

HC 499

Annual report and accounts 2019/20



NHS Resolution

Annual report and accounts 2019/20

**Presented to Parliament pursuant to Paragraph 6 of Schedule 15
of the National Health Service Act 2006.**

Ordered by the House of Commons to be printed 16 July 2020.



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Any enquiries regarding this publication should be sent to
151 Buckingham Palace Road, London, SW1W 9SZ.

ISBN: 978-1-5286-1997-4

CCS: CCS0620708408

07/20

Printed on paper containing 75% recycled fibre content minimum.

Printed in the UK by the APS Group on behalf of the Controller of Her Majesty's Stationery Office.

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Performance report

Chair's welcome



Ian Dilks / Chair

This is my seventh and final Chair's welcome and increasingly in recent years I have talked of change. This year is no different and there are more changes to come, both in pursuit of our strategy and as a consequence of the recent and dramatic impacts of Covid-19.

Some of these will be temporary but others will be with us for years and are difficult to assess at this time so I have commented separately at the end of this welcome. This is the right place to note, though, that we have taken a number of steps to support providers at this difficult time including pausing reporting requirements, as well as releasing a number of our clinically qualified staff to return to frontline duties.

We launched our new NHS Resolution five-year strategy three years ago which heralded some significant changes in our role and ambition to improve outcomes for patients and the NHS. During the last year we took the opportunity to review progress and refresh the strategy in the light of both experience and changes in the NHS since it was launched. The over-arching conclusion to the review, including feedback from a range of sources, was that it was absolutely the right approach and was delivering improvements. Inevitably, though, with the benefit of experience we have decided some resetting of the sails is appropriate and of course we have now to reflect both the challenges of incorporating our new indemnity cover for general practice and the opportunities this provides for some more radical changes. Our [refreshed strategy](#) is now available on our website.

The [Clinical Negligence Scheme for General Practice](#) (CNSGP), the indemnity scheme which covers the NHS work of GPs and those working in general

practice in England for incidents after 1 April 2019, was launched successfully a year ago and we have also implemented oversight arrangements of claims for earlier periods for two of the main medical defence organisations. Progressively this requires us to increase our workforce to take on this extra work which we have done by increasing our foothold in Leeds, ahead of a planned move of our London office to a new site in Canary Wharf, now expected to take place in the second half of 2021. This is already creating some useful efficiencies to us and the wider system but in the next two years we wish to use this increased scale as an opportunity to make changes to the way we are organised to handle claims and to align more closely with our client base and other parts of the NHS.

Our Early Notification scheme, for brain injuries at birth, also launched in 2017, is now delivering [real benefits to patients](#) and the system as we start to learn from incidents some years earlier than was possible previously. Our use of mediation to resolve disputes has continued to increase and evolve and we have recently published a [report](#) on our experience of the last two years which both shows the benefits already achieved and gives pointers for increased future benefits.

Our Safety and Learning team continues to expand its activities. We now issue a range of publications on learnings from claims experience and run a number of well-attended events to discuss, on the basis of that experience, what can be done to further reduce harm. One area where we would like to do more

is the better use of analytics to provide useful information from the data we hold, particularly where this can be looked at in combination with data held by other parts of the system. Recent developments in technology, notably enhanced artificial intelligence, give exciting opportunities which we are keen to explore, although data privacy legislation can currently be a constraint. We of course support the use of data in an appropriate way and within the current legal framework but we also encourage the continued review of the framework to ensure the right balance is achieved between the rights of individuals and system learning so that the benefits of these new technologies can be fully exploited.

Of course the elephant in the room, even if in this case it is now being talked about, remains the cost of clinical negligence. For the first time in many years our provisions for claims against the secondary care system in England have reduced, to £82.8 billion, largely due to reductions in expected future claims inflation. Our accounts also this year include an estimate of the claims arising in the primary care system from the CNSGP scheme that we operate and the claims from past events that we oversee of £1.3 billion. This is not yet the full cost of claims in general practice because we don't administer all claims but it is now possible to see a better estimate of the full cost of claims against the NHS, something that has not previously been visible.

The cost of harm for CNST in 2019/20 is estimated to be £8.3 billion, which for the first time is clearly shown in our accounts. This is slightly lower than the c£9 billion we reported last year, again largely due to lower inflation expectations. The pay-as-you-go nature of our schemes, however, means that our cash outflows and hence the contributions required from

scheme members will continue to increase. After two years of small increases or reductions in scheme charges it has unfortunately been necessary to increase our overall charges for 2020/21 by 15%. One third of this increase, 5%, results from the need to collect from our scheme members £100 million of the impact of the change in the personal injury discount rate (PIDR) made in 2017 that is no longer all funded centrally. For maternity, which bears the majority of this additional cost, this means an increase of 24% once the combined impact of underlying inflationary pressures on maternity claims and the continuing rise in cash outflows resulting from the increased number of prior year claims settled on an annual payment basis is taken into account. Charges for all other specialties have increased by less than 10% in total over three years. Approximately £230 million of the increased costs resulting from the PIDR change will still be borne centrally.

The number of new claims has risen this year by 6% in secondary care. Further details as to why are contained on page 47 but even though this is the largest increase in some years, compared to the significant increase in activity in the NHS in the last few years this represents a significant reduction in the proportion of hospital episodes resulting in claims.

We continue to play our part in reducing the cost of claims through actions to improve both patient safety and the way incidents and complaints are handled but, as the National Audit Office (NAO) report published in 2017 concluded, any strategy to tackle the drivers of cost will need to include legal reform. We continue to await the Government's response to the November 2017 Public Accounts Committee request for a cross-government strategy and further progress on the Department of Health

and Social Care's (DHSC's) proposals for fixed recoverable claimant legal costs. We hope that through legal reform a way can be found to significantly reduce the cost to the public purse at no detriment to justice.

It is necessary for us to finalise our expected cash requirements six months before the beginning of the financial year. Our cash forecasting methods continue to improve but this is offset by increased uncertainty about the environment we operate in created by factors which for the most part are beyond our control, and which next year will include the impact of Covid-19. In the last two years a series of factors, including the benefits of our own actions, have meant that, as our accounts show at the end of the year, we have not utilised all of the funds collected from scheme members and there is a small surplus. The government annual budgeting framework means that we cannot simply utilise excess funds to reduce future scheme charges but the money is not lost to the system and is available to meet other costs within the NHS.

One of the most significant changes in the way NHS Resolution now works is the increased partnership and collaboration with others in the NHS family. This is radically different to our ways of working just six years ago. We are grateful for both the input and support from colleagues in many other parts of the system and hope that we have been able to support others to achieve their objectives.

Notable and visible examples are our work with the Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives, MBRRACE, Care Quality Commission (CQC), NHS England and NHS Improvement, NHS Digital and others on both our Early Notification and maternity incentive schemes; and our joint work with the Parliamentary and Health Service Ombudsman (PHSO) on the development of improved ways of handling

complaints against the NHS. However, we also worked closely with the Royal College of General Practitioners in the launch of CNSGP and now work closely with most major health system arm's length bodies (ALBs), Royal Colleges and the General Medical Council.

I commented last year on the more robust action we were taking on the thankfully rare examples of exaggerated claims that had resulted in custodial sentences for claimants and action against a solicitor by the Solicitors Regulation Authority (SRA). This action continues, with claimant posts on social media and judicious and tightly controlled use of surveillance identifying a number of exaggerated claims, and we continue to work with the SRA on issues of concern. We have recently for the first time recovered costs against a claimant's expert witness who was criticised by the court. However, it is important to recognise that, contrary to some media reporting in the last year, our role is not to "defend" the NHS at all costs.

Our role is to handle claims that are made against the NHS and achieve a fair resolution for all parties. We investigate and where claims are not valid they are rejected, as were over 40% of all claims we received last year. However, where claims are valid we aim to achieve a fair resolution, avoiding wherever possible the need for claimants to pursue legal action. That is one of the reasons we were established as an independent ALB. Our panel law firms are remunerated in a way that is not dependent on the outcome of the claim, which we believe helps us to achieve this fair outcome.

The significant changes in the nature and scale of our activities is putting increasing pressure on our infrastructure which has not kept pace, with some of our key systems coming towards the end of their efficient life. We have started the necessary changes with a new finance system which was successfully implemented during the year. Looking ahead we

will need to invest further in our operational systems and infrastructure but, importantly, this will give us the opportunity, when combined with some of the other changes referred to above, to significantly enhance both the effectiveness and efficiency of our operations.

