation of sensitive information.

For more on this, see ‘Managing and enhancing operational delivery’ in ‘Strategic priority one: Fair resolution’ in the ‘Performance analysis’.

Governance and use of artificial intelligence (AI)

We are exploring the use of AI and other digital tools to drive efficiencies and enhance our processes, always taking a balanced approach that respects data sensitivity and aligns with government guidelines. For examples, see ‘Managing and enhancing operational delivery’ in ‘Strategic priority one: Fair resolution’ in the ‘Performance analysis’.

Using AI has clear benefits for enhancing productivity, however, it also introduces governance, ethical, and data-protection considerations.

In addition, the increasing use of AI by external users may create new demands on our services and ways of working.

This is an emerging area of risk that we are actively considering and will assess further during 2026/27 including reviewing the scale and nature of AI use, the adequacy of existing policies and controls, and whether additional governance, oversight or assurance arrangements are required within our risk management framework.

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 administers on behalf of the Secretary of State for Health and Social Care (as per Regulations) 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 negligence schemes for the NHS, to be managed within 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 the liabilities falling due 12 months from the reporting date.

Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements for the year ended 31 March 2026.

Performance summary

Infographic 5: Key highlights against our three strategic priorities

Strategic priority one: Fair resolution

84% clinical claims kept out of formal court proceedings, providing earlier resolution for patients and healthcare staff, and saving costs.

15,236 new clinical negligence claims and reported incidents received.

11,841 clinical claims resolved (reached settlement about the payment or non-payment of damages).

10,047 clinical claims for compensation closed (all elements agreed and paid).

383 new primary care contracting appeal and dispute cases received.

354 primary care contracting appeal and dispute cases closed.

1,576 new and reopened requests for advice received from healthcare organisations with concerns about the practice of individual practitioners as well as services.

Strategic priority two: Data and insights

Published two major reports on high impact areas relating to patient harm that reflect national priorities: Delayed Diagnosis of Cancer and Learning From Obstetric Anal Sphincter Injury Claims Within the NHS in England, alongside three new Insights papers and supporting resources drawing on our unique data and insights.

Worked in partnership with royal colleges, arm's length bodies, regulators, and professional bodies, and engaged with patient safety networks to address a range of clinical and systems issues.

Worked with educational bodies to develop education curricula.

Delivered **1,029** engagements across all five regions in England, reaching front line clinicians and supporting the use of claims data as a catalyst for improvement.

Delivered **57** educational workshops to **880** delegates, sharing learning derived from Practitioner Performance Advice casework and promoting the embedding of good practice.

Strategic priority three: Maternity and neonatal care

Published a landmark evaluation of the MIS, with independent input from THIS Institute.

Worked with cross-system partners to significantly refresh MIS Year 8, reflecting feedback from the evaluation and wider system.

90% NHS hospital trusts delivering maternity and neonatal care in England were fully compliant with all elements of the Year 7 MIS (pending any appeals submissions).

Delivered **10** Board reporting and governance workshops.

115 cases received through our EN scheme.

Further developed our family resources to ensure a more personalised approach.

Launched an EN scheme FutureNHS workspace to support collaboration and share resources and updates on scheme developments.

Published case stories, identifying learning generated from EN cases.

Worked with trusts to help them analyse their data in relation to health inequalities in maternity claims.

The year in review

Strategic priority one: Fair resolution

2025/26 saw the transition from our legacy Claims Management System to our new system, CaseHub. This represented a significant organisational change and brought operational challenges that are reflected in some of our numbers. Throughout, we focused on the needs of harmed patients and their families. Continuing the trend from previous years, our Practitioner Performance Advice service saw an increase in the number of requests for case advice and our Primary Care Appeals service saw an increase in the number of appeal and dispute cases.

In 2025/26, 84% of clinical claims were kept out of formal court proceedings, which reflects the success of our first strategic priority and the hard work and continued efforts of all staff and stakeholders to support collaborative working.

We received 15,236 new clinical negligence claims and reported incidents, an increase of 6% on 2024/25. This included the largest volume of Clinical Negligence Scheme for Trusts (CNST) claims we have ever received.

We resolved 11,841 clinical claims, a decrease of 11% on 2024/25.

We closed 10,047 clinical claims for compensation, a decrease of 30% on 2024/25.

Both these decreases are linked to the transition to CaseHub, which had a short-term impact in relation to the day-to-day management of claims. Our focus throughout was on minimising the impact for patients and their families.

We received 1,576 new and reopened requests for advice from healthcare organisations with concerns about the practice of individual practitioners as well as services, an 11% increase on 2024/25. To meet this sustained increase in demand, our Practitioner Performance Advice service is strengthening its capabilities.

We received 383 new primary care contracting appeal and dispute cases and closed 354 cases. This compares with 361 and 278 cases respectively in 2024/25.

For a full description of our performance against this strategic priority, see ‘Strategic priority one: Fair resolution’ in the ‘Performance analysis’.

Strategic priority two: Data and insights

Our remit means we hold a uniquely important role in the patient safety landscape. In 2025/26, we continued to work in partnership with others in the health system to ensure the lessons held in our data are shared as widely as possible. We have also further focused on making sure we collectively prioritise and rigorously test the work we do. By doing this, we can be sure our work continues to add value, contributes towards improvement, and gives staff the practical tools they need to implement necessary change.

Reflecting national priorities, we published two major reports on high-impact areas of patient harm: Delayed Diagnosis of Cancer: A Thematic Review of General Practice Indemnity Claims[1] and Learning From Obstetric Anal Sphincter Injury claims within the NHS in England: A Thematic Review[2], which was produced in collaboration with the Royal College of Obstetricians & Gynaecologists (RCOG).

We published three new Insights papers and a range of supporting resources (see infographic 9 under 'Supporting organisations to manage concerns' in 'Strategic priority two: Data and insights' in the 'Performance analysis'), drawing on claims data to support learning across the health system.

We worked in partnership with NHS England and Loughborough University to develop the Patient Safety Syllabus for patient safety specialists and investigators.

We delivered 1,029 engagement sessions using claims data to support learning and improvement, with an estimated reach of more than 25,000 people.

We delivered 57 educational workshops attended by 880 delegates, sharing learning derived from Practitioner Performance Advice casework.

For a full description of performance against this strategic priority, see 'Strategic priority two: Data and insights' in the 'Performance analysis'.

[1] resolution.nhs.uk/resources/delayed-diagnosis-of-cancer-a-thematic-review-of-general-practice-indemnity-claims/
[2] resolution.nhs.uk/resources/learning-from-obstetric-anal-sphincter-injury-claims-within-the-nhs-in-england-a-thematic-review/

Strategic priority three: Maternity and neonatal care

2025/26 has been a year of deep reflection and reform. The evaluation of the MIS was published, providing vital insight that supported work to refine and develop the scheme for Year 8, working with cross-system partners to maximise the scheme's effectiveness in supporting maternity and neonatal safety improvements. We look forward to sharing the findings from the EN scheme evaluation, which is due for publication in 2026/27.

All NHS hospital trusts delivering maternity and neonatal care in England participated in Year 7 of the MIS. At least 90% were found to be fully compliant with all elements of the MIS (pending any appeals submissions). This is the highest compliance since establishing the scheme.

We continued to deliver the Board reporting and governance workshops to support Boards and senior teams in their assurance and governance responsibilities, as recognised through the MIS.

We received 115 cases through our EN scheme and continue to develop our family resources to ensure a more personalised approach, including providing letters translated into different languages and easy-read formats.

We launched an EN scheme FutureNHS workspace to support collaboration and share resources and updates on scheme developments. (See 'Strategic priority two: Data and insights' in the 'Performance analysis' for more information on our engagement with the FutureNHS platform.)

We also worked with trusts to help them analyse their data in relation to health inequalities in maternity claims by supporting them to triangulate claims scorecard data with locally held data to identify possible disparities.

For a full description of our performance against this strategic priority, see 'Strategic priority three: Maternity and neonatal care' in the 'Performance analysis'.

The year in numbers

Table 1: The finance year in numbers

Financial element	2025/26 (£ million)	2024/25 (£ million)	Change (£ million)	(%)	
Payments in respect of clinical schemes					
Damages payments to claimants	**2,427.9**	2,286.7	141.2	6.2%	↑
Claimant legal costs	**622.2**	620.9	1.3	0.2%	↑
NHS legal costs	**188.4**	181.3	7.1	3.9%	↑
Total clinical scheme payments	**3,238.5**	**3,088.9**	**149.6**	**4.8%**	↑
Payments in respect of non-clinical schemes					
Damages payments to claimants	**29.8**	23.4	6.4	27.4%	↑
Claimant legal costs	**17.5**	14.5	3.0	20.7%	↑
NHS legal costs	**7.7**	7.1	0.6	8.5%	↑
Total non-clinical scheme payments	**55.0**	**45.0**	**10.0**	**22.2%**	↑
NHS Resolution administration costs					
Clinical schemes administration	**62.2**	55.7	6.5	11.7%	↑
Non-clinical schemes administration	**9.3**	7.7	1.6	20.8%	↑
Other activities	**8.8**	8.3	0.5	6.0%	↑
Total administration expenditure	**80.3**	**71.7**	**8.6**	**12.0%**	↑
Cost of harm[1] incurred in the financial year					
• CNST	**4,460.3**	4,585.7	(125.4)	(2.7%)	↓
• GPI	**323.5**	293.1	30.4	10.4%	↑
• Other schemes	**45.9**	40.5	5.4	13.5%	↑
Total cost of harm incurred	**4,829.7**	**4,919.3**	**(89.6)**	**(1.8%)**	↓
Provisions for claims	**60,259.1**	**60,326.1**	**(67.0)**	**(0.1%)**	↓
Headcount	**2025/26**	**2024/25**	**Change**	**(%)**	
Average staff numbers (full-time equivalent)	**832**	**778**	**54**	**6.9%**	↑

For a full insight into the finance year in numbers, see the 'Finance report' in 'Performance analysis' and the 'Financial statements', including the 'Notes to the financial statements'. (Note, figures are subject to rounding differences when compared to other sections of this report.)

[1] The claims cost of harm above differs slightly to the Statement of Comprehensive Net Expenditure and Provisions (see 'Note 2.1' in the 'Notes to the financial statements') due to payments made on incidents arising in the year, the difference is not material due to the time lags involved.

Table 2: Claims – year in numbers[1]

Claims element	2025/26	2024/25	Change	(%)	
Notified claims for clinical schemes					
Clinical Negligence Scheme for Trusts (CNST)	12,001	11,396	605	5.3%	↑
Clinical Negligence Scheme for General Practice (CNSGP)	3,091	2,575	516	20.0%	↑
Clinical Negligence Scheme for Coronavirus (CNSC)	2	8	(6)	(75.0%)	↓
Existing Liabilities Scheme for General Practice (ELSGP)	70	341	(271)	(79.5%)	↓
DHSC Funded Schemes (Existing Liabilities Scheme (ELS), Ex-Regional Health Authority Scheme, and DHSC Clinical)	72	108	(36)	(33.3%)	↓
Total clinical schemes	**15,236**	**14,428**	**808**	**5.6%**	↑
Notified claims for non-clinical schemes					
Liabilities to Third Parties Scheme (LTPS)	3,151	3,068	83	2.7%	↑
DH Liabilities (DHSC Non-clinical)	11	11	0	0.0%	→
Property Expenses Schemes (PES)	71	43	28	65.1%	↑
Total non-clinical schemes	**3,233**	**3,122**	**111**	**3.6%**	↑
Resolved for clinical schemes					
CNST	9,280	10,304	(1,024)	(9.9%)	↓
CNSGP	2,139	2,262	(123)	(5.4%)	↓
CNSC	10	22	(12)	(54.5%)	↓
ELSGP	346	652	(306)	(46.9%)	↓
DHSC Funded Schemes	66	89	(23)	(25.8%)	↓
Total clinical schemes	**11,841**	**13,329**	**(1,488)**	**(11.2%)**	↓
Resolved for non-clinical schemes					
LTPS	3,016	3,229	(213)	(6.6%)	↓
DHSC Liabilities	7	16	(9)	(56.3%)	↓
PES	49	39	10	25.6%	↑
Total non-clinical schemes	**3,072**	**3,284**	**(212)**	**(6.5%)**	↓
Closed for clinical schemes					
CNST	7,642	11,063	(3,421)	(30.9%)	↓
CNSGP	1,903	2,229	(326)	(14.6%)	↓
CNSC	11	17	(6)	(35.3%)	↓
ELSGP	391	878	(487)	(55.5%)	↓
DHSC Funded Schemes	100	244	(144)	(59.0%)	↓
Total clinical schemes	**10,047**	**14,431**	**(4,384)**	**(30.4%)**	↓
Closed for non-clinical schemes					
LTPS	3,149	3,394	(245)	(7.2%)	↓
DHSC Liabilities	7	20	(13)	(65.0%)	↓
PES	51	45	6	13.3%	↑
Total non-clinical schemes	**3,207**	**3,459**	**(252)**	**(7.3%)**	↓

For a full insight into these numbers, see 'Strategic priority one: Fair resolution' in the 'Performance analysis'.

[1] Details of each scheme are given in 'Our indemnity schemes' in the 'Appendix'.

Performance analysis

The performance analysis reflects on our performance against the key performance indicators and deliverables set out in our 2025/26 Business Plan[1].

[1] resolution.nhs.uk/corporate-publications/resolution-through-collaboration-2025-26-business-plan/

Key performance indicators

Our key performance indicators (KPIs) cover all areas of our operations and provide an objective assessment of our performance against our strategy.

Our KPIs are agreed and set annually by our Board and DHSC, a process that helps us continuously develop our services and ensure we maintain focus on the areas that matter most. We track each KPI throughout the year, identifying trends, monitoring variations, and making data-driven decisions, ultimately improving our strategic planning and risk management.

Unless otherwise stated, N/A indicates that the KPI was not in operation in that reporting year. Where a KPI was within tolerance, it means we were within 10% of the target figure and it has not impacted our ability to deliver against our strategic objectives.

Our KPIs provide high-level assurance to our Board and to DHSC that we are conducting our business as intended and for which we are funded.

Overall, annual KPI performance reflects sustained and effective delivery across the organisation, with most measures consistently achieved and strong performance evident across fair resolution, data and insights, maternity and neonatal care, and financial control.

	No.	Annual KPI	Area	2023/24		2024/25		2025/26		
				Actual	Target	Actual	Target	Actual	Target	Performance
Fair Resolution	1	Time to resolution from claims decision to agreement of damages (days)	Claims Management	397	401	417	401	536	417	Not directly comparable*
	2	Reduction in volume of cases that enter litigation before appropriate dispute resolution	Claims Management	4.50%	< 15%	5.30%	< 15%	3.80%	< 15%	Achieved
	3	80% of pharmacy appeals where decision maker agreed with recommendation of case manager	Primary Care Appeals	83%	80%	86%	80%	100%	80%	Achieved
	4	90% of Advice and other case interventions delivered within target timeframe	Practitioner Performance Advice	-	-	99%	90%	100%	90%	Achieved
	5	90% of all Exclusions/Suspensions critically reviewed (where due)	Practitioner Performance Advice	83%	90%	82%	90%	80%	90%	Not Achieved
	6	Reduction in the time from notification to a decision on entitlement to compensation on an Early Notification scheme case compared to a similar cerebral palsy case received via the traditional claims route	Claims Management	3.57 (Baseline)		3.24	≤ 3.57	3.22	≤ 3.24	Achieved
	7	Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative info	Organisation Wide	100%	100%	100%	100%	100%	100%	Achieved
		Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed)		100%	100%	100%	100%	100%	100%	Achieved
		Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way		67.0%	100%	100%	100%	100%	100%	Achieved
Data & Insights	8	Demonstrate engagement with the system to share learning products/services; respond to feedback on these; and review evidence of uptake/implementation	Safety and Learning	N/A	N/A	100%	90%	100%	90%	Achieved
	9	90% of delegates rate the workshops not less than 4 out of 5 for overall quality	Practitioner Performance Advice	N/A	N/A	100%	90%	97%	90%	Achieved
Maternity & Neonatal	10	EN clinical review within 30 days of acceptance within the Early Notification Scheme	Safety and Learning	N/A	N/A	100%	100%	98%	100%	Within tolerance
	11	Maternity Incentive Scheme reverification – 90% of reverification processes completed within their respective predefined timescales	Safety and Learning	N/A	N/A	95%	90%	98%	90%	Achieved
Finance	12	Management of budgets within net Departmental Expenditure Limits. Measured as income from members plus budget from DHSC vs expenditure	Finance	-2.20%	with 5% underspend	-0.50%	with 5% underspend	-0.54%	with 5% underspend	Achieved

*While reported time to resolution has increased over the period, figures for 2025/26 are not directly comparable with previous years due to the transition to CaseHub and changes in how case closures are managed in the system. For further commentary, see 'Fair resolution' below.

Fair resolution

Despite the temporary impacts from the transition to CaseHub, overall, the data demonstrates sustained improvement across key fair resolution and financial KPIs over the three-year period.

The proportion of cases entering litigation before appropriate dispute resolution (KPI 2) remains consistently well below the <15% target, improving further to 3.8% in 2025/26, reflecting effective early resolution and dispute avoidance.

Performance across decision making, timeliness and quality-related measures has strengthened year on year, with pharmacy appeal decisions (KPI 3) and, advice interventions (KPI 4) delivered within target timeframes, and all Significant Concerns Group measures achieving their targets in 2025/26.

Decision making on EN scheme cases (KPI 6) has continued to improve, with time to entitlement decisions reducing to 3.22, meeting the required threshold.

Time to resolution (KPI 1) increased in 2025/26, but this is not directly comparable with prior years following the transition to CaseHub and changes in how case closures are managed in the system. While rolling out the new system, the focus has been on minimising the impact for patients and their families, rather than the day-to-day administration of claims.

The only area where the target was not achieved relates to the critical review of exclusions and suspensions (KPI 5), which continues to be monitored and addressed. 2025/26 ended on 80%, with 193 of 241 exclusions/suspensions reviewed within the required timescales.

Performance against this KPI has in part been impacted by frontline pressures experienced by employing or contracting organisations which can delay the timing of review discussions with the Practitioner Performance Advice service. In some instances, it is not feasible 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.

The Practitioner Performance Advice service has taken steps to strengthen our approach to critically review such cases, ensuring active management and monitoring.

Data and insights

Engagement with system partners and the application of learning has been consistently strong, with full achievement against targets to share learning products and services, respond to feedback, and evidence subsequent updates or improvements (KPI 8).

Delivery quality remains high, with delegate feedback demonstrating sustained satisfaction with Practitioner Performance Advice workshops; 97% of attendees rated workshops at least 4 out of 5 for overall quality in 2025/26, exceeding the 90% target (KPI 9).

Collectively, these measures evidence effective learning, continuous improvement, and a strong focus on practitioner experience.

Maternity and neonatal care

Performance against maternity and neonatal care KPIs has been consistently high, with all measures fully achieved, or met within tolerance in 2025/26.

98% EN clinical reviews were completed within 30 days of receipt of the required documentation, maintaining full compliance with the target (KPI 10).

Delivery of the MIS reverification process has continued to improve, with 98% of reverifications completed within agreed timescales in 2025/26, exceeding the 90% target and reflecting robust oversight and effective operational processes (KPI 11).

Finance

Financial performance against the Departmental Expenditure Limit (DEL) has remained within required tolerances across the three-year period (KPI 12).

In 2025/26, expenditure continued to be managed within the agreed limits, delivering a 0.5% underspend against DEL and achieving the target of operating within a 5% underspend.

This reflects continued effective financial control and disciplined budget management.

Business Plan objectives 2025/26

Our 2025/26 Business Plan objectives set out the specific commitments through which we delivered the first year of our three-year strategy, Resolution Through Collaboration. The objectives reflect the organisation's statutory role, strategic priorities, and the operating environment. They cover all major areas of NHS Resolution's activity, including fair resolution, data and insights, maternity and neonatal care, and enabling corporate activity.

The Business Plan is developed by NHS Resolution's Senior Management Team and is agreed annually by the Board, in line with our governance and accountability arrangements and in discussion with the DHSC. Once approved, the Business Plan provides the authoritative statement of the organisation's delivery commitments for the year and forms the basis for performance monitoring and assurance.

The table below summarises delivery of the 2025/26 Business Plan commitments. It signposts to supporting evidence within the report to provide a line of sight between planned activity and status of delivery.

Strategic priority	No.	Business Plan objective	Area	Status	Further information in the Performance analysis
Fair resolution	1	Implement effective processes to manage any changes in the legal market	Claims Management	Achieved	Managing our processes
	2	Procure a new legal panel framework	Claims Management	Paused	Managing our processes
	3	Deliver a range of dispute resolution options including resolution meetings, mediation, early neutral evaluation, and stock takes	Claims Management	Achieved	Our approach to dispute resolution
	4	Provide prompt and fair resolution of appeals and disputes between primary care contractors, or those wishing to provide primary care services, and the commissioners of primary care services	Primary Care Appeals	Achieved	Resolving primary care contracting disputes and appeals
	5	Deliver resources and training to our key stakeholders to build capacity for fair resolution and continue to respond to changing casework requirements	Primary Care Appeals	Achieved	Resolving primary care contracting disputes and appeals
	6	Deliver a consistently excellent case advice service, PLR applicant check process and HPAN scheme	Practitioner Performance Advice	Achieved	Providing practitioner performance advice
	7	Deliver an assessment and intervention service that facilitates opportunities for reflective practice and behaviour change	Practitioner Performance Advice	Achieved	Providing practitioner performance advice
	8	Invite senior healthcare leaders to join a reference group to inform service development	Practitioner Performance Advice	Achieved	Providing practitioner performance advice
	11	Deliver the next phase of our Claims Evolution Programme, using our expert workforce more effectively to reduce the amount we spend on external lawyers.	Claims Management	In progress	Managing and enhancing operational delivery
	12	Further modernise our operations, including the implementation of SharePoint	Organisation wide	In progress	Managing and enhancing operational delivery
	13	Explore how technology such as our new system, CaseHub, could enable future process efficiencies	Organisation wide	In progress	Managing and enhancing operational delivery
	14	Continue to operate and continuously improve our framework to manage concerns referred to our Significant Concerns Group	Organisation wide	Achieved	Managing and enhancing operational delivery

Data and Insights	9	Support the sharing of our data and insights by migrating our Claims Management and Appeals services to CaseHub	Organisation wide	In progress	Managing and enhancing operational delivery
	10	Enable and support a programme of continuous improvement and the further development of CaseHub	Organisation wide	Achieved	Managing and enhancing operational delivery
	15	Work closely with the DHSC, other Government departments, and other arm's length bodies, contributing our data and expertise	Organisation wide	Achieved	Strategic priority two: Data and insights
	16	Work with stakeholders at every level to improve the system-wide response to harm and ensure that options for patients are clearly explained	Organisation wide	Achieved	Working with stakeholders to improve the system-wide response to harm
	17	Deliver evidence driven expert views and practical tools through Advice insights and education programmes	Practitioner Performance Advice	Achieved	Supporting organisations to manage concerns
Maternity and neonatal care	18	Work collaboratively with partner organisations who contribute to the delivery of safe maternity and neonatal care	Safety and Learning	Achieved	Contributing to system-wide work to improve maternity and neonatal care
	19	Support a just and learning culture in maternity and neonatal services	Safety and Learning	Achieved	Contributing to system-wide work to improve maternity and neonatal care
	20	Support cross-system action to tackle maternal and neonatal health inequalities	Safety and Learning	Achieved	Contributing to system-wide work to improve maternity and neonatal care
	21	Continue to offer our maternity team reviews via our Practitioner Performance Advice service	Practitioner Performance Advice	Achieved	Contributing to system-wide work to improve maternity and neonatal care
	22	Deliver timely investigations and fair support and compensation to harmed individuals where negligence has caused the harm	Claims Management	Achieved	The Early Notification scheme
	23	Complete the formal evaluation of the EN scheme in collaboration with THIS Institute	Safety and Learning	In progress	Evaluating and enhancing the EN scheme
	24	Continue to deliver and continuously improve the EN scheme	Safety and Learning	Achieved	Evaluating and enhancing the EN scheme
	25	Collaborate with stakeholders to further develop the EN scheme	Safety and Learning	Achieved	Evaluating and enhancing the EN scheme
	26	Continue to deliver and improve the Maternity (Perinatal) Incentive Scheme (MIS) and complete its formal evaluation in collaboration with THIS Institute	Safety and Learning	Achieved	Evaluating and enhancing the MIS

Strategic priority one: Fair resolution

Our first strategic priority is fair resolution. All of our services focus on fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost.

In 2025/26 we have, once again, kept a record number of cases out of formal processes, reflecting the ongoing strength of our commitment to fair resolution that avoids the cost and distress of litigation and the hard work of our staff and external partners in ensuring we continue to deliver on this commitment.

Managing negligence claims

The claims journey

The time lag between a clinical incident occurring and a claim being reported to us means we do not have a complete 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. The portfolio does not reflect all clinical incidents that have occurred across the NHS, only those that result in a claim.

On average, there are three years between a clinical incident occurring and a claim being reported to us.

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.

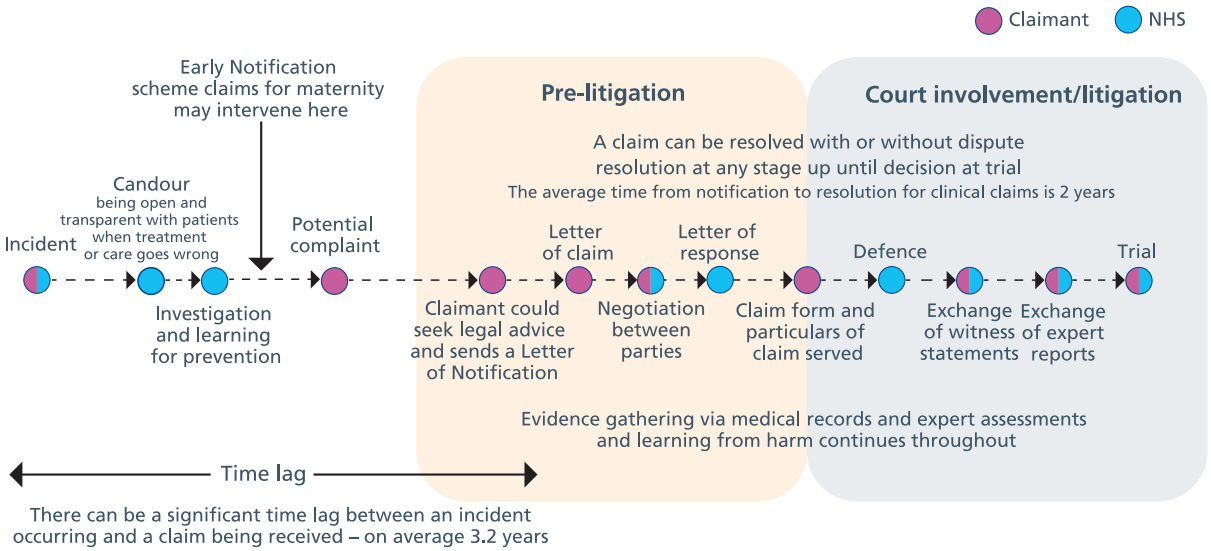
Once a patient or family member decides to make a claim there are several procedural and investigative stages to be undertaken before a decision can be made on liability.

Multiple factors have the potential to increase the time it takes to reach a resolution, including issues in the justice system. In the healthcare system, the prioritisation of frontline care can also restrict the availability of clinicians to provide expert advice.

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. To ensure this time is kept to a minimum, we monitor the length of time between a claim decision being made and damages being agreed as our first key performance indicator.

The clinical claims journey is illustrated in infographic 6.

Infographic 6: The clinical claims journey[1]



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 that 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).

Reported claims and incidents

Reported clinical claims and incidents

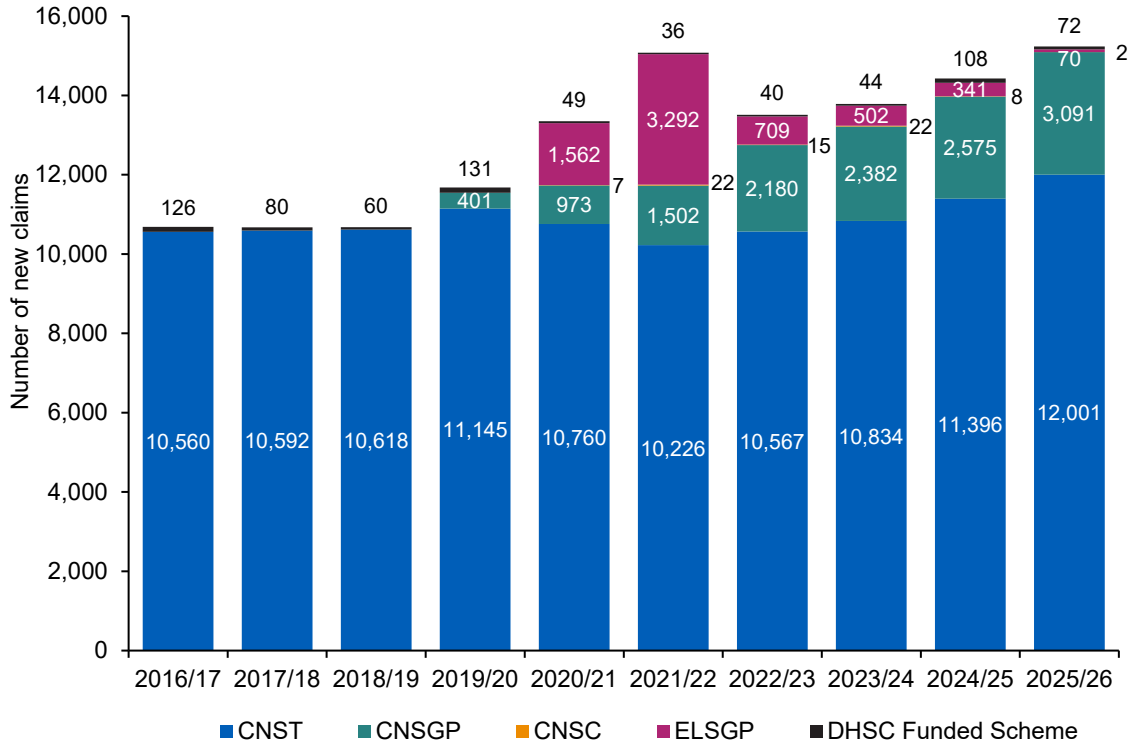
As figure 1 shows, we received 15,236 new clinical negligence claims and reported incidents in 2025/26, compared with 14,428 in 2024/25.

There were:

- 605 more Clinical Negligence Scheme for Trusts (CNST) claims (12,001 in 2025/26 compared with 11,396 in 2024/25), an increase of 5% compared with 2024/25;
- 516 more Clinical Negligence Scheme for General Practice (CNSGP) claims (3,091 in 2025/26 compared with 2,575 in 2024/25), an increase of 20% compared with 2024/25; and
- 271 fewer Existing Liabilities Scheme for General Practice (ELSGP) claims (70 in 2025/26 compared with 341 in 2024/25), a decrease of 80% compared with 2024/25.

[1] Timescales in this infographic are an average across all clinical schemes (excluding ELSGP because of a bulk migration of claims in 2021/22 – see 'Reported clinical claims and incidents').

Figure 1: The total number of new clinical claims and incidents reported in each financial year from 2016/17 to 2025/26



The volume of new CNST claims is the largest we have ever received.

As context, NHS activity (with reference to finished consultant episode volumes) has increased since the pandemic: by 5% In 2022/23 and 10% in 23/24. Linked to the recognised time lag between incident and claim notification (as explained in infographic 6: The clinical claims journey), claims volumes in 2025/26 may be influenced by increased NHS activity. For example, of the emergency medicine claims reported in 2025/26, 49% arose from incidents occurring in 2022/23 and 2023/24.

CNSGP covers clinical negligence liabilities in relation to incidents that occurred on or after 1 April 2019. The 20% increase is larger than the 8% increase we saw in 2024/25 and reflects the fluctuations in numbers we would expect as the scheme matures. We expect numbers to stabilise over time as the scheme reaches maturity.

What do we mean by scheme maturity?

Scheme maturity describes the point at which an indemnity scheme moves from its initial implementation phase to a more stable pattern of claim reporting. In the early years of a scheme, claim volumes may fluctuate or increase as incidents occurring after the scheme begin to be reported, often following a delay of several years, and as awareness and reporting pathways become established. As the scheme matures, these effects reduce and claim volumes begin to reflect underlying activity more consistently, enabling more meaningful interpretation of longer-term trends.

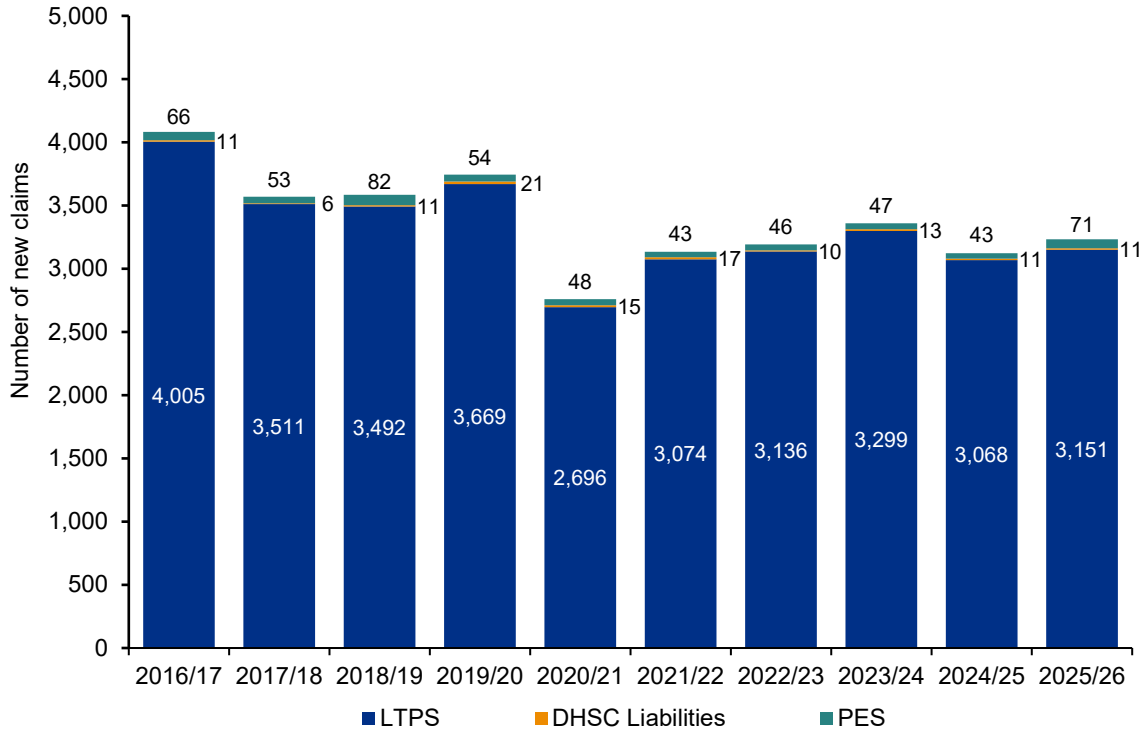
The reduction in ELSGP claims is in line with what we would expect. The scheme provides indemnity cover in respect of liabilities incurred before 1 April 2019 and so we expect numbers to reduce over time as fewer new claims for incidents before that date are reported (as explained in infographic 6: The clinical claims journey). Reported numbers in 2021/22 were particularly high due to the bulk migration of 2,005 claims from the Medical Protection Society. (For more information on this, see our Annual Report and Accounts 2022/23[1].)