Our Practitioner Performance Advice and Primary Care Appeals teams, which now report to the same Director, both continued to perform well throughout the year with positive feedback from users.

It would of course not have been possible to meet our business as usual targets, successfully implement new operations and plan for the changes ahead without the commitment and hard work of everyone at NHS Resolution, and the support of our panel firms and system partners. Their efforts deserve recognition. Our Board and senior management team have remain unchanged in the last year which has helped the organisation through this demanding period.

The comments above reflect what happened last financial year and represent the core of our plans for the future. However, we cannot ignore the major impacts of the Covid-19 pandemic. This impacted the way we had to operate through the period of lockdown and we were grateful to the professional way our staff responded to the challenges of remote working. It required changes to our interaction with care providers to reduce the burden on them at a time of severe strain. We have also been asked to provide additional centrally funded indemnity arrangements to the NHS to support the rapid changes in care provision resulting from the pandemic, chiefly through the creation of a new scheme, the Clinical Negligence Scheme for Coronavirus (CNSC). Further detail is given on page 19. It is too early to assess the long-term impacts of Covid-19 on issues such as future claims frequency and cost and the demand for our advice services.

We do not expect our strategy or the main elements of our business plan to change but inevitably there will be some changes, in particular to the speed at which plans can be implemented. For us these are important issues but they are of course secondary to the tragic loss of life suffered by so many people and the impact this will have on the bereaved.

My term as Chair comes to an end later this year. It has been a privilege and pleasure to act as the Chair through this period of significant change. I would like to thank my Board colleagues and the senior management for their support, particularly through these last difficult few months, and I wish them, my successor and those to whom we provide such important services well for the future.



Ian Dilks
Chair

Chief Executive's report

Helen Vernon / Chief Executive



We started the year with the launch of a new indemnity scheme, the Clinical Negligence Scheme for General Practice (CNSGP), bringing information on clinical negligence claims against the NHS in England under one roof for the first time with significant opportunities for learning from claims across primary and secondary care.

While claims numbers for CNSGP have been low in the early days, engagement with the new scheme has been high with over 3,000 queries on the scheme's scope and operation, high levels of readership of our online publications and well-received regional events. The scheme was delivered in partnership with others including DHSC, NHS England and NHS Improvement, the Royal College of General Practitioners, British Medical Association and Medical Defence Organisations who collectively have provided exemplary support in ensuring that the scheme meets its objectives for General Practice and the patients it serves, for which we thank them.

CNSGP represents a different and more flexible model of indemnity to reflect the rapidly changing healthcare landscape. Rather than operating on a membership model, CNSGP responds to the main GP contracts and so provides an assurance of comprehensive and unlimited cover not just to GPs themselves but also to practice nurses, receptionists and indeed anyone who plays a part in delivering care to patients working in GP practices. On the launch of CNSGP we could not have anticipated that almost exactly a year later we would use our learning from this model to rapidly launch another indemnity scheme, the CNSC. The Coronavirus Act 2020 received Royal Assent on 25 March 2020 and CNSC launched formally just over one week later on 3 April 2020, putting the powers for a clinical negligence indemnity 'safety net' for health in the Act into practice. The financial year therefore ended, as it

did for many organisations, with an absolute focus on ensuring the health and wellbeing of our staff and in doing whatever we could to support the NHS in its response to the crisis.

A feature of our strategy has been to be more upstream in our activity – to prevent mistakes being repeated but also to help improve the response when something does go wrong. Our work in maternity exemplifies the former where we have sought to know more about the causes of the tragic incidents which result in brain injury at birth through our Early Notification scheme. Our report on the first year of progress with the scheme reiterated conclusions already drawn by ourselves and others in relation to the improvements needed, such as the urgent need for an evidence-based, standardised approach to fetal monitoring in England, but also highlighted potential emerging risks such as impacted fetal head at caesarean section. Our biggest ever event brought together a range of professionals involved in maternity care to consider these findings and has led to valuable work to move forward with the recommendations.

The report highlighted the need for support to be offered to all NHS staff to manage the distress that can be associated with providing acute health services and in particular those involved in incidents, including addressing mental health. In more recent times, this recommendation seems more important than ever. The publication of our guidance *Being fair*

set out the argument for organisations adopting a more reflective approach to learning from incidents and supporting staff, recognising that aside from the very visible financial and legal costs that we describe in this report, the emotional, physical and psychological costs to patients, their families and the staff involved are immense. The response when things do not go as planned, if not handled well, may be a [*significant driver to bringing a claim*](#) against the NHS and leave a legacy of additional harm to both patients and healthcare staff.

Our Practitioner Performance Advice service has developed new models of support for a specialist response where concerns are identified. Assessments are now far more flexible in their approach, which has substantially reduced the time taken and ensures that steps can be taken more promptly to support practitioners to return to safe and valued practice. Similarly, action plans have become more focused and as a result swifter in delivery, benefitting both healthcare organisations and those who work for them and ultimately patient care.

In recognition of the unprecedented challenges for the NHS, Covid-19 led us to pause some work. This included halting the majority of reporting requirements relating to the maternity incentive scheme, while still seeking compliance with the required actions vital for patient care. An interim evaluation of the scheme carried out in the year concluded that the scheme had delivered demonstrable progress in driving compliance with the ten essential actions which support the safety work stream of the national Maternity Transformation Programme, highlighting in particular improvements in safety culture and trust board engagement in maternity issues as well as additional funding being made available to recruit to key posts and

greater influence for multi-disciplinary working. The verification process led to a number of trust certifications being queried and, in a small number of cases, revoked and escalated in line with scheme rules to NHS England and NHS Improvement and the CQC to consider any further regulatory action. It is expected that publication of mis-certification coupled with improvements to the certification process will encourage Board scrutiny of submissions and in turn enhanced consideration of maternity safety issues at Board level.

Our staff have responded to the changes necessitated by Covid-19 with professionalism, flexibility and immense patience, moving rapidly to homeworking, with a number of our colleagues volunteering to be redeployed into front-line healthcare or other key strategic posts in the NHS and I want to take the opportunity to record my thanks to them. In the past year we have undertaken the preparatory work for a step-change in our infrastructure which we have identified as necessary if we are to fully deliver against our objectives. This means that change has become a constant for our organisation rather than something exceptional and so ensuring that our people have every opportunity to contribute their expertise and ideas and fulfil their potential is more important than ever. We took a number of steps towards this over the course of the year, including continuing our leadership development programme and accessing external opportunities to develop staff talent such as the Nye Bevan programme to develop senior leaders run by the NHS Leadership Academy. We launched our first claims apprenticeship scheme, supported by the Chartered Insurance Institute, and substantially increased the range and accessibility of our training and development programmes as well as the support delivered through coaching and mentoring. We were therefore delighted to end the

year by achieving silver status under our Investors in People accreditation, particularly as we had approached this organically, to allow the progress made to speak for itself.

We have been fortunate to both recruit and retain excellent and talented people but inevitably we also wish others on their way. After 27 years' service with the organisation we said goodbye to our highly respected Head of Appeals Lisa Hughes, who retired this year. We took the opportunity to restructure the Primary Care Appeals service and bring it under the wing of our Director of Advice (and now Appeals) Vicky Voller, ensuring that the Primary Care Appeals service continued to operate to the high standards achieved under Lisa's leadership. In order to drive forward the required changes to our systems and achieve our ambitions in relation to the use of our data to drive improvement, we also established NHS Resolution's first chief information officer post and commenced the recruitment process.

Finally, the progress made by NHS Resolution in the last six years is in large part a testament to the leadership of our departing Chair, Ian Dilks. His vision, expertise and commitment to building constructive relationships for NHS Resolution will be greatly missed. We look forward to welcoming his successor and to taking the next step in our strategic plans.