[1] resolution.nhs.uk/wp-content/uploads/2023/07/4405-NHSR-Annual-Report-and-Accounts_Rollout_A_Access2.pdf

Reported non-clinical claims and incidents

In the Liabilities to Third Parties Scheme (LTPS), which covers non-clinical claims such as public and employers' liability, we received 3,151 claims in 2025/26 compared with 3,068 claims in 2024/25, an increase of 3%. These numbers, along with numbers from our other non-clinical schemes, are shown in figure 2.

Figure 2: The total number of new non-clinical claims and incidents reported in each financial year from 2016/17 to 2025/26



Categories of clinical claim

Largest categories of claim

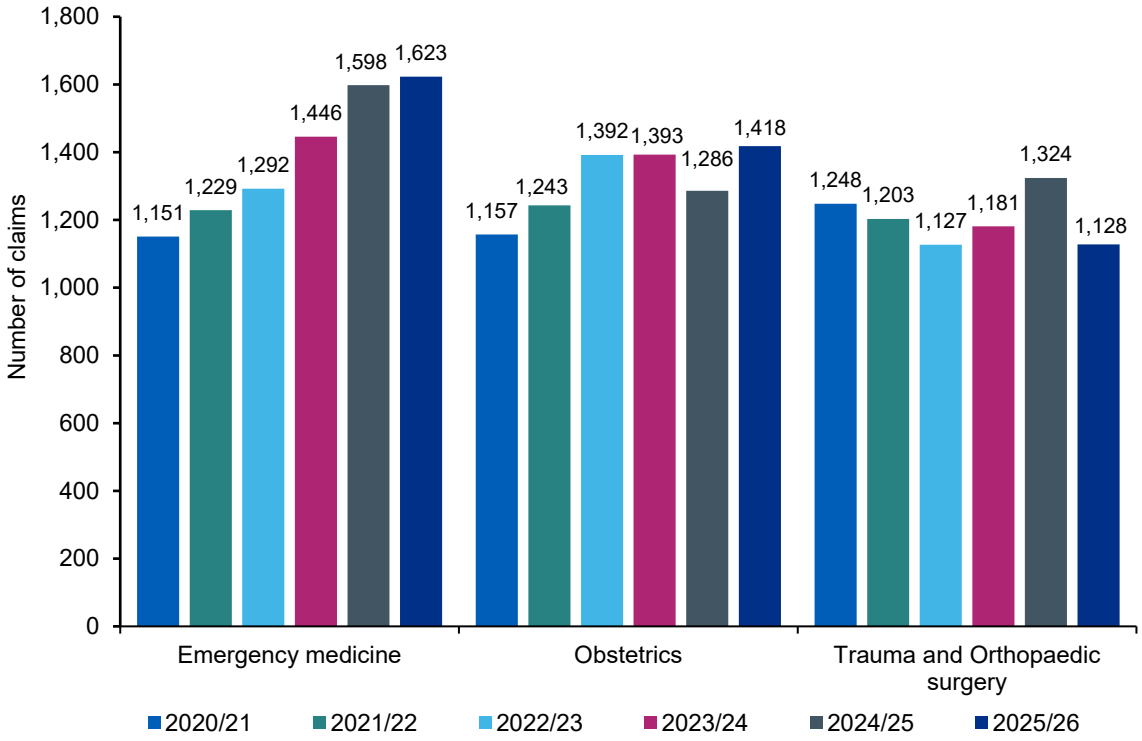
Figure 3 shows the largest three categories of newly-reported clinical claim numbers (excluding General Practice Indemnity (GPI)) by specialty in 2025/26: emergency medicine, obstetrics, and trauma and orthopaedic surgery.

As in the past two financial years, emergency medicine is the largest specialty by volume. We are seeing numbers in this specialty increase year on year, from 1,228 in 2021/22 to 1,623 in 2025/26, accounting for a significant proportion of the overall increase in CNST claims in that time.

Since April 2017, when the EN scheme was first launched, we now receive notification of EN incidents earlier than would have been expected if the scheme hadn't been in place. This year we have seen an increase in reported obstetrics claims compared with last year. This is against a backdrop of a rising volume of claims overall and the percentage increase in reported obstetric cases since 2021/22 is smaller than the increase in clinical claims (excluding GPI) overall (14% compared with 17%).

For more information on EN claims in 2025/26, see 'Strategic priority three: Maternity and neonatal care' in the 'Performance analysis'.

Figure 3: The top three categories of clinical negligence claims (excluding GPI) reported in each financial year between 2020/21 and 2025/26[1]



Covid-19 related claims

We are not reporting Covid-19 claims this year. The number of claims we have received has reduced this year in line with what we would expect given the passage of time (as explained in infographic 6: The clinical claims journey). We are continuing to progress all Covid-19 related claims in the same way we progress any other claim.

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. We refer to these simplified processes as gateways.

The aim of the gateways is to manage the procedure for reporting and investigating claims without the need for litigation. Our assessment and investigation processes into any claims are not substantively different from any other negligence claim.

In 2025/26, we received 21 claims via the vaginal mesh gateway and nine claims via the sodium valproate gateway. Claims in relation to vaginal mesh and sodium valproate have also been received and progressed through regular claims management arrangements during 2025/26.

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

Resolved claims

- KPI 1: Time to resolution from claims decision to agreement of damages

We monitor the time it takes to move from a claim decision being reached to the agreement of damages as KPI 1. The time to resolution has increased this year. This is linked to the transition to CaseHub, which measures closure rates differently to our previous case management system, along with some short-term disruptions caused by migration to the new system. Our focus throughout was on minimising the impact for patients and their families rather than day-to-day administration activities.

What are damages?

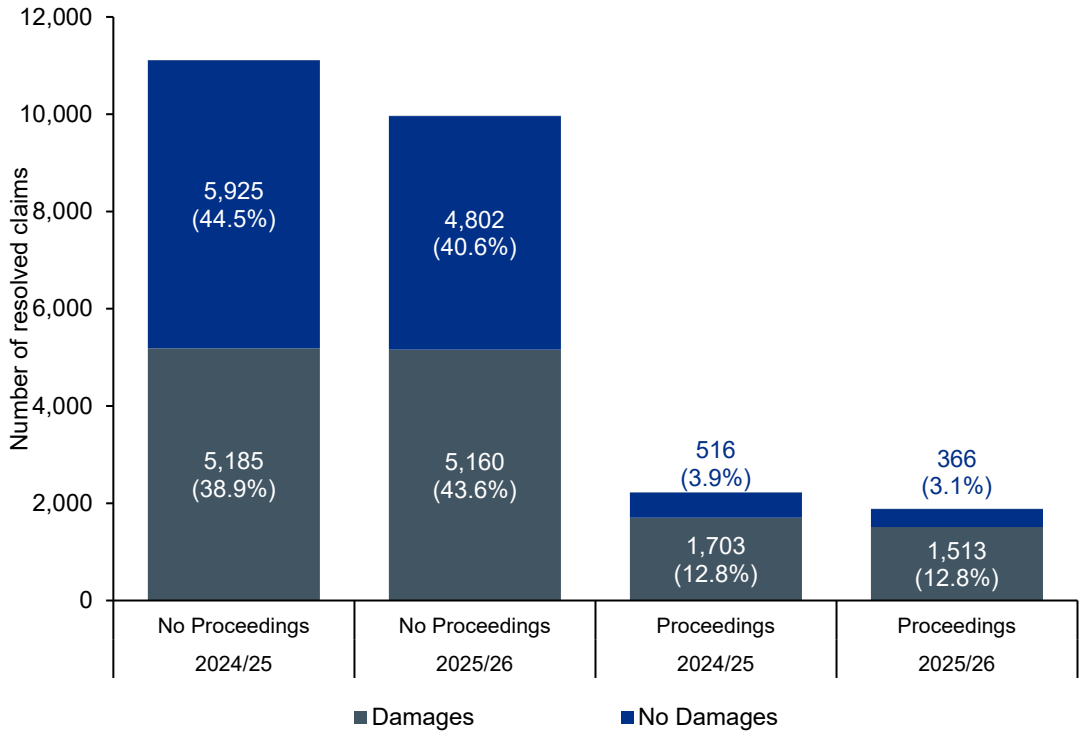
Damages is another term for compensation and can include general damages and special damages. General damages is compensation for both the pain suffered and impact on quality of life (usually referred to as loss of amenity incurred). Special damages is compensation for any additional losses incurred,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

Resolved clinical claims

As figure 4 shows, the total number of clinical claims that were resolved in 2025/26 decreased to 11,841 from 13,329 in 2024/25 (a decrease of 11%). The decrease relates to the transition to CaseHub.

Of these claims, 56% resulted in a payment of damages, an increase from 52% in 2024/25. There was a payment of damages on 6,673 claims in 2025/26 compared with 6,888 claims in 2024/25. These figures demonstrate our continued commitment to investigating claims robustly and fairly, even in a year of operational challenges, and to ensuring that damages are paid where it is right to do so.

Figure 4: The number of clinical claims resolved in 2024/25 compared with 2025/26, by settlement type, and with or without damages

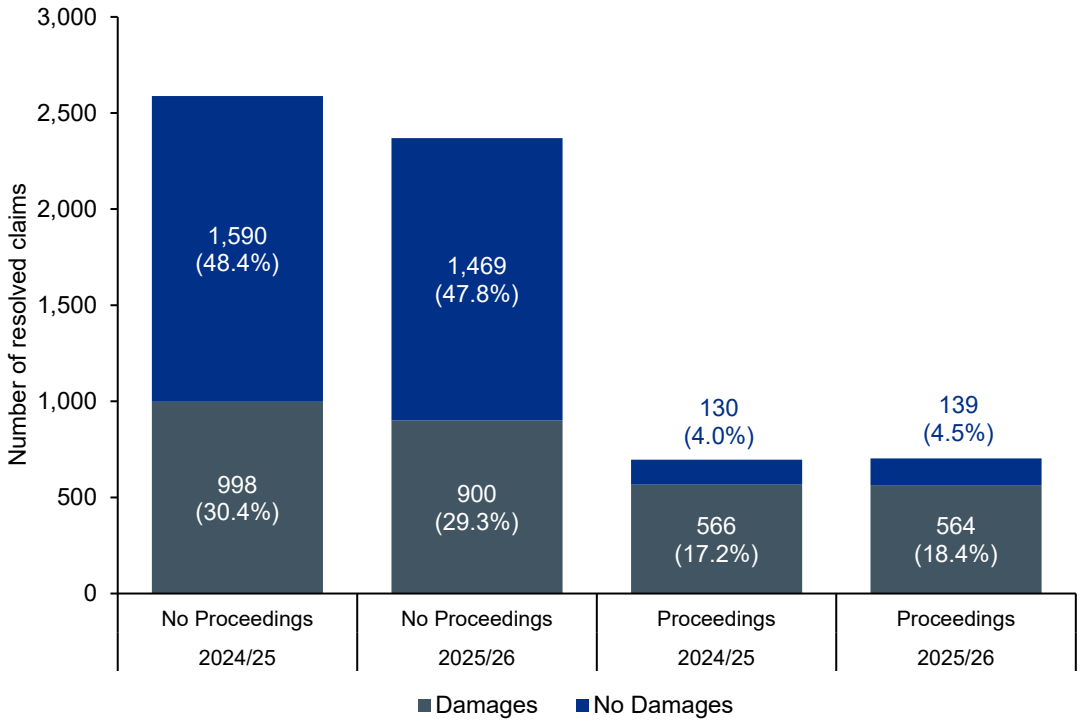


Resolved non-clinical claims

As figure 5 shows, the total number of non-clinical claims that resolved in 2025/26 decreased to 3,072 from 3,284 in 2024/25 (a decrease of 6%). The number of resolved cases will fluctuate year on year depending on the portfolio of cases investigated and we do not see this small decrease as a trend or pattern of concern.

Of these claims, 48% resulted in a payment of damages, compared to 48% in 2024/25. There was a payment of damages on 1,464 claims in 2025/26 compared with 1,564 claims in 2024/25. These figures again demonstrate our continued commitment to investigating claims robustly and fairly, and to always ensuring that damages payments are made where the merits of the case warrant it.

Figure 5: The number of non-clinical claims resolved in 2024/25 compared with 2025/26, by settlement type, and with or without damages



Litigation rate

- KPI 2: Reduction in volume of cases that enter litigation before appropriate dispute resolution

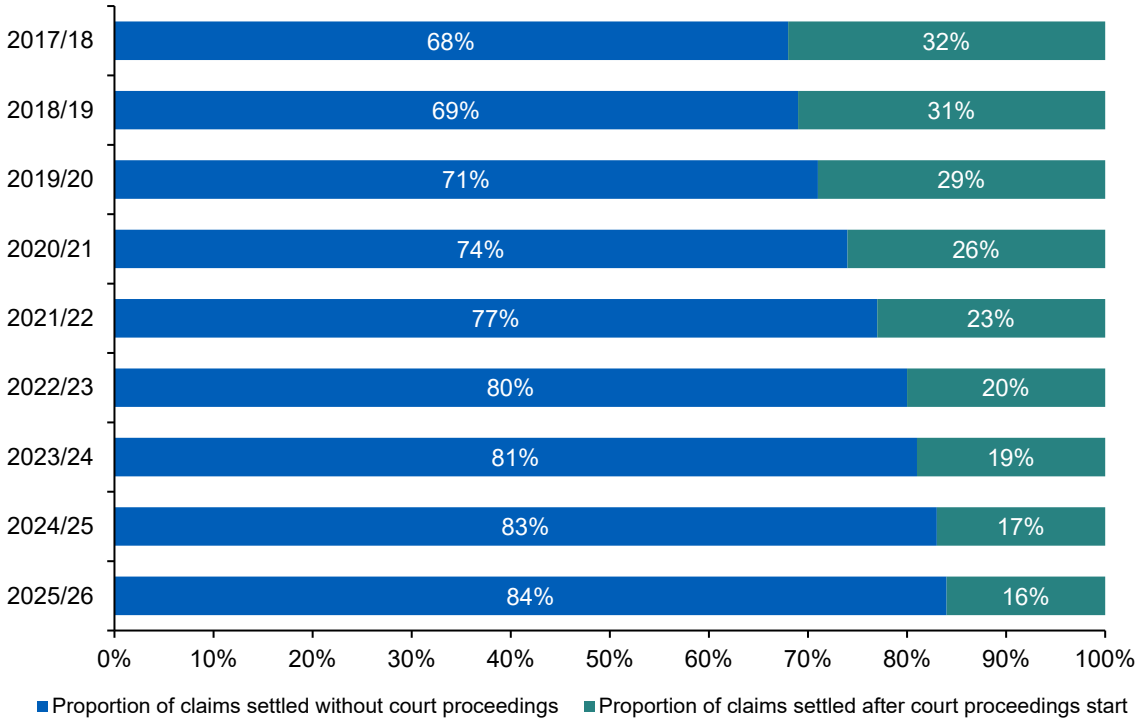
As figure 6 illustrates, 84% of clinical claims were resolved without litigation in 2025/26 (compared with 83% in 2024/25).

In a year affected by operational challenges, this continued increase reflects the ongoing strength of our commitment to fair resolution that avoids the cost and distress of litigation, and to the hard work of our staff and external partners in ensuring we continue to deliver on this commitment.

The achievement also reflects the continued efforts of all stakeholders to support collaborative working. This approach is set out in our Clinical Negligence Claims Agreement for 2024, which was developed in collaboration with key stakeholders, including Action against Medical Accidents (and the Society of Clinical Injury Lawyers. It is designed to encourage positive behaviours from claimant and defendant organisations and consistency of approach in practices across England. It also reduces the risk of costs being spent unnecessarily on formal proceedings because it supports the resolution of more claims before the start of formal court proceedings.

We recognise this upward trend cannot continue indefinitely but, as we discuss in 'Our approach to dispute resolution' below, we 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.

Figure 6: Litigation rate for clinical claims from 2017/18 to 2025/26[1]



In 2025/26, 38 clinical and non-clinical claims were litigated to trial. This represents 1.5% of litigated cases and indicates continued stability in the proportion of claims that litigate to trial. In 2024/25, the percentage was also 1.5%. In both 2023/24 and 2022/23 it was 1.6%.

In 71% of the claims litigated to trial this year, the court agreed with our assessment on the merits of the claim and awarded no damages (compared with 60% in 2024/25).

Within the total number of clinical and non-clinical claims litigated to trial, 16 were clinical claims:

- in 63% (10) of these the court agreed with our assessment on the merits of the claim and awarded no damages. This compares with 63% (15) in 2024/25.
- in 38% (6) of these there was an award of damages. This compares with 38% (9) in 2024/25.

Within the total number of clinical and non-clinical claims litigated to trial, 22 were non-clinical claims:

- in 77% (17) of these the court agreed with our assessment on the merits of the claim and awarded no damages. This compares with 57% (12) in 2024/25.
- in 23% (5) of these there was an award of damages. This compares with 43% (9) in 2024/25.

[1] Data is provided from 2017/18 when monitoring of the litigation rate began using current metrics.

In all the above claims, seeking the input of the court was appropriate to ensure there was a fair outcome delivered for all parties.

Closed claims

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. In cases where a Periodical Payment Order (PPO) is involved, the claim is referred to as resolved or settled 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.

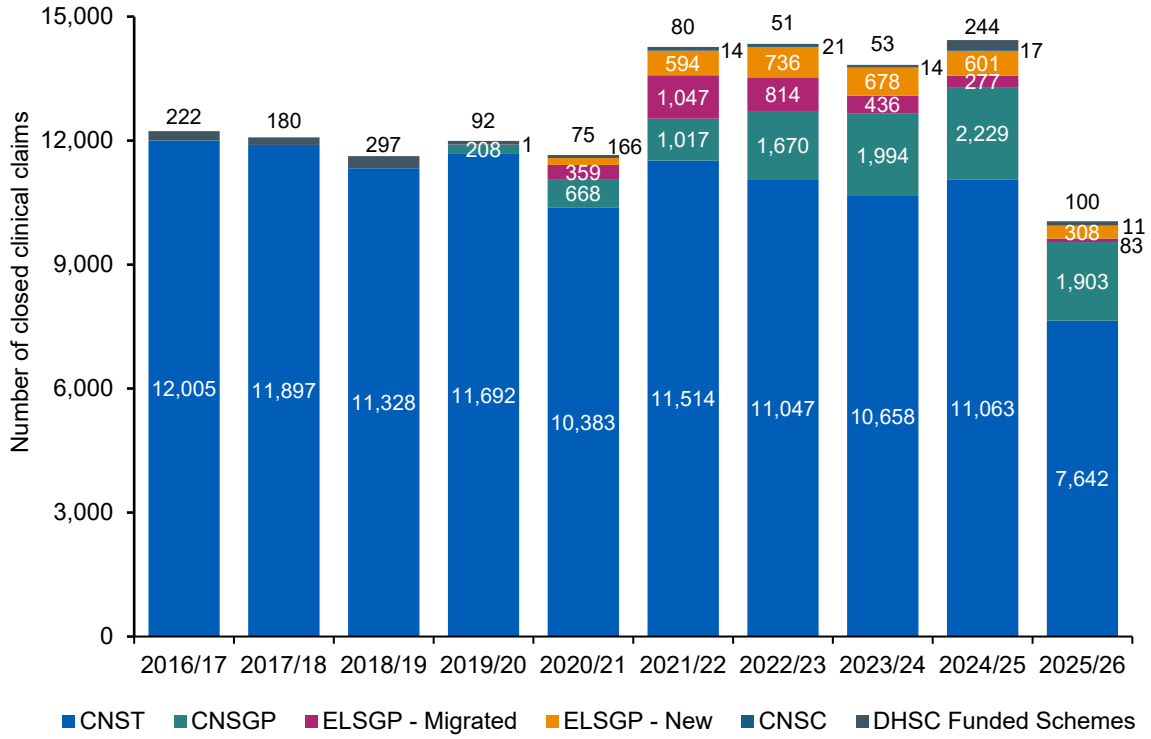
In 2025/26 we closed 13,254 claims (compared with 17,890 in 2024/25), a decrease of 26%.

The period between resolution and closure is often a non-patient facing administrative task and the decrease therefore reflects the way we focused our resources on patient-facing activity during the transition to CaseHub.

Closed clinical claims

As shown in figure 7, in 2025/26 we closed 10,047 clinical claims (compared with 14,431 in 2024/25), a decrease of 30%.

Figure 7: The total number of clinical claims closed (broken down by scheme) in each financial year from 2016/17 to 2025/26[1]



We closed 5,990 clinical claims with damages in 2025/26, compared with 7,806 in 2024/25, a decrease of 23% (1,816 claims).

We closed 4,057 clinical claims without damages in 2025/26, compared with 6,625 in 2024/25, a decrease of 39% (2,568 claims). The estimated total value of clinical claims we closed with no damages payment was £2.9 billion[2].

In 2025/26, the percentage of clinical claims closed with damages was 60%. In 2024/25, it was 54%. The increase demonstrates our continued commitment to investigating claims robustly and fairly, and to making damages payments where the merits of the case warrant it.

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[1] CNSC refers to the Clinical Negligence Scheme for Coronavirus. Further information about the scheme can be found under 'Our indemnity schemes' in the 'Appendix'.

[2] 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. We have reported this figure for the past four financial years. However, in previous years, the figure given was the estimated value of CNST claims closed with no damages payment, not all clinical claims. The estimated value of all clinical claims closed with no damages payment in previous years was as follows: 2024/25: £4.5 billion; 2023/24: £4.4 billion; 2022/23: £5.3 billion.

Closed non-clinical claims

In 2025/26, we closed 3,207 non-clinical claims (compared with 3,459 in 2024/25), a decrease of 7%.[1]

We closed 1,564 non-clinical claims with damages in 2025/26, compared with 1,703 in 2024/25, a decrease of 8%.

We closed 1,643 non-clinical claims without damages in 2025/26, compared with 1,756 in 2024/25, a decrease of 6%.

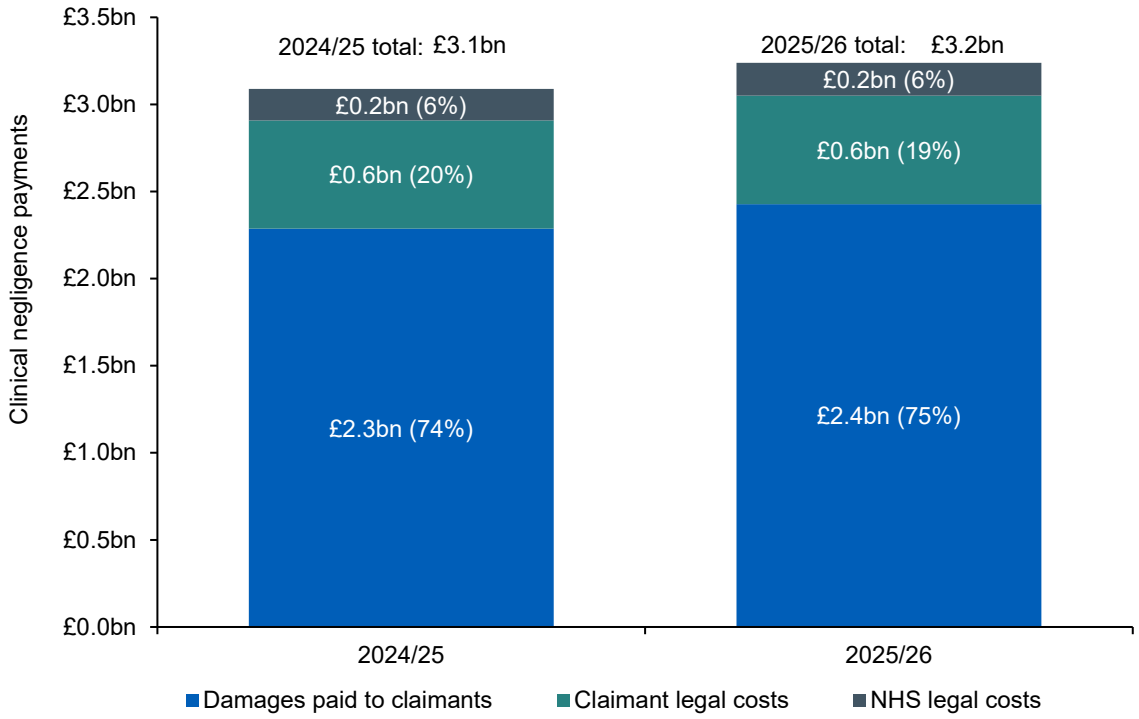
This means 49% of non-clinical claims were closed with damages, the same as in 2024/25, again demonstrating our continued commitment to investigating claims robustly and fairly, and to making damages payments where the merits of the case warrant it.

Payments

As illustrated in figure 8, payments against all our clinical schemes totalled £3,238.5 million in 2025/26. This includes:

- £2,427.9 million damages paid to claimants, an increase of 6% compared with 2024/25;
- £622.2 million claimant legal costs, an increase of 0.2% compared with 2024/25; and
- £188.4 million NHS legal costs, an increase of 4% compared with 2024/25.

Figure 8: Clinical negligence payments made in 2024/25 compared with 2025/26



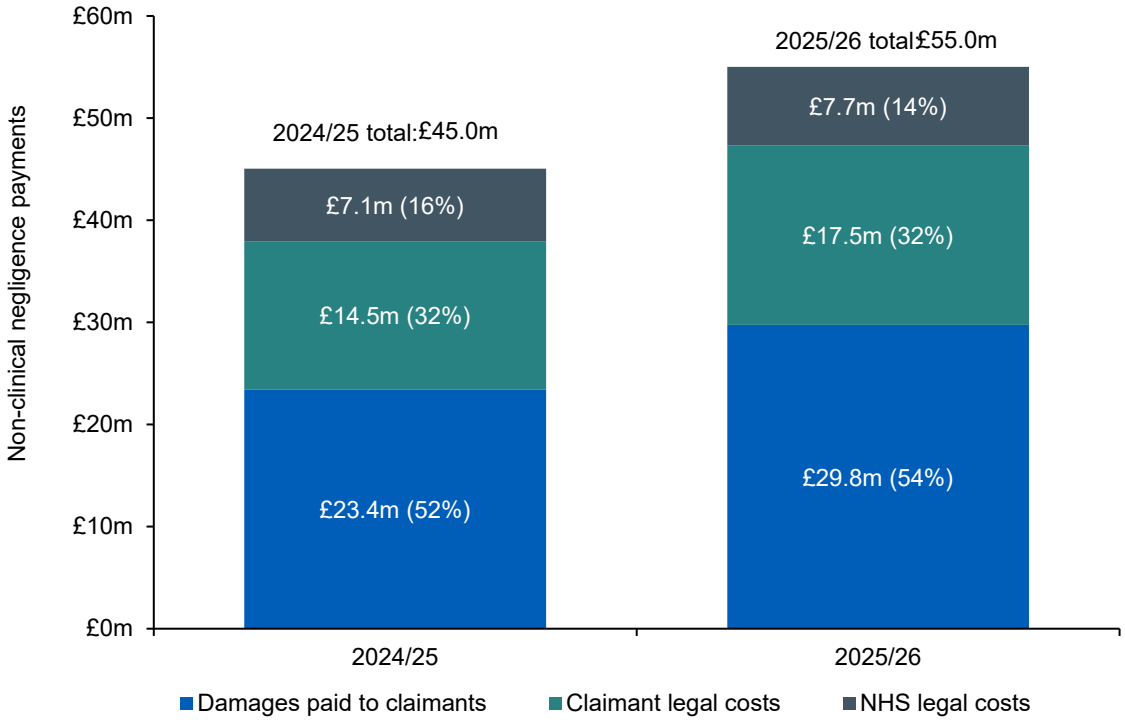
[1] The change in percentages in non-clinical claims can be more volatile than the changes in clinical claims because of the smaller volume of claims numbers involved.

As shown in figure 9, payments against our non-clinical schemes in 2025/26 totalled £55.0 million. This includes:

- £29.8 million damages paid to claimants, an increase of 27% compared with 2024/25;
- £17.5 million claimant legal costs, an increase of 21% compared with 2024/25; and
- £7.7 million NHS legal costs, an increase of 9% compared with 2024/25.

For commentary on payments in 2025/26, see 'Indemnity schemes in-year financial position' in the 'Finance report' in the 'Performance analysis'.

Figure 9: Non-clinical negligence payments made in 2024/25 compared with 2025/26



Across both clinical and non-clinical schemes, the split of spend between claimant legal costs, defence costs and damages has remained broadly similar between 2024/25 and 2025/26.

An overview of the financial performance across each scheme is described in the 'Finance report' in the 'Performance analysis'.

Legal costs

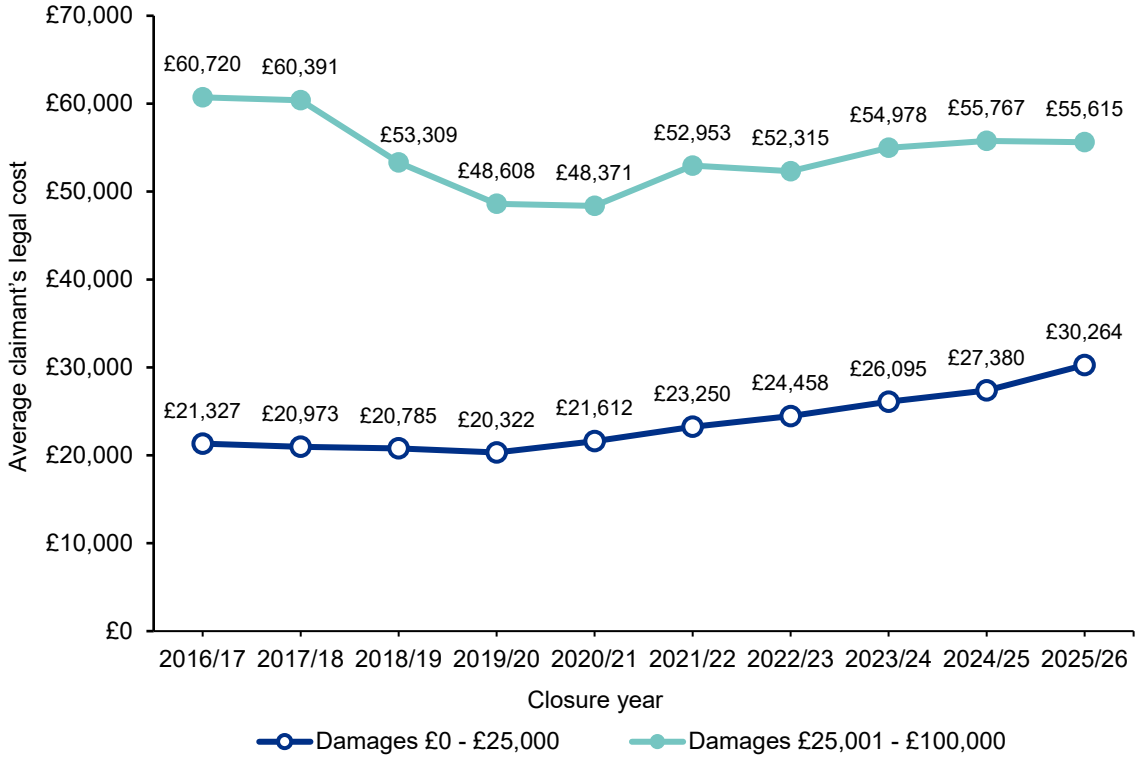
We work hard to secure value for money alongside fair resolution.

As shown in figure 10, for clinical claims valued up to £25,000, the average claimant legal costs paid per claim have increased to £30,264 in 2025/26 from £27,380 in 2024/25. This represents an increase of 11% and means average legal costs on claims

valued up to £25,000 have again exceeded the highest damages paid in this cohort of claims.

For clinical claims valued between £25,001 and £100,000, the average claimant legal costs paid per claim have decreased to £55,615 in 2025/26 from £55,767 in 2024/25, a decrease of 0.2%.

Figure 10: Average claimant's legal costs for clinical claims closed in each financial year from 2016/17 to 2025/26

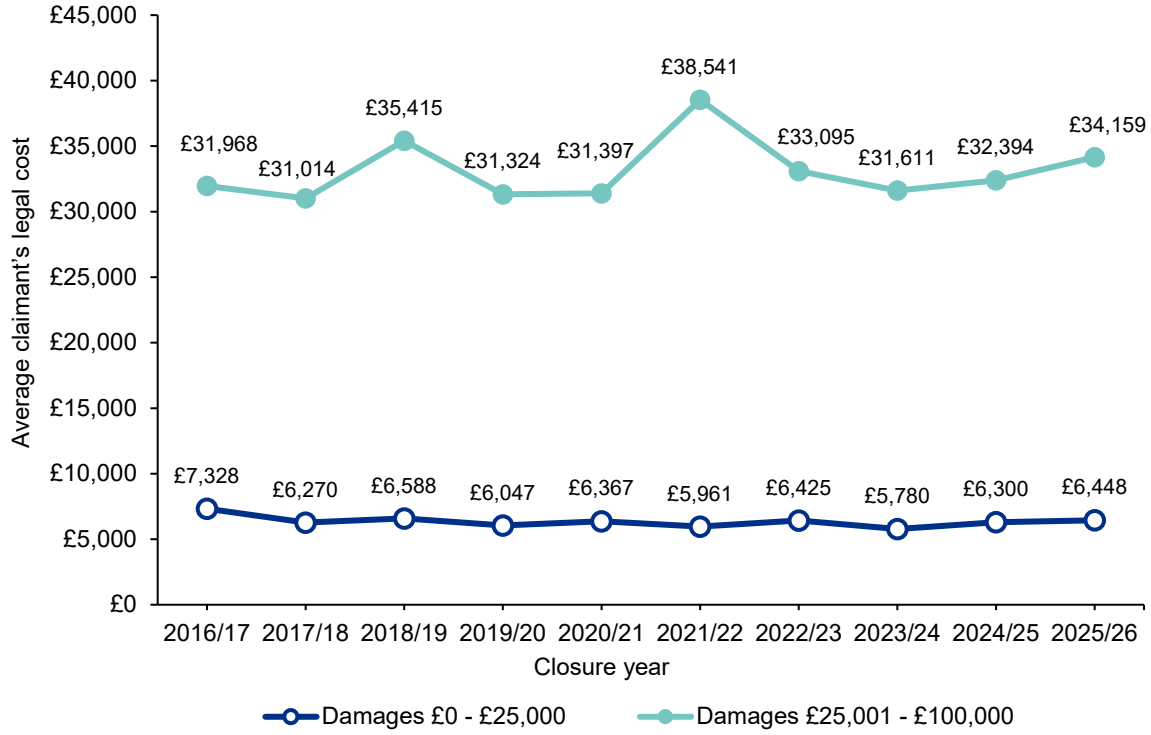


Costs are fixed for non-clinical claims and in 2025/26, for non-clinical claims valued up to £25,000, the average claimant legal costs paid have increased from £6,300 to £6,648, an increase of 5%.

For non-clinical claims valued between £25,001 and £100,000, the average claimant legal costs paid have increased from £32,394 to £34,159, an increase of 5%.

These numbers can be seen in figure 11.

Figure 11: Average claimant's legal costs for non-clinical claims closed in each financial year from 2016/17 to 2025/26



Managing our processes

- Business Plan objective 1: Implement effective processes to manage any changes in the legal market

We continued to work closely with system partners nationally and locally to ensure we are sighted on upcoming policy changes and are well-placed to contribute, respond, and adapt services as required.

We similarly maintained our close working relationship with DHSC, providing input and technical support where required to support the Government to develop related policy.

- Business Plan objective 2: Procure a new legal panel framework

We considered the commercial model of our legal panel framework in great detail in order to ensure it will reflect our future operating state and obtain the best commercial outcome. We consequently deferred procurement to 2026/27.

Our approach to dispute resolution

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

To achieve this, we offer a range of dispute resolution options, which are outlined in infographic 7. Resolving matters without the need for court proceedings can reduce costs[1] 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.

Dispute resolution options

- Business Plan objective 3: Deliver a range of dispute resolution options including resolution meetings, mediation, early neutral evaluation, and stock takes

In 2025/26, we continued to develop and expand our use of resolution meetings, stock take meetings, mediation, 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.

[1] See National Audit Office: Managing the costs of clinical negligence in trusts (www.nao.org.uk/reports/managing-the-costs-of-clinical-negligence-in-trusts/)

Infographic 7: Dispute resolution options

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.

Mediation

Our mediation service provides access to an independent and accredited mediator and allows claimants, patients and their families to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution. It also provides benefits to clinicians, allowing them to bring closure to historical concerns.

Stock take meetings

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.

Early neutral evaluation

Neutral evaluation 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.

During 2025/26, we continued to embed and strengthen the use of resolution meetings with a range of claimant firms, building on the collaborative approach established in previous years. We brought two new claimant firms into this process and held resolution meetings with them during the year, both of which delivered excellent outcomes. This has further enhanced constructive engagement and early dialogue between the parties, reducing protracted litigation and reinforcing the value of resolution meetings as an effective dispute resolution tool.

Interest in participating in resolution meetings continues to grow, with a number of additional claimant firms expressing a desire to engage in this way. This increasing uptake reflects the positive outcomes achieved to date and the strength of collaborative relationships being developed through the process.

In 2025/26 we continued to hold stock take meetings in relation to claims where appropriate.

Our mediation service is in its tenth year and in 2025/26 a total of 143 claims proceeded to mediation with 71% of the claims settling on the mediation day or within 28 days of the mediation. In comparison, in 2024/25, 138 claims proceeded to mediation with 73% of the claims settling on the mediation day or within 28 days of the mediation.

In April 2023, in collaboration with two claimant law firms, we initiated a pilot programme to assess the benefits and effectiveness of early neutral evaluation. The pilot, conducted over 18 months, yielded positive results by providing a pathway for cases unresolved through other dispute resolution methods and facilitating closure for claimants. It fostered

collaborative working, openness, and transparency, effectively mitigating the need for litigation. Additionally, the pilot influenced wider case management approaches, leading to increased mutual exchange of expert evidence and the adoption of stock take meetings.

Of the 47 claims processed through the early neutral evaluation pilot, 70% were successfully resolved.

Following the success of the pilot, we have started to further develop our neutral evaluation service. We carried out a competitive procurement exercise to award four-year contracts for the provision of neutral evaluation services. The launch date for the new service will be confirmed shortly.

Setting legal precedent

While working to ensure litigation is always by choice, we also recognise there will always be some claims where litigation is necessary, for example, where the court must approve a settlement in the best interests of a protected party.

It is also 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[1].

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

During 2025/26, the Supreme Court delivered rulings on two of our claims.

Lewis-Ranwell v. Devon Partnership NHS Trust and others

The claimant had been diagnosed with schizophrenia. In 2019 he killed three strangers during a serious psychotic episode. At his criminal trial the jury found him not guilty of murder owing to insanity and he was sentenced to a hospital order. The claimant then sought damages against the trust and other bodies, plus an indemnity in respect of claims from his victims, alleging the defendants had been negligent in dealing with his case. The Supreme Court unanimously held that his claims could not be successful and he could not receive damages because, although he was not convicted of murder, his actions were still unlawful.

CCC v. Sheffield Teaching Hospitals NHS Foundation Trust

A baby suffered severe brain damage at birth owing to the trust's negligence. She is predicted to live until the age of 29. She was awarded damages to cover the cost of her care needs and for loss of earnings up to the age of 29. Damages were sought for the loss of income during the 'lost years', namely those beyond the age of 29. Such damages are routinely awarded to adults in similar circumstances, but the Court of

[1] resolution.nhs.uk/category/case-of-note/

Appeal ruled in 1982 that lost years claims for young children were inappropriate. By a majority of four Justices to one, the court held that the 1982 decision was incorrect and that children should be able to recover for the lost years. The dissenting Justice, Lady Rose, agreed with our argument that a different approach for children was justified because of the numerous uncertainties involved in quantifying such claims.

For more on how this affects NHS Resolution's provision, see 'Change in provision for all schemes in 2025/26' in the 'Finance report' in the 'Performance analysis' and 'Note 7.3' in the 'Notes to the financial statements'.

Tackling exaggerated or false claims

Where there is evidence of a fabricated or exaggerated claim, we will always take steps to protect public funds and demonstrate to claimants the very serious consequences of submitting dishonest and exaggerated claims, as the following case study shows.

Kae Burnell-Chambers brought a clinical negligence claim against Northern Lincolnshire and Goole NHS Foundation Trust in November 2019 for an alleged delay in diagnosis and treatment of Cauda Equina Syndrome (a condition which can occur when the nerves at the base of the spinal canal are compressed) seeking damages in excess of £3 million.

However, surveillance footage and extracts of social media entries and videos obtained by NHS Resolution revealed significant discrepancies in Burnell-Chambers' account of her condition and capabilities. Following disclosure of this evidence, Burnell-Chambers accepted her medical negligence claim was fundamentally dishonest and discontinued her claim.

Contempt proceedings were commenced by NHS Resolution against Ms Burnell-Chambers in September 2023.

On 25 July 2025, almost two years after proceedings were issued against her, Burnell-Chambers provided a written guilty plea in which she accepted she had deliberately misled the legal teams and medical experts instructed during the clinical negligence claim, with the intention of seeking to receive more compensation.

Burnell-Chambers was found to have deliberately misrepresented a claim for damages against the NHS. She received a 26-week custodial sentence for contempt of court, of which she will serve a minimum of half. She was also ordered to pay £135,000 towards the trust's legal costs.

Resolving primary care contracting disputes and appeals

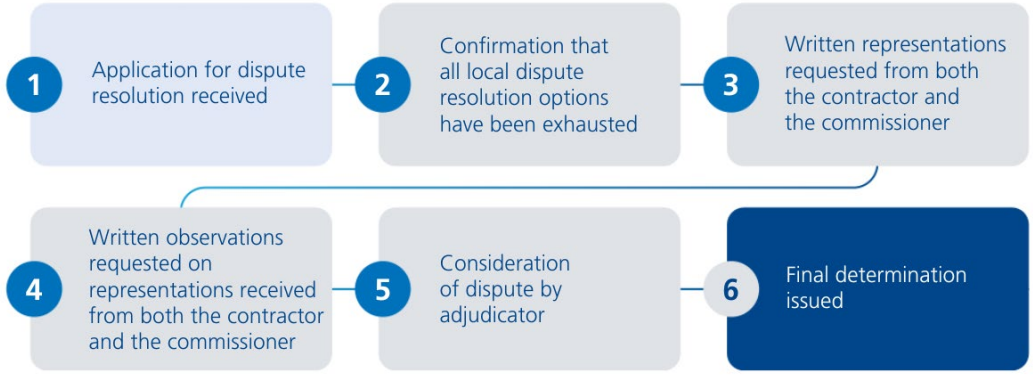
- KPI 3: 80% of pharmacy appeals where decision maker agreed with the recommendation of the case manager

- Business Plan objective 4: Provide prompt and fair resolution of appeals and disputes between primary care contractors, or those wishing to provide primary care services, and the commissioners of primary care services

In 2025/26 our Primary Care Appeals service has continued to deliver fair resolution across a wide range of appeals and disputes that have a direct bearing on the delivery of primary care services.

The Primary Care Appeals contracting disputes journey is summarised in infographic 8. 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.

Infographic 8: The Primary Care Appeals contracting disputes journey



In 2025/26, we received 383 new appeals and dispute applications, as shown in figure 12. This compares with 361 in 2024/25. We closed 354 cases (as shown in figure 13) compared with 278 in 2024/25.

We received 188 ‘market entry’ cases in 2025/26, including relocations, compared to 131 in 2024/25, representing a 43% increase.

Of these cases, we received 116 appeals regarding Distance Selling Pharmacies (DSP) applications compared to 29 in 2024/25. We also determined 66 DSP appeals, compared with 25 in 2024/25.

These significant increases are because on 2 June 2025 the DHSC announced that, with effect from 23 June 2025, no new applications to open DSPs could be lodged. This resulted in a surge of applications at local level.

Figure 12: Appeals and disputes received in 2025/26

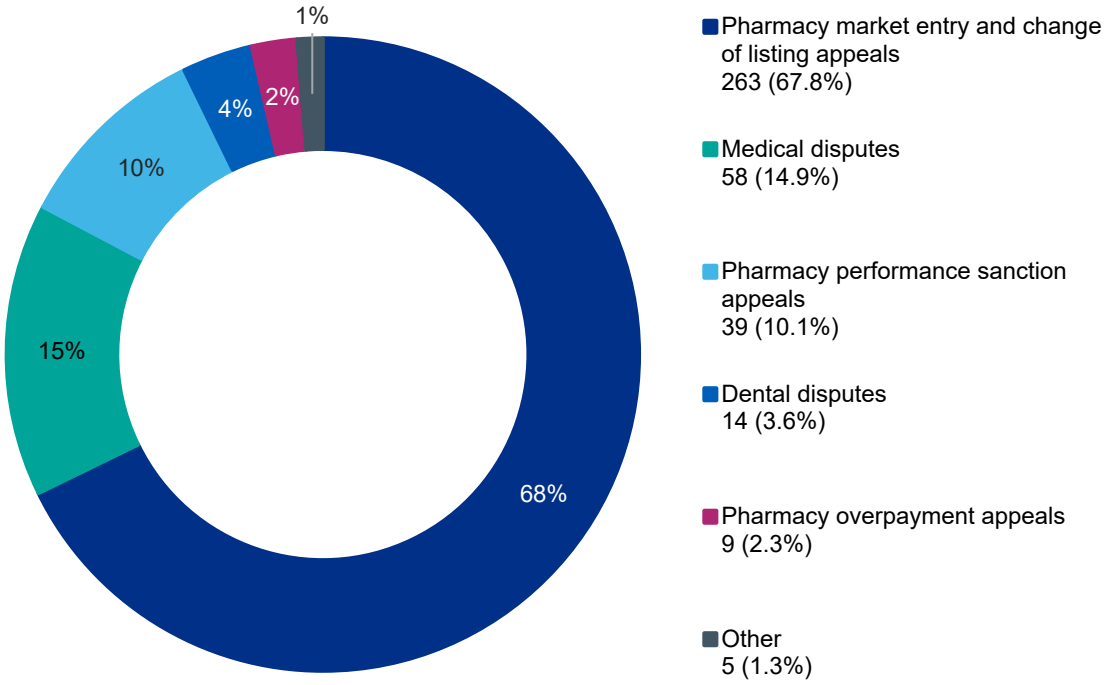
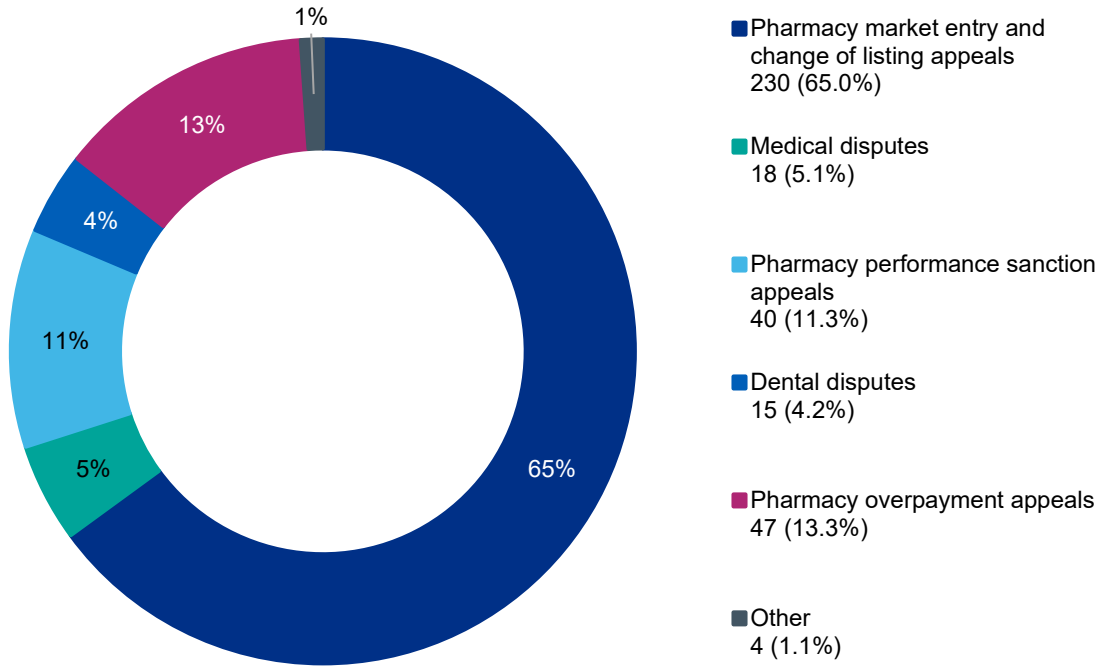


Figure 13: Appeals and disputes resolved in 2025/26



- Business Plan objective 5: Deliver resources and training to our key stakeholders to build capacity for fair resolution and continue to respond to changing casework requirements

While being mindful of our independence, we continue to support wider learning. In 2025/26, this included continuing our work with integrated care boards to help improve local decision making and ensure effective use of resources to support primary care delivery.

Across all workstreams, there has been a notable increase in procedural challenges from parties in either how their cases were handled at a local level or how they wish their cases to be handled at appeal.

This heightened level of challenge requires careful management in line with public law principles and is driven by our commitment to support fair resolution in all cases.

Providing practitioner performance advice

Our Practitioner Performance Advice service provides independent and impartial expertise to help the NHS resolve individual and team performance concerns.

The service advocates local and informal resolution first, with the aim of resolving issues in a fair, timely, and proportionate way at the earliest possible stage to reduce adverse impacts on the practitioner, their team, and the organisation.

We have continued to see increasingly high demand for case advice in 2025/26. We had 1,576 new and reopened requests for case advice, an 11% increase on 2024/25. Our open case load at the end of the financial year stood at 1,242, an 8.5% increase when compared with 2024/25, reflecting the increasing complexity of these cases.

Our assessment and remediation services help to clarify and understand the performance of individual practitioners and provide the healthcare organisation and practitioner with a sound basis upon which to bring the case towards a resolution.

Requests for these services reduced slightly from a total of 104 in 2024/25 to 99 in 2025/26. We delivered 54 professional support and remediation action plans, 40 behavioural assessments, three clinical performance assessments and two team reviews.

- KPI 4: 90% of Advice and other case interventions delivered within target timeframe

- KPI 5: 90% of all exclusions/suspensions critically reviewed (where due)

Despite the growing workload, we continued to deliver a valued service to employers and contracting organisations, consistently meeting KPI 4, which sets the timeframe for delivery on a number of our key services and interventions.

KPI 5, which sets a timeframe for reviewing exclusions/suspensions, has seen significant improvement this year. However, we did not achieve our KPI. There is further explanation under 'Key performance indicators' at the start of the 'Performance analysis'.

- Business Plan objective 6: Deliver a consistently excellent case advice service, PLR applicant check process and HPAN scheme

To respond to the sustained increase in the number of new advice cases and deliver a consistently excellent case advice service, the service has continued to strengthen its capabilities, including by recruiting new Advisers.

In 2025/26, as part of the transition to CaseHub, we also launched the Performer and Healthcare Professional Check[1], where registered users can submit Healthcare Practitioner Alert Notices (HPAN) and/or Performers List Regulations (PLR) search requests. The service replaces the former Fitness to Practise Search and allows healthcare organisations and partners to quickly and securely validate the credentials of healthcare professionals and body corporates.

Since the new system launched, there have been over 20,000 HPAN checks and over 8,000 PLR checks. It is receiving positive feedback.

- Business Plan objective 7: Deliver an assessment and intervention service that facilitates opportunities for reflective practice and behaviour change

We made changes to our professional assessment and remediation service using feedback from external stakeholders designed to improve our users' experience and make the implementation of our action plans easier and more effective.

- Business Plan objective 8: Invite senior healthcare leaders to join a reference group

In 2025/26, we established the Advice NHS Reference Group, which includes members from across the NHS. The purpose of the group is to give members the opportunity to shape our national work on the management of performance concerns and be a source of insights and horizon scanning we can use in our service design. The group met twice in the year.

Managing and enhancing operational delivery

In 2025/26 we have continued to drive forward necessary and planned changes and improvements to our services and how we operate to ensure we are keeping pace with wider changes in the NHS and justice systems.

- Business Plan objective 9: Support the sharing of our data and insights by migrating our Claims Management and Appeals services to CaseHub

- Business Plan objective 10: Enable and support a programme of continuous improvement and the further development of CaseHub

[1] resolution.nhs.uk/nhs-resolution-performer-and-healthcare-professional-check/

Our aim is always to identify and implement continuous improvement initiatives that further enhance our efficiency and effectiveness to deliver best value to the wider NHS.

In 2025/26 we transitioned our two largest externally facing services, the Performer and Healthcare Professional Check service (discussed above under 'Providing practitioner performance advice') and our Clinical Negligence Claims Management service to CaseHub.

We are adopting a continuous improvement model that is helping us to implement regular updates, fixes, and optimisations based on user feedback. These are making the platform easier and quicker to use, as well as continually enhancing the service for all.

- Business Plan objective 11: Deliver the next phase of our Claims Evolution Programme, using our expert workforce more effectively to reduce the amount we spend on external lawyers
  - Expand our Pre-Litigation service
  - Test processes for managing higher-value claims in-house while exploring whether alternative suppliers could deliver further cost efficiencies

We intentionally paused the Claims Evolution Programme to make sure we could prioritise embedding CaseHub and avoid overloading staff. The programme's timeline is within our control and the pause has had a minimal impact on return in investment.

Expansion of our Pre-Litigation service began towards the end of 2025/26. The expansion will see us increase the volume of low and medium-value claims being managed in-house, enabling us to drive the timely and fair resolution of claims in line with our strategic priority to manage cases outside of litigation, where appropriate.

We also started to explore processes for managing higher-value claims in-house while undertaking early market engagement to understand whether alternative suppliers could help us deliver further cost efficiencies.

- Business Plan objective 12: Further modernise our operations, including the implementation of SharePoint

- Business Plan objective 13: Explore how technology such as our new system, CaseHub, could enable future process efficiencies

Away from our two major transformation programmes (CaseHub and the Claims Evolution Programme), we continue to explore areas where technology can enable future process efficiencies.

We continue to further modernise our operations to support more effective working practices. In 2025/26 we continued our journey to fully onboard to NHS.net Connect in line with the NHS 10 Year Plan by expanding our use of SharePoint, OneDrive, and the NHS England-supported Copilot AI pilot.

Broader technology-based future efficiencies, notably concerning AI, are being actively explored by our Data Science team, always being mindful of good governance processes, as discussed in 'The risks we face' in the 'Performance overview'.

In addition, our Data Science teams are drawing insights from our data to support activities across the organisation, notably working with our Practitioner Performance Advice and Safety and Learning teams to support the development of clearer, more robust insight. This included the publishing of analysis on sexual misconduct concerns (see 'Supporting organisations to manage concerns' in 'Strategic priority two: Data and insights' in the 'Performance analysis'), as well as developing thematic and causal analysis, enabling us to start to identify new patterns in our data.

- KPI 7a: Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative information

- KPI 7b: Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed)

- KPI 7c: Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way

- Business Plan objective 14: Continue to operate and continuously improve our framework to manage concerns referred to our Significant Concerns Group

The data we hold can sometimes suggest evidence of harm or potential harm (for example, unsafe clinical practice). When this happens, our Significant Concerns Framework allows us to consider sharing information with relevant NHS bodies or regulators.

The Framework is overseen by our Significant Concerns Group, and its activity is monitored as KPIs 7a, 7b, and 7c.

During this financial year, the Group continued to receive and review notifications from individual directorates in line with its terms of reference. Individual directorates also updated their indicators for significant concerns.

We initiated a work programme to further develop our approach to the identification and escalation of emerging concerns to ensure we remain responsive to a changing healthcare landscape.

Strategic priority two: Data and insights

The focus of our second strategic priority is to contribute our unique data and insights to learn from harm and the response to harm across the health and justice systems.

The data and insights we hold give us a uniquely important role in the patient safety landscape. In 2025/26, our Safety and Learning service and our Practitioner Performance Advice service have continued to work in partnership with others in the health system to ensure the lessons held in our data across all service areas are shared as widely as possible.

We have dedicated workspaces on the FutureNHS platform for both the EN scheme and the MIS, and our Practitioner Performance Advice service uses the platform to share important training material for delegates where appropriate.

FutureNHS is supported by NHS England and provides secure online workspaces to facilitate information sharing, service improvement, and innovation across the health and care system.

In 2025/26, we rolled out the strategic approach to events we piloted in 2024/25. The approach emphasises joined up and collaborative working across our Safety and Learning, Practitioner Performance Advice, and Claims Management services, enhancing stakeholder engagement and resource efficiency both internally and externally.

We have also further focused on making sure we collectively prioritise and rigorously test the work we do. By doing this, we can be sure our work continues to add value, contributes towards improvement, and gives staff the practical tools they need to implement necessary change.

We will continue to develop this work, including by ensuring that any associated recommendations are considered within the remit of a revamped National Quality Board.

- Business Plan objective 15: Work closely with the DHSC, other Government departments, and other arm's length bodies, contributing our data and expertise

We have continued to support DHSC by providing our unique data and insights to support policy development and Government priorities.

We also continue to take part in the informal patient safety leaders' network, which is represented by key stakeholders including the Patient Safety Commissioner, Care Quality Commission, and Parliamentary and Health Services Ombudsman.

Working with stakeholders to improve the system-wide response to harm

- KPI 8: Demonstrate engagement with the system to share learning products/services; respond to feedback on these; and review evidence of uptake/implementation

- Business Plan objective 16: Work with stakeholders at every level, from frontline clinicians to legal teams and leaders to improve the system-wide response to harm and ensure that options for patients are clearly explained

We share our insights in a range of ways and with a wide range of stakeholders in order to contribute to system-wide work to improve the response to harm. We measure our engagement as KPI 8.

In 2025/26, a key publication was Delayed Diagnosis of Cancer: A Thematic Review of General Practice Indemnity Claims[1], which had a foreword from Professor Peter Johnson, National Clinical Director for Cancer at NHS England.

Professor Trish Greenhalgh, Professor of Primary Care Health Sciences at the University of Oxford said: “[T]his meticulous report translates missed opportunities into clear proposals for action – offering a real chance to save lives.”

Callum Metcalfe-O'Shea, UK Professional Lead at the Royal College of Nursing said: “Nursing staff play a vital role in ensuring the principles highlighted in NHS Resolution’s Delayed Diagnosis of Cancer review are embedded in everyday practice. The report’s themes – optimising diagnostic processes, strengthening communication, and supporting timely escalation – align closely with the core strengths of the nursing profession. Nurses are uniquely positioned to build sustained, trusting therapeutic relationships that enable people to share concerns earlier, disclose subtle changes, and feel confident returning when symptoms persist.”

During the year, another major report on a high-impact area of patient harm was Learning From Obstetric Anal Sphincter Injury Claims Within the NHS in England: A Thematic Review[2]. The work was a collaboration between NHS Resolution and a clinical advisory group, with expertise provided by the Royal College of Obstetricians and Gynaecologists. It reflects a shared commitment to learning from claims and improving safety by highlighting key areas for improvement.

In 2025/26, our activity also included three topic-based webinars, including a national journey to improvement webinar at which member trusts shared improvement work focused on strengthening engagement with patients, families and staff.

[1] resolution.nhs.uk/resources/delayed-diagnosis-of-cancer-a-thematic-review-of-general-practice-indemnity-claims/
[2] resolution.nhs.uk/resources/learning-from-obstetric-anal-sphincter-injury-claims-within-the-nhs-in-england-a-thematic-review/

Seven regional face-to-face forums and 12 regional networking meetings were also delivered. Forty-four organisations attended at least one activity, and 169 organisations attended more than one activity. The satisfaction rating for the national journey to improvement webinar was 3.4 out of 4.0, and the average rating for regional forums was 4.0 out of 5.0.

A summary of all the resources we provided in 2025/26 is provided in infographic 9.

Partnership working was a central feature of our approach. The Safety and Learning directorate worked with NHS England and university partners to develop the Patient Safety Syllabus, aimed at patient safety specialists and investigators. The modules build on NHS Resolution's established approach to promoting a just and learning culture, reflective systems-based learning from incidents, support for staff, and evidence-based safety behaviours. During 2025/26, the team also supported delivery and facilitation of the syllabus.

Support for members and beneficiaries also continued through the use of claims data to identify themes, triangulate these with information from complaints and incidents, and inform areas for improvement. In total, 1,029 engagements were facilitated, providing opportunities to use claims data to support learning, with an estimated reach of more than 25,000 people.

Quantitative feedback from engagement activity indicated that:

- 91% of respondents reported increased knowledge of NHS Resolution;
- 94% reported an improved understanding of how claims data can be used to support learning; and
- 91% reported that they would disseminate learning within their organisation.

Analysis of qualitative feedback from member engagements during 2025/26 identified benefits from the structured approach to data triangulation promoted by the Safety and Learning team, including its use in informing quality improvement activity.

We have also continued to explore ways to embed our work within education curricula, including collaborative work with Loughborough University and the Health Services Safety Investigations Body, the Nursing and Midwifery Council, the Medical Schools Council, and the Dental Schools Council.

Supporting organisations to manage concerns

- KPI 9: 90% of delegates rate the workshops not less than 4 out of 5 for overall quality

- Business Plan objective 17: Deliver evidence driven expert views and practical tools through Advice insights and education programmes

In 2025/26 we continued to identify, share, and promote good practice in managing and resolving performance concerns in order to help build local capacity and capability to resolve concerns in a fair, timely, and proportionate way.

Our work supports the retention of a skilled and valued clinical workforce and supports employee wellbeing that in turn contributes to the delivery of safe and effective patient care.

We delivered 57 workshops, reaching 880 delegates.

We consistently receive good feedback from our delegates, with over 90% rating their experience 4/5 for overall quality, meaning we achieved KPI 9.

We continued to publish Insights to respond to emerging themes in concerns, including Demographics, Professions and Concerns: Analysis of Practitioner Performance Advice Cases Including a Focus on Sexual Misconduct Concerns[1].

A selection of the resources we provided in 2025/26 is provided in infographic 9.

We continued to embed our Being Fair[2] work, including hosting a Being fair webinar in collaboration with the Yorkshire and Humber Improvement Academy which provided attendees with the practical tools to embed just and learning cultures within their organisations. The webinar was attended by over 300 delegates from a range of backgrounds including HR, legal, and patient safety.

[1] resolution.nhs.uk/learning-resources/demographics-professions-and-concerns-analysis-of-practitioner-performance-advice-cases-including-a-focus-on-sexual-misconduct-concerns/
[2] resolution.nhs.uk/being-fair-campaign/

Infographic 9: A selection of the products to share our insights developed in 2025/26

Clinicians

Virtual forums

South Quarterly Network Meeting – November 2025

Midlands and East Quarterly Network meeting – November 2025

Virtual Forum: South Region Safety and Learning Networking Forum – 23rd September 2025

Exploring Consent in Maternity Care: Insights from the Midlands and East Regional Networking Event

Journey to Improvement Webinar: Engaging Patients, Families and Staff in the Improvement of NHS Services

Virtual Webinar: National Mental Health Networking

Virtual Forum: South Region Safety and Learning Networking Forum – 25 March 2025

Publications

Reports

Learning From Obstetric Anal Sphincter Injury Claims Within the NHS in England: A Thematic Review

Delayed Diagnosis of Cancer: A Thematic Review of General Practice Indemnity Claims

Case stories

Workplace Culture and Escalation

Fetal Growth Disorder

Undiagnosed Breech Presentation in Advanced Labour

Good Practice: Management of Shoulder Dystocia

Delayed Therapeutic Hypothermia

Antenatal Computerised CTG Monitoring

Caesarean Birth

Maternity Triage

Maternal Multimorbidity

Claims scorecards

Interactive claims scorecards for our 217 CNST and LTPS scheme member trust (members only).

Managers

Virtual events

Preventing and Managing Workplace Violence Webinar

Journey to Improvement Webinar: Engaging Patients, Families and Staff in the Improvement of NHS Services

Maternity (Perinatal) Incentive Scheme (MIS) year 7 Launch Event

Publications

Reports

A Year in the Maternity Incentive Scheme, 2024/25 – Report

Maternity Incentive Scheme Evaluation

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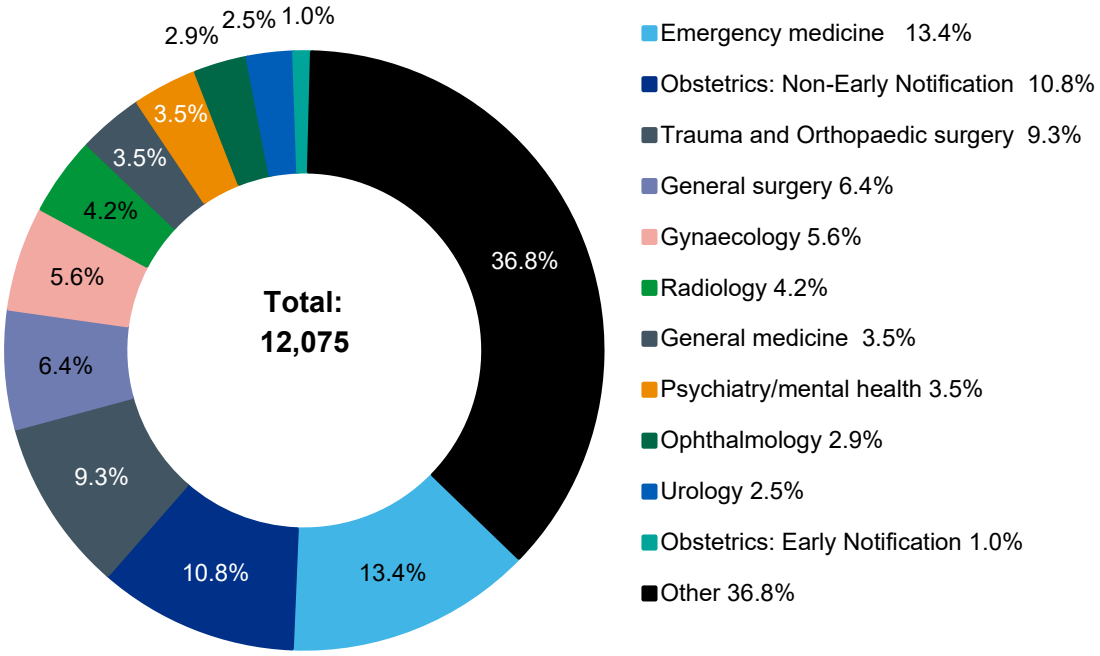
Strategic priority three: Maternity and neonatal care

Our third strategic priority focuses on maternity and neonatal care. We recognise that avoidable errors in maternity and neonatal services still occur and that incidents have devastating consequences for the child, mother, and wider family, as well as the NHS staff involved. We can never reverse the damage that has been caused, but we can play our part to support those affected by these incidents and bring in measures to contribute to improved maternity and neonatal care.

As figures 14 and 15 highlight, obstetric claims accounted for 11% of clinical claims reported by volume (excluding the General Practice Indemnity scheme (GPI)) but accounted for 55% of all clinical claims by value received in 2025/26 (excluding GPI), compared with 53% in 2024/25.

These include claims reported under our Early Notification (EN) scheme, which are discussed later on in this section. A breakdown of the financial value of obstetric claims is shown in figure 16.