Helen Vernon
Chief Executive

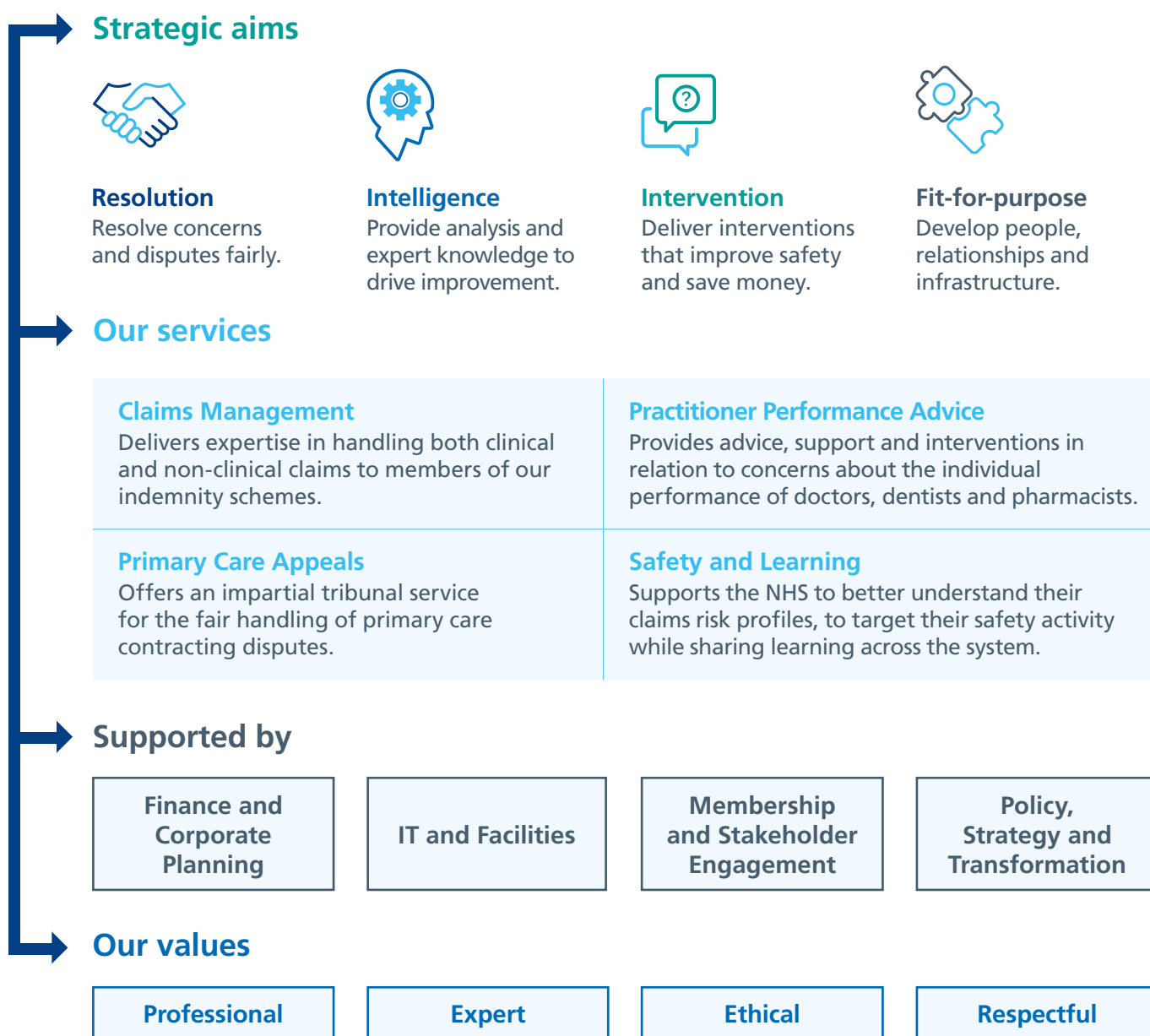
Performance summary

Performance summary

This performance summary provides an overview of the work of NHS Resolution, including our purpose, the key risks to achieving our objectives and a summary of activities we have undertaken over the past year. In particular, it sets out the activity to meet the four strategic aims outlined in our business plan for 2019/20.*

Figure 1: Who we are and what we do

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



* For more detailed information about how we have delivered against our aims, please refer to the Performance analysis section (from page 37).

Understanding our indemnity schemes

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

The *seven clinical negligence schemes* we manage are:

- **Clinical Negligence Scheme for Trusts (CNST)** which covers clinical negligence claims for incidents occurring on or after 1 April 1995.
- **Existing Liabilities Scheme (ELS)** which is centrally funded by DHSC and covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.
- **Ex-Regional Health Authority Scheme (Ex-RHAS)** which is a relatively small scheme, centrally funded by DHSC, covering clinical negligence claims against former Regional Health Authorities abolished in 1996.
- **DHSC clinical** which covers clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies, these are centrally funded by DHSC.
- **Clinical Negligence Scheme for General Practice (CNSGP)** which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.
- **Existing Liabilities for General Practice (ELGP)** describes the arrangements under which NHS Resolution carry out the Secretary of State's oversight and governance responsibilities, under the interim arrangements relating to existing liabilities agreed with two medical defence organisations (MDOs). This is where, the legal and operation responsibility of handling claims within scope of those interim arrangements remains with the MDOs. **The Existing Liabilities Scheme for General Practice (ELSGP)** is a new scheme launched on 6 April 2020. Medical and Dental Defence Union of Scotland (MDDUS) claims fully transferred to NHS Resolution on that date. Medical Protection Society (MPS) claims are intended to transfer into the ELSGP at the end of the 2020/21 financial year.
- **Clinical Negligence Scheme for Coronavirus (CNSC)**, a new scheme launched on 3 April 2020 to meet clinical negligence liabilities arising from NHS services provided in response to the coronavirus pandemic where no other indemnity or insurance arrangements are in place already to cover such liabilities.

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

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

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

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

The year in numbers

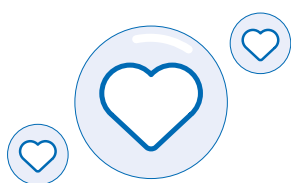
Table 1: The year in numbers

	2018/19 (£ million)	2019/20 (£ million)	Change (£ million)	%	
Funding for clinical schemes					
Income from members	1,993.5	1,951.3	(42.2)	(2.1%)	↓
Funding from DHSC (budget)	496.0	487.5	(8.5)	(1.7%)	↓
Total funding	2,489.5	2,438.8	(50.7)	(2.0%)	↓
Payments in respect of clinical schemes					
Damages payments to claimants – excluding PIDR	1,393.6	1,413.4	19.8	1.4%	↑
Damages payments to claimants – PIDR	384.4	269.8	(114.6)	(29.8%)	↓
Claimant legal costs	442.3	497.5	55.2	12.5%	↑
NHS legal costs	139.6	143.5	3.9	2.8%	↑
Total payments	2,359.9	2,324.2	(35.7)	(1.5%)	↓
Funding for non-clinical schemes					
Income from members	59.3	52.1	(7.2)	(12.1%)	↓
Funding from DHSC (budget)	12.0	7.0	(5.0)	(41.7%)	↓
Total funding	71.3	59.1	(12.2)	(17.1%)	↓
Payments in respect of clinical schemes					
Damages payments to claimants – excluding PIDR	33.9	28.5	(5.4)	(15.9%)	↓
Damages payments to claimants – PIDR	3.5	1.5	(2.0)	(57.1%)	↓
Claimant legal costs	17.8	18.1	0.3	1.7%	↑
NHS legal costs	6.6	7.4	0.8	12.1%	↑
Total payments	61.8	55.5	(6.3)	(10.2%)	↓
NHS Resolution administration of schemes					
Clinical	13.3	19.4	6.1	45.7%	↑
Non-clinical	4.2	4.5	0.3	7.0%	↑
NHS Resolution other activities					
Income	1.1	1.0	(0.1)	(8.2%)	↓
Expenditure	8.3	6.9	(1.4)	(17.0%)	↓
Staff numbers	293	328	35	12.0%	↑
Provisions cost of claims in 2019/20					
Claims provisions	8,809	3,057	(5,752)	(65.3%)	↓
Provisions for claims	83,376	84,053	677.4	0.8%	↑

Our response to the Covid-19 outbreak

NHS Resolution started responding to the Covid-19 pandemic at the beginning of February 2020. We monitored the situation, reviewed our pandemic preparedness and business continuity processes, implementing them as appropriate, adhering to the latest government guidance as the situation evolved.

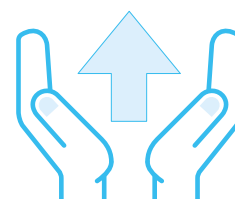
Our response was three-fold:



To ensure the safety and wellbeing of our staff.



To continue to serve the NHS and other members and customers with minimal disruption.



To provide the NHS with the support it needed to respond as required – through for example the launch of a new scheme, the CNSC and supporting the expansion of the primary care workforce.

To ensure there are no gaps in indemnity coverage, the Coronavirus Act 2020 included additional powers to provide clinical negligence indemnity arising from NHS activities related to the Covid-19 outbreak, where there were no existing indemnity arrangement in place. Our CNSC (which was launched on 3 April 2020 but will cover claims arising from 2019/20 onwards) provides cover for services directly related to the NHS response to Covid-19 and for any backfill arrangements that may be needed, as a

consequence of outbreak, to sustain the delivery of NHS services. During the pandemic, existing indemnity arrangements continued to cover clinical negligence liabilities arising from the vast majority of NHS services, including staff working in a place that is not their ordinary place of work. For example where NHS trusts hosted special healthcare arrangements, such as the NHS Nightingale hospitals, then clinical negligence liabilities are covered by our existing CNST.

For retired staff coming back to work to support the response to the Covid-19 outbreak, in most cases indemnity is covered by one of the two existing state clinical negligence schemes: the CNST if they returned to work in an NHS trust; and the CNSGP if they were engaged by a GP practice providing NHS GP services. However, in the rare instances where these or other indemnity arrangements did not apply, the indemnity provision was made under the CNSC. We have worked with NHS England and NHS Improvement to support the expansion of the primary care workforce. The online survey inviting professionals to indicate their willingness to return to practice and the direct communication with all practitioners who have recently left the service has resulted in over 25,000 GPs coming forward. The existing checks to allow admission to the Performers List are to stay in place (as they constitute an important pre-employment check for employers in primary care). This includes NHS Resolution performing checks of our databases against doctors who are making an application to join the Performers List, to see whether we hold any record of past or current investigations or proceedings involving such individuals.

The changes in healthcare provision due to the pandemic response, for example the reduction in elective activity and attendances at hospitals and the presentation of patients with Covid-19, are likely to affect the pattern of claims NHS Resolution may receive in the future. Given the time lags between incidents, claims and their settlement, and the lack of data we have on how claims may manifest in the future, no provision for such potential changes has been made in the 2019/20 accounts.

The majority (approximately 70%) of the CNST provision is as a result of claims arising from the brain damage of babies at birth from negligent care. The Early Notification scheme requires the

notification by providers of maternity care of cases where there is a risk of brain damage at birth. Clearly the birth rate during March 2020 will not have been affected by the pandemic, but the reporting of incidents may have been, and it is too early to conclude whether there is a change in this particular risk.

We have considered how we can enable NHS services to focus on delivering critical services to patients through the pandemic response, and have reviewed our reporting arrangements in relation to our maternity activities in that light.

In April 2020, a joint letter was sent to trusts from NHS Resolution, RCOG, MBRRACE-UK and the Healthcare Safety Investigation Branch (HSIB) to outline reporting requirements. From 1 April 2020, it is no longer necessary for trusts to report Early Notification cases to NHS Resolution (this decision is to be reviewed in September 2020). Trusts are now required to report all cases that meet the Early Notification criteria to HSIB during this time. HSIB will triage all cases and prioritise those where there is evidence of harm (brain injury) to the baby and will share these cases directly with NHS Resolution. Any Early Notification liability investigations will commence once the HSIB report has been received, and the Early Notification team will liaise directly with trusts.

In addition, trusts were informed in March 2020 that reporting for the maternity incentive scheme had been paused, but were encouraged to apply the principles of the maternity incentive scheme safety actions. Also, within this communication, the importance of maintaining some external reporting was outlined such as reporting eligible cases perinatal deaths to MBRRACE-UK and also where possible every reasonable effort to make a monthly Maternity Services Data Set submission to NHS Digital.

We recognised the enormous pressure placed on our colleagues across the NHS in dealing with the challenge of Covid-19.

NHS Resolution continue to work with key stakeholders during this time, continue to be members of the Maternity Transformation Programme (work stream 2) national programme board which focuses on safety, and also contribute to wider key stakeholder maternity meetings which have responsibility for oversight on safety within maternity services during the Covid-19 pandemic.

We will also monitor and consider the changes in the healthcare environment through our Reserving and Pricing Committee in relation to updating our valuation of liabilities arising from claims for the 2020/21 financial year.

Just before the government recommendation to stay home announced on 23 March, we moved to a position where the majority of our staff worked remotely to minimise the risk of exposure while taking all necessary steps to minimise the impact of this decision on the continued provision of our services. This escalated work already in train to prepare for greater levels of home working as part of our move to a new office in Canary Wharf in 2021 and allowed us to test options to improve our approach as a flexible employer via our Ways of Working programme.

We also worked to support government advice to avoid unnecessary travel and practise social distancing, with our staff using online meeting software to ensure continuity of service. This had a knock-on effect to some of our activities such as planned training and events, assessments and

mediations, pharmacy market entry site visits and hearings as well as GP premises rent valuations that couldn't be delivered online. Understandably a decision was taken by the joint hosts (UK and Republic of Ireland medical indemnity organisations) to cancel the Global Medical Indemnity Forum scheduled to take place in London on 24-25 June 2020.

We recognised the enormous pressure placed on our colleagues across the NHS in dealing with the challenge of Covid-19. In addition to the changes in our reporting arrangements for maternity activity described above, we have extended our Practitioner Performance Advice service operating hours, and paused activity which requires utilisation of frontline clinicians.

In consultation with NHS Employers we have also published interim guidance to help support the management of concerns in accordance with Maintaining High Professional Standards in the modern NHS (MHPS) during this difficult time.