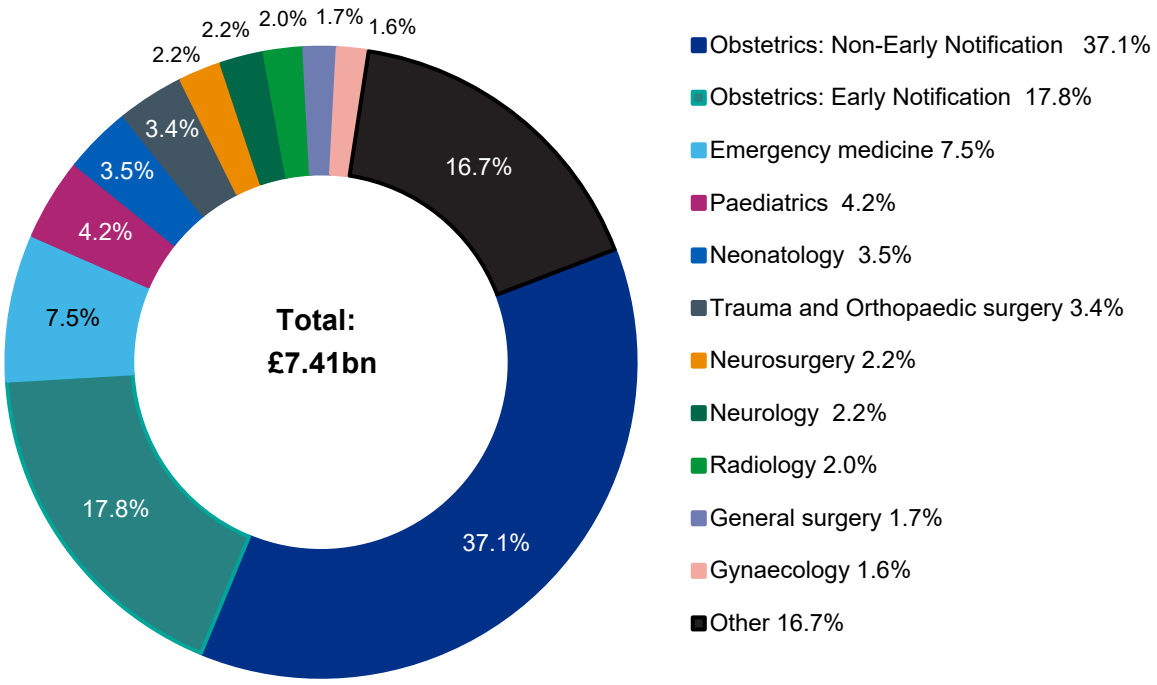
Figure 14: Total number of clinical claims received in 2025/26 by specialty (excluding GPI)[1]



*'Other' category includes 55 specialties including gastroenterology, oncology, paediatrics, neurosurgery, and ambulance.

[1] Figure 14 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

Figure 15: Total value of clinical claims received in 2025/26 by specialty (excluding GPI)[1]

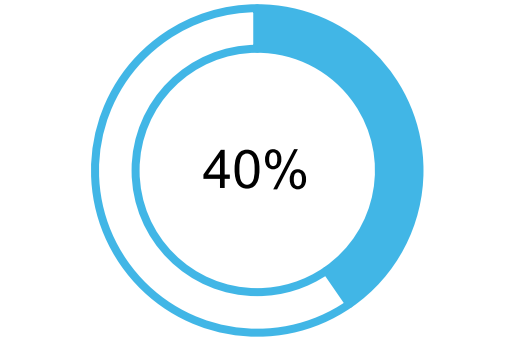


*'Other' category includes 55 specialties including ophthalmology, psychiatry/ mental health, ambulance, paediatric surgery, and vascular surgery.

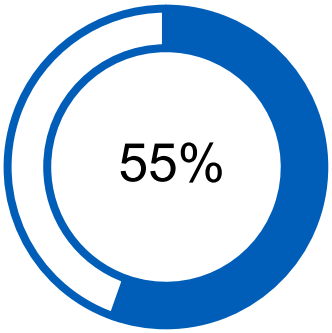
as the care of women during pregnancy, childbirth, and the period following delivery (typically 3–6 weeks).

[1] Figure 15 includes all claims received against our CNSC, CNST, DHSC Clinical, and ELS schemes. It does not include claims received against our General Practice Indemnity scheme.

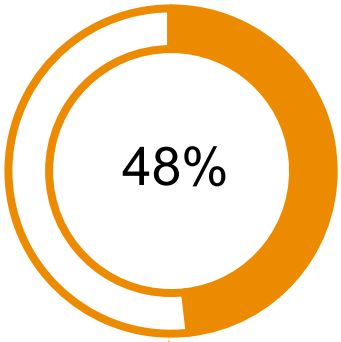
Figure 16: The financial value of obstetric claims as of 31 March 2026



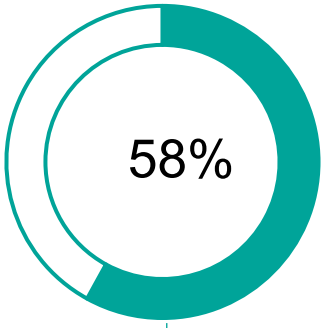
40% (£1.3bn) of the total clinical negligence payments (£3.2bn) in 2025/26 related to maternity. This is a reduction from 42% in 2024/25



55% (£4.1bn) of notified claims by value, excl GPI* (£7.4bn) in 2025/26 related to maternity. This is an increase from 54% in 2024/25



48% (£2.3bn) of the total clinical negligence cost of harm (£4.8bn) relates to maternity. This is a reduction from 51% in 2024/25



58% (£34.7bn) of the total clinical negligence provision (£60.0bn) relates to maternity. This is a reduction from 62% in 2024/25

*GPI is General Practice Indemnity scheme

Contributing to system-wide work to improve maternity and neonatal care

- Business Plan objective 18: Work collaboratively with partner organisations who contribute to the delivery of safe maternity and neonatal care

- Business Plan objective 19: Support a just and learning culture in maternity and neonatal services

- Business Plan objective 20: Support cross-system action to tackle maternal and neonatal health inequalities

- Business Plan objective 21: Continue to offer our maternity team reviews via our Practitioner Performance Advice service

We continue to support system-wide work to improve maternity and neonatal safety via the Maternity (Perinatal) Incentive Scheme (MIS) and our Collaborative Advisory Group, our collaborative work with partner organisations who contribute to the delivery of safe maternity and neonatal care, and our membership of national and regional perinatal and maternity and neonatal committees and groups.

We will remain responsive to the full findings of the upcoming National Maternity and Neonatal Investigation and Thirlwall Inquiry, and are ready to support the work of the National Maternity Taskforce.

To support trusts in relation to their maternity services, the MIS team delivered a programme of targeted engagement during 2025/26.

This included 10 Board reporting and governance workshops and sessions which focused on oversight, governance, culture, and leadership in maternity and neonatal services.

Our Safety and Learning service is working with trusts to help them analyse their data in relation to health inequalities in maternity claims – supporting them to triangulate claims scorecard data with locally-held data in order to identify possible disparities. This includes supporting trusts to examine claims and compare their findings with local complaints, incidents, inequalities, and demographic data to see if any disparities exist.

Our Practitioner Performance Advice service continues to develop networks and gather feedback from maternity services and other users about how team reviews might be helpful.

The Early Notification scheme

The Early Notification scheme

We launched the 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.

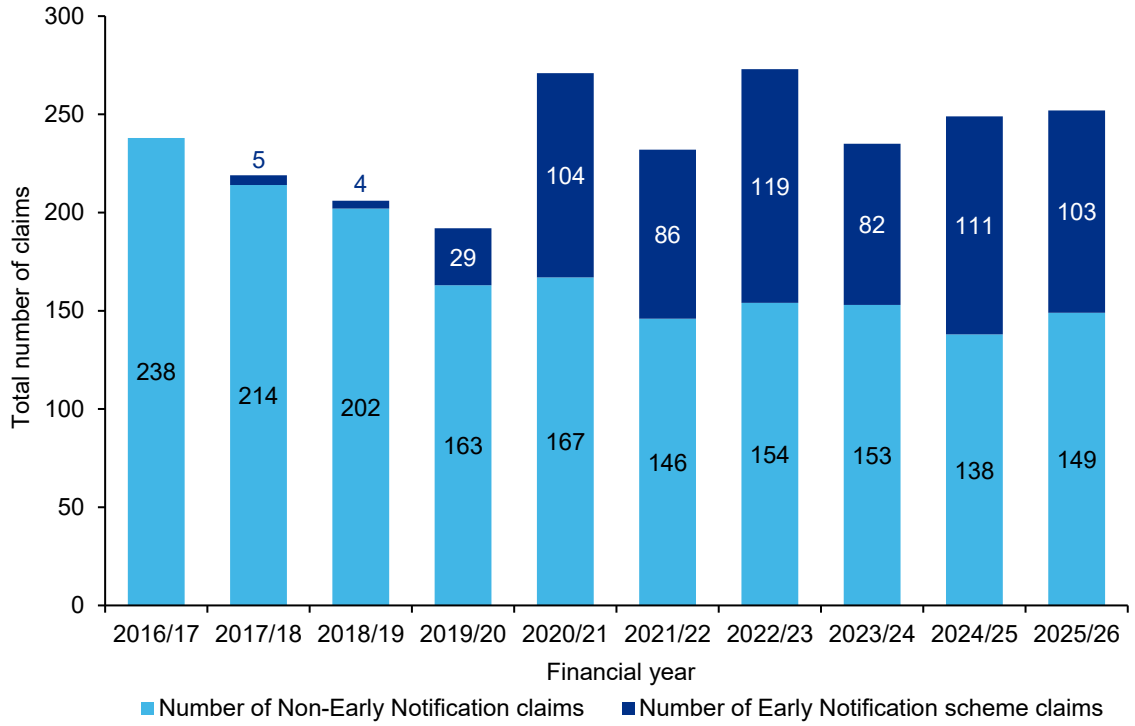
You can see where our EN scheme intervenes before notification in our claims in infographic 6: Clinical claims journey at the start of 'Strategic priority one: Fair resolution' in the 'Performance analysis'.

Figures 17 and 18 provide an overview of the year-on-year movement in the volume and value[1] of cerebral palsy/brain damage claims over the last 10 financial years.

The total number of obstetric cerebral palsy/brain damage claims identified across our EN scheme and other clinical schemes, when combined, shows some fluctuation between the years (as shown in figure 17). This is due to changes in the criteria for entry into the EN scheme and the fact that incidents can occur across a range of different years. Overall, it appears that numbers of non-EN claims appear to be stabilising.

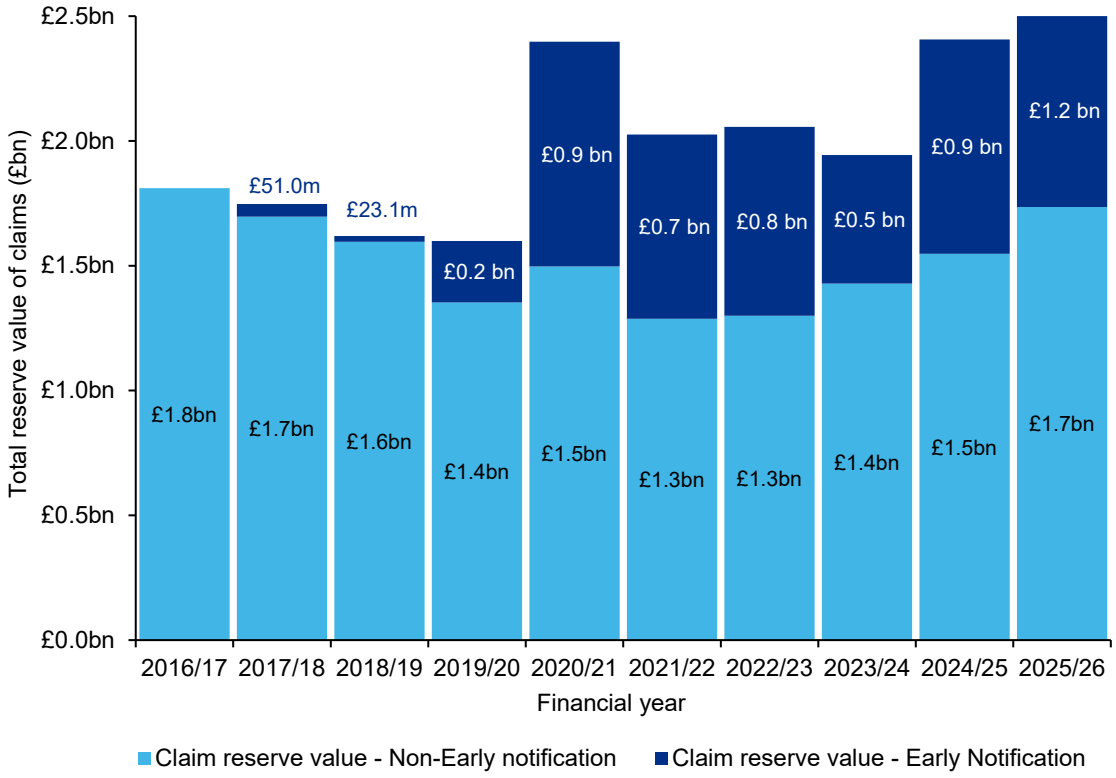
[1] This can result in changes in the reported total value of all cerebral palsy/brain damage claims from the year that they are reported to the year they are resolved.

Figure 17: The total number of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2016/17 and 2025/26[1]



[1] Given 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.

Figure 18: The total reserve value of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2016/17 and 2025/26[1]



- KPI 6: Reduction in the time from notification to a decision on entitlement to compensation on an EN scheme case compared to a similar cerebral palsy case received via the traditional claims route

- KPI 10: EN clinical review within 30 days of acceptance within the EN scheme

- Business Plan objective 22: Deliver timely investigations and fair support and compensation to harmed individuals where negligence has caused the harm

In 2025/26, we achieved KPI 6, a reduction in the time from notification to a decision on entitlement to compensation of an EN scheme case compared to a similar cerebral palsy case received via the traditional claims route, and KPI 10, which requires 100% of eligible cases to receive an EN clinical review within 30 days of acceptance within the EN scheme.

[1] Given 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.

Evaluating and enhancing the EN scheme

- Business Plan objective 23: Complete the formal evaluation of the EN scheme in collaboration with THIS Institute

To support the publication of the MIS evaluation concurrently with MIS Year 8 of the scheme, we re-phased the formal evaluation of the EN scheme. Work on the formal evaluation continues and is due for publication in 2026/27.

- Business Plan objective 24: Continue to deliver and continuously improve the EN scheme

- Business Plan objective 25: Collaborate with stakeholders to further develop the EN scheme

While we await the evaluation report we intentionally paused major updates to the EN scheme in 2025/26.

We did, however, continue to enhance the way we communicate with stakeholders.

This included launching an EN scheme FutureNHS workspace to support collaboration and share resources and updates on scheme developments (see 'Strategic priority two: Data and insights' in the 'Performance analysis' for more information on FutureNHS).

We also continued to enhance our engagement with families and work towards providing services that meet their individual needs.

This included achieving the Plain English Crystal Mark for our resources for families and translating the animation that explains how the EN scheme works into 21 languages.

We completed the work to ensure our systems would integrate with NHS England's Submit a Perinatal Event Notification (SPEN). The platform, which launched from September 2025, replaces previously separate reporting platforms and aims to make the reporting process simpler and faster, as well as to ensure greater accuracy in the data provided.

Maternity (Perinatal) Incentive Scheme

The Maternity (Perinatal) 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 the 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 10 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 10 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 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.

- KPI 11: Maternity Incentive Scheme reverification – 90% of reverification processes completed within their respective predefined timescales

All NHS hospital trusts delivering maternity care in England participated in Year 7 of the MIS. At least 90% of trusts were found to be fully compliant with all elements of the scheme (pending any appeals submissions). This is an increase on the compliance rate for Year 6 of the scheme, which was 84%.

For those trusts unable to achieve all 10 safety actions this year, discretionary funding has been made available under the terms of the MIS to support them on their improvement journey.

KPI 11 sets a standard for completing reverification processes[1] within predefined timescales for 90% of all cases.

We have consistently met this standard, achieving completion within the required timeframe for a minimum of 95% of all reverification cases.

[1] resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/#toc-item-7

Evaluating and enhancing the MIS

- Business Plan objective 26: Continue to deliver and improve the Maternity (Perinatal) Incentive Scheme (MIS) and complete its formal evaluation in collaboration with THIS Institute

We published a report on the Maternity Incentive Scheme Evaluation[1] in March 2026.

Key findings included that since its launch in 2018, the MIS has strengthened Board engagement and prioritisation, improved compliance with essential safety standards and practices, supported local improvements and enhanced local governance processes.

Reflecting our commitment to continuous improvement, MIS Year 8 (April 2026 to March 2027) responds directly to the findings of our MIS evaluation, as well as to system feedback and trust-level learning from previous years.

The changes serve as an interim, transitional step ahead of the final report from the National Maternity and Neonatal Investigation and the outputs of the National Maternity and Neonatal Taskforce.

The changes to MIS Year 8 can play a part in addressing many of the factors that are highlighted as contributing to the pressures on the maternity and neonatal system in the Independent Investigation into Maternity and Neonatal Services in England – Interim Report[2].

[1] resolution.nhs.uk/learning-resources/the-maternity-incentive-scheme-evaluation-a-summary/
[2] www.matneoinv.org.uk/updates/independent-investigation-into-maternity-and-neonatal-services-in-england-interim-report/

Sustainability report

NHS Resolution reports on climate-related financial disclosures consistent with His Majesty's Treasury'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 a proportionate manner and in line with the implementation timetable.

As discussed in the 'Sustainability' section of the 'Governance statement' in the 'Accountability report', we have concluded that, at present, we have no principal risks relating to climate change. For this reason, no climate-related targets have been set. This also explains why we have not disclosed against phase 3 of the TCFD reporting requirements. Where we have not disclosed other required information it is because data is not available to us or the disclosure requirement is not relevant to our activity.

We recognise it is important to mitigate the effects of climate change on delivering our core business as well as our impact on the environment.

We provide regular quarterly reporting to the Board on our carbon emissions via the Greening Government Commitments (GGC) template. We also report to the Board on a regular basis using the below metrics.

We are a hybrid organisation, with staff working from their own homes and our offices. We occupy shared office space in line with Government recommendations. 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 (the Government Property Agency (GPA) and His Majesty's Revenue and Customs (HMRC) respectively) taking primary responsibility for providing gas, electricity, and water and waste services. Our occupancy represents a very small percentage of the total properties (part occupancy of floors representing around 4% and 1.08% respectively of the estates).

As such, we do not have scope 1 emissions. We have not set reduction targets because we have limited control over the majority of our carbon emissions, which relate to building energy consumption and waste, although we do monitor these on a regular basis. We have set 2024/25 as our baseline year for data.

Although we are not directly responsible for the management of these services, we recognise our operational activities and use of resources have an impact on our landlords' own net-zero initiatives and GGC targets. We participate in regular meetings with our landlords where these are held. 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.

Data published for the financial years 2021/22 to 2025/26[1]

Table 3: Greenhouse gas emissions in each financial year from 2021/22 to 2025/26[2]

Greenhouse gas emissions (tonnes CO2)	2021/22	2022/23	2023/24	2024/25	2025/26
Gross emissions for scope 2 Gas	1.5	1.9	10.85	6.81	3.26
Gross emissions for scope 2 Electricity	116.4	117.3	95.86	122.1	87.11
Gross emissions for scope 3 Business travel emissions Data centre emissions[3]	5	20	26.11	32.58	26.67 0.069

The significant year-on-year reduction in gas emissions as shown in table 3 reflects the installation of air source heat pumps to replace gas-powered heating in Q4 of 2024/25 at 10 South Colonnade as well as a reduction in workspace at Wellington Place which has reduced our apportioned consumption metrics accordingly.

The reduction in electricity emissions as shown in table 3 can be attributed to building management system upgrades at 10 South Colonnade that mean plant is running more efficiently and inefficient portable heaters are no longer needed to overcome heating issues, as well as the reduction in workspace at Wellington Place.

[1] Sourced from GPA, HMRC and external suppliers. All figures (including for prior years) have been stated in KWh (where applicable) to align with GGC reporting.
[2] Data for 7&8 Wellington Place is included from 2023/24 onwards.
[3] Data centre emissions are included for 2025/26 only.

Table 4: Building energy consumption in each financial year from 2021/22 to 2025/26

Building energy consumption[1]		2021/22[2]	2022/23	2023/24	2024/25	2025/26
10 South Colonnade						
Electricity	Quantity (KWh)	293,261	360,814	365,232	483,376	410,411
	Cost (£)	49,308	49,075	92,267	121,991	123,177
Natural gas	Quantity (KWh)	8,266	10,413	11,759	5,239	0
	Cost (£)	1,260	449	551	587	0
7&8 Wellington Place[3]						
Electricity	Quantity (KWh)	Not available	Not available	60,741	58,497	35,383
	Cost (£)	N/A	N/A	18,796	18,662	11,116
Natural gas	Quantity (KWh)	Not available	Not available	47,519	32,036	17,909
	Cost (£)	N/A	N/A	2,867	2,118	1,261

As discussed above, electricity consumption at 10 South Colonnade has reduced this year, as shown in table 4, because we are seeing the results of building management system upgrades that mean the plant is running more efficiently. Gas consumption is nil because of the move to air source heat pumps.

As discussed above, gas and electricity consumption is down at Wellington Place because a reduction in workspace has reduced our apportioned consumption metrics accordingly.

Table 5: Data centre electrical energy consumption in each financial year from 2021/22 to 2025/26

Data centre energy consumption		2021/22	2022/23	2023/24	2024/25	2025/26
Data centre 1	Quantity (KWh)	147,305	124,658	126,314	155,763	132,247

Data centre emissions are down year on year because we have moved some systems to the cloud, which has reduced our dependence on local infrastructure.

[1] Electricity and gas consumption are both calculated per building tenant as a percentage of total building consumption.
[2] We moved into 10 South Colonnade part way through 2021 so figures are July 2021 onwards.
[3] Figures from 7&8 Wellington Place are included from 2023/24 onwards.

Table 6: Mileage and cost for road, air and rail travel in each financial year from 2021/22 to 2025/26

Travel		2021/22	2022/23	2023/24	2024/25	2025/26
Road	Miles	8,080	15,792	21,449	15,520	17,349
	Cost (£)	4,976	8,843	12,519	9,645	13,909
Air	Miles	0	54,332	6,291	6,372	5,473
	Cost (£)	0	5,443	1,741	3,228	2,444
Rail	Miles	39,817	142,544	327,496	469,111	363,230
	Cost (£)	15,049	76,487	149,716	192,150	143,168
Total mileage		47,897	212,668	355,236	491,003	386,052

Business travel metrics in total are below the metrics for 2024/25 despite a continued increase in Practitioner Performance Advice's workload. This is because all cases are now delivered remotely. In addition, while the service delivers both public and in-house training, it encourages organisations to consider a public workshop as a first option.

Table 7: Recycled waste quantity and cost in each financial year from 2021/22 to 2025/26

Waste	2021/22	2022/23	2023/24	2024/25	2025/26
10 South Colonnade					
Waste recycled (tonnes)	6.0	6.5	4	2.15	2.52
Energy from waste				2.20	2.28
Food waste				0.42	0.67
Cost (£)	702	2,972	1,565	2,402	2,404
7&8 Wellington Place					
Waste recycled (tonnes)				0.84	0.51[1]
Energy from waste				0.95	0.26[2]
Food waste				0.05	0.08[3]
Cost (£)				Not available[4]	Not available[5]

[1] Q4 data (for January to March 2026) was not available in time for publication. To estimate a total figure for 2025/26 we have estimated Q4 data using an average of Q2 and Q3 data (for July to September 2025 and October to December 2025).
[2] Q4 data (for January to March 2026) was not available in time for publication. To estimate a total figure for 2025/26 we have estimated Q4 data using an average of Q2 and Q3 data (for July to September 2025 and October to December 2025).
[3] Q4 data (for January to March 2026) was not available in time for publication. To estimate a total figure for 2025/26 we have estimated Q4 data using an average of Q2 and Q3 data (for July to September 2025 and October to December 2025).
[4] 2024/25 cost information for waste was not provided to us by HMRC.
[5] Cost information for waste is provided annually by HMRC too late for inclusion in the Annual Report and Accounts.

We have not reported on ICT waste in this section because we did not dispose of any end-user devices, peripherals, networking, telephony equipment, audio-visual devices, or imaging devices in 2025/26.

Table 8: Use of finite resources in terms of water consumption and paper in each financial year from 2021/22 to 2025/26

Use of finite resources[1]		2021/22	2022/23	2023/24	2024/25	2025/26
10 South Colonnade water consumption (m^3)	Usage	367	693	945	959	1,071
	Cost (£)	934	1,655	2,253	1,864	4,360
7&8 Wellington Place water consumption (m^3)	Usage	N/A	N/A	162	230	106
	Cost (£)	N/A	N/A	556	522	493
Paper (reams)	Usage	20	60	140	155	38
	Cost (£)	49	208	666	594	227

As before, workspace reduction at Wellington Place explains the reduction in water consumption.

Paper consumption has also significantly reduced and reflects our commitment to working with all directorates to further reduce our paper, printer, and toner usage.

This Sustainability report has been reviewed and signed off by the NHS Resolution management team and Board.

[1] Water consumption is calculated per building tenant as a percentage of total building consumption for both 10 South Colonnade and 7&8 Wellington Place.

Finance report

- KPI 12: Management of budgets within net Departmental Expenditure Limits.

  Measured as income from members plus budget from DHSC vs expenditure

Headlines in numbers

The three key aspects of our financial activities are the provision for liabilities arising from incidents that have already happened, the cost of harm, 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.

- ✓ **Provisions:** as at 31 March 2026 provisions were £60.26 billion with a minor decrease of 0.1% compared to last year's provision of £60.33 billion.
- ✓ **Cost of harm:** Clinical Negligence Scheme for Trusts (CNST) cost of harm decreased 2% to £4.5 billion for incidents in 2025/26 compared to 2024/25 incidents. Prior to applying the His Majesty's Treasury (HMT) discount rate updates, the CNST cost of harm would have increased by 5%.
- ✓ **Budget position:**
  - **Departmental Expenditure Limit (DEL):** Expenditure was £3.4 billion with net expenditure £18.3 million (0.5%) under budgeted income and funding.

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.

Year-end provisions

The provision is the value of liabilities arising from incidents across all schemes that occurred before 31 March 2026 including claims received and our estimate of claims likely to be received in future but not yet reported as claims (incurred but not reported (IBNR)).

The provision has decreased by £67 million (0.1%), from £60.33 billion as at 31 March 2025 to £60.26 billion as at 31 March 2026. Figure 19 below shows the key drivers for that change. Prior to applying the HMT discount rates change, the provision would have increased by 7%. This increase is largely driven by additional liabilities arising from another year's worth of activity and claims experience from the existing known claims.

With broadly stable activity, the provision would usually rise year on year due to inflation and the ongoing maturity of the claims book (including Periodical Payment Orders (PPOs), where payments are spread over a claimant's lifetime). Year-on-year movements also reflect experience against assumptions and updates to key assumptions, including HMT discount rates.

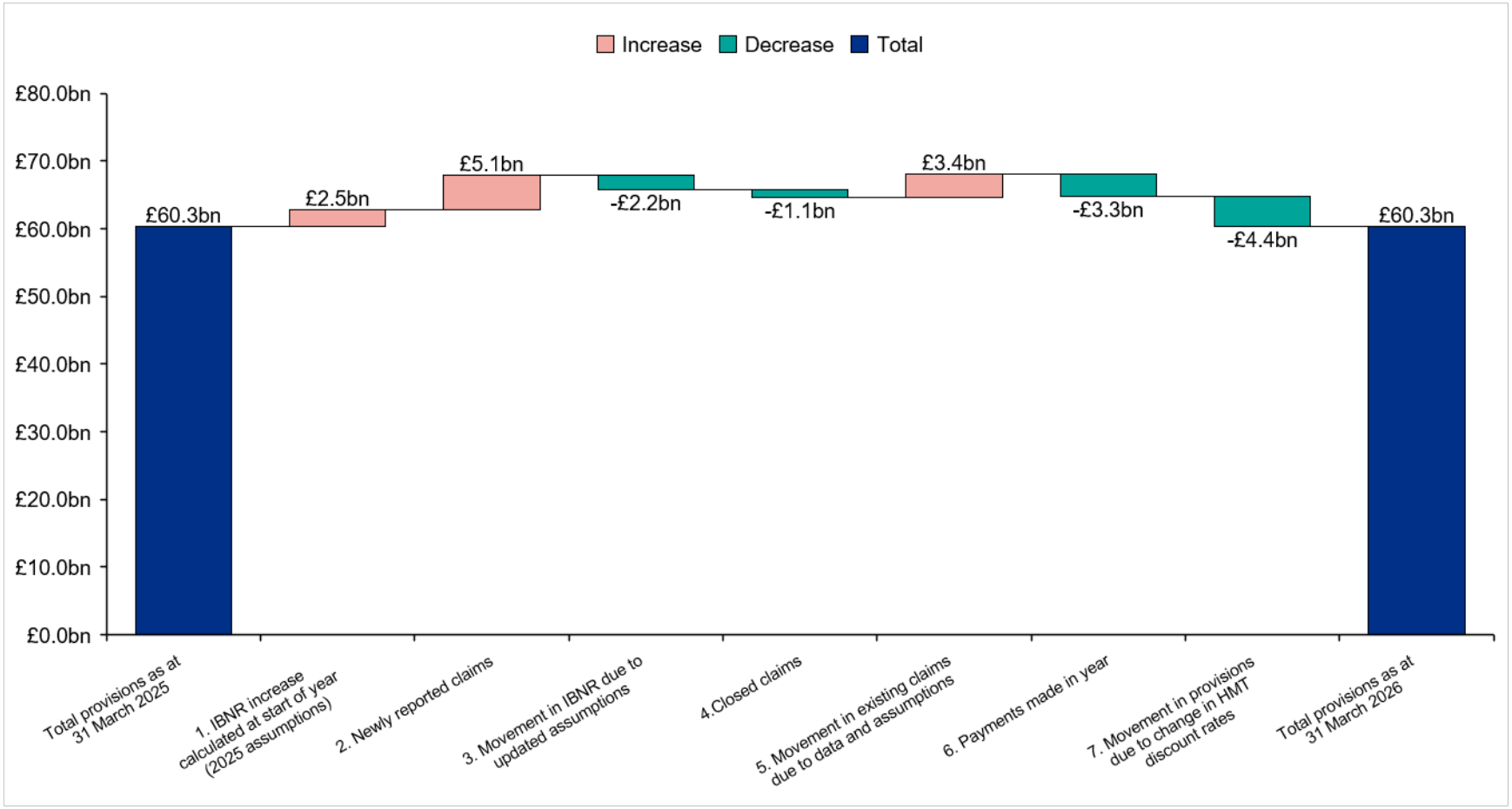
What are His Majesty's Treasury discount rates for general provisions and why do they matter?

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 PPOs with payments provided over the remaining lifetime of the claimant. Further information about HMT's discount rates can be found in 'Note 7' in the 'Notes to the financial statements'.

The HMT discount rates provide a consistent basis on which to present values for future costs across government accounts. Changes in these rates do not change the underlying future payments that will be incurred in meeting the obligations arising from claims when they fall due. Hence, they do not 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 at which any payments might increase in the future.

Change in provision for all schemes in 2025/26

Figure 19: The change in NHS Resolution's provisions for all schemes from 31 March 2025 to 31 March 2026



Note: figures may not sum due to rounding

Movements 1 and 2: Liabilities from another year's worth of activity in 2025/26 for all schemes for all incident years are £7.6 billion.

Movement 3: The main drivers of this decrease are in CNST, of which the most material components are updates to the Annual Survey of Hours and Earnings (ASHE) indexation assumptions to align with the latest long-term historical averages and a decrease in respect of claim number projections for IBNR, this being driven by a change in approach for estimating claim numbers for the EN scheme, which utilises the latest experience data for these cases.

Movement 4: The liability has reduced by £1.1 billion in respect of claims closed during this financial year.

Movement 5: The liability has increased by £3.4 billion in respect of changes in data (such as reserve values and other data held for individual claims) and assumptions affecting known claims.

Movement 6: £3.3 billion was paid out during the financial year in relation to claims.

Movement 7: There is a decrease in the provision of £4.4 billion due to updates to the discount rates specified for use by HMT.

This year's provision movements reflect impact of the February 2026 UK Supreme Court ruling (see our section on 'Setting legal precedent' in 'Our approach to dispute resolution' in 'Strategic priority one: Fair resolution' in the 'Performance analysis' for further detail) which decided that children with significantly reduced life expectancy can claim 'lost years' damages. The methodology to determine the precise level of compensation that will be applied in practice has not yet been confirmed, so there does remain uncertainty as to the level of additional compensation resulting from this ruling. We have therefore provisioned for the ruling on a best estimate basis, it is not material in the context of the total provision.

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 7.3' in the 'Notes to the financial statements'.

Cost of harm

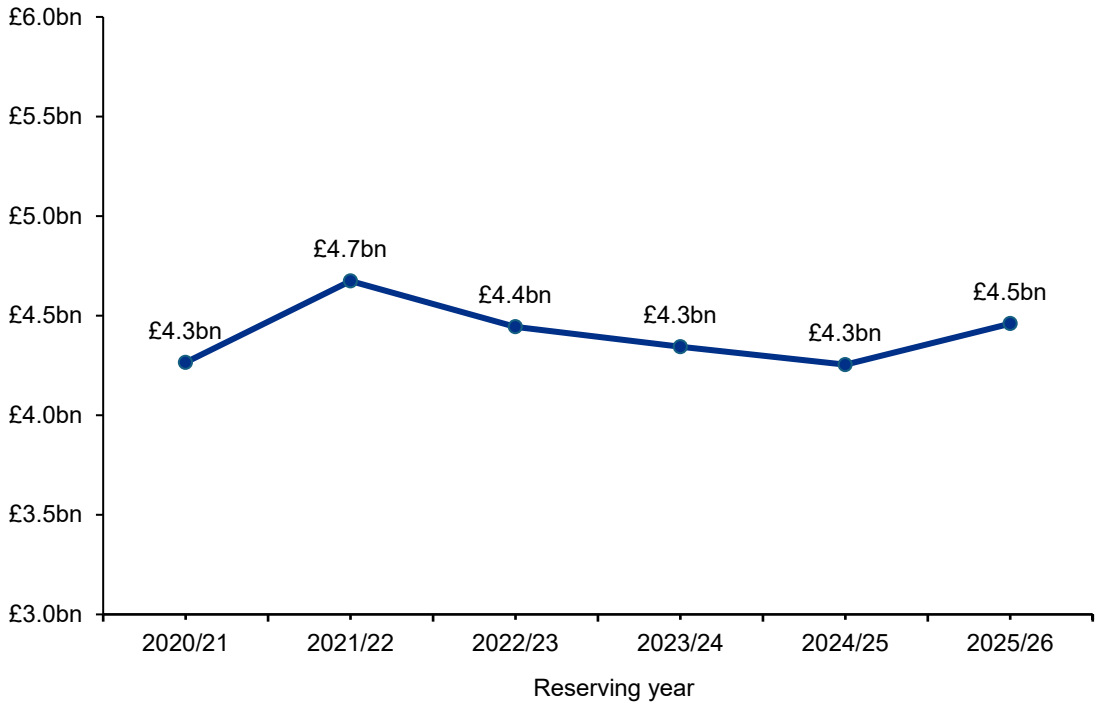
The cost of harm is our estimate of the cost of claims arising from incidents in the most recent financial year (2025/26). Unlike the total provision, which largely relates to earlier incident years, this measure focuses on current-year incidents. In a stable claims environment, the cost of harm is expected to increase year on year due to inflationary pressures. Given, however, that these incidents are on average unlikely to be reported

and then resolved for many years, the cost of harm is highly sensitive to the assumptions made, including HMT discount rates, and can be highly volatile year on year as a result.

The estimated cost of harm in 2025/26 covered by CNST was £4.5 billion (see table 1), a decrease of 3%[1] compared to the previous year's figure of £4.6 billion. Prior to applying the HMT discount rate updates, the cost of harm would have increased by 5%.

To support comparison of underlying movements, figure 20 below shows prior years' cost of harm rebased to the 2025/26 HMT discount rates.

Figure 20: CNST Cost of harm (rebased to 2025/26 HMT discount rates)



This highlights that the 5% increase from 2024/25 to 2025/26 is consistent with inflationary growth expectations over the year.

The increase between 2020/21 and 2021/22 was driven by an assumption of increased clinical activity in 2021/22, following the pandemic-related reduction in the previous year. Subsequent decreases were driven by updates to assumptions used in various provisioning exercises. These reflect trends in actual experience being more favourable than expected for example lower projected PPO claim numbers, lower long-term claims inflation for PPOs, and lower average cost assumptions, as well as the increase in the Personal Injury Discount Rate (PIDR) (affecting 2024/25 only).

The cost of harm is broadly equal to the provision for incidents in 2025/26 (see 'Note 2.1' in the 'Notes to the financial statements' for further details) but also includes payments

[1] Percentages are subject to rounding differences.

on claims with incident dates in 2025/26. Due to the time lags in reporting, the payments for 2025/26 incidents are minimal.

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.

DHSC sets a budget in respect of this financing on a Departmental Expenditure Limit (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.

Despite the disruption to claims expenditure as a result of the migration to CaseHub, total expenditure against DEL budget was a 1% underspend consistent with the prior year.

What is the Departmental Expenditure Limit (DEL)?

The DEL is a HMT budgetary control, which covers income and spending on general administration costs, including 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 2025 to 26 (www.gov.uk/government/publications/consolidated-budgeting-guidance-2025-to-2026).

Indemnity schemes in-year financial position

As seen in figure 21 below in 2025/26 we spent £3.3 billion on resolving claims (excluding administrative expenditure).

Figure 21: Cost of resolving claims 2025/26 (£ billions)

Table 9: Clinical schemes financial performance

	2025/26				2024/25
Clinical schemes	**Income/ budget (£ million)**	**Expenditure[1] (£ million)**	**Under/ (over) spend (£ million)**	**Under/ (over) spend Percentage**	**Expenditure[1] (£ million)**
Member funded – CNST	2,999	2,987	12	0.4%	2,867
DHSC funded schemes	129	136	(7)	(5.1%)	115
GPI	184	177	7	4.0%	161
CNSC	3	1	2	65.2%	1
Total clinical schemes	**3,315**	**3,301**	**14**	**0.4%**	**3,144**

CNST is our largest scheme and was in line with budget expenditure.

Payments on CNST claims and scheme administration (expenditure) increased £120 million (4%) rising from £2,867 million to £2,987 million year on year (2024/25: £253 million, 10% increase). Expenditure was in line with income collected from members. Income from members increased by £131 million (5%) to £3.0 billion in 2025/26 in the expectation of a continued trend in increasing claims costs.

£115 million of the year-on-year increase in CNST costs relates to damages payments. The increase was primarily due to lump sum payments on claims with a reserve value of £3.5 million or higher. In addition, annual payments on PPOs increased by £61 million (15%). These costs are expected to rise as we add around 150 newly settled claims of this nature every year.

CNST claimant legal costs decreased by £5 million (1%), while NHS legal costs increased by £5 million (3%). Cost increases were generally spread across claims of all values. Total CNST expenditure was £10 million (under 1%) underspent to budget.

For the EN scheme within CNST, while still at a relatively early stage of its development, spend on claims has increased compared to 2024/25 due to a small number of claims settling.

Expenditure on GPI schemes increased by £16 million (10%) to £177 million compared to the previous year expenditure of £161 million. The growth in the Clinical Negligence Scheme for General Practice (CNSGP) scheme, which provides cover for incidents from April 2019, is expected as it is a maturing scheme. The Existing Liabilities Scheme for General Practice (ELSGP) scheme covers historic incidents prior to that date and it is expected that new claims and settlements will reduce over time. In 2025/26 ELSGP expenditure decreased £22 million (24%). GPI schemes were £7 million (4%) underspent to budget.

DHSC clinical schemes were £7 million (5%) overspent to budget and increased £21 million (18%) to £136 million compared to the previous year expenditure of £115 million. The largest increase was in payments against claims with a value of over £3.5 million.

[1] These expenditure figures include administrative costs which are not included in the payments figures in table 1 in the Performance report.

There was one new claim received for the Clinical Negligence Scheme for Coronavirus (CNSC) during the year. £0.8 million has been spent on managing claims.

Table 10: Non-clinical schemes financial performance

	2025/26				2024/25
Non-clinical schemes	**Income/ budget (£ million)**	**Expenditure[1] (£ million)**	**Under/ (over) spend (£ million)**	**Under/ (over) spend Percentage**	**Expenditure[1] (£ million)**
Member funded – LTPS	51	51	0	0.2%	42
Member funded – PES	8	5	3	34.9%	6
DHSC funded scheme	8	8	0	5.8%	5
Total non-clinical schemes	**67**	**64**	**3**	**3.5%**	**53**

As table 10 shows, expenditure on the Liabilities to Third Parties Scheme (LTPS) has increased by £9 million (22%) to £51 million compared to the previous year expenditure of £42 million. This was mainly due to payments against claim values in the range £0.25 million to £1 million and £1 million to £3.5 million. LTPS scheme expenditure pattern is inconsistent and influenced by a small number of large value claims settlements. In 2025/26 high value settlements increased compared to previous years.

Expenditure on the Property Expenses Scheme (PES) is subject to fluctuation 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 £50,000 has been spent on administration (primarily in relation to meeting financial reporting needs).

What is Annually Managed Expenditure (AME)?

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

The budget for AME is in respect of the net movement in provisions for all the indemnity schemes. 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.

The AME budget was based on projection ranges estimated in December 2025 and was set at the upper range of projections at £5 billion. The final provision resulted in the AME budget not being required.

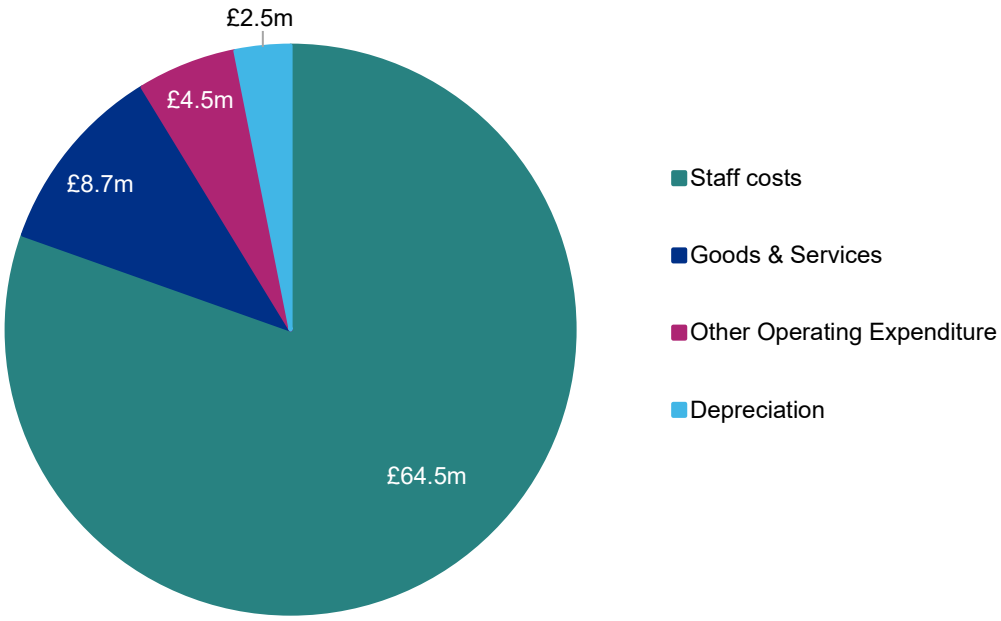
Administration costs in-year financial performance

Administration costs for all our activities (including the costs of administering member-funded schemes and GPI arrangements) have increased by £8.6 million (12%) to £80.3

[1] These expenditure figures include administrative costs which are not included in the payments figures in table 1 under the Performance overview.

million. This was 2% of our total DEL expenditure. A breakdown of core expenditure is depicted in figure 22 below.

Figure 22: Administrative expenditure (£ millions)



Average full-time equivalent staff numbers increased by 54 to 832, with the majority of this growth occurring in 2024/25. Year-end FTE grew from 832 in 2024/25 to 838 in 2025/26, demonstrating growth of 6 FTE across the full year. Expenditure increased primarily due to the pay award, which accounted for approximately £2.2m of growth and the full year effect of roles recruited within 2024/25.

Activities delivered by our Practitioner Performance Advice service have generated £0.9 million (£1.0 million in 2024/25) of income. Services range from advice, assessments, and intervention to training and other expert services provided to NHS organisations and other bodies.

The Claims Management service has continued to expand as the team continued the transformation work as part of the Claims Evolution Programme (CEP). In addition, work to migrate our Claims Management service to the new CaseHub platform is largely complete. Both of these activities are discussed in 'Managing and enhancing operational delivery' in 'Strategic priority one: Fair resolution' in the 'Performance analysis'.

Capital

There was £0.5 million in capital expenditure in the year, £3.5 million less than the prior year. The majority of the capital expenditure was for ongoing development work on CaseHub which went live during the year. Work will continue into 2026/27 as further schemes are migrated and further development and enhancements are rolled out, however no further capital expenditure is expected.

Cash

The balance has decreased by £0.6 billion to £0.7 billion by the end of the year due to the in-year timing of claims payments. We aim to pay all administration vendors within 30 days from date of invoice in line with our prompt payment policy. Details of our prompt payment performance can be found on our website: Finance and corporate planning – NHS Resolution[1].

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, we will continue our commitment to delivering fair, timely and effective resolution for patients, healthcare staff and the wider NHS, while driving forward improvements that keep pace with changes in the health and justice systems and support the delivery of safer healthcare for patients.

We will continue to work with ministers and officials across Government to tackle the wider issues raised by the recent reports on the costs of clinical negligence by the National Audit Office and the Public Accounts Committee, including supporting the work of David Lock KC.

Our Practitioner Performance Advice service will continue to deliver the expertise needed by frontline organisations to support the fair, timely and proportionate resolution of performance concerns that enables the retention of a skilled and valued clinical workforce to deliver safe and effective patient care.

Our Primary Care Appeals service will continue to deliver a fair, prompt and cost-effective appeals function that avoids the need for the parties to pursue costly and prolonged legal processes, involving judicial review or civil litigation. We will continue to be responsive to the changing healthcare landscape to achieve resolution, supporting local resolution of disputes by providing training and resources to build capacity and capability at a provider level.

We will continue to leverage our unique data and insights to learn from harm and improve the response to the issues we see across the health and justice systems and, in line with the conclusions of the Dash review, we will explore new opportunities to maximise the impact of our learning resources.

We will continue to drive improvements in safety in maternity and neonatal care through the MIS and the EN scheme and our wider work in this area. We will do this by responding to findings from the independent evaluations of our schemes. We will also

[1] See https://resolution.nhs.uk/about/corporate-services/finance-and-corporate-planning/

support the work of our partner organisations and the wider maternity and neonatal system through our chairing of the system-wide MIS Collaborative Advisory Group.

Recognising the importance of adapting to the external environment, including developments in policy, technology and the wider NHS landscape, we are fully committed to supporting the delivery of the NHS 10 Year Plan with its three strategic policy shifts.

As part of this, the integration of our continuous improvement programmes, CaseHub and our Claims Evolution Programme, into business-as-usual will help us deliver more efficient and responsive services that are fit for the future.

Helen Vernon
Chief Executive and Accounting Officer
Date: 3 July 2026

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 there is a sound system of internal control allowing us to fulfil our purpose and role.

Directors' report

NHS Resolution's Board

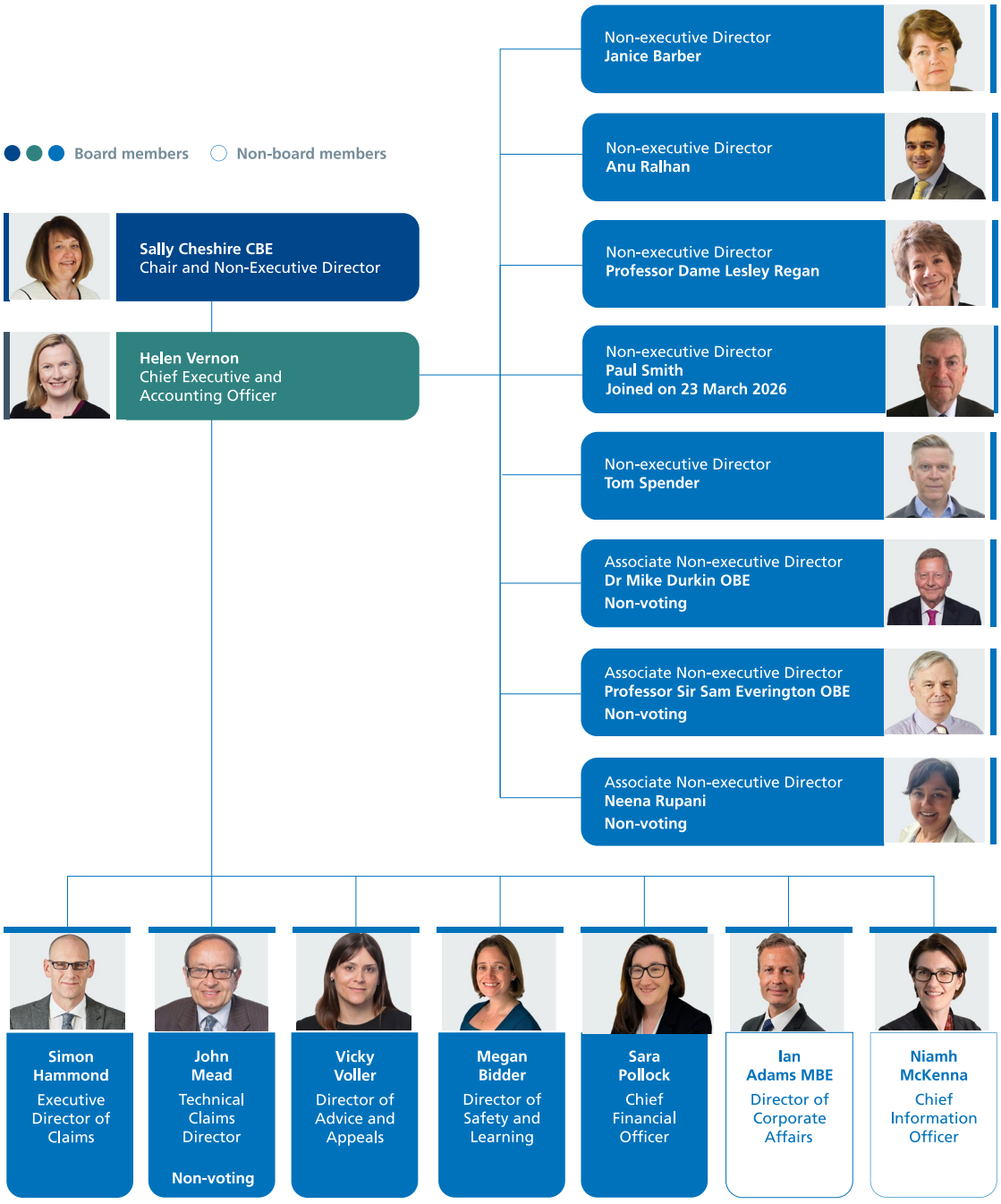
This report primarily provides information about the composition of the Board of NHS Resolution. The Board had authority or responsibility for directing or controlling the major activities of the entity during the year and has responsibility for setting the strategic direction and risk appetite of the 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. Details of the Board's activities are given in table 12.[1]

Board composition

As at 31 March 2026, the Board consisted of a non-executive Chair, five non-executive members, and five executive members. There are also three associate non-executive directors and one associate executive director. The Board can consist of the Chair, between three and five non-executive directors and between three and five executive directors.[2]

[1] Further information about our Board and governance structures can be found on our website at resolution.nhs.uk/about/governance/governance-structures.
[2] A register of interests of each of our Board members can be found on our website at resolution.nhs.uk/leadership.

Infographic 10: NHS Resolution's Board in operation from 1 April 2025 to 31 March 2026



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 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 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[1], 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 NHS Resolution's 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 NHS Resolution's auditors are aware of that information.

[11] https://www.gov.uk/government/publications/managing-public-money

I confirm that the Annual Report and Accounts as a whole are fair, balanced, and understandable, and I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that they 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*.

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.

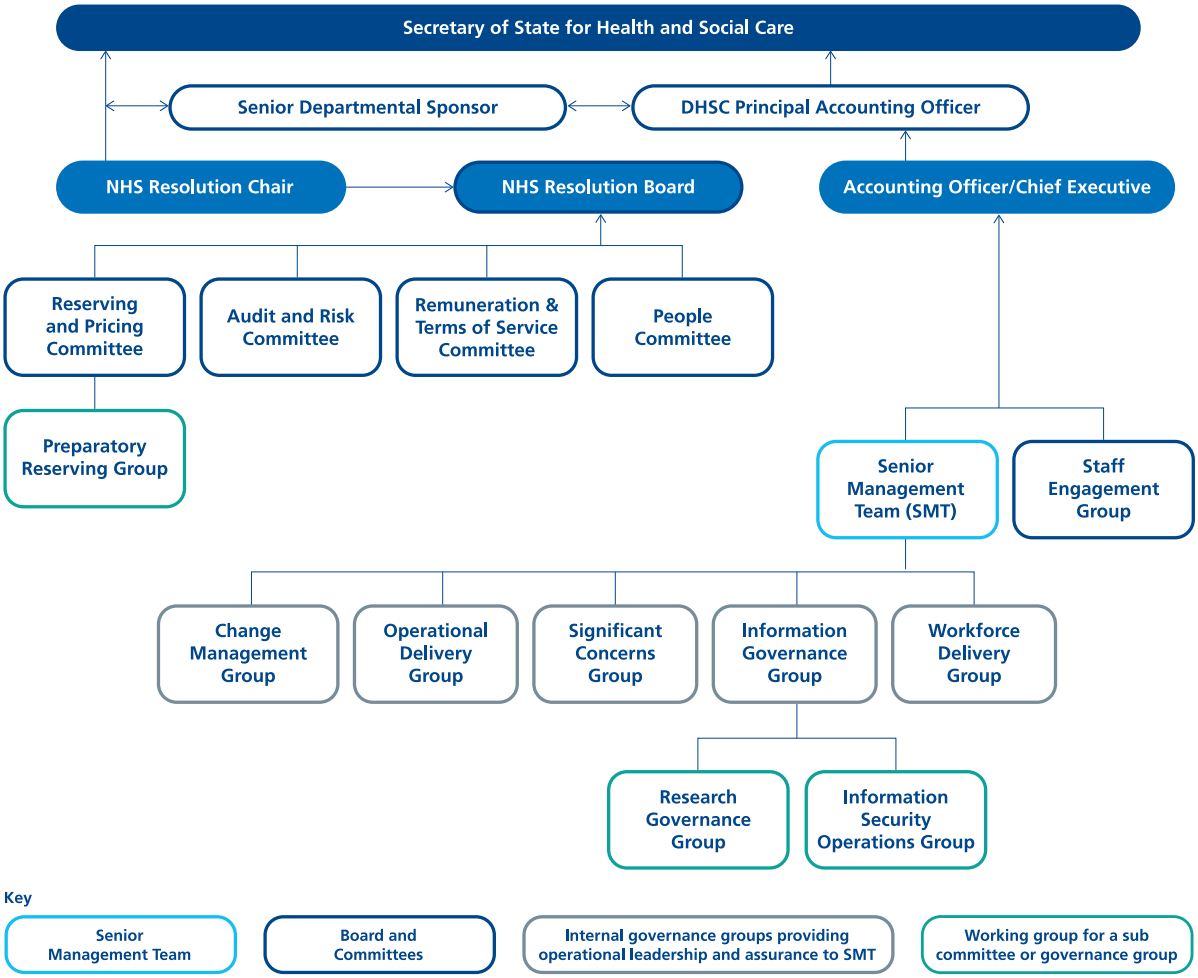
As Accounting Officer, I am supported by our Senior Management Team (SMT), internal audit, and the Audit and Risk Committee (ARC), and make recommendations to the Board on the matters outlined in this statement as they relate to effective governance. I am supported by the Board and SMT in ensuring we commit to and embed our values, as outlined in infographic 11, in everything we do.

Infographic 11: Our PEER values

The governance framework structures

Infographic 12 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.

Infographic 12: NHS Resolution governance structure in operation from 1 April 2025 to 31 March 2026



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 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 2025 to 31 March 2026 the Board met on six occasions. Table 11 provides further information on the attendance of the Board at these meetings and table 12 provides an overview of the key matters considered at these meetings.

Table 11: NHS Resolution Board meeting attendance from 1 April 2025 to 31 March 2026

Name	Post	Meetings attended
Sally Cheshire CBE	NHS Resolution Chair	6/6
Professor Dame Lesley Regan	Non-executive Director	5/6
Janice Barber	Non-executive Director	6/6
Anu Ralhan	Non-executive Director	6/6
Paul Smith[1]	Non-executive Director & ARC Chair	1/1
Tom Spender	Non-executive Director	6/6
Helen Vernon	Chief Executive	6/6
Sara Pollock	Chief Financial Officer	6/6
Megan Bidder	Director of Safety and Learning	5/6
Simon Hammond	Executive Director of Claims	6/6
Vicky Voller	Director of Advice and Appeals	6/6
Dr Mike Durkin OBE	Associate Non-executive Director	5/6
Sir Sam Everington OBE	Associate Non-executive Director	5/6
Neena Rupani	Associate Non-executive Director	6/6
John Mead	Associate Board Member	6/6

Table 12: Frequency of key matters discussed at Board meetings from 1 April 2025 to 31 March 2026

Matter	Number of meetings discussed
Chief Executive's report	
The Board considered reports from the Chief Executive that 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 plan, portfolio and key programme delivery and the strategy.	6/6
Annual Report and Accounts: Considered the drafting and endorsement of the Annual Report and Accounts for Accounting Officer signing.	2/6

[1] Appointed as NED March 2026.

Matter	Number of meetings discussed
Business plan: Discussed the development of and approved the 2025/26 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.	6/6
Administrative approvals	
Policies: Considered and approved polices as retained by the Board.	1/6

Compliance with the corporate governance code

As a public sector organisation, NHS Resolution has complied with the principles of the Corporate Governance in Central Government Departments: Code of Good Practice[1], taking account of our status as an arm's length body and the requirements set out in our Framework Agreement with the Department of Health and Social Care.

During the year, the organisation's governance arrangements were subject to an independent Board effectiveness review, providing an external assessment of Board effectiveness and the operation of the governance framework. The outcome was positive, confirming arrangements remain appropriate and proportionate to the organisation's role and operating environment.

Board and committee effectiveness

The Board keeps its effectiveness under regular review to ensure it remains fit for purpose and provides effective leadership, oversight, and challenge. In line with good practice, an independent external review of Board and Committee effectiveness was undertaken during the year.

The review provided assurance that the Board and its Committees are operating effectively and that governance arrangements are supporting proportionate, transparent, and confident decision-making. It highlighted positive progress in areas including strategic focus, Board cohesion, the quality of reporting, and the effectiveness of key Committees in supporting assurance and oversight. The findings also identified opportunities for further development, which will inform ongoing improvement activity during 2026/27 as the organisation continues to mature its governance arrangements.

Committees of the Board

The Board is supported by four Committees, which have been established to enable the Board, and me as Accounting Officer, to discharge our responsibilities and to ensure effective financial stewardship and internal controls are in place.

[1] assets.publishing.service.gov.uk/media/5a747d24e5274a7f9902893d/PU2077_code_of_practice_2017.pdf

Following a period of interim co-chairing arrangements, a permanent non-executive director was appointed as Chair of the Audit and Risk Committee during the year, ensuring continued effective leadership and stability.

The People Committee has had interim chairing arrangements in place to cover for six to nine months pending a newly appointed non-executive director taking on the role.

Each of the committees benefits from having independent, external members in place to support Board members on challenge and assurance.

Each of the committees has discharged its duties in line with its Terms of Reference and annual work plans.

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 supported by internal and external auditors.

As at March 2026, the Audit and Risk Committee is chaired by a Non-executive Director and comprises a further Non-executive Director and two independent members. These arrangements ensure the Committee is appropriately constituted and able to operate effectively, providing assurance to the Board in line with its Terms of Reference.

During this reporting period the Committee met on four occasions, table 13 provides further information on the attendance of ARC at these meetings.

Table 13: NHS Resolution ARC meeting attendance from 1 April 2025 to 31 March 2026

Name	Post	Meetings attended
Paul Smith[1]	Non-executive Director and Chair of ARC	0/0
Janice Barber	Non-executive Director and Co-chair of ARC	4/4
Marcus Hine	Independent Member and Co-chair of ARC	4/4
Kafui Tay	Independent Member	4/4

The Committee's key responsibilities are set out in its Terms of Reference[2] along with the standing items considered at its meetings. The Committee provided assurance to the Board on the adequacy and effectiveness of risk management, internal control, and governance arrangements, and considered other matters requiring assurance in line with its approved annual work plan.

[1] Appointed as Chair of the Audit and Risk Committee in March 2026. The Chair's first Committee meeting took place in May 2026.
[2] resolution.nhs.uk/wp-content/uploads/2026/04/NHSR-Audit-and-Risk-Committee-ARC-Terms-of-Reference-V6-2026.pdf

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee of the Board, chaired by the Chair of NHS Resolution. It determines remuneration, benefits, and terms of service for staff covered by the Executive and Senior Managers' pay framework, reviews senior recruitment proposals, and ensures effective systems are in place for performance monitoring. The Committee also oversees contractual arrangements for senior staff and reviews the effectiveness of succession-planning processes for senior positions.

Further details on the work of the Committee can be found in the Remuneration and staff report.

People Committee

The People Committee provides assurance to me, as Accounting Officer, and to the Board on people-related matters, including organisational development activity and associated workstreams. Since January 2025, the Committee has been chaired on an interim basis by the Chair of the NHS Resolution Board, ensuring continuity of governance in line with its Terms of Reference.

During the reporting period, the Committee held two meetings, supported by additional offline correspondence regarding the People Plan.

Name	Post	Meetings attended
Sally Cheshire	NHSR Board Chair – Interim People Committee Chair from 1 January 2025.	2/2
Lornette Pemberton	Independent Member and Advisor	2/2
Tom Spender[1]	Non-executive Director	2/2
Simon Hammond	Executive Director of Claims	2/2
Vicky Voller	Director of Advice and Appeals	2/2
Sara Pollock[2]	Chief Financial Officer	2/2

The Committee provides a dedicated forum for the consideration of people matters, offering oversight and support and escalating issues to the Board where further discussion or decision is required

Reserving and Pricing Committee

The Reserving and Pricing Committee (RPC) is chaired by a Non-executive director and also comprises me as Chief Executive Officer, the Chief Financial Officer, the Executive Director of Claims, an Associate Non-executive Director, and an independent member who is a qualified actuary.

The Committee's key responsibilities are set out in its Terms of Reference[3] along with the standing items considered at its meetings.

[1] Appointed to the Committee June 2025.
[2] Appointed as a member April 2025.
[3] resolution.nhs.uk/wp-content/uploads/2026/04/NHSR-Reserving-and-Pricing-Committee-RPC-Terms-of-Reference-V7-2026.pdf

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.

The Committee met on nine occasions through 2025/26:

Name	Post	Meetings attended
Anu Ralhan[1]	Non-executive Director and Chair of RPC	9/9
Neena Rupani[2]	Associate Non-executive Director	3/3
Helen Vernon	Chief Executive	8/9
Sara Pollock	Chief Financial Officer	9/9
Simon Hammond	Executive Director of Claims	8/9
Amerjit Grewal	Independent Member	8/9

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

The Government Actuary's Department (GAD) provides independent actuarial advice to support RPC in determining assumptions for the provisions on a best estimate basis.

[1] Chair from April 2025.
[2] Member from November 2025.

A statement from GAD for the year is set out below.

I, David 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 (excluding known incidents) for all schemes combined as at 31 March 2026 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 (excluding known incidents) for NHS Resolution as at 31 March 2026 that I have calculated, and are to be included in NHS Resolution's report and accounts, have been determined using an appropriate actuarial methodology and assumptions that are reasonable 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, known incidents and settled PPO provisions for NHS Resolution as at 31 March 2026 have been determined using an appropriate actuarial methodology and assumptions that are reasonable 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 and provides strategic leadership to the organisation. 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 discusses issues concerned with the activity of NHS Resolution of which the SMT has oversight or for which approval is required. This includes performance and 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 2025/26, the SMT continued to work 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 14, provide assurance to the SMT through regular reporting and the escalation of any risks or issues that could impact our business objectives.

Table 14: SMT sub-groups in operation from 1 April 2025 to 31 March 2026

SMT sub-group	Function
Change Management Group (CMG)	Oversees governance, prioritisation and delivery of change initiatives (projects and programmes) that support delivery of the business plan. Focuses on ensuring change activity is well managed, delivers intended benefits and represents value for money. Monitors risks and issues associated with delivery of change initiatives and ensures appropriate escalation.
Operational Delivery Group (ODG)	Monitors the delivery of business plan objectives and identifies associated risks and issues. Reviews operational performance and ensures improvement plans are implemented. Monitors operational risks, including the impact of change on service delivery, and ensures appropriate escalation. Ensures compliance with the policies approval process and assesses key changes to operational policies.

SMT sub-group	Function
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. 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). Ensures NHS Resolution has an effective organisational culture and workforce plan and consistent application of HR policies that support delivery of organisational objectives. 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. The Board is responsible for setting NHS Resolution's risk appetite and ensuring that an effective framework of governance, risk management, and control is in place and operating as intended.

Risk appetite

The Board has a risk appetite statement, which sets out the level of risk the organisation is willing to tolerate in delivering its strategy and operations while ensuring compliance with good standards of governance. The statement provides a framework for managers when considering their approach to risks, the options available to them, and the level of priority and resources that should be applied to mitigating actions.

During the year, NHS Resolution continued work to develop a more dynamic and practical approach to risk appetite. This includes strengthening how risk appetite informs the identification and response to our principal risks and ensuring that the framework better supports decision making at all levels of the organisation. As part of this work, we are moving towards more regular consideration of risk appetite by the Board as our risk management framework evolves, ensuring that changes in the internal and external environment can be reflected in a timely and proportionate way.

The Board expects that NHS Resolution's management will apply the risk appetite framework appropriately, ensuring that risks are well understood and managed effectively, while supporting the health and wellbeing of our staff and the continuity of our core services.

Risk management

Our approach to identifying, recording, escalating, and managing risks is set out in our Risk Management Policy and Procedure[1], which provides a consistent framework for managing strategic and operational risks across NHS Resolution.

Our risk management approach aligns with HM Treasury's Orange Book: Management of Risk – Principles and Concepts (2023)[2], including the treatment of emerging risks and integration of risk appetite.

Through this framework, risks that could affect our business objectives, finances, people, reputation, and environmental impacts, including climate-related matters, are regularly identified and assessed. Controls are evaluated and, where necessary, treatment plans are developed to manage risks within appetite, including arrangements to support business resilience and continuity in the event of significant disruption.

Strategic risks are overseen by the Senior Management Team, while operational risks are reviewed through the Operational Delivery Group, with escalation routes in place where additional oversight is required. These activities feed into a single integrated corporate risk register, enabling a coordinated and dynamic approach to risk management across the organisation. Regular risk reports are considered by the Board and the Audit and Risk Committee, with risks outside appetite subject to additional scrutiny and action as required.

Maturing our focus on principal risks

During the year, we strengthened the maturity of our approach to risk management by sharpening our focus on the organisation's principal risks. A structured programme of joint risk review sessions between the Senior Management Team and the Operational Delivery Group, supported by horizon scanning and benchmarking, enabled refinement of risk descriptions to better reflect both internal and external drivers.

This work supported clearer identification of those risks requiring active management, alongside enhanced Board oversight through improved dashboard reporting and twice-yearly deep dive discussions. Risk appetite is increasingly embedded as a practical management tool, informing how risks are categorised, prioritised, and responded to. This approach enables the Board to focus its attention on the risks that are most significant to the delivery of our strategy, while maintaining appropriate assurance over risks that are monitored or accepted.

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[1] resolution.nhs.uk/wp-content/uploads/2020/04/Risk-Management-Policy-and-Procedure-CG04.pdf

[2] assets.publishing.service.gov.uk/media/6453acadc33b460012f5e6b8/HMT_Orange_Book_May_2023.pdf

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 six reviews in the financial year.

Audit title	Audit opinion
Data Security Protection Toolkit	**Substantial**
Payroll Investigation	**Advisory**
Contract Management	**Reasonable**
Key Financial Controls – Payments / CaseHub Controls	**Substantial**
Data Strategy	**Advisory**
Claims Evolution Programme (CEP)	**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 2025/26.

Management assurance

Our assurance arrangements bring together governance and quality linked to our strategic objectives. These arrangements ensure 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

NHS Resolution monitors the risks associated with fraud, bribery, and corruption and has established arrangements to prevent, detect, and respond to them in line with the Government Counter Fraud Functional Standard (GovS013). 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, which remains the key fraud risk we face.

These arrangements are supported by our 2025–28 Counter Fraud, Bribery and Corruption Plan: A Strategic Approach and associated 2025/26 annual action plan.

During the year we reviewed and refreshed our Fraud Risk Assessments (FRAs) to ensure they reflect emerging threats, organisational changes, and cross-government intelligence. Outputs from these updated assessments informed improvements to internal controls, targeted awareness activity, and the prioritisation of proactive work.

We continued to deliver the annual action plan, including mandatory training, counter-fraud awareness activity informed by data, FRA findings, and insight from previous investigations. Progress was reported regularly to the Senior Management Team and the Audit and Risk Committee, consistent with GovS013 requirements.

Our Local Counter Fraud Specialists (GIAA) provided professional counter-fraud services, including targeted reviews, investigation support, and advice to strengthen controls. Where fraud, bribery or corruption concerns arose, these were investigated promptly and referred to statutory authorities where appropriate, with civil recovery or other proportionate actions considered to protect public funds.

These measures, alongside the ongoing review of key policies and alignment with our wider governance and risk management processes, support a consistent organisational approach to managing fraud risks, and maintaining an anti-fraud culture.