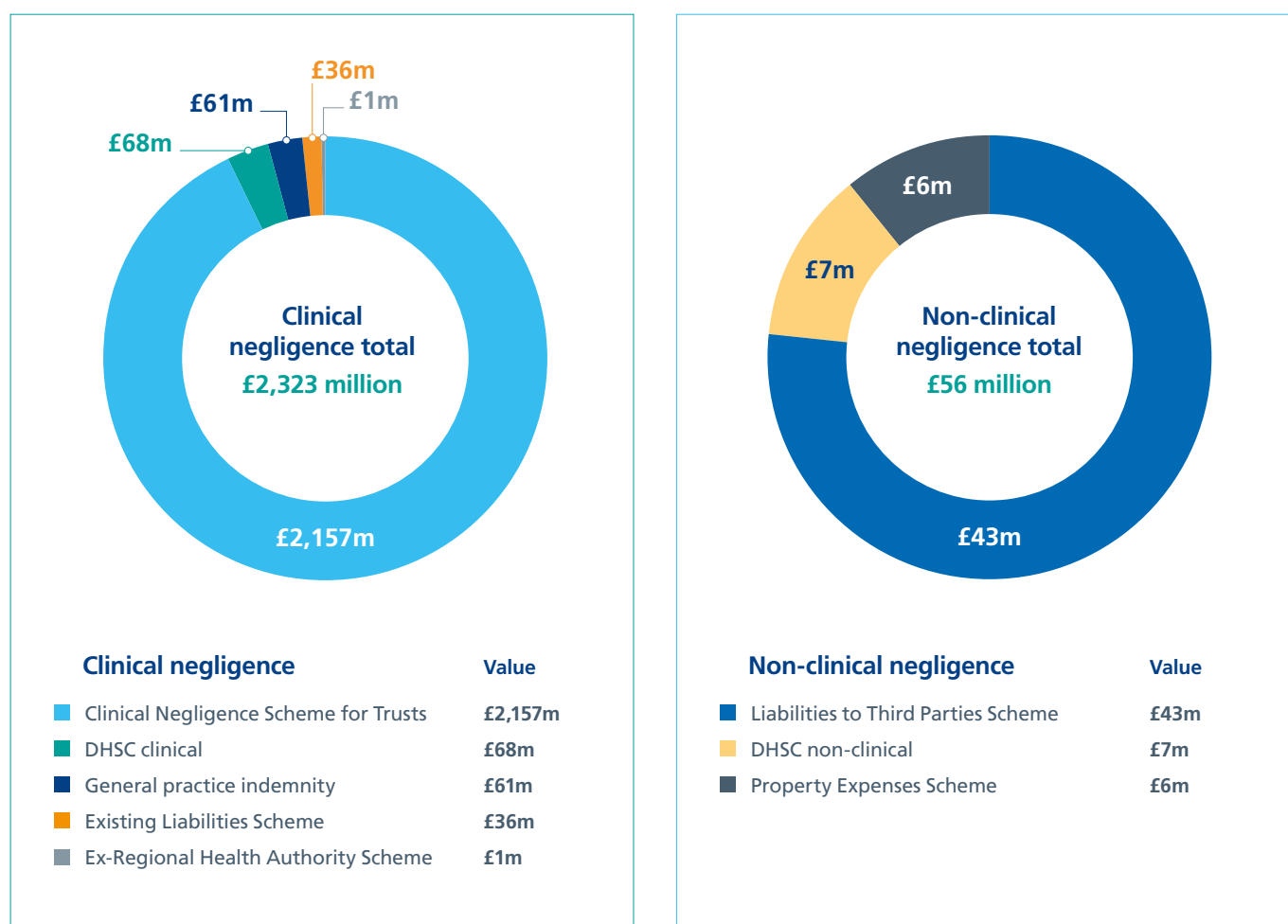
Performance overview

This section provides some of the main headlines concerning our activities during the financial year and greater detail can be found in the main Performance analysis section from page 37.

Liabilities arising from claims under all of our indemnity schemes have increased by £0.7 billion, from £83.4 billion to a total of £84.1 billion, at current prices, at the end of this financial year. This is the value of liabilities arising from incidents that occurred up to and including 31 March 2020, both in relation to claims received and our estimate

of claims that we are likely to receive in the future from those incidents which have occurred but have yet to be reported as claims. Of this £1.3 billion related to liabilities recognised for the first time in respect of general practice. This means that the value of liabilities for longstanding schemes reduced by £0.6 billion.

Figure 2: The value of payments (damages, claimant and NHS legal costs) across all indemnity schemes for 2019/20 demonstrating the relative size of the schemes



The overall financial picture this year shows that trends in claims activity, inflation in particular, continue to be lower than forecast in relation to the assumptions affecting the provision. The cost of settling claims in-year has reduced, due to the change in the PIDR rate from minus 0.75% to minus 0.25% on 5 August 2019 (see page 29), although this has been partly offset by new costs arising from

the introduction of general practice indemnity arrangements. These improvements in trends overall are reflected in the reduction of the annual cost of harm arising from the clinical activity covered by our CNST scheme from £8.8 billion to £8.3 billion in 2019/20. This represents the cost of claims, both those received and those expected to be received in the future, from incidents in 2019/20.

Received claims

In 2019/20 we received 11,682 new clinical negligence claims and reported incidents, compared to 10,684 in 2018/19, an increase of 998 (9.3%). This includes 401 claims and incidents for the new CNSGP scheme. The number of new non-clinical claims, typically employers' and public liability claims, rose from 3,585 received in 2018/19 to 3,744 in 2019/20, an increase of 159 (4.4%).

Settled claims

When considering settled¹ claims in 2019/20, of the 15,550 claims settled, 71.5% were settled without proceedings, 27.9% with proceedings and 0.6% at trial. Respectively, 37.3%, 5.3% and 0.5% of claims were settled without damages. Overall, the proportion settling without damages increased by 1% compared to 2018/19.

Closed claims

When considering the 16,378 closed claims in 2019/20, of the 11,992 clinical and 4,386 non-clinical claims the proportion settled without damages was 37% and 47% respectively. This compares to 16,393 closed claims in 2018/19; of the 11,625 clinical and 4,768 non-clinical claims the proportion settled without damages was 41% and 52% respectively.

New referrals

The number of new referrals received in relation to the performance of doctors, dentists and pharmacists within the NHS remained broadly consistent, with 775 **new requests for advice** compared to 925 in the previous year. In addition, we received 162 **appeals** in accordance with the Pharmacy Regulations compared to 171 in the last financial year. In doing so, we did not receive any judicial challenges to any of our pharmacy decisions. We continued to meet key performance indicators despite increasing complexity in cases.

¹ Settled claims include claims that have been agreed with ongoing periodical payment orders and claims where damages have been agreed or successfully defended, and costs have yet to be agreed. This is a different cohort to closed claims which do not include ongoing periodical payment orders and may fall in different years.

Key headlines

This section provides an overview of some of the key activity undertaken by NHS Resolution during 2019/20 under the six priorities we identified in our business plan 2019/20, which will be described in greater detail in the Performance analysis section from page 37.

Priority 1

Operate the Clinical Negligence Scheme for General Practice

In 2019/20 our role in primary care expanded significantly. DHSC had recognised that the rising cost of indemnity for clinical negligence liabilities was a great source of concern for general practitioners and those working in general practice and was impacting negatively on the workforce including out-of-hours staffing and GP recruitment and retention.

This was exacerbated in early 2017 when there was a change in the personal injury discount rate which had a significant impact on compensation. As a result DHSC sought to put in place a more stable and affordable system of indemnity for general practice. We were given responsibility for the overall administration of a state-backed indemnity scheme for general practice and expanded our indemnity offer to the sector through the introduction of our CNSGP on 1 April 2019 for all incidents occurring on or after that date. This was also a key recommendation from the GP Partnership Review. CNSGP now operates at the interface between clinical negligence indemnity and other types of cover so it is vital that GPs and others continue with their membership of a MDO or alternative provider for activities not covered under the scheme.

On behalf of the Secretary of State for Health and Social care, DHSC entered into interim arrangements with MPS and MDDUS to indemnify claims for the NHS historical liabilities (in tort) of their general practice members, to be indemnified in due course by the state under the ELSGP, once established.

Under the terms of the transaction documents giving effect to these interim arrangements, we have provided an oversight and gatekeeping function on behalf of the Secretary of State.

From 6 April 2020, historical liability claims (i.e. liabilities arising from incidents prior to 1 April 2019) against members of the MDDUS transferred over to Government to be administered by NHS Resolution for the Secretary of State under the Existing Liabilities Scheme for General Practice (ELSGP) which was established on the same date for the purposes of providing indemnity and managing NHS historical liabilities of general practice members (and former members) of MDOs with which interim ELS arrangements are agreed.

Our success in delivering the CNSGP has led to some additional challenges and opportunities. Our greater presence in primary care led us to explore the size of our operations, and how we undertake our operations and stakeholder engagement to resolve concerns, claims or appeals. As a result we also adjusted the specifications and requirements of our core IT systems review to ensure we can meet our strategic priorities around intelligence and effective use of data to drive safety and learning, and being fit-for-purpose to drive operation efficiencies. With an increased and changing workload, we have initiated a restructure of Claims Management to improve our services and are exploring new ways of working to get the most from our planned London office move in 2021, which is driven by the national government accommodation strategy.

Working more effectively across primary care

To support our new and significant strand of work around general practice indemnity, and to engage others in the range of work we undertake in primary care, we delivered a series of regional workshops in partnership with NHS England and NHS Improvement, described in more detail in our section on *Regional member events and primary care roadshows* on page 72.

The changing needs of the primary care sector have also influenced the existing services provided by Practitioner Performance Advice and Primary Care Appeals. While the total number of cases handled by our Practitioner Performance Advice service are

fewer than last year, our reach has nevertheless expanded across all primary care regions. One element of our work is to resolve appeals against NHS England and NHS Improvement's decisions relating to the set-up, relocation and opening hours of pharmacies. A decrease in new community pharmacy applications, against a backdrop of rising numbers of appeals and disputes elsewhere, may be due to the financial challenges of operating in the area. For the first time we have been involved in appeals relating to the merger of pharmacies, which may be indicative of the changing primary care landscape and the issues the sector faces.

Priority 2

Incentivise NHS providers to deliver safer maternity and neonatal services. Get closer to the most serious incidents to share learning and deliver support to families and staff

Nowhere better exemplifies our approach to sharing learning in partnership than our work with key bodies in the maternity sector. In the maternity arena we published [*the results of a second year of the maternity incentive scheme \(MIS\)*](#) and launched the scheme for a [*third year*](#).

One of the MIS actions was 100% reporting to our Early Notification scheme where learning is shared in real time with the NHS. In order to share the common themes seen in the most serious incidents reported to us under this scheme, we released [*The Early Notification scheme progress report: collaboration and improved experience for families*](#). The findings of that report and of our wider work in maternity were then debated with front-line clinical staff and national partners at our national maternity conference.

Priority 3

Use the findings of our research to improve how the NHS responds when something goes wrong

Developing our role within primary care also supports our work with secondary care providers to, where possible, provide earlier resolution that is fair, timely, supportive and understanding of all the perspectives involved.

Our [Being fair](#) report launched in July 2019, with the aim of encouraging local conversations to develop a just and learning culture in the NHS. This is the balance of fairness, support for both patients and staff when things do not go as planned together with accountability for what happened and responsibility for learning and taking action. In relation to our work, it is about creating an environment where all NHS staff feel safe to *'say sorry'*, supporting the duty of candour. In turn this is likely to reduce the costs

associated with claims for compensation when these are raised solely to obtain an apology and to understand what has happened following an incident.

In partnership with the PHSO, we have contributed to the development of work to support the handling of concerns and complaints by the NHS in a consistent fashion. Although this work will now be delayed due to Covid-19, we look forward to exploring how we can practically contribute to the development of a national training and development offer for NHS complaints managers. The strand of work is in line with our commitment to move upstream in order to prevent claims and it also supports our [joint statement](#) which commits both organisations to help the NHS respond more effectively when things go wrong.

Priority 4

Intervene to help resolve concerns about practitioner performance quickly and locally

A just and learning culture is also clear about where the line is drawn between acceptable and unacceptable behaviour. Often the behaviour reported to Practitioner Performance Advice requires a specific and sometimes specialist response.

The advice we provide is based on a 'local first' response, informed by preliminary conversations with the case manager before we offer a suggested way forward. We are supportive of the General Medical Council's work in this area, with their introduction of Professional behaviours and patient safety programme which will also stimulate a discussion at a local level around what culture we wish to have in the NHS and in turn drive improvements.

In 2019/20 we piloted [team reviews to reflect modern multidisciplinary care](#) and Action Learning Circles to support improvements in managing concerns about practitioners at a local level.

We have extended the time to address our ambition to develop a framework for the reporting, analysis and evaluation of Practitioner Performance Advice data in order to ensure proper consultation with our partners. This means that the approach we take is informed by engagement with our users and stakeholders to ensure that our reporting, analysis and evaluation work adds tangibly to the healthcare system's understanding about current issues surrounding practitioner performance.

Priority 5**Continue our drive to keep patients and healthcare staff out of court and/or avoid the need for formal court processes**

In order to reduce unnecessary legal costs associated with claims and to keep patients and healthcare staff out of court we have pressed forward with other types of dispute resolution including mediation.

We have continued to explore different approaches and to evaluate what works where so that a broad approach is considered as standard; this includes global settlement meetings on cohorts of cases and greater use of technology as well as conventional round table meetings. This year we reported on the impact our Claims Management mediation service is having on outcomes in [*Mediation in healthcare claims – an evaluation*](#), published on 12 February 2020. In March 2020 we appointed a new mediation panel to continue the work from 1 May 2020.

Priority 6**Translate data into learning by bringing a clinical lens to emergency care claims – the biggest claims area by volume**

We appointed a clinical fellow to undertake a thematic review of claims relating to the emergency care department.

The driver for this exploratory work was the rising number and cost of claims in this area, identified as part of our monitoring of trends emerging from various clinical specialties. Due to the diverse nature of claims in this area, the work has taken longer than expected. Having undertaken the research and data analysis, the next stage is working with key stakeholders and partners to co-design recommendations to take forward in improving safety and reduction of harm in the emergency department. The full report will be published during 2020.

Some other areas that have proved to be challenging have tended to be the aspects of our five-year strategy that required greatest fundamental change and complex preparatory work. This has included our review of our core IT systems: although this work has taken longer than planned, we have made significant progress in determining our requirements and now have a clear focus for the next phase of implementing change.

We decided at this stage not to pursue a planned pilot with members to determine how the learning from expert witness reports is shared and implemented, pending a wider review of data protection considerations and how we hold and share data.

Refreshed strategy

In April 2017 we published [*Our strategy to 2022: Delivering fair resolution and learning from harm.*](#)

The external environment inevitably changes and at the mid-point in our implementation period we paused to take stock of progress, achievements to date and to consider if we needed to refocus efforts and, if so, where. We are reassured, and if anything more convinced by this evaluation that our core strategic approach is the right one – of where appropriate ‘moving upstream’ or ‘doing more, sooner, in the chain of events that lead to a claim, concern or dispute’.

[*Our refreshed 2019-2022 strategic plan: Delivering fair resolution and learning from harm*](#) was published in February 2020. This should be considered as supplementary to our existing strategy and includes priority updates across our four strategic aims – resolution, intelligence, intervention and fit-for-purpose – including revised medium-term priorities critical to our success.

The environment we work in

Law reform and the legal environment

Cross-government strategy and fixed recoverable costs

The Government's work to develop a cross-government strategy to address the challenge of the rising costs of clinical negligence in response to the recommendations of the National Audit Office and Public Accounts Committee's 2017 findings continues. We continue to support this work by contributing our expertise, experience and data.

Personal injury discount rate and the Civil Liability Act 2018

As noted in our [Annual report and accounts 2018/19](#), passage of the Civil Liability Act 2018 started a process under which the prevailing PIDR of minus 0.75% in England and Wales was reviewed by the Lord Chancellor. This rate governs the calculation of claims for future losses. The statutory presumption is now that recipients of personal injury damages will accept "more risk than a very low risk" on their investments, but "less risk than would ordinarily be accepted by a prudent and properly advised individual investor". This replaced the previous assumption that such individuals were "no risk" investors.

It was announced in July 2019 that the PIDR would be altered with effect from 5 August 2019 to minus 0.25%. The rate is net of taxation and investment charges. It therefore assumes that claimants will continue to lose money on their investments once these factors have been taken into account. The Act requires this rate to be reviewed at least once every five years, although significant changes to investment returns could result in a quicker reassessment. On all future reviews, the Lord Chancellor must consult a group of experts in addition to the Government Actuary and HM Treasury.

Overall, the effect of this change is to reduce damages for future loss (such as earnings and therapies) by a modest degree, but such compensation payments will still be much higher than they were before 20 March 2017, when the PIDR was plus 2.5%, a position that had remained unchanged since 2001.

The health landscape

NHS Improvement's patient safety consultation

The [*NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*](#) was published in July 2019 by NHS Improvement (now NHS England and NHS Improvement), following a consultation between December 2018 and February 2019.

The three strategic aims as outlined in the Patient Safety Strategy are:

- **Insight**
Improving understanding of safety by drawing intelligence from multiple sources of patient safety information
- **Involvement**
Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
- **Improvement**
Designing and supporting programmes that deliver effective and sustainable change in the most important areas

We contributed to the Patient Safety Strategy by highlighting the learning that can be extracted from clinical negligence claims in the insight section of the strategy.

Mental health

The adoption of our recommendations in our [*Learning from Suicide-related claims*](#) report continues, most notably with the adoption of recommendations for staff training in observation² but also in sharing our data with the Ministry of Justice to help inform risks to prevent deaths in custody.

In collaboration with Zero Suicide Alliance national initiative to improve awareness and support for those at risk of suicide or those suffering bereavement following a suicide, we ran an internal training campaign. This was taken up by staff from across the organisation and helped stimulate open discussion and disclosure of mental health challenges.

Aligned with this initiative we have also worked in collaboration with experts to develop our [*Being fair*](#) principles guide. This expounds the benefits of adopting a just culture from the top down by allowing others to admit mistakes and highlight risks and opportunities by implementing the values associated with such a culture (kindness, openness, honesty, respect, compassion and building trust).

The learning insights and recommendations for adoption have been shared in a series of both internal and external events and endorsed by a joint blog with the Health, Safety and Wellbeing Partnership Group (hosted by NHS Employers).