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 due legal process is adhered to.

Business critical models

All business critical models undergo an annual assurance review in line with the HM Treasury AQuA Book guidance[1]. The outputs of which are reported to the Reserving and Pricing Committee.

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.

[1] www.gov.uk/guidance/the-aqua-book

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, is 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.

During the year, the implementation of CaseHub resulted in operational challenges as services transitioned to new ways of working. These were managed through established governance arrangements, including Board and Senior Management Team oversight, with risks monitored and addressed within the organisation's overall control framework.

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 the Procurement Act 2023. As such, we include social value as a weighted evaluation criterion in all relevant 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.

Sustainability

We consider sustainability-related and climate-related matters as part of our wider approach to governance and risk management. Through our established risk management processes, we have considered sustainability-related risks within the organisation's overall risk profile. During 2025/26, no sustainability or climate-related risks were identified that met the threshold for inclusion as principal risks.

We report on climate-related financial disclosures in line with HM Treasury's Task Force on Climate-related Financial Disclosures (TCFD) aligned guidance, adopting a proportionate approach consistent with the phased implementation timetable. Further detail on our approach, including emissions monitoring and environmental performance, is set out in the 'Sustainability report' in the 'Performance analysis'.

Oversight of sustainability and environmental performance is supported through established reporting arrangements, including regular reporting to the Board.

We will keep our approach under review as expectations, data maturity, and the operating environment continue to develop.

Information governance and security

NHS Resolution has maintained ISO 27001 Information Security certification, demonstrating we have an effective information security management system. The recertification audit in November 2025 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.

Our incident policy and procedure 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.

During the year, NHS Resolution reported two information security incidents to the Information Commissioner's Office (ICO) in line with statutory requirements. None of these incidents resulted in regulatory action by the ICO.

Complaints and feedback

During the year, the organisation maintained effective arrangements for managing complaints, providing assurance that concerns about service quality are handled fairly, consistently, and in line with recognised standards. Our Complaints Policy[1] was updated to align with the UK Central Government Complaint Standards[2], introducing a simplified two stage process to strengthen clarity, proportionality, and oversight.

Our Complaints Policy is designed to address concerns about the quality of the service provided, rather than to review or overturn decisions made by service areas. We continue to ensure this distinction is clearly communicated, so expectations are managed appropriately and the complaints process remains focused on service improvement and learning.

There have been no complaints formally referred to the Parliamentary and Health Service Ombudsman (PHSO).

Health, safety, and wellbeing

Policies and procedures are in place to support the health, safety, and wellbeing of our staff, and staff are required to participate in training to ensure they are aware of these. All staff have completed a display screen equipment assessment to make sure they are working safely both in the office and at home. We provide an Employee Assistance Programme, various health and wellbeing tools, and the assistance of staff who act as trained mental health first aiders. Further information about the support we provide can

[1] resolution.nhs.uk/wp-content/uploads/2024/12/Complaints-Policy-CG12.pdf
[2] www.ombudsman.org.uk/organisations-we-investigate/complaint-standards/uk-central-government-complaint-standards

be found in the 'Supporting our people' section of the 'Staff report' (found in 'Remuneration and staff report' in the 'Accountability report').

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 engagement with the Human Resources / Organisational Development (HR/OD) team, including structured discussions on matters raised through Freedom to Speak Up activity and participation in relevant people-related work. This included contributing insight to internal activity such as policy review, management practice discussions and organisational development initiatives taking place during the year.
- Engagement with teams and managers, including meetings where appropriate, to share relevant intelligence arising from Freedom to Speak Up conversations and to support internal consideration of issues raised through established management and governance routes.
- Participation in corporate induction and wider engagement activity, supporting awareness of Freedom to Speak Up arrangements and the routes available to staff to raise concerns, including during periods of organisational change.

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[1] 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 deductions from salary, employer's

[1] https://www.gov.uk/government/publications/ppn-0223-tackling-modern-slavery-in-government-supply-chains/ppn-0223-tackling-modern-slavery-in-government-supply-chains-guidance-html

contributions, and payments into the scheme are in accordance with the scheme rules, and 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.

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 has been in place for the year ended 31 March 2026 and up to the date of approval of the Annual Report and Accounts, and has been effectively maintained throughout 2025/26.

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 twice during the 2025/26 financial year. All meetings were quorate (had the required minimum number of members present) with the attendance of members shown in table 15.

Table 15: Remuneration and Terms of Service Committee meeting attendance from 1 April 2025 to 31 March 2026

Name	Post	Meetings attended
Sally Cheshire CBE	Chair	2/2
Janice Barber	Non-executive Director	2/2
Professor Dame Lesley Regan	Non-executive Director	2/2
Anu Ralhan	Non-executive Director	2/2
Tom Spender	Non-executive Director	1/2

In July 2025, the Committee considered an update on the appraisals discussions that had been held with each of the ESMs as presented by the CEO. This included the performance of each of the ESMs and the assigned performance ratings. They also considered the performance of the CEO as presented by the Chair, including the assigned performance rating. The Committee considered and approved the application of the 2025/26 pay awards and the performance related payments for the 2024/25 performance year.

In March 2026 the Committee noted the relevant off-line approvals provided in May 2025 and September 2025 which included the approval of the business case to extend the existing senior maternity clinical adviser positions on a fixed-term basis. They noted the stepping down of two associate non-executive directors from the end of their current tenures and approved the extension to one existing associate non-executive director. They also agreed the 2026/27 annual work plan.

The Committee considered its performance in 2025/26 as satisfactory and concluded it had discharged its obligations as set out in the Terms of Reference[1]. The Committee also considered that the Terms of Reference remain appropriate and fit for their purpose.

[1] resolution.nhs.uk/wp-content/uploads/2026/04/NHSR-People-Committee-Terms-of-Reference-V1.8-2026.pdf

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 for which it is 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[1]. 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[2].

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, pay protection, 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 2025/26, except for the associate executive directors who have no voting rights on the Board. There were two changes in Board membership during 2025/26. A new non-executive director and Audit and Risk Committee Chair, Paul Smith, started his term of office on 23 March 2026. Sara Pollock, Chief Financial Officer, commenced in post from 1 April 2025 replacing Joanne Evans who left on 5 April 2025.

Tables 16, 17, and 18 that follow are subject to audit.

[1] www.nhsemployers.org/publications/tchandbook
[2] www.nhsemployers.org/articles/pay-and-conditions-circulars-medical-and-dental-staff

Table 16: Executive and non-executive director salaries and allowances[1] for 2025/26

Name and title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	All pension-related benefits [2] total to nearest £1,000	Total (bands of £5,000) £000
Sally Cheshire CBE *(Chair)*	60-65	5,000	0	N/A	**65-70**
Helen Vernon[3] *(Chief Executive)*	165-170	0	5-10	59,000	**230-235**
Sara Pollock[4] *(Chief Financial Officer)*	120-125	0	0	38,000	**160-165**
Joanne Evans[5] *(Director of Finance & Corporate Planning)*	0-5	0	0	-	**0-5**
Vicky Voller *(Director of Advice and Appeals)*	135-140	1,100	0	45,000	**180-185**
John Mead *(Technical Claims Director)*	120-125	0	0	60,000	**180-185**
Megan Bidder *(Director of Safety and Learning)*	105-110	0	0	27,000	**135-140**
Simon Hammond *(Director of Claims Management)*	125-130	2,000	5-10	35,000	**165-170**
Janice Barber *(Non-executive Director)*	10-15	0	N/A	N/A	**10-15**
Professor Dame Lesley Regan *(Non-executive Director)*	5-10	0	N/A	N/A	**5-10**
Anu Ralhan *(Non-executive Director)*	5-10	0	N/A	N/A	**5-10**
Tom Spender *(Non-executive Director)*	5-10	0	N/A	N/A	**5-10**
Paul Smith[6] *(Non-executive Director)*	0-5	0	N/A	N/A	**0-5**
Dr Mike Durkin OBE *(Associate Non-executive Member)*	5-10	0	N/A	N/A	**5-10**
Sir Sam Everington OBE *(Associate Non-executive Member)*	5-10	0	N/A	N/A	**5-10**
Neena Rupani *(Associate Non-executive Member)*	5-10	0	N/A	N/A	**5-10**

[1] 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.
[2] 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.
[3] 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.
[4] Sara Pollock was appointed Chief Financial Officer and executive director on 1 April 2025.
[5] Joanne Evan's appointment as Director of Finance & Corporate Planning ended on 5 April 2025.The full year equivalent salary is in the band of £130-135k.
[6] Paul Smith's appointment as Non-executive Director and Chair of the ARC commenced on 23 March 2026. The non-executive director full year equivalent salary is in the band of £10–15k.

Table 17: Executive and non-executive director salaries and allowances[1] for 2024/25

Name and title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	All pension-related benefits [2] total to nearest £1,000	Total (bands of £5,000) £000
Sally Cheshire CBE[3] *(Chair)*	60–65	7,100	0	N/A	**70–75**
Helen Vernon[4] *(Chief Executive)*	165–170	0	5–10	33,000	**210–215**
Joanne Evans *(Director of Finance and Corporate Planning)*	135–140	7,800	0	42,000	**185–190**
Vicky Voller *(Director of Advice and Appeals)*	130–135	300	0	23,000	**150–155**
John Mead *(Technical Claims Director)*	110–115	4,700	0	28,000	**145–150**
Megan Bidder *(Director of Safety and Learning)*	100–105	0	0	26,000	**130–135**
Simon Hammond[5] *(Director of Claims Management)*	120–125	1,100	5–10	33,000	**160–165**
Charlotte Moar[6] *(Non-executive Director)*	5–10	2,000	N/A	N/A	**10–15**
Nigel Trout[7] *(Non-executive Director)*	5–10	100	N/A	N/A	**5–10**
Janice Barber *(Non-executive Director)*	5–10	0	N/A	N/A	**5–10**
Professor Dame Lesley Regan *(Non-executive Director)*	5–10	0	N/A	N/A	**5–10**
Anu Ralhan *(Non-executive Director)*	5–10	0	N/A	N/A	**5–10**
Tom Spender[8] *(Non-executive Director)*	0–5	0	N/A	N/A	**0–5**
Dr Mike Durkin OBE *(Associate Non-executive Member)*	5–10	0	N/A	N/A	**5–10**
Sir Sam Everington OBE *(Associate Non-executive Member)*	5–10	0	N/A	N/A	**5–10**
Neena Rupani[9] *(Associate Non-executive Member)*	0–5	0	N/A	N/A	**0–5**

[1] 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.
[2] 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.
[3] Sally Cheshire was reappointed as Chair of NHS Resolution for three years from 18 September 2024.
[4] 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.
[5] Simon Hammond was appointed as executive director on 1 April 2024.
[6] Charlotte Moar's non-executive director appointment and Chair of the ARC ended on 31 December 2024. The non-executive director full year equivalent salary is in the band of £10–£15k.
[7] Nigel Trout's non-executive director appointment ended on 31 December 2024. The non-executive director full year equivalent salary is in the band £5–£10k.
[8] Tom Spender's appointment as non-executive director commenced on 17 January 2025. The non-executive director full year equivalent salary is in the band of £5–10k.
[9] Neena Rupani's appointment as associate non-executive member commenced on 17 March 2025. The associate non-executive member full year equivalent salary is in the band of £5–10k.

Pension entitlements for executive directors

Table 18: 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 2026 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2026 £000	Cash equivalent transfer value at 31 March 2025 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Helen Vernon *(Chief Executive)*	2.5-5	0-2.5	55-60	135-140	1,285	1,181	63	0
Sara Pollock[1] *(Chief Financial Officer)*	2.5-5	0	20-25	0	275	235	21	0
Vicky Voller *(Director of Advice and Appeals)*	2.5-5	0-2.5	40-45	90-95	782	716	37	0
Megan Bidder *(Director of Safety and Learning)*	0-2.5	0	5-10	0	60	35	11	0
John Mead *(Technical Claims Director)*	2.5-5	0-2.5	45-50	100-105	0	0	0	0
Simon Hammond *(Director of Claims Management)*	2.5-5	0	15-20	0	255	212	24	0

[1] Sara Pollock was appointed as executive director on 1 April 2025.

Cash equivalent transfers

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was in existence at 31 March 2026. HMT published updated guidance on 27 April 2023; this guidance has been used in the calculation of 2025/26 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.

Fair pay disclosures

The fair pay disclosures are subject to audit.

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 2025/26 was £170,000–£175,000 (£175,000–£180,000 in 2024/25)

reflective of a decrease of 2.8%. The relationship to the remuneration of the organisation's workforce is disclosed in the following table.

Table 19: Fair pay ratios

		25th percentile	Median	75th percentile
2025/26	Total remuneration	£46,580	£56,276	£68,631
	Pay ratio – total remuneration	3.70:1	3.07:1	2.51:1
	Salary component of total remuneration	£46,580	£56,276	£68,631
2024/25[1]	Total remuneration	£44,962	£54,320	£66,246
	Pay ratio – total remuneration	3.95:1	3.27:1	2.68:1
	Salary component of total remuneration	£44,962	£54,320	£66,246

In 2025/26, the 25th percentile pay ratio has reduced more compared to the prior year than the median/75th percentile ratios because the average salary of staff has increased by more than 3%, whereas the remuneration of the highest-paid director has reduced from 2024/25.

In 2025/26 no employee (2024/25 no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £26,500 to £175,000 (2024/25 £26,500 to £178,000). 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 is £5,000 less than the banding for 2024/25.

Non-consolidated performance related pay (non-pensionable) applies only to Executive and Senior Management (ESM) within NHS Resolution and responsibility for deciding such performance pay awards is delegated by DHSC to NHS Resolution's Remuneration Committee. The framework by which performance related payments are made is subject to the performance rating applied (developing/meeting/exceeding), and in conjunction with the national pay award, the recommendations made by the (Senior Salaried Review Body) which are accepted by Government and notified via DHSC.

There are no specific KPIs/performance targets set in relation to performance pay, but instead key work objectives are set each year. These objectives and the overall performance rating (developing/meeting/exceeding) are discussed as part of the annual performance and development review process. This process is completed by the CEO and presented to the Remuneration Committee for review and their decision on performance pay awards. It should be noted that performance payment awards are paid in arrears.

The basic pay of the highest-paid director in NHS Resolution in the financial year 2025/26 was £165,000–£170,000 (2024/25 £165,000–£170,000) reflecting no change

[1] 2024/25 figures have been restated to exclude non-executive directors as per updated FReM guidance.

year on year. The performance and bonus pay of the highest-paid director for 2025/26 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 3.2% increase (2024/25 3.9% increase[1]), with the percentage change in basic pay being a 3.2% increase (2024/25 4.3% increase). Total performance pay and bonuses decreased 2.72% year on year. In 2024/25 staff were paid an NHS Agenda for Change pay award of 5.5% compared to a pay award of 3.6% in 2025/26. Therefore in 2025/26 the average total remuneration increased from the prior year but at a lower rate than in 2024/25.

The increase in pay and allowances that can be seen is a result of the NHS Agenda for Change pay award of 3.6%. In addition, the average workforce grew by 54 full-time equivalent at an average remuneration lying between the median and the upper quartile.

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

Staff report

NHS Resolution's workforce supports the delivery of its statutory functions through a combination of specialist, professional, and corporate roles. The organisation's People Plan 2025-28 was launched in September 2025. It is aligned to the planned growth and transformation programmes, placing strong emphasis on workforce planning, skills development, and leadership capacity. This includes ensuring the organisation can attract, retain, and develop the skills required to support transformation activity and longer-term organisational sustainability. At the end of the first year of the plan, we made good progress across a number of key areas of activity. Approximately half of the People Plan KPIs were met or partially met, with others to be carried forward into 2026/27.

Our people

During the year, the organisation continued to plan for future growth and transformation, including changes to operating models, systems, and ways of working, to ensure it has the capacity and capability required to meet anticipated demand. In 2025/26 there has been an increase in average full-time equivalent (FTE) staff from 778 in 2024/25 to 832 in 2025/26. Year-end FTE grew from 832 in 2024/25 to 838 in 2025/26, demonstrating growth of six FTE across the full year. Delivery of the Claims Evolution Programme has continued to shape the organisation's workforce profile, with the increase in average FTE staff reflecting the capacity required to support the expansion of in-house claims handling, alongside the implementation of new operating models and systems, including CaseHub.

The overall turnover rate for 2025/26 was 9.5% an increase compared to 8% in 2024/25. Our voluntary staff turnover rate was 7.2% in 2025/26 compared to 5% in 2024/25. Non-voluntary turnover includes the end of fixed-term contracts, cases of death in service,

[1] 2024/25 figures have been restated to exclude non-executive directors as per updated FReM guidance.

and dismissals which includes compulsory redundancies. The organisation had no compulsory redundancies in 2025/26.

Staff costs

Tables 20 and 21 set out staff costs and average staff numbers, which are subject to audit.

Table 20: Staff costs 1 April 2025 to 31 March 2026 compared to 1 April 2024 to 31 March 2025

Staff costs	Permanently employed staff	Other[1]	2025/26 Total	2024/25 Total
	£000	£000	£000	£000
Salaries and wages	47,445	870	**48,315**	43,526
Social security costs	6,499	0	**6,499**	4,942
Employer contributions to NHS Pensions	9,579	0	**9,579**	8,794
NEST pension contributions	3	0	**3**	4
Apprenticeship levy	225	0	**225**	203
Total	**63,751**	**870**	**64,621**	**57,469**

Table 21: The average full-time equivalent staff employed broken down by related costs 1 April 2025 to 31 March 2026 compared to 1 April 2024 to 31 March 2025

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other[2]	2025/26 Total	2024/25 Total
Core department	824	8	832	766
Capital projects	0	0	0	12
Total	**824**	**8**	**832**	**778**

Off-payroll engagement

As of 31 March 2026, NHS Resolution has one off-payroll appointment costing more than £245 per day. This appointment is unlikely to last longer than 12 months and, at the time of reporting, the appointment has existed for less than six months. The appropriate pre-placement checks were completed for this and all off-payroll engagements, with the required assurances obtained to confirm these placements were assessed to ensure the

[1] Other is seconded/agency staff.
[2] Other is seconded/agency staff.

appropriate tax and National Insurance arrangements were in place as they were not covered by IR35.[1]

Table 22: All off-payroll engagements as of 31 March 2026, for more than £245 per day

Off-payroll engagements as of 31 March 2026	
No. of existing engagements as of 31 March 2026	1
Of which:	
No. that have existed for less than one year at time of reporting	1
No. that have existed for between one and two years at time of reporting	-
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 23: All off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

Off-payroll engagements between 1 April 2025 and 31 March 2026	
No. of temporary workers engaged between 1 April 2025 and 31 March 2026	7
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	7
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	-

[1] 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.

Table 24: Any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026

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	-
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	8

Exit packages

Table 25: 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	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
Less than £10,000	-	-	3	11	3	11	-	-
£10,000–£25,000	-	-	-	-	-	-		
£25,001–£50,000	-	-	-	-	-	-	1	42
£50,001–£100,000	-	-	-	-	-	-	-	-
£100,001–£150,000	-	-	-	-	-	-	-	-
£150,001–£200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Totals for 2025-26	**-**	**-**	**3**	**11**	**3**	**11**	**1**	**42**
Totals for 2024-25	**-**	**-**	**5**	**43**	**5**	**43**	**-**	**-**

Table notes

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.

Table 26: 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	3	11
Exit payments following employment tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**3**	**11**

Table notes

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 25, which will be the number of individuals.

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

Sickness absence

The following figures are based on the 2025 calendar year. DHSC considers the resulting figures to be a reasonable proxy for financial year equivalents.

Table 27: Sickness absence figures

Figures converted by DHSC to best estimates of required data items			Statistics published by NHS Digital from ESR Data Warehouse	
Average FTE 2025	Adjusted FTE days lost to Cabinet Office definitions	Average sick days per FTE	FTE days available	FTE days recorded sickness absence
832	**4,162**	**5.0**	**303,544**	**6,751**

Table notes

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

Period covered: January to December 2025.

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.

Equality, diversity, inclusion and belonging

NHS Resolution remains committed to promoting equality, diversity, inclusion and belonging and to meeting its statutory equality duties. As part of its business-as-usual activity, the organisation continued to embed inclusive practices across employment processes and to support a respectful and inclusive working environment. As detailed in figure 23, in 2025/26, the proportion of employees from ethnic minority groups has decreased in 2025/26 to 32.9% compared to 34% in 2024/25. Similarly, the proportion of employees from white groups (including white minority groups) has decreased to 63% compared to 63.7% in 2024/25.

Figure 23: Ethnicity of NHS Resolution staff (organisational profile) in 2025/26

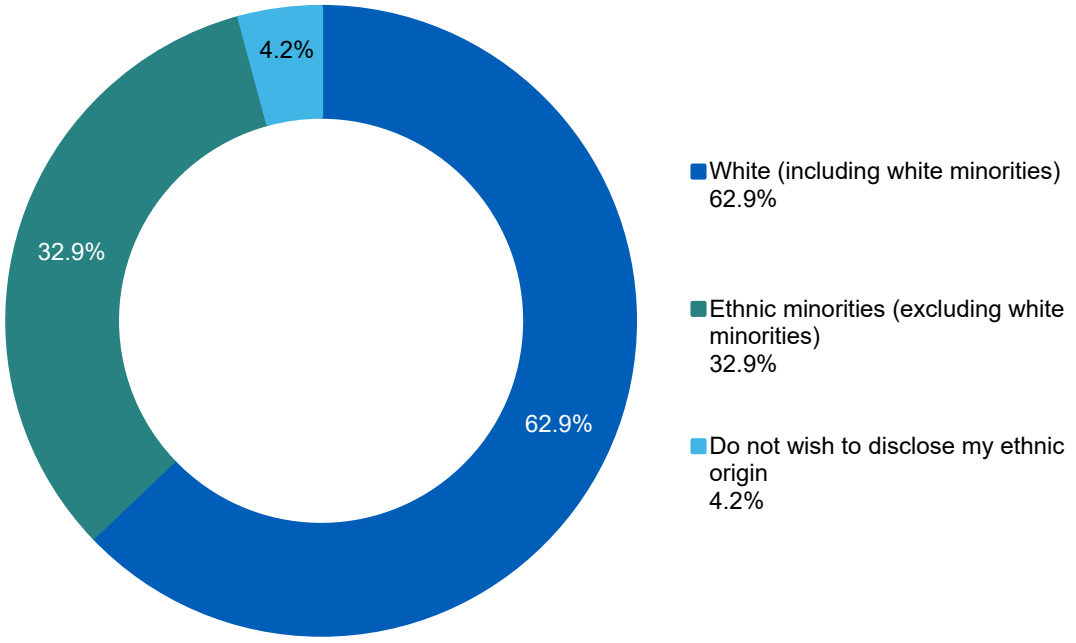
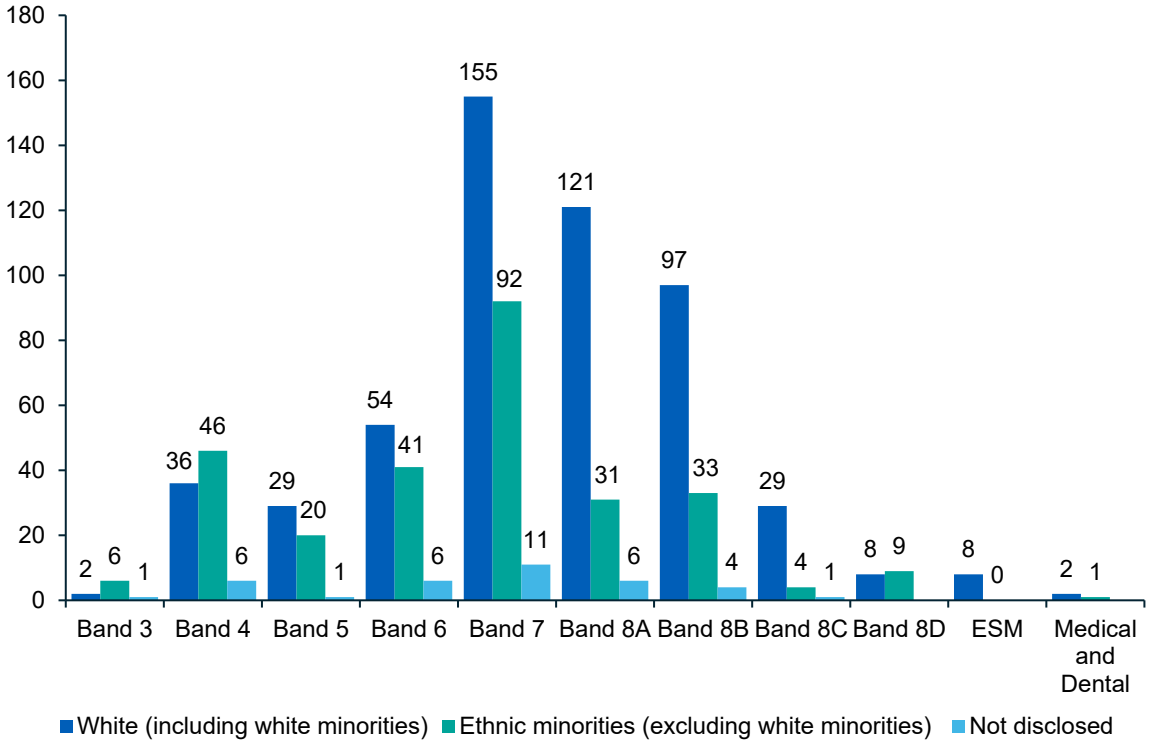


Figure 24: Ethnicity of staff based at NHS Resolution's London and Leeds offices compared to regional ethnicity data

The organisation's regional ethnicity numbers have remained largely comparable to the 2024/25 figures. The only notable changes are a decrease in the percentage of staff within the ethnic minority groups (excluding white minorities) for the London region which reduced to 40.2% from 42.3% in 2024/25, and a decrease in the percentage of staff within the white groups (including white minorities) for the Leeds regions down from 69.6% in 2024/25 to 68.2% in 2025/26.

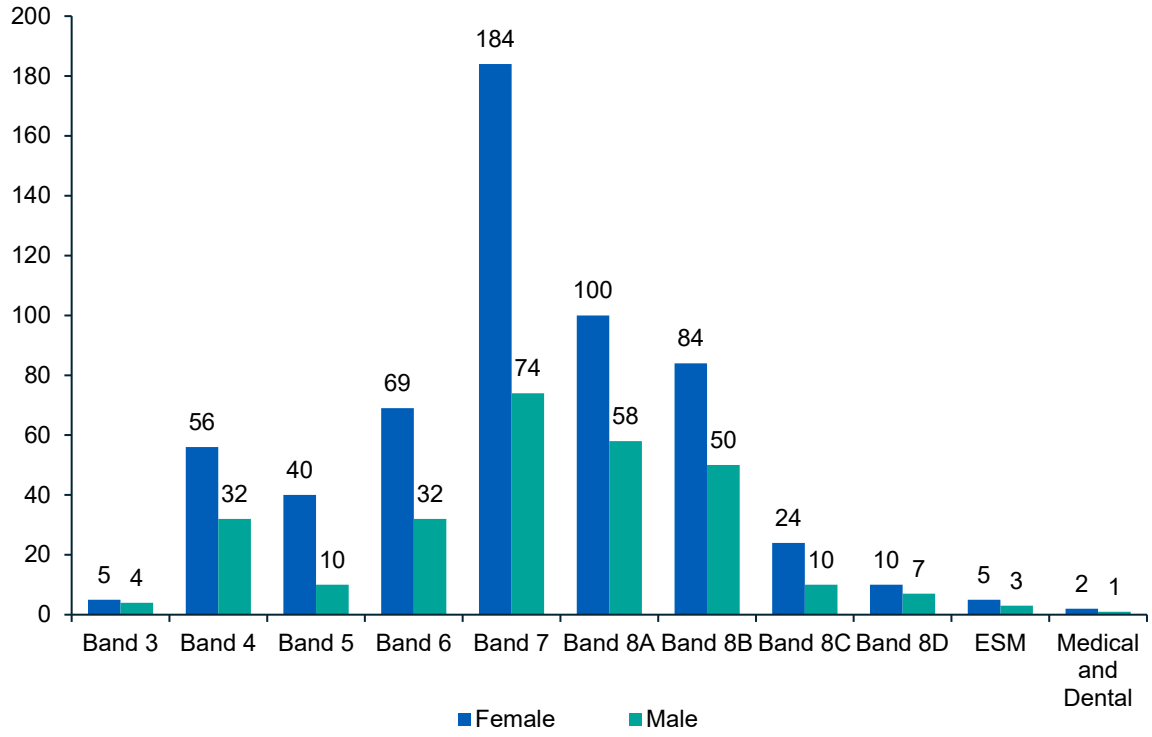
Figure 25: Headcount by ethnicity as at 31 March 2026



The headcount numbers in Figure 25 are broadly consistent with those reported in 2024/25 with no areas of significant change.

As at 31 March 2026, the organisation's gender split ratio for all employees was 33% male and 67% female. This is unchanged from the 2024/25 figures. Of the eight executive and senior managers, three were male (38%) and five were female (62%) which also remains unchanged from 2024/25.

Figure 26: Staff headcount broken down by gender and banding from 1 April 2025 to 31 March 2026



The ratio of female and male staff within each of the pay bands has remained broadly consistent when compared to 2024/25. There is a notable increase in the number of female staff within pay bands 7 and 8C.

Information on our gender pay gap (GPG) report for the 12-month period ending 31 March 2026 can be found in the section below.

Table 28 shows for each application category, the percentage of applications that were shortlisted and the percentage of appointments made from the shortlisted candidates. It also provides a comparison to the previous year.

Table 28: A comparison of the proportion of job candidates shortlisted and appointed to role at NHS Resolution in 2025/26 and 2024/25 with and without a disclosed disability

Application category	% Shortlisted 2025/26	% Shortlisted 2024/25	% Appointed from shortlisting 2025/26	% Appointed from shortlisting 2024/25
Disabled	21.6	22.6	23.2	21.5
Not disabled	19.6	22.3	22.4	25.3
Not disclosed	28.8	32.1	18.2	10.2

Table notes: The above figures exclude appointments made via agencies.

We appointed to 123 vacancies in 2025/26 when testing the external market, which was lower than the 168 in 2024/25. Throughout 2025/26 we shortlisted and appointed a marginally higher number of candidates who considered themselves as having a disability compared to those who did not. While the percentage of applicants shortlisted reduced across all categories compared to 2024/25, the percentage of appointments made from those who considered themselves as having a disability increased to 23.2%, up from 21.5% in 2024/25.

The percentage of employees disclosing that they consider themselves as having a disability has remained at 9% from 2024/25.

We continue to demonstrate our commitment to our Disability Confident Leader award achieved in July 2023 and we are currently working towards our re-accreditation due in July 2026. Our staff-led Disability Network has continued to meet throughout 2025/26.

Supporting our people

In line with our People Plan, our key activities during 2025/26 were as follows.

Cultivating a safe, inclusive culture

Create a culture where everyone feels safe, supported, and proud to belong ensuring our Equality, Diversity, Inclusion and Belonging (EDIB) activities are a golden thread in all interventions.

Our Investors in People (IiP) reaccreditation process was completed in Q4 and we were successful in maintaining our gold level accreditation. This achievement is a recognition of the hard work of everyone across the organisation. The IiP framework supports the improvement of workplace culture by focusing on employee engagement, communication, organisational culture, and work practices.

Empowering staff through everyday and transformational change

Supporting our staff with the practical and technical challenges of adopting new systems, operating models and ways of working.

We created a corporate learning and development offer based on the workforce needs identified through the People Plan engagement sessions, a corporate learning needs analysis, and input from our Freedom to Speak Up Guardians and employee assistant programme provider. The key themes fed into an enhanced learning and development offer which includes sessions on:

- Leading and managing change
- Resilience and managing stress
- Project management
- Time management and productivity
- Developing leadership and management capability

We have continued to review and update our range of health and wellbeing resources available and rolled out the new ‘Champion Health’ app which was made available via our EAP provider.

Developing leadership and management capability

Ensuring that our managers are developed and supported to lead.

We commenced a procurement business case to commission a leadership and management development programme. While approval is pending, for the interim period, we developed an enhanced internal offer for structured management development session in support of *'Managing the employee lifecycle'.*

Enhancing digital workforce solutions

Continue to develop our digital capability to support the workforce and managers, including workforce systems, workforce reporting and developing digital training.

In May 2025, following a successful pilot, the whole organisation went live with an end-to-end applicant tracking system, giving us a modern, reportable, and easy-to-use system for candidates, hiring managers, and the resourcing function. The new system has supported 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. Feedback from users is sought on an ongoing basis and to date has been extremely positive.

We established a corporate digital training team, which has continued to evolve the offer of digital training, education, and learning for the organisation. The main responsibilities of this team are:

1. To continue to progress and optimise the use of our workforce systems to drive efficiencies making best use of people processes for both employees and line managers.
2. To continue to develop comprehensive digital training to support our change and transformation programmes.

We have developed a new monthly performance pack for people and workforce related data. This monthly report provides organisational and directorate level information to inform the business on how the organisation is performing. Where appropriate, this pack is also used for our People Committee and Board meetings, reducing the duplication of reports and streamlining processes.

Gender Pay Gap

In March 2026, in accordance with the requirements under the Equality Act 2010, we published our 2025 gender pay gap (GPG) report.

What are the key findings of the 2025 GPG report?

- The mean gender pay gap has decreased from 8.2% in 2024 to 6.4% in 2025
- The median gender pay gap has decreased from 10.9% in 2024 to 7.2% in 2025
- The mean bonus pay gap is -9.1%[1]
- The median bonus pay gap is 0.0%[2]
- The proportion of male staff paid a bonus was 1.4% and for females it was 1.4%
- Females occupied 57.1% of the highest paid roles (upper quartile) on 31 March 2025, compared to 55.9% in the previous reporting period. However, 57.1% is lower than the organisational profile of females which is 67%.

[1] In reviewing the most recent guidance, this data now includes employees who have received employee of the month/year awards during the 2024/25 financial year, and not just those who received their award in March 2025. In 2025, females received a higher level of bonus compared to male employees. The minus figure, therefore, denotes a mean bonus pay figure which is higher for females than males.

[2] In 2025, the median bonus pay was the same for females and males.

Parliamentary accountability and audit report

The following disclosures are subject to audit except where specified.

Losses and special payments

For the year under review, we reported losses of £175,000 (2024/25 £63,000) and special payments of £72,000 (2024/25 £353,000) the latter made up of two special payments one of which was a severance payment and both approved by HM Treasury. Of the special payments made in year, all individual payments were below the £300,000 threshold.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, including the Clinical Negligence Scheme for Trusts (CNST), the Liabilities to Third Parties Scheme (LTPS), and Property Expenses Scheme (PES), are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy in 'Note 1.3' in the 'Notes to the financial statements'. The member contributions collected are set on the estimated full cost recovery basis. In addition to member contributions, NHS Resolution earns income from advice services which makes up our total operating income as detailed in 'Note 3' in the 'Notes to the financial statements'. For 2025/26 total operating income was £3.1 billion (2024/25 £2.9 billion) with related expenditure totalling £3.0 billion (2024/25 £2.9 billion).

Expenditure on consultancy

No expenditure was incurred on consultancy in 2025/26 (2024/25 nil).

Gifts – notation of gifts made over the limits proscribed in Managing Public Money

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 staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Regularity of expenditure

All expenditure is regular within the bounds of Parliament's intentions.

Indemnity schemes cover for NHS Resolution (not subject to audit)

For 2025/26, NHS Resolution was covered under both LTPS and PES.

Government Functional Standards (not subject to audit)

We continue to be compliant with the mandated requirements of the Government Functional Standards. We consider actions for continuous improvement in line with the Government Functional Standards Continuous Improvement Frameworks where relevant and proportionate to the work of NHS Resolution.

Remote contingent liabilities

The judgements and estimates taken to place a value on the provision and contingent liabilities (see 'Note 7' and 'Note 8' in the 'Notes to the financial statements') arising from the indemnity schemes that NHS Resolution administers do not include an assessment for events that, at this point in time, are too uncertain or remote to include. Therefore, there is no recognition of potential change in the value of the provision arising from policy developments, in particular around efforts to improve safety in the NHS (other than through experience reflected in current and past claims).

The Department of Health and Social Care previously proposed a scheme to apply Fixed Recoverable Costs (FRCs) to clinical negligence claims valued at between £1,500 and £25,000 coupled with a streamlined pre-action protocol with fixed timelines. The current Government has made no announcement on the future of the FRC scheme. The Civil Procedure Rule Committee (CPRC) will be responsible for enacting any necessary rule changes and we continue to monitor progress to ensure that NHS Resolution is in a position to respond if FRC proceeds.

Disclosures in relation to liabilities arising from the Covid-19 pandemic have been made in 'Note 7' and 'Note 8' in the 'Notes 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 2025/26.

Helen Vernon

Chief Executive and Accounting Officer

Date: 3 July 2026

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 2026 under the National Health Service Act 2006.

The financial statements comprise NHS Resolution's:

- Statement of Financial Position as at 31 March 2026;
- 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 2026 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 (2024). 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 2024. 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 12 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 Comptroller and Auditor General (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 issued under the National Health Service Act 2006;
- preparing the annual report, which includes the Remuneration and Staff Report, in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- 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 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 relevant specialists, including actuarial and IT 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 recognition, posting of unusual journals and complex transactions and bias in management estimates. In common with all audits under ISAs (UK), I am also 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.

6 July 2026

Gareth Davies

Comptroller and Auditor General

National Audit Office

157–197 Buckingham Palace Road Victoria

London

SW1W 9SP

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2026[1]

Comprehensive net expenditure	Notes	31 March 2026 £000	31 March 2025 £000
Other operating income	3	**(3,058,867)**	(2,929,613)
Total operating income		**(3,058,867)**	**(2,929,613)**
Staff costs	2	**64,621**	57,469
Purchase of goods and services	2	**8,658**	8,386
Depreciation and impairment charges	2	**2,491**	1,713
Provision (release)/expense	7/7.1	**1,691,841**	3,674,306
Other operating expenditure	2	**4,492**	4,006
Total operating expenditure		**1,772,103**	**3,745,880**
Net operating expenditure		**(1,286,764)**	**816,267**
Finance costs – interest on lease liability	2/9	**69**	**78**
Finance costs – claims	7	**1,534,632**	**1,305,762**
Net expenditure for the year		**247,937**	**2,122,107**
Comprehensive net expenditure for the year		**247,937**	**2,122,107**

[1] The accompanying notes form part of these financial statements.

Statement of financial position as at 31 March 2026

Statement of financial position	Notes	31 March 2026 £000	31 March 2025 £000
Non-current assets			
Property, plant, and equipment		**516**	544
Intangible assets		**13,503**	14,476
Right of use assets		**6,337**	7,362
Total non-current assets		**20,356**	**22,382**
Current assets			
Trade and other receivables	4	**25,870**	15,643
Cash and cash equivalents	5	**733,688**	739,241
Total current assets		**759,558**	**754,884**
Total assets		**779,914**	**777,266**
Current liabilities			
Trade and other payables	6	**(76,261)**	(88,058)
Lease liability – short term	9	**(1,001)**	(971)
Provisions for liabilities and charges – known claims	7	**(4,233,177)**	(3,668,755)
Total current liabilities		**(4,310,439)**	**(3,757,784)**
Total assets less current liabilities		**(3,530,525)**	**(2,980,518)**
Non-current liabilities			
Lease liabilities	9	**(5,702)**	(6,702)
Provisions for liabilities and charges – known claims	7	**(33,615,173)**	(32,575,315)
Provisions for liabilities and charges – IBNR	7	**(22,410,704)**	(24,082,000)
Total non-current liabilities		**(56,031,579)**	**(56,664,017)**
Total assets less liabilities		**(59,562,104)**	**(59,644,535)**
Taxpayers' equity			
General Fund		**54,022**	38,284
Ex-RHA reserve		**(33,410)**	(35,328)
ELS reserve		**(636,115)**	(672,660)
CNST reserve		**(54,920,113)**	(55,198,419)
DHSC clinical reserve		**(1,644,991)**	(1,701,224)
ELSGP reserve		**(424,346)**	(483,666)
CNSGP reserve		**(1,678,573)**	(1,352,902)
CNSC reserve		**(5,301)**	(7,212)
CTIS reserve		**(54)**	(4)
DHSC non-clinical reserve		**(99,101)**	(83,631)
PES reserve		**(721)**	8,429
LTPS reserve		**(173,401)**	(156,202)
Total taxpayers' equity		**(59,562,104)**	**(59,644,535)**

The General Fund and individual scheme reserves are used to account for all financial resources. For a brief description of each scheme to which the reserves relate please see ‘Our indemnity schemes’ in the ‘Appendix’.

The Board approved a recommendation on 24 June 2026 that the financial statements should be signed by the Accounting Officer and these were signed by Helen Vernon on 3 July 2026. The accompanying notes form part of these financial statements.

Helen Vernon

Chief Executive and Accounting Officer

Date: 3 July 2026

Statements of cash flows for the year ended 31 March 2026[1]

Cash flows	Notes	31 March 2026 £000	31 March 2025 £000
Cash flows from operating activities			
Net income/(expenditure)		**(247,937)**	(2,122,107)
Net finance cost – IFRS 16		**69**	78
Other cash flow adjustments	2	**2,514**	1,721
(Increase)/decrease in receivables	4	**(10,227)**	11,023
(Decrease)/increase in payables	6	**(11,797)**	26,113
(Decrease)/increase in provisions	7	**(67,016)**	1,846,099
Net cash (outflow) from operating activities		**(334,394)**	**(237,073)**
Cash flows from investing activities			
Purchase of property, plant, and equipment		**(250)**	(7)
Purchase of intangible assets		**(238)**	(4,023)
Net cash (outflow) from investing activities		**(488)**	**(4,030)**
Cash flows from financing activities			
Net Parliamentary funding		**330,368**	295,911
Repayment of lease liability – capital	9	**(970)**	(941)
Repayment of lease liability – interest	9	**(69)**	(78)
Net financing		**329,329**	**294,892**
Net (decrease)/increase in cash and cash equivalents		**(5,553)**	53,789
Cash and cash equivalents at the beginning of the period		**739,241**	685,452
Cash and cash equivalents at the end of the period	**5**	**733,688**	**739,241**

[1] The accompanying notes form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2026[1]

Changes in taxpayers' equity	General Fund £000	Ex-RHA Reserve £000	ELS Reserve £000	CNST Reserve £000	DHSC Clinical Reserve £000	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
Balance at 1 April 2025	**38,284**	**(35,328)**	**(672,660)**	**(55,198,419)**	**(1,701,224)**	**(483,666)**	**(1,352,902)**	**(7,212)**	**(4)**	**(83,631)**	**8,429**	**(156,202)**	**(59,644,535)**
Changes in taxpayers' equity for 2025/26													
Expenditure													
Authority and claims administration	(8,849)	-	(58)	(45,867)	(279)	(9,953)	(5,808)	(149)	(50)	(264)	(214)	(8,840)	**(80,331)**
(Increase)/decrease in provision for known claims	-	318	9,940	(4,530,878)	(13,749)	(47,618)	(233,722)	(1,616)	-	(8,478)	(15,943)	(56,023)	**(4,897,769)**
(Increase)/decrease in the provision for IBNR	-	-	(5,637)	1,856,200	(25,039)	21,491	(158,341)	2,076	-	(15,028)	(993)	(3,433)	**1,671,296**
	(8,849)	**318**	**4,245**	**(2,720,545)**	**(39,067)**	**(36,080)**	**(397,871)**	**311**	**(50)**	**(23,770)**	**(17,150)**	**(68,296)**	**(3,306,804)**
Income													
Scheme and other income	919	-	-	2,998,851	-	-	-	-	-	-	8,000	51,097	**3,058,867**
Total recognised income and expense for 2025/26	**(7,930)**	**318**	**4,245**	**278,306**	**(39,067)**	**(36,080)**	**(397,871)**	**311**	**(50)**	**(23,770)**	**(9,150)**	**(17,199)**	**(247,937)**
Net Parliamentary funding	23,668	1,600	32,300	-	95,300	95,400	72,200	1,600	-	8,300	-	-	**330,368**
Balance at 31 March 2026	**54,022**	**(33,410)**	**(636,115)**	**(54,920,113)**	**(1,644,991)**	**(424,346)**	**(1,678,573)**	**(5,301)**	**(54)**	**(99,101)**	**(721)**	**(173,401)**	**(59,562,104)**

[1] The accompanying notes form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2025[1]

Changes in taxpayers' equity	General Fund £000	Ex-RHA Reserve £000	ELS Reserve £000	CNST Reserve £000	DHSC Clinical Reserve £000	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
Balance at 1 April 2024	**36,291**	**(35,328)**	**(655,757)**	**(53,529,293)**	**(1,711,315)**	**(576,000)**	**(1,089,997)**	**(26,133)**	**(100)**	**(83,325)**	**7,064**	**(154,446)**	**(57,818,339)**
Changes in taxpayers' equity for 2024/25													
Expenditure													
Authority and claims administration	(8,250)	-	(32)	(40,965)	(281)	(8,898)	(5,325)	(178)	(59)	(189)	(149)	(7,326)	**(71,652)**
(Increase)/decrease in provision for known claims	-	(1,608)	(41,724)	(4,215,658)	(65,651)	(52,054)	(186,740)	(1,347)	-	(5,233)	(7,486)	(78,567)	**(4,656,068)**
(Increase)/decrease in the provision for IBNR	-	-	-	(280,000)	(10,000)	48,000	(128,000)	18,000	-	(4,000)	-	32,000	**(324,000)**
	(8,250)	**(1,608)**	**(41,756)**	**(4,536,623)**	**(75,932)**	**(12,952)**	**(320,065)**	**16,475**	**(59)**	**(9,422)**	**(7,635)**	**(53,893)**	**(5,051,720)**
Income													
Scheme and other income	979	-	-	2,867,497	-	-	-	-	-	-	9,000	52,137	**2,929,613**
Total recognised income and expense for 2024/25	**(7,271)**	**(1,608)**	**(41,756)**	**(1,669,126)**	**(75,932)**	**(12,952)**	**(320,065)**	**16,475**	**(59)**	**(9,422)**	**1,365**	**(1,756)**	**(2,122,107)**
Net Parliamentary funding	9,264	1,608	24,853	-	86,023	105,286	57,160	2,446	155	9,116	-	-	**295,911**
Balance at 31 March 2025	**38,284**	**(35,328)**	**(672,660)**	**(55,198,419)**	**(1,701,224)**	**(483,666)**	**(1,352,902)**	**(7,212)**	**(4)**	**(83,631)**	**8,429**	**(156,202)**	**(59,644,535)**

[1] The accompanying notes form part of these financial statements.

Notes to the financial statements

1. Accounting policies

The financial statements have been prepared in accordance with the 2025/26 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 considered material to the accounts.

The accounts are presented in pounds sterling and all values are rounded to the nearest thousand pounds, with the exception of IBNR provisions which are rounded to the nearest million 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 where material. 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 or amendments effective and adopted in these accounts

NHS Resolution has not adopted any IFRSs, amendments or interpretations early. However, the following have been adopted for 2025/26:

IFRS 17 Insurance Contracts

In previous years NHS Resolution conducted several thorough assessments of IFRS 17 and determined that the schemes we administer on behalf of the Secretary of State for Health and Social Care are outside the scope of IFRS 17 (see 'Note 1.10' for more information).

IAS 16 Property, Plant and Equipment (PPE)

In December 2023 HM Treasury released an exposure draft on potential changes to make to valuing and accounting for non-investment assets (e.g. PPE, intangible assets). The following changes to the valuation and accounting of non-investment assets have been implemented from 2025-26.

References to assets being held for their 'service potential' and the terms 'specialised/non-specialised' assets have been removed from the FReM. Non-investment assets are instead described as assets held for their 'operational capacity'. This change has no impact on the valuation basis of non-investment assets which remains Existing Use Value (EUV) or Net Book Value (NBV).

NHS Resolution's tangible assets are immaterial to the accounts. NHS Resolution has elected to apply the exemption in section 10.1.19 of FReM which states that "entities may elect to adopt a depreciated historical cost basis as a proxy for current value in existing use for assets that that have short useful lives or low values (or both)".

The option to measure intangible assets using the revaluation model is withdrawn. The carrying values of intangible assets at 31 March 2025 are considered the historical cost at 1 April 2025.

These changes to the standard have not materially impacted the accounts as our non-investment assets are immaterial and therefore, we will continue to account for PPE and intangible assets under historical cost less depreciation and right of use assets as per IFRS 16 requirements.

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 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. 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. NHS Resolution will carry out a formal assessment in due course once there is sufficient information as to how the standard will be adopted within the FReM.

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. 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.

IAS 21 The Effects in Foreign Exchange Rates

The revisions to IAS 21 were published in August 2023 and the effective date for adoption is for accounting periods beginning on or after 1 January 2025. The revisions relate to the rate of exchangeability on foreign currency when one currency cannot be exchanged into another. It is our assessment that as NHS Resolution has minimal foreign currency

transactions and that all such transactions have always been in known currencies such as US Dollar, Euro and NZ Dollars, we do not consider that this update is applicable and therefore we do not have a policy on it.

Annual improvements process

The International Accounting Standards Board (IASB) makes minor amendments to improve the clarity and internal consistency with IFRS Accounting Standards. Only those applicable to NHS Resolution are listed below.

IFRS 9 Financial Instruments

The amendments to IFRS 9 will become effective for accounting periods beginning on or after 1 January 2026. The key amendments to IFRS 9 are:

- Amendment on trade receivables – IFRS 9 has been amended to require companies to initially measure a trade receivable without a significant financing component at the amount determined by applying IFRS 15.
- Derecognising lease liabilities – if a lease liability is derecognised, then its derecognition is accounted for under IFRS 9. However, when a lease liability is modified, the modification is accounted for under IFRS 16 Leases. The amendment states that when lease liabilities are derecognised under IFRS 9, the difference between the carrying amount and the consideration paid is recognised in profit or loss.
- Financial liabilities are derecognised on the settlement date, however the standard further allows an optional policy election that financial liabilities may be derecognised at the instruction date of the settlement payment but only for payment systems that meet stringent criteria (e.g. BACS, CHAPS or SEPA).

It is anticipated that the above amendment to trade receivables will have minimal impact on NHS Resolution's accounts as we already report under IFRS 15 for trade receivables. With regards to the amendment in respect of IFRS 16 Leases we currently anticipate no impact as we have no foreseeable need to derecognise lease liabilities early and the application of IFRS 16 will run its course for the remainder of the initial 10-year lease period on which it was calculated for London and Leeds office leases.

For financial liabilities, based on historic experience, it is NHS Resolution's assessment that the impact would be immaterial given the level of payments made around year end.

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 NHS England (NHSE) 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' 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 10 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 10 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 10 actions may be able to recover a lesser sum from the fund to help them achieve the actions.

Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within the same financial year that NHS Resolution receives the returned funds.

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.

Annual compliance with the 10 safety actions for year 6 of the scheme was assessed in 2025/26. The contributions to the MIS were collected and distributed against achievement of the actions in the 2025/26 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[1]. 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 2026 is based on valuation data as at 31 March 2024, updated to 31 March 2026 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.

[1] www.nhsbsa.nhs.uk/nhs-pensions

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 (considering recent demographic experience), and to recommend the contribution rate payable by 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.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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. The minimum contributions remain set at 8%. Contributions are taken from qualifying earnings, which for the tax year 2025/26 were earnings between £6,240 and £50,270. Employee contributions are set at 5% although most employees will only pay around 4% of their take-home pay as they will get tax relief from the government every time they contribute. Employer contributions are set at 3%. More details on NEST can be found on the NEST website[1].

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 reporting 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.

[1] www.nestpensions.org.uk/schemeweb/nest/my-nest-pension/contributions-and-fees

The ELS, Ex-RHA, CNSC, CTIS, and DHSC clinical and non-clinical schemes are funded by DHSC. Member schemes being CNST, LTPS, and PES are funded from member contributions. The provisions for the schemes are prepared in accordance with IAS 37.

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 2024/25).

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'.

IFRS 17 Insurance Contracts

In previous years NHS Resolution conducted a thorough assessment of IFRS 17 and determined that the schemes we administer on behalf of the Secretary of State for Health and Social Care are outside the scope of IFRS 17, on the basis that:

- the schemes are established under legislation and the terms of the rules supporting the schemes do not add or amend the requirements set out in legislation; and
- the rules do not create additional financial rights or obligations beyond those that were already established within the relevant legislation.

The basis for this significant judgement is the FReM's interpretation and adaptation of IFRS 17 for public sector. FReM chapter 8 (section 8.2) states that:

"For the purpose of applying IFRS 17 in central government, legislation and regulations, in isolation, are not equivalent to insurance contracts. Legislation and regulations can include binding rights or obligations, can facilitate the creation of arrangements that fall within the definition of a contract and can form part of the implied terms of a contract, but in themselves are not agreements between parties. (IFRS 17 para 2)."

We will therefore continue to account for provisions in accordance with IAS 37 as detailed in 'Note 1.7' above.

There have been no other 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

The London lease is for 10 years, and the Leeds lease is for 20 years with five-year break clauses. NHS Resolution recognised both leases for a 10-year period based on reasonable certainty that this would be the expected life of both property leases. NHS Resolution will review again when appropriate.

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 12 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	2025/26 £000	2024/25 £000
Non-executive members' remuneration[1]		**125**	153
Other salaries and wages[2]			
Salaries and wages		**48,315**	43,526
Social security costs		**6,499**	4,942
Pension costs		**9,582**	8,798
Apprenticeship levy		**225**	203
Education, training, and conferences		**193**	190
Establishment expenses		**696**	694
Low-value and short-term leases			
Land and buildings		**18**	73
Lease cars		**(9)**	4
Insurance		**136**	139
Transport (business travel)		**168**	225
Premises and fixed plant		**6,600**	6,341
External contractors			
Actuary's advice		**2,082**	1,886
Appeals advisory expenditure		**78**	150
External corporate legal fees[3]		**419**	319
Practitioner Performance Advice assessment expenditure		**264**	292
Other[4]		**1,907**	1,504
Auditor's remuneration: audit fees[5]		**338**	310
Internal audit fees		**99**	91
Bank charges and interest		**13**	13
Disposal of assets		**23**	8
		77,771	**69,861**
Depreciation		**255**	312
Depreciation – right of use assets		**1,025**	1,025
Amortisation		**1,211**	376
Total depreciation and amortisation		**2,491**	**1,713**
Total expenditure before provisions and finance costs[6]		**80,262**	**71,574**
Finance costs – unwinding of discount	7	**1,534,632**	1,305,762
Increase in provision for known claims (excl. unwinding of discounts and change in the discount rates)	7	**5,822,645**	3,898,060
Change in the discount rates[7]	7	**(4,406,780)**	(1,053,754)
Increase in the provision for IBNR	7	**275,976**	830,000
Total provision (release)/expense	2.1/7.1	**3,226,473**	**4,980,068**
Finance costs – interest on lease liability		**69**	78
Total provision (release)/expense and finance costs		**3,226,542**	**4,980,146**
Total expenditure		**3,306,804**	**5,051,720**

[1] Additional explanations can be found in the 'Remuneration and staff report' in the 'Accountability report'.
[2] Additional explanations can be found in the 'Remuneration and staff report' in the 'Accountability report.
[3] External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included in 'Note 7'.
[4] Other external contractor costs have increased primarily due to additional spend in professional services on Core Systems Projects.
[5] No non-audit services were provided by the external auditor.
[6] Of the £80.3 million total expenditure for 2025/26, £6.0 million is shown as administration expenditure in DHSC consolidated group accounts.
[7] The discount rates used are mandated by HMT and are set out in 'Note 7.3'.

2.1 Analysis of the provision expense

2025/26	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
2025/26 incidents												
Known claims	-	-	47,553	-	-	10,143	-	-	13	10,245	10,186	**78,140**
IBNR	-	-	4,412,159	-	-	313,178	-	-	56	2,916	22,410	**4,750,719**
Total 2025/26	**-**	**-**	**4,459,712**	**-**	**-**	**323,321**	**-**	**-**	**69**	**13,161**	**32,596**	**4,828,859**
Prior year incidents												
Known claims	(318)	(9,940)	4,483,325	13,749	47,618	223,579	1,616	-	8,465	5,698	45,837	**4,819,629**
IBNR	-	5,637	(6,268,359)	25,039	(21,491)	(154,837)	(2,076)	-	14,972	(1,923)	(18,977)	**(6,422,015)**
Total prior years	**(318)**	**(4,303)**	**(1,785,034)**	**38,788**	**26,127**	**68,742**	**(460)**	**-**	**23,437**	**3,775**	**26,860**	**(1,602,386)**
Total	**(318)**	**(4,303)**	**2,674,678**	**38,788**	**26,127**	**392,063**	**(460)**	**-**	**23,506**	**16,936**	**59,456**	**3,226,473**

2024/25	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
2024/25 incidents												
Known claims	-	-	28,464	-	-	2,759	-	-	0	3,563	7,384	**42,170**
IBNR	-	-	4,556,978	-	-	290,264	-	-	78	2,545	26,823	**4,876,688**
Total 2024/25	**-**	**-**	**4,585,442**	**-**	**-**	**293,023**	**-**	**-**	**78**	**6,108**	**34,207**	**4,918,858**
Prior year incidents												
Known claims	1,608	41,724	4,187,193	65,652	52,054	183,981	1,347	-	5,233	3,923	71,182	**4,613,897**
IBNR	-	-	(4,276,977)	9,999	(48,000)	(162,264)	(18,000)	-	3,922	(2,545)	(58,822)	**(4,552,687)**
Total prior years	**1,608**	**41,724**	**(89,784)**	**75,651**	**4,054**	**21,717**	**(16,653)**	**-**	**9,155**	**1,378**	**12,360**	**61,210**
Total	**1,608**	**41,724**	**4,495,658**	**75,651**	**4,054**	**314,740**	**(16,653)**	**-**	**9,233**	**7,486**	**46,567**	**4,980,068**

3. Operating income

Operating income	2025/26 £000	2024/25 £000
CNST contributions	**2,998,851**	2,867,497
LTPS contributions	**51,097**	52,137
PES contributions	**8,000**	9,000
Practitioner Performance Advice	**919**	979
Total	**3,058,867**	**2,929,613**

4. Receivables

Receivables	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Adminis-tration £000	Total 31 March 2026 £000	Total 31 March 2025 £000
NHS receivables – revenue	-	-	22	-	-	-	-	-	-	6	717	44	**789**	789
Accrued income	-	-	291	-	-	-	-	-	-	-	-	40	**331**	765
Prepayments	9	493	381	1,562	-	-	-	-	-	-	-	1,781	**4,226**	4,928
VAT	-	33	10,009	83	215	616	4	-	34	27	311	334	**11,666**	5,755
Other receivables	-	93	2,040	21	6,521	-	-	-	-	-	46	137	**8,858**	3,406
At 31 March 2026	**9**	**619**	**12,743**	**1,666**	**6,736**	**616**	**4**	**-**	**34**	**33**	**1,074**	**2,336**	**25,870**	**15,643**

5. Cash and cash equivalents

Cash and cash equivalents	Ex-RHA £000	ELS £000	CNST £000	ELSGP £000	CNSGP £000	PES £000	LTPS £000	Adminis-tration £000	Total 31 March 2026 £000	Total 31 March 2025 £000
At 1 April 2025	423	61,235	516,107	24,249	816	23,180	89,952	23,279	**739,241**	685,452
Change during the year	4	(3,124)	(7,325)	(4,443)	3,848	2,870	1,182	1,435	**(5,553)**	53,789
At 31 March 2026[1]	**427**	**58,111**	**508,782**	**19,806**	**4,664**	**26,050**	**91,134**	**24,714**	**733,688**	**739,241**

[1] Cash and cash equivalents is made up of cash only. All cash balances are held in Government Banking Service accounts.

6. Trade payables and other current labilities

Trade payables	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Adminis-tration £000	Total 31 March 2026 £000	Total 31 March 2025 £000
NHS payables – revenue	-	-	-	-	-	-	-	-	-	-	137	-	**137**	11
Prepaid income	-	-	17,246	760	-	-	-	-	-	-	-	75	**18,081**	19,140
Accruals	-	42	20,261	3,718	846	3,137	5	-	23	48	568	2,433	**31,081**	14,105
Other payables	-	183	22,190	384	302	559	2	-	51	80	881	2,330	**26,962**	54,802
At 31 March 2026	**-**	**225**	**59,697**	**4,862**	**1,148**	**3,696**	**7**	**-**	**74**	**128**	**1,586**	**4,838**	**76,261**	**88,058**

7. Provisions for liabilities and charges

Provisions	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	34,963	648,534	32,944,764	1,660,575	388,953	386,496	4,291	-	13,438	14,155	147,901	**36,244,070**
Opening provisions for IBNR	-	55,000	22,678,000	116,000	123,000	949,000	5,000	-	80,000	3,000	73,000	**24,082,000**
Total provisions as at 1 April 2025	**34,963**	**703,534**	**55,622,764**	**1,776,575**	**511,953**	**1,335,496**	**9,291**	**-**	**93,438**	**17,155**	**220,901**	**60,326,070**
Movement in known claims												
Provided in the year	473	31,386	7,725,290	89,325	108,157	301,420	1,998	-	10,734	17,625	82,171	**8,368,579**
Provision not required written back	(12)	(23,104)	(2,306,530)	(40,267)	(62,202)	(77,841)	(544)	-	(2,625)	(2,192)	(30,617)	**(2,545,934)**
Unwinding of discount	1,608	29,644	1,393,905	74,305	14,529	14,326	146	-	343	402	5,424	**1,534,632**
Change in discount rates	(2,387)	(47,866)	(2,281,787)	(109,614)	(12,866)	(4,183)	16	-	26	108	(955)	**(2,459,508)**
Provisions utilised in the year	(1,648)	(25,177)	(2,940,986)	(108,969)	(70,294)	(90,589)	(805)	-	(7,869)	(4,994)	(42,158)	**(3,293,489)**
Movement in known claims	**(1,966)**	**(35,117)**	**1,589,892**	**(95,220)**	**(22,676)**	**143,133**	**811**	**-**	**609**	**10,949**	**13,865**	**1,604,280**
Movement in IBNR												
Change in discount rates	-	(5,841)	(1,805,927)	(6,297)	(2,811)	(121,746)	2	-	(3,519)	93	(1,226)	**(1,947,272)**
Increase/(decrease) in provision for IBNR	-	11,478	(50,273)	31,336	(18,680)	280,087	(2,078)	-	18,547	900	4,659	**275,976**
Movement in IBNR	**-**	**5,637**	**(1,856,200)**	**25,039**	**(21,491)**	**158,341**	**(2,076)**	**-**	**15,028**	**993**	**3,433**	**(1,671,296)**
Closing provision for known claims	32,997	613,417	34,534,656	1,565,355	366,277	529,629	5,102	-	14,047	25,104	161,766	**37,848,350**
Closing provisions for IBNR	-	60,637	20,821,800	141,039	101,509	1,107,341	2,924	-	95,028	3,993	76,433	**22,410,704**
Total provision as at 31 March 2026	**32,997**	**674,054**	**55,356,456**	**1,706,394**	**467,786**	**1,636,970**	**8,026**	**-**	**109,075**	**29,097**	**238,199**	**60,259,054**
Analysis of expected timing of discounted cash flows[1]												
Not later than one year[2]	1,661	30,183	3,814,088	103,195	82,847	121,448	2,137	-	12,052	15,860	49,706	4,233,177
Later than one year and not later than five years	6,334	116,167	12,556,261	320,706	154,136	553,869	4,073	-	26,609	12,824	132,559	13,883,538
Later than five years	25,002	527,704	38,986,107	1,282,493	230,803	961,653	1,816	-	70,414	413	55,934	42,142,339
Total provision as at 31 March 2026	**32,997**	**674,054**	**55,356,456**	**1,706,394**	**467,786**	**1,636,970**	**8,026**	**-**	**109,075**	**29,097**	**238,199**	**60,259,054**

[1] 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.
[2] The one-year projected cash flow figures shown above reflect an updated view of 2026/27 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 2026/27 as part of the 2026/27 cash flow projection exercise that was performed during the summer of 2025, 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.

Provisions for liabilities and charges (prior year)

Provisions	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	34,914	635,774	31,555,133	1,679,543	429,418	254,034	3,904	-	13,329	12,067	103,855	**34,721,971**
Opening provisions for IBNR	-	55,000	22,398,000	106,000	171,000	821,000	23,000	-	76,000	3,000	105,000	**23,758,000**
Total provisions as at 1 April 2024	**34,914**	**690,774**	**53,953,133**	**1,785,543**	**600,418**	**1,075,034**	**26,904**	**-**	**89,329**	**15,067**	**208,855**	**58,479,971**
Movement in known claims												
Provided in the year	657	36,430	6,861,206	64,780	128,949	250,170	1,837	-	8,290	9,437	105,651	**7,467,407**
Provision not required written back	(79)	(11,978)	(3,311,143)	(47,470)	(88,775)	(72,501)	(651)	-	(3,410)	(2,349)	(30,991)	**(3,569,347)**
Unwinding of discount	1,578	28,077	1,174,605	72,656	14,736	9,438	148	-	333	365	3,826	**1,305,762**
Change in discount rates	(548)	(10,805)	(509,010)	(24,315)	(2,856)	(367)	13	-	20	33	81	**(547,754)**
Provisions utilised in the year	(1,559)	(28,964)	(2,826,027)	(84,619)	(92,519)	(54,278)	(960)	-	(5,124)	(5,398)	(34,521)	**(3,133,969)**
Movement in known claims	**49**	**12,760**	**1,389,631**	**(18,968)**	**(40,465)**	**132,462**	**387**	**-**	**109**	**2,088**	**44,046**	**1,522,099**
Movement in IBNR												
Change in discount rates	-	(1,000)	(500,000)	(3,000)	(1,000)	(1,000)	-	-	-	-	-	**(506,000)**
Increase/(decrease) in provision for IBNR	-	1,000	780,000	13,000	(47,000)	129,000	(18,000)	-	4,000	-	(32,000)	**830,000**
Movement in IBNR	**-**	**-**	**280,000**	**10,000**	**(48,000)**	**128,000**	**(18,000)**	**-**	**4,000**	**-**	**(32,000)**	**324,000**
Closing provision for known claims	34,963	648,534	32,944,764	1,660,575	388,953	386,496	4,291	-	13,438	14,155	147,901	**36,244,070**
Closing provisions for IBNR	-	55,000	22,678,000	116,000	123,000	949,000	5,000	-	80,000	3,000	73,000	**24,082,000**
Total provision as at 31 March 2025	**34,963**	**703,534**	**55,622,764**	**1,776,575**	**511,953**	**1,335,496**	**9,291**	**-**	**93,438**	**17,155**	**220,901**	**60,326,070**
Analysis of expected timing of discounted cash flows[1]												
Not later than one year[2]	1,566	26,745	3,314,574	97,035	86,402	78,481	1,348	-	11,313	8,902	42,389	3,668,755
Later than one year and not later than five years	5,969	105,185	10,914,943	329,207	170,503	520,034	3,167	-	23,527	8,190	125,446	12,206,171
Later than five years	27,428	571,604	41,393,247	1,350,333	255,048	736,981	4,776	-	58,598	63	53,066	44,451,144
Total provision as at 31 March 2025	**34,963**	**703,534**	**55,622,764**	**1,776,575**	**511,953**	**1,335,496**	**9,291**	**-**	**93,438**	**17,155**	**220,901**	**60,326,070**

[1] 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.
[2] The one-year projected cash flow figures shown above reflect an updated view of 2025/26 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 2025/26 as part of the 2025/26 cash flow projection exercise that was performed during the summer of 2024, 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.