²Reference: 7th Edition of Standards for Acute Inpatient Services for Working Age Adults.
<https://www.rcpsych.ac.uk/improving-care/ccqil/quality-networks-accreditation/assessment-and-triage-wards-aims/our-standards>

NHS Long Term Plan

In 2019/20 we welcomed the [Long Term Plan](#) (LTP) for the NHS. The plan describes how the NHS will increasingly be more joined up and coordinated in its care. We continue to work internally and with our system partners to capitalise on the opportunities that will be presented by the drive to improve out-of-hospital care through integrated primary and community care. This will include careful consideration as to how our indemnity schemes need to evolve to best serve the future of the NHS and to maximise the benefit of our now wider view of harm across the primary and secondary care sectors.

The LTP recognises that the performance of any healthcare system ultimately depends on its people, and that delivery of the plan will require NHS staff to work in a more supportive culture. As mentioned previously, in 2019/20 we contributed to this discussion by publishing [Being fair](#), discussed in more detail in our Learning from harm section on page 72.

The LTP sets out clinical priority areas including cancer, cardiovascular disease, maternity and neonatal health, mental health, stroke, diabetes and respiratory care. In 2019/20, we continued to work within maternity and neonatal health and to support the LTP agenda to support the delivery of safer maternity care through an incentive element to the contribution to the CNST. Work in 2019/20 has reflected the priorities outlined in the plan concerning digital technology in the NHS as we worked throughout the year to reform our digital and technological capabilities.

Five year GP contract framework

The new [five-year GP contract framework for general practice](#), agreed between NHS England and the BMA General Practitioners Committee, marked a significant change in primary care, including historic levels of funding to create primary care networks, integrating primary and community services, addressing workforce pressures and expanding the workforce, improvements to the Quality Outcomes Framework, and digitalisation of services. This was developed in parallel with the LTP. We look forward to engaging with primary care networks and sharing our learning with those working in general practice, including new and emerging professional groups of clinical pharmacists, community paramedics, physician associates and social prescribing link workers.

Consultations: Health Education England – national patient safety syllabus

During the financial year we provided responses to a number of consultations. Of particular note was our response to the opportunities offered by Health Education England for us to inform the development of a national patient safety syllabus and supporting curricula. We support the overall ambition of the syllabus as the basis of education and training at all levels throughout the NHS. For example, we called for the syllabus to reference ways to address and respond to concerns, complaints, claims and inquests in the round including the triangulation of the insights.

We encouraged greater clarity around what we expect all staff (clinical and non-clinical) to know in the event that something goes wrong and a claim or significant concern is pursued. And for a greater emphasis on communication skills and the key competencies required to support staff in having difficult conversations.

Key risks and issues

This section describes the key risks and issues we have identified and responded to during the reporting year.

Responding to the pace of change

NHS Resolution operates in a dynamic and fast-changing policy environment. This presents us with a number of challenges including being able to recognise and respond to new or proposed changes. A prime example is the need for wide-ranging changes to the way we worked and the services we delivered in response to the Covid-19 pandemic as described earlier in this report.

We have sought to mitigate the risks posed by the policy environment by establishing a Policy, Strategy and Transformation function. The team ensures that we identify emerging issues early and consider the potential impact on our strategic direction. We have also reviewed and enhanced our stakeholder engagement strategy to ensure that we are working effectively with key partners across the healthcare and legal systems.

As an organisation we have needed to address the increase in activity from our new role in administering general practice indemnity arrangements, and from a number of other significant change management programmes, such as the review of our IT architecture, preparing for a move to a new main London office and embedding new ways of working. All have required cross-organisational input and contributions from all of our services. We have recruited more staff and introduced new key roles, e.g. the chief information officer position, to meet our business needs and widening remit.

Raising concerns

As an NHS body, patient safety and public protection, including the safety of staff, are our paramount concerns, balanced alongside our responsibilities around data protection. On occasion we may identify a significant concern and have a duty to share information externally, for example with other NHS bodies or those with responsibility for regulation within the healthcare system. This would happen if we see activity that has caused significant harm or puts individuals at significant risk because of unsafe clinical practice or conduct that severely compromises the effective delivery of services. In line with our strategy, during the course of this year we took steps to strengthen our arrangements to respond to those situations with the establishment of a framework for managing such concerns. Our approach to this work will continue to evolve and we will keep these arrangements under review as we move forward.

Ian Paterson Inquiry

NHS Resolution recognises the distress caused to the patients and their families involved in this case and we would like to take this opportunity to extend our sympathies to them for both the physical and mental pain caused by the actions of Ian Paterson, a consultant surgeon who performed inappropriate or unnecessary procedures and operations. The [report of the independent inquiry](#) into the issues raised by Paterson was published early in February 2020. We welcome the Inquiry's recommendations to protect patients and strengthen local governance arrangements of doctors and will be working through the details to consider how we act on them. Our Practitioner Performance Advice service supports organisations to resolve concerns fairly and share learning. We have made a number of improvements to our service which include strengthening the promotion of information-sharing between organisations in the interests of patient safety.

In relation to claims arising, 378 claims have been reported of which one is an ongoing claim; 237 have settled and 140 discontinued with no damages payment. We have paid £9,954,458 in damages for NHS cases related to Ian Paterson. A total of 558 private claims have been reported to NHS Resolution. On behalf of the Heart of England Foundation Trust NHS Resolution agreed to contribute £3.6 million to the global settlements made by Spire of £37 million, to include damages and claimant costs and with respect to all private patients. This settlement was approved by the Court on 27 September 2017. In addition £887,025 has been paid by NHS Resolution with respect to NHS legal costs.

Legal compliance

During a period of considerable change over the last year, we have made particular efforts to understand, develop and work within the legal framework to enable us to deliver the new areas of business for which we have been given responsibility, e.g. general practice indemnity arrangements and, latterly, the response to Covid-19. We have worked closely with the Department, the Government Legal Department and our own legal advisors to update our legal framework and to ensure that our guidance to staff and users of our services is effective in achieving compliance.

IT infrastructure

A project has been underway since 2018 to review our current information systems and business processes. The aim is to develop a set of requirements to enable us to deliver our strategic ambitions concerning data analytics and operational efficiency. During 2019 we engaged Deloitte consultants to validate the findings and develop options for the next stage of the project. While the review concluded that currently our systems are fit for purpose, there is a risk that these will become obsolete in the medium term and that the ability to develop current systems to meet our needs is limited. The Board has approved in principle the proposal to source new systems, subject to a full business case and funding. In addition, we have agreed a revised support and development contract with our core systems supplier to secure the relationship, and are preparing to recruit to key project roles.

Cyber security

Our IT team is constantly striving to keep up with the ever-evolving threat of cyber security. We have successfully maintained our Cyber Security Essentials Plus certification as well as revising our end-user computing security tools. Following a full re-certification audit we retained our ISO 27001 certified status. We have continued our programme of penetration and vulnerability testing and further extended this to social engineering and physical security assessments. The Board and Audit and Risk Committee are fully apprised of emerging threats and our ability to deal with them.

Fraud

The risk of fraud is ever-present. With support from our local counter-fraud specialist providers, RSM, and participation in DHSC's Counter Fraud Liaison Group we continually review and monitor potential threats, provide awareness training to staff and undertake pro-active exercises to detect potential fraud and improve our control framework.

UK's future relationship with the EU

We have been actively engaged in working with DHSC on preparations for the UK's departure from the European Union (EU). In line with government requirements our nominated director oversaw our preparations and related risk assessments and planning. In line with government guidance, we provided reassurance to staff members from other EU countries on their future employment status, and established a robust emergency planning and response framework. Given the work we do, there is relatively little direct impact from the UK's departure from the EU but it is not without risk. We continue to work with DHSC to monitor the impact on the system of the UK's future relationship with the EU.

Going concern

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

On 27 February 2017, the Lord Chancellor announced a change to the PIDR from 2.5% to minus 0.75%, effective from 20 March 2017. A subsequent change in the rate to minus 0.25% was introduced on 5 August 2019 arising from the Civil Liability Act 2018. The Government has funded the additional costs during 2019/20.

DHSC has confirmed that it will continue to provide support to NHS Resolution to meet the additional costs in settling claims arising from the current PIDR for DHSC schemes and partly for CNST. The remaining costs for CNST and LTPS have been included in contributions charged to members, with equivalent funding levels provided through NHS budgets.

On this basis NHS Resolution is not required to hold assets to cover liabilities arising from the indemnity schemes. Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements of 31 March 2020.