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	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total 2025/26 £000	Total 2024/25 £000
Unwinding of discount/finance charge	**1,608**	**29,644**	**1,393,905**	**74,305**	**14,529**	**14,326**	**146**	**-**	**343**	**402**	**5,424**	**1,534,632**	**1,305,762**
Increase in known claims provision	473	31,386	7,725,290	89,325	108,157	301,420	1,998	-	10,734	17,625	82,171	**8,368,579**	**7,467,407**
Provision not required written back	(12)	(23,104)	(2,306,530)	(40,267)	(62,202)	(77,841)	(544)	-	(2,625)	(2,192)	(30,617)	**(2,545,934)**	**(3,569,347)**
Change in discount rates (known claims and IBNR)	(2,387)	(53,707)	(4,087,714)	(115,911)	(15,677)	(125,929)	18	-	(3,493)	201	(2,181)	**(4,406,780)**	**(1,053,754)**
Increase/(decrease) in provision for IBNR	-	11,478	(50,273)	31,336	(18,680)	280,087	(2,078)	-	18,547	900	4,659	**275,976**	**830,000**
Provision expense charged to Statement of comprehensive net expenditure	**(1,926)**	**(33,947)**	**1,280,773**	**(35,517)**	**11,598**	**377,737**	**(606)**	**-**	**23,163**	**16,534**	**54,032**	**1,691,841**	**3,674,306**
Total charge to Statement of comprehensive net expenditure	**(318)**	**(4,303)**	**2,674,678**	**38,788**	**26,127**	**392,063**	**(460)**	**-**	**23,506**	**16,936**	**59,456**	**3,226,473**	**4,980,068**

7.2 Explanatory notes

Nature and scope of the obligation

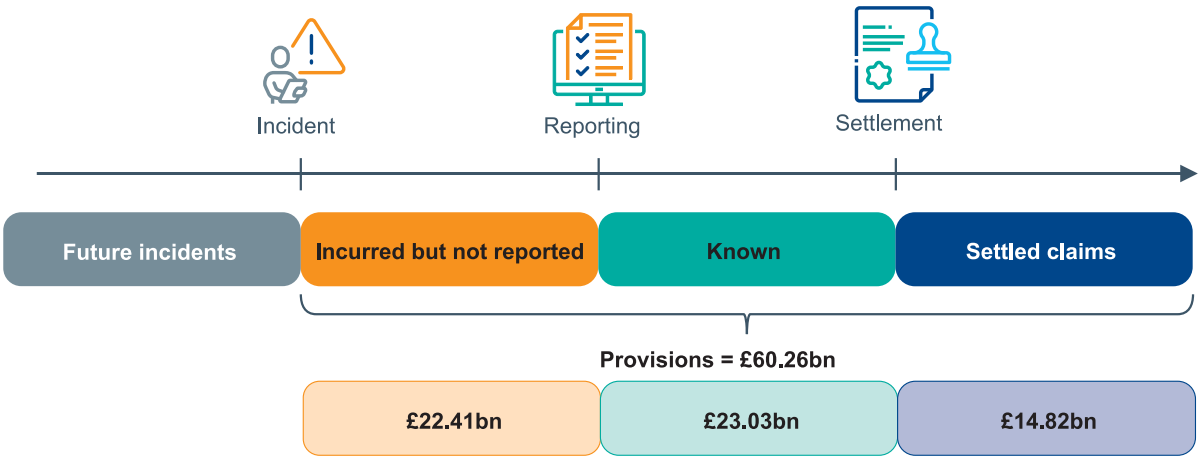
NHS Resolution administers indemnity cover for clinical negligence and non-clinical claims under 11 schemes or arrangements. Provisions are calculated in accordance with IAS 37 and relate to liabilities arising from incidents covered by these arrangements. The three key elements of NHS Resolution's provisions are:

- **Known claims** – provision for claims received by NHS Resolution but not yet settled;
- **Settled Periodical Payment Orders (Settled PPOs)** – provision for claims that have settled in the past but involve 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.

This element also includes a provision for known incidents, incidents that NHS Resolution is aware of having occurred, but where these are not yet formally recognised as reported claims.

The different parts of the provision and their link to the claims journey is shown in figure 27.

Figure 27: Provision and the claims journey



The schemes we administer are shown in 'Our indemnity schemes' in the 'Appendix'.

Setting the provisions

Process and approach

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 methodologies, assumptions and judgements underlying the provision. The RPC chooses 'best estimate' assumptions, which are set on the basis that they are not judged to have a consistent under- or over-estimation in the value expected. The work of the RPC is supported by the advice of the actuaries alongside the Reserving, Cashflows and Pricing Working Group, which reports into the RPC and brings together colleagues from across the organisation to scrutinise the analysis.

Although assumptions, in general, are set in line with past experience, the RPC has considered whether it would be appropriate for any individual assumptions to differ from past experience, for example due to changes in NHS Resolution's policies or processes, or changes in the external environment.

In addition to the PIDR and HMT prescribed discount rates, there are other factors that influence the provision that are 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 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, rather than purely as a lump sum; and
    - the difference in cost if the case were to settle as a PPO.
- **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 indexation increases (e.g. in line with assumed future 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.

- **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 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. Further assumptions are made in respect of how many claims will result in payment of damages.
    - 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 levels of future claims inflation, over both long- and short-term time horizons.
    - 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 only 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 liabilities using the HMT-prescribed discount rates, and this gives the estimated 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 lump sum only type claims. We continue to set separate assumptions for the maternity claims reported under the EN scheme within the IBNR provision.
- For ELSGP and CNSGP, the reserving assumptions are based upon a combination of 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 more recent claims experience (where claims have been handled by NHS Resolution), weighted as appropriate.
- For CNSC and other coronavirus liabilities, the provisions have been estimated using the actual reported claims experience and by considering the proportion of Covid to non-Covid IBNR claims.

Note that the IBNR includes a provision in respect of known incidents. For financial reporting purposes, these matters are (and have always been) regarded as IBNR, as they are not yet formally recognised as reported claims, so the provision for these incidents is included within the IBNR figures presented throughout this report. However, the approach to provisioning for these incidents is consistent with the methodology adopted for known claims.

Key assumptions

Given the uncertainty over the level of historical incidents and the corresponding future cost of settling resulting claims, assumptions need to be adopted, many of which regard significant levels of judgements. Table 29 shows a summary of the key assumptions used to determine the CNST provision. The CNST provision is by far the largest scheme within 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.

The impacts of the various assumptions can be found detailed in CNST sensitivities as at 31 March 2026.

Table 29: Key assumptions in the CNST provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes[1]	Change in assumption between 31 March 2025 and 31 March 2026	Year-on-year effect of change
Nominal discount rates	HMT prescribed	Prescribed	High	All discount rates have been updated. The short-term rate has decreased by 0.39 percentage points. The medium-term, long-term and very long-term rates have increased by 0.15 percentage points, 0.51 percentage points and 0.52 percentage points respectively.	-£4.1 billion
Personal Injury Discount Rate (PIDR)	Prescribed by Lord Chancellor	Prescribed	Medium	The PIDR has remained unchanged this year at +0.50%.	-
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	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. These claims have developed further since last year and the observed experience for EN is now more credible. Applying greater weight to this experience in the analysis has improved alignment between EN PPO projections and the number of incidents under investigation (and hence the implied pipeline of potential future claims). Overall, the change reduces reliance on expert judgement and brings projected claim numbers closer to the observed experience.	-£0.9 billion
	Value threshold derived from recent years' settled claims data	Medium	Medium	A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has increased from £4.25 million to £4.50 million.	
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High	The average cost per claim assumptions that are used to set the IBNR have increased broadly in line with the rates previously assumed.	+£0.1 billion
		Medium	Medium	There has been an update to the standard reserve held for claims relating to children born with cerebral palsy or brain damage.	+£1.0 billion
Claims inflation	Long-term claims inflation: derived from past settled claims (rather than using HMT prescribed CPI forecasts - see below)	High	High	The long-term inflation assumptions for all segments remain unchanged from the previous year.	-

[1] Sensitivity to changes selected with regard to the overall level of sensitivity, rather than the movement that has been observed in the year.

Assumption	Approach	Degree of uncertainty	Sensitivity to changes[1]	Change in assumption between 31 March 2025 and 31 March 2026	Year-on-year effect of change
	Short-term claims inflation: derived from short-term HMT prescribed CPI forecasts			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.	+£0.1 billion
PPO indexation - ASHE 6115 (80th percentile)	Based on earnings increases over the longer term	Medium	High	The ASHE assumption has been reduced by 0.15%.	-£1.1 billion
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium	Assumptions for the probability of paying damages for all segments (i.e. non-EN PPOs, EN PPOs and lump sum only claims) are unchanged from last year.	-
Creation to payment lags	Derived from past settled claims	Low	Low	Lag range remains from 2.9 to 7.4 years, with very marginal changes to the mean lag for PPO damages.	<-£0.1 billion
Life expectancy for PPO payments	Based on analysis of past settled PPO claims	Medium	Low	Separate life expectancy assumptions are specified for EN claims (43 years on average) and non-EN claims (39 years on average) – these have been updated based on the book of settled PPO claims and are broadly unchanged from last year.	<+£0.1 billion
Claims Evolution Programme (CEP)	Based on expected future savings profile	Medium	Low	The anticipated savings profile is unchanged from last year, so there has not been any impact on the provision.	-

Claims inflation

The HMT Public Expenditure System (PES) discount rate note from December 2025 (which specifies the financial assumptions to be used for valuing provisions at March 2026) states all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) CPI forecasts unless certain conditions (they are set out in Paragraph 41 of Annex B of the HMT PES note PES (2025) 09) are met for this assumption to be rebutted.

For NHS Resolution's IBNR provisions, the conditions have been met and as a result, the claims inflation assumptions are not based on CPI forecasts but are instead 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.

Early notification

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 the overall level of risk in relation to brain damage at birth is broadly similar to the period before EN. Hence, we generally 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 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 Covid-19

The Covid-19 pandemic has had a significant impact on the NHS over the last five years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes established for 2021/22 (CNSC and CTIS), the liabilities covered under the arrangements already in place (i.e. through CNST, CNSGP and LTPS) have also been affected owing to changes in healthcare provision.

The estimated impact on the NHS Resolution provision remains limited (£0.1 billion on the IBNR and £0.3 billion on the known claims), reducing by £0.6 billion this year in line with the emerging claims experience, which has been lower than previously anticipated. The impact is limited because a large proportion (58% for 2025/26 compared to 62% in 2024/25) 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 there will be a similar level of claims as in previous years.

Note that since being established in 2020/21, the CTIS has not received a single claim, so we continue to assume a nil IBNR provision for this scheme.

Claims Evolution Programme (CEP)

The implementation of CEP (described in more detail in 'Managing and enhancing operational delivery' in 'Strategic priority one: Fair resolution' in the 'Performance analysis') is expected to lead to a reduction in NHS legal costs in future years. Anticipated future reductions in NHS legal costs continues to be allowed for within the provisioning calculation.

Risk and uncertainty

The provision is subject to uncertainty arising from both model assumptions and inherent variability in future outcomes. To illustrate this, two uncertainty ranges are presented: the first reflects plausible alternative assumptions that could reasonably have been selected based on the same analysis of past data, focusing on the most material and subjective inputs; the second captures a broader range of plausible assumptions informed by wider historical variation and potential future developments. Together, these ranges provide insight into both model risk and inherent uncertainty in the provision estimate. Further detail is provided in 'Note 7.3' below.

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.

7.3 Key areas of uncertainty in the estimation of the claims provision

As with any 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) and the GPI schemes (given the recent changes in these arrangements with the take-on of claims from two medical defence organisations).

The IBNR provision in particular is subject to considerable uncertainty. At a high level, the IBNR provision assumes future experience will be in line with past experience and is calculated on the basis of the current legal and claims environment, making adjustments for emerging risks and changes where relevant. 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.

The key areas of uncertainty are outlined in more detail below:

- **The number of clinical claims reported to NHS Resolution and lag patterns**: There is considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in

past claim trends. The year 2020/21 saw a reduction in the number of claims received due to Covid-19; however, the clinical activity has recovered since, resulting in the number of claims received stabilising to the 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 and potential disruptions owing to Covid-19 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 and PPO indexation**: 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 the lost years ruling) and changes in legal costs. The variety of potential external influences on future claims inflation means this assumption is subject to significant uncertainty.
  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).
- **Legal environment**: The provisions have been valued using the latest PIDR of +0.50%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR, requiring the Government to review the rate in England and Wales at least every five years. There is no certainty on the outcomes of future reviews, so

no adjustments have been made to the IBNR or known claims provisions for the potential effects of such changes.
The provision calculation allows for the expected impact of the lost years ruling, through adjustments that have been applied to the relevant assumptions e.g. average cost per claim and standard reserve assumptions. The methodology to determine the precise level of compensation that will be applied in practice has not yet been confirmed, so there does remain some uncertainty as to the level of additional compensation resulting from this ruling.

- **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.

Sensitivities as at 31 March 2026

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 index;
  - claims inflation;
  - life expectancy; and
  - payment pattern.
- Additional sensitivity analysis and uncertainty ranges for CNST only, given that this is the largest scheme.

The sensitivity levels were selected to reflect an equivalent likelihood of occurrence across assumptions. For example, a 1% change in discount rates is considered as likely as a 1.5% change in claims inflation. This methodology was recommended by the RPC. While this equivalence is inherently subjective, it is supported by historical trends – particularly the observation that base inflation (e.g. PPO inflation) has typically been higher and more volatile than discount rates. As such, a higher sensitivity is applied to inflation. For life expectancy, a 30% sensitivity continues to be adopted to reflect a stressed scenario.

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 ASHE index, claims inflation, life expectancy and payment patterns. The ranges of the sensitivity tests that follow are based on potential levels of variability for each assumption, including observations 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

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 38% of total provisions.
- The **settled PPO** provision. This represents 25% 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 37% 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.

Note also that the relationship between the value of the total provision and the effect of changes in assumptions is often not a symmetrical one, due to the impacts of compound inflation and discounting.

Sensitivity to HMT tiered nominal discount rates

HMT specifies discount rates in nominal terms. These rates have increased this year for durations in excess of five years, which has led to decreases in the provision for the majority of schemes.

Due to the generally 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.

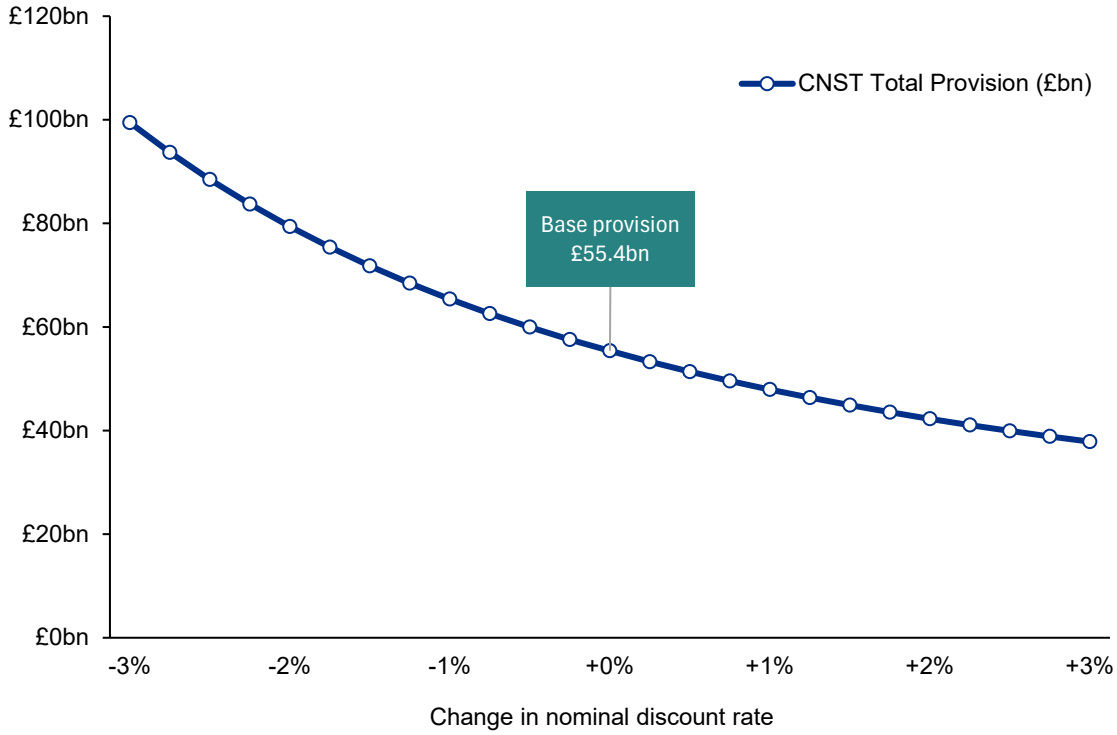
Discount rates term	31 March 2025 nominal rates (%pa)	31 March 2026 nominal rates (%pa)	Change
Short-term (<5 years)	4.03%	3.64%	-0.39%
Medium-term (5–10 years)	4.07%	4.22%	+0.15%
Long-term (10–40 years)	4.81%	5.32%	+0.51%
Very long-term (over 40 years)	4.55%	5.07%	+0.52%

The table below is based on adjusting the nominal discount rates by +1% and -1%. A change in the nominal discount rate of +1% would represent short-, medium-, long-term and very long-term nominal discount rates of 4.64%, 5.22%, 6.32% and 6.07% respectively. An increase of 1% in the discount rates will decrease the total provision by 18%, but a 1% decrease will increase the provision by 13%.

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	26,066	+13%	23,026	20,738	-10%
Settled PPOs	17,973	+21%	14,822	12,516	-16%
IBNR	27,324	+22%	22,411	18,950	-15%
Total provisions	**71,363**	**+18%**	**60,259**	**52,204**	**-13%**

Figure 28 is based on adjusting the nominal discount rate by the increments shown for the CNST scheme only (as it is the most significant scheme).

Figure 28: CNST sensitivity to changes in the nominal discount rate



Sensitivity to ASHE

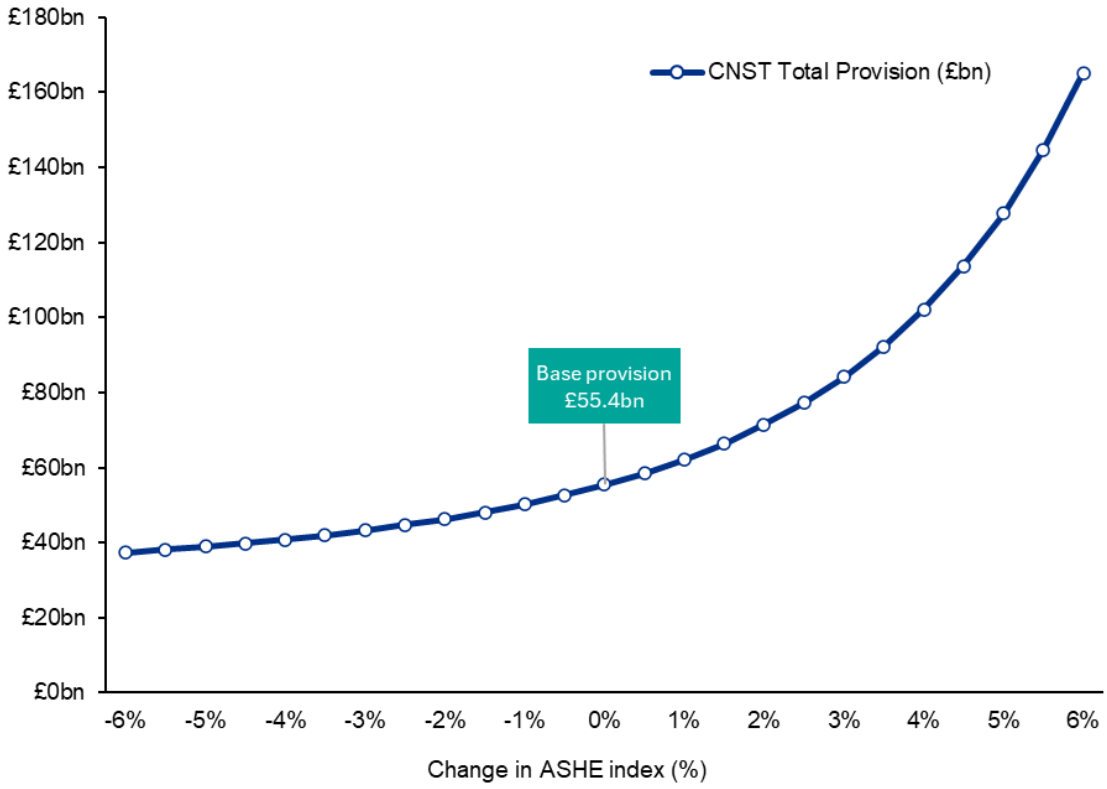
The ASHE index, used in the calculation of damages in PPO claims where care costs are a component, measures the rate of change in the wages of carers. The current assumption is that the rate of increase in carers' wages is 3.6% per annum.

The table that follows shows the effect on the value of the provision where this assumption is varied. An additional +/- 1.0% will either increase the provision by 12% or decrease it by 9% respectively. The impact is 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).

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	21,368	-7%	23,026	25,219	+10%
Settled PPOs	12,549	-15%	14,822	17,898	+21%
IBNR	20,933	-7%	22,411	24,353	+9%
Total provisions	**54,850**	**-9%**	**60,259**	**67,470**	**+12%**

Figure 29 shows the non-linear relationship between this assumption and the value of the CNST provision.

Figure 29: CNST sensitivity to ASHE



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.

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	21,915	-5%	23,026	24,231	+5%
Settled PPOs	14,662	-1%	14,822	15,042	+1%
IBNR	19,414	-13%	22,411	26,023	+16%
Total provisions	**55,991**	**-7%**	**60,259**	**65,296**	**+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 15%, while increasing life expectancy by 30% increases the provision by 13%.

Sensitivity of total provisions to life expectancy (£m)					
Provisions	All life expectancies reduced by		Base assumptions	All life expectancies increased by	
	30%	%		30%	%
Known claims	20,610	-10%	23,026	24,972	+8%
Settled PPOs	10,454	-29%	14,822	18,537	+25%
IBNR	20,117	-10%	22,411	24,352	+9%
Total provisions	**51,181**	**-15%**	**60,259**	**67,861**	**+13%**

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 and shortening the payment patterns by 1 year does not make material differences to the provision.

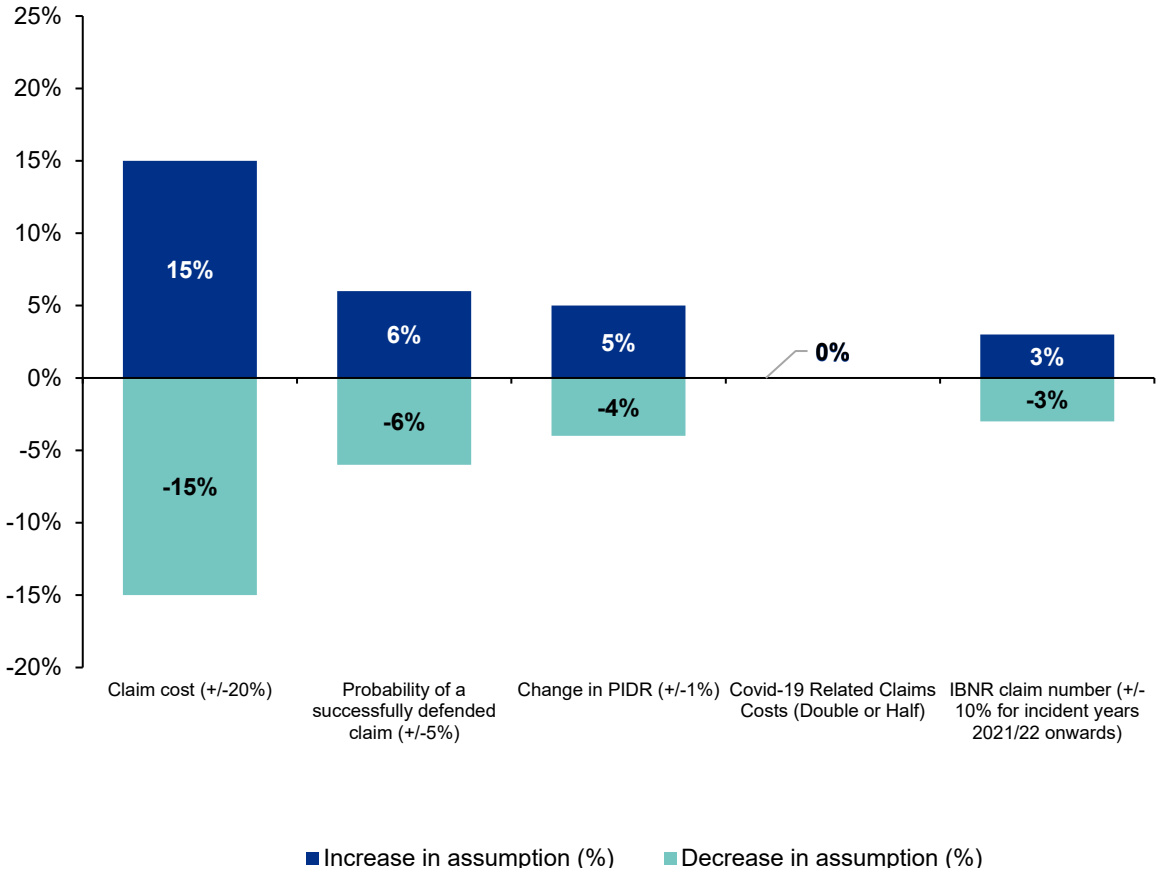
Sensitivity of total provisions to payment pattern (£m)					
Provisions	Creation to payment lag reduced by		Base assumptions	Creation to payment lag increased by	
	1 year	%		1 year	%
Known claims	22,941	0%	23,026	23,126	0%
Settled PPOs	14,822	0%	14,822	14,822	0%
IBNR	22,315	0%	22,411	22,507	0%
Total provisions	**60,078**	**0%**	**60,259**	**60,455**	**0%**

CNST: sensitivity of provision to other assumptions

The additional sensitivity analysis that follows indicates how variations in a further selection of assumptions would affect the CNST total provision.

CNST sensitivities as at 31 March 2026

Figure 30: The percentage impact of variations in further assumptions within the CNST estimate



CNST: uncertainty range

As CNST makes up the majority of the provision, changes to the assumptions underpinning this scheme have the greatest potential to affect the estimate of the total provision.

The CNST IBNR, known claims and settled PPOs 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, uncertainty ranges set out below 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 possible 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 PES discount rate or PIDR as these are both prescribed (by HMT and the Lord Chancellor, respectively). As the HMT discount rate is prescribed and therefore not under NHS Resolution control, we do not consider this as a plausible option but instead show HMT discount rate sensitivities separately.

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.

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	20,822	22,396	+8%	19,337	-7%
	Known Claims	21,754	23,304	+7%	20,275	-7%
	Settled PPOs	12,780	12,889	1%	12,663	-1%
	Total	**55,356**	**58,589**	**+6%**	**52,275**	**-6%**
Range 2: range of possible outcomes	IBNR	20,822	27,665	+33%	16,084	-23%
	Known Claims	21,754	25,589	+18%	18,494	-15%
	Settled PPOs	12,780	13,329	+4%	12,212	-5%
	Total	**55,356**	**66,583**	**+20%**	**46,790**	**-16%**

The plausible alternative assumptions range (Range 1) was derived by varying the following assumptions in aggregate:

- For IBNR claims (excluding known incidents):
  - the estimate for numbers of PPO damages claims for the incident years 2017/18 onwards;
  - the average cost for PPO damages;
  - PPO damages claims inflation; and
  - ASHE
- For known incidents and known claims:
  - case estimates in respect of each known incident/claim;
  - the probability of a claim being successful; and
  - PPO damages claims inflation; and
  - ASHE
- For settled PPOs:
  - ASHE

Note that the uncertainty ranges this year includes variation of the ASHE assumption. The impact of varying assumptions in respect of Covid-19 is no longer included, as this is no longer a material uncertainty.

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 (excluding known incidents):
  - the probability of defence for PPO-type claims; and

    - the creation to settlement lag for PPO claims.
- For known incidents and known claims:
    - the creation to settlement lag for PPO claims.
- For settled PPOs, no further assumption changes are made.

In summary, the provision in the accounts for CNST could have been set at a value between £52.2 billion and £58.5 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 £55.4 billion provision in the accounts.

This uncertainty range of £6.3 billion demonstrates the sensitivity of the provision to relatively small changes in the assumptions, as summarised in Figure 30.

- For the IBNR, the change in the estimate for the numbers of PPO damages claims and the alternative view of PPO damages inflation have the largest impact on the uncertainty range calculation. This is further compounded by the sensitivity of the other factors.
- For the Known Claims, judgement is required as to the probability and cost of settlement, and it is these uncertainties that drive the uncertainty range for this element of the provision.
- The remainder of the range reflects uncertainty in respect of the ASHE indexation and the impact of changing this assumption on the Settled PPO provision.

Range 2 shows a variation of between £46.7 billion and £66.6 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 £19.9 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 uncertainty ranges of -5% to +6% and -13% to +17% for Ranges 1 and 2 respectively. This is broadly comparable to the uncertainty ranges 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	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
Contingent liability as at 31 March 2026	**-**	**90,632**	**24,011,337**	**168,021**	**190,493**	**891,366**	**3,288**	**-**	**69,502**	**15,159**	**154,065**	**25,593,863**
Contingent liability as at 31 March 2025	-	100,054	23,794,828	209,239	207,140	706,602	5,217	-	59,935	9,859	149,383	**25,242,257**

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.

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	2025/26 £000	2024/25 £000
Within 1 year	-	1,062	-	**1,062**	1,040
Between 1 and 5 years	-	4,461	-	**4,461**	4,374
After 5 years	-	1,391	-	**1,391**	2,539
Total undiscounted lease liabilities at 31 March	**-**	**6,914**	**-**	**6,914**	**7,953**

Lease liabilities included in the statement of financial position at 31 March	Leased from DHSC	Leased from other governmen t bodies	Leased from bodies external to government	2025/26 £000	2024/25 £000
Current	-	1,001	-	**1,001**	971
Non-current	-	5,702	-	**5,702**	6,702
	-	**6,703**	**-**	**6,703**	**7,673**

Amounts recognised in profit and loss	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2025/26 £000	2024/25 £000
Interest on lease liabilities	-	69	-	**69**	78
Expenses related to low-value assets	-	-	9	**9**	77

Amounts recognised in the statement of cash flows	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2025/26 £000	2024/25 £000
Repayment of lease liability – capital	-	970	-	**970**	941
Repayment of lease liability – interest	-	69	-	**69**	78
	-	**1,039**	**-**	**1,039**	**1,019**

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 English NHS foundation trusts

All English NHS trusts

All integrated care boards

Care Quality Commission

NHS Digital

Health Education England

Health Research Authority

NHS Blood and Transplant

NHS Business Services Authority

NHS England

NHS Property Services Limited

NHS Trust Development Authority

NHS Counter Fraud Authority

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out 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.

The transactions between NHS Resolution and the related parties are all arm's length and concern solely those arising in the ordinary course of NHS Resolution indemnity schemes services and not the individuals referred to in the following table.

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. There were no disclosures for DHSC in 2025/26.

NHS Resolution directors and transactions with other organisations

Name and position in NHS Resolution	Party	Nature of relationship	Payments to related organisation £000	Receipts from related organisation £000	Amount owed to related organisation £000	Amount due from related organisation £000
Dr Mike Durkin OBE Associate Non-executive Director	Health Services Safety Investigations (HSSIB)	Non-executive Director	-	3	-	-
Professor Sir Sam Everington Associate Non-executive Director	East London Foundation Trust	Non-executive Director	121	2,399	-	-
	NHS England	Non-executive Director	13	4,154	-	34
Helen Vernon Chief Executive Officer	Mid Cheshire Hospitals NHS Foundation Trust	Non-executive Director (Family member)	459	10,979	-	-

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

As the majority of NHS Resolution's income comes from contracts with other NHS bodies, NHS Resolution has low exposure to credit risk. The maximum exposures are in receivables from customers, as disclosed in 'Note 4: Receivables'.

12. Events after reporting period

These financial statements were authorised for issue on the date that the Comptroller and Auditor General certified the accounts.

References

Glossary

An online glossary[1] is available to support this document.

[1] resolution.nhs.uk/glossary/

Appendix

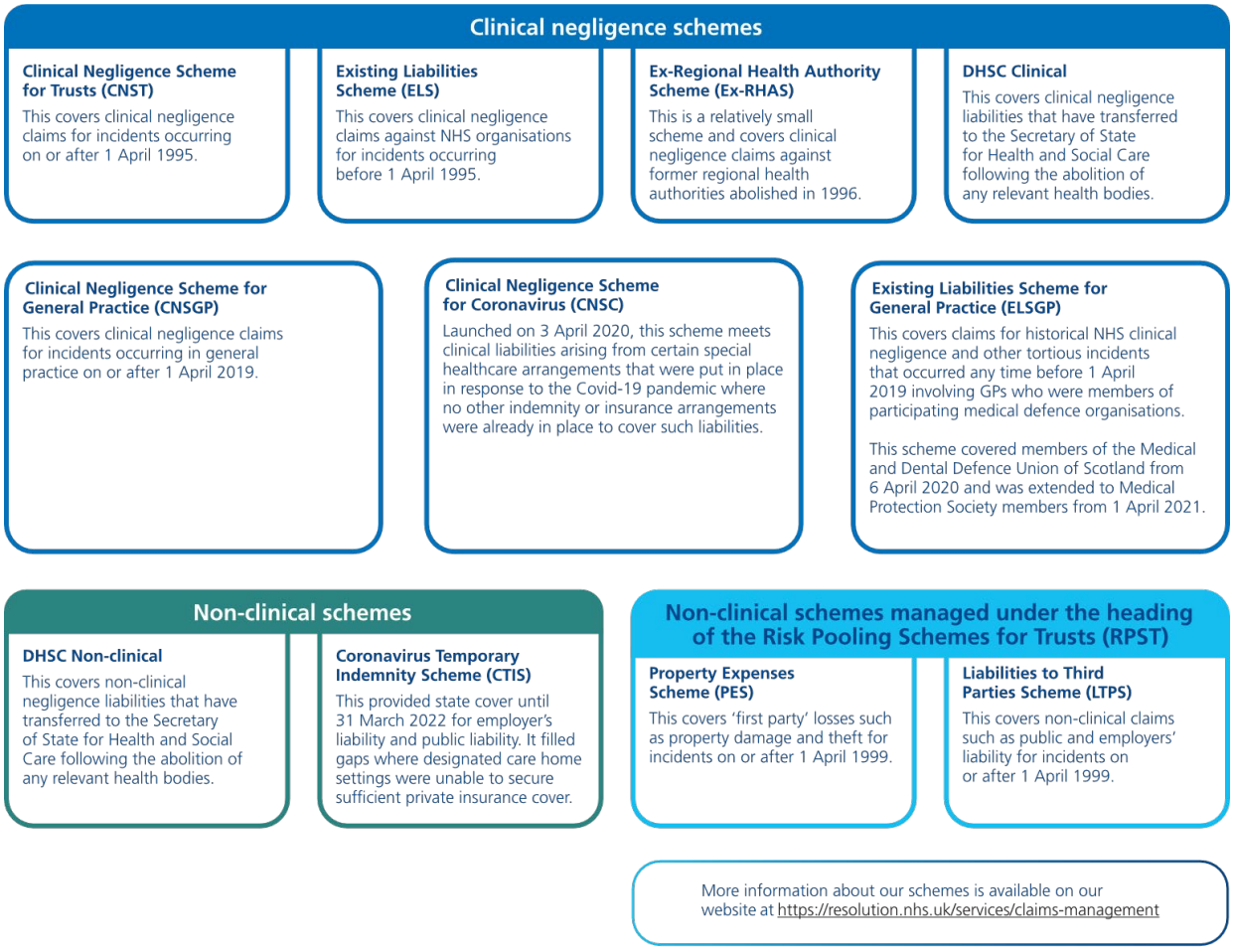
Our indemnity schemes

Most of our work involves managing negligence claims against the NHS in England.

We do this via seven clinical negligence indemnity schemes and four non-clinical indemnity schemes. These are described below.

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

Our indemnity schemes



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