Performance analysis

Our strategic aims to 2022

Purpose

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



Strategic priority 1 – Resolution

Resolve concerns and disputes fairly.

We will know we have succeeded when...

We systematically deploy the right dispute resolution approaches at the right time, resulting in fewer cases escalating into formal processes.



Strategic priority 2 – Intelligence

Provide analysis and expert knowledge to drive improvement.

We will know we have succeeded when...

Others have taken action in response to our data, insight and recommendations to enable improvements in patient and staff experience across primary and secondary care.



Strategic priority 3 – Intervention

Deliver interventions that improve safety and save money.

We will know we have succeeded when...

We continue to be a trusted source for learning from claims, concerns and disputes while utilising the unique levers at our disposal to make a positive difference to patient and staff safety.



Strategic priority 4 – Fit-for-purpose

Develop people, relationships and infrastructure.

We will know we have succeeded when...

We have evolved to meet increasing demand, staff work flexibly across functions and systems and are empowered to make decisions and develop their skills, with succession plans in place for key roles.

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

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

Our strategic aims set out in our business plan for 2019/20 were:

Strategic priority 1 – Resolution



- To continue to provide cost effective dispute resolution services
- To reduce litigation and increase the use of alternative dispute resolution
- To reduce the unnecessary costs attached to claims and inform policy initiatives designed to achieve this outcome
- To extend the reach of Performance Practitioner Advice into organisations that are currently not using its services, particularly when there is a serious incident or safety concern.

Strategic priority 2 – Intelligence



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

Strategic priority 3 – Intervention



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

Strategic priority 4 – Fit-for-purpose



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

Performance measures

Our performance measures provide an objective assessment of our operational performance and how we delivered against our strategic aims.

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

Our KPIs are agreed by our Board and DHSC and published annually via our business plan with the exception of some of our internal claims KPIs where publication could prejudice the effective management of claims. The performance of our legal panel firms is also monitored closely under a balanced range of KPIs that are specified in our contracts with them in order to ensure a high-quality service at a competitive price. We monitor through regular performance meetings to address any issues or concerns raised and discuss continuous improvement.

Throughout 2019/20, we continued to review the distribution of work and performance in relative, as well as absolute, terms and intervened as required.

Our Board and workforce strategy group monitored a variety of workforce indicators, including establishment levels, employee turnover, recruitment, sickness absence, levels of pay, and equality and diversity statistics, to ensure that the associated HR issues flowing from our business were properly managed. We use a RAG rating (red, amber and green) to show which KPIs we have fully met, came close to meeting (within 10% of target) and failed to meet.



Strategic priority 1 Resolution

	Area	Target	Met
To respond to a letter of claim within the pre-action protocol period	Claims Management	Internal	Clinical claims Partially met
			Non-clinical claims Not met
To respond to a letter of claim within the agreed timeframe	Claims Management	Internal	Not met
Time to resolution	Claims Management	Internal	Met
The volume of cases that are repudiated but then a payment is made	Claims Management	Internal	Not met
Reduction in the volume of cases litigating	Claims Management	Internal	Partially met
The movement in the financial reserves placed on a claim	Claims Management	Internal	Partially met
The accuracy of key data	Claims Management	Internal	Met
% of 'first step' letters sent out within seven days of receiving the appeal or dispute	Primary Care Appeals	90%	Met
% of appeals or disputes where 14 or more days' notice of hearing has been given	Primary Care Appeals	100%	Met
% of pharmacy appeals where the decision maker agreed with recommendation of case manager	Primary Care Appeals	80%	Met
% outcome of quality audits for appeals and dispute files	Primary Care Appeals	90%	Met
The average number of weeks taken to resolve appeals and disputes – internal input only	Primary Care Appeals	15 weeks	Met
The average number of weeks taken to resolve appeals and disputes – additional input	Primary Care Appeals	19 weeks	Met
The average number of weeks taken to resolve appeals and disputes – oral hearing	Primary Care Appeals	25 weeks	Partially met
The average number of weeks taken to resolve disputes – current market rent valuation input required	Primary Care Appeals	33 weeks	Met

Claims Management key performance indicators framework

We are constantly monitoring and refining our KPIs to ensure that they are a balanced measure of our performance and that they reflect the changing environment we work in and drive continuous improvement across the claims function. On 1 April 2019 we introduced a new framework with modified measures and targets, to include measures not previously reported. We fully expected some of these measures to take time to translate into achieving our ambitions around performance, with stretching targets being set.

Some of the new measures required a change to the way we historically captured data and therefore such historic cases would not be compliant with the new framework. We considered it appropriate to introduce the new framework to measure the right metrics, in order to meet our strategic aim of resolving claims fairly, with an understanding that some of the targets would not be achieved through the financial year.

We have met some of our targets and continue to work towards achieving the desired performance in the ones we have not. Overall our performance was stronger on those KPIs linked to our action and decision making, such as time to resolution. It was less strong on the KPI linked to repudiations turning to payments, in part due to this being a new KPI as discussed below. Those that are more heavily influenced by outside factors, such as the need for expert input before serving letters of response, were more challenging. This provides a solid foundation on which to build performance. In addition, throughout the financial year we developed our continuous improvement model to drive best practice to assist our case managers in achieving the new KPI measurements. This included introducing new operational performance monitoring.

Response time to a formal claim for compensation

This measure records the time taken to respond to a formal claim for compensation under the pre-action protocol applicable to the type of claim.

The protocols require us to provide a liability decision within strict timeframes, varying from thirty working days for low-value employers' liability claims notified in the claims portal to four months for a clinical negligence claim. Since April 2019 we have begun monitoring performance in higher value tranches, not done previously. In the lower value tranches we partially met the target, with performance very similar to 2018/19 performance. In 2019/20 70% of our responses in this cohort were served within protocol periods against 68% the previous year.

In the higher value tranches, targets had not previously been measured and were set guided by the experience of the lower values tranches, with some allowance for complexity and element of stretch. The KPI in these tranches were not met although compliance improved by 5% over the year across the mid-value tranches. The higher value claims are generally more complex due to the evidential requirements and take longer to investigate. Some factors for achieving the target are outside of our control, such as the availability of experts to prepare reports so that we can provide a formal response in the required timeframe. Nevertheless performance improved by 2% over the year.

For the first time we also measured service of letters of response within deadlines agreed with other parties, outside of protocol periods. This KPI took some time to establish and the target was set at a stretch so was not met overall. There was however a 14% improvement across the year.

Time to resolution

This is a modification of the previous measure and records the elapsed time between a decision being made on whether to admit liability and payment of any agreed compensation. The target is intended to shorten the time taken to resolve the claim following a decision on the merits of the case. This KPI contributes to the strategic aim of resolving claims fairly, which is reflected in the volume of settled claims. The target was achieved.

Repudiation failure rate

This is a new KPI introduced in 2019/20 in addition to which we introduced changes to the way in which our decision making is captured on our case management system. The purpose of the KPI is to measure the robustness of decision making in the claims process. It records the number of claims where a decision to deny liability is reversed, but also recognises that there will be claims where the evidence changes and an earlier legitimate denial becomes unsustainable. The robustness of our decision making will contribute to the volume of claims entering formal court proceedings, which has reduced this year.

We expected this KPI to take some time to achieve the desired performance. By its nature this KPI is a reflection of previous performance. Although it was introduced in 2019/20, early in the year it was largely a reflection of decision making on cases which were coded in a different way on our case management system before our processes were changed.

The target was not achieved but improvement in performance was noted throughout the financial year across clinical claims where performance improved by 7%.

Litigation rate

This measure records and seeks to reduce the number of claims moving into formal litigation. It reflects our commitment to using all forms of dispute resolution to keep claims out of formal court processes. We continue to develop and expand our dispute resolution initiatives to achieve our aim of a continued reduction in litigation.

The target was met in non-clinical claims but not met in clinical claims.

Overall the volume of claims entering a formal court process reduced and the combined target was missed by only 0.9%. Performance in this KPI contributes to the overall reduction of settled cases entering a formal court process, which has reduced this year.

Reserve movement

This was a new KPI introduced in 2019/20 and tracks movement in our reserves. It is intended to measure the accuracy and consistency of our reserving. The target was partially met, being missed by 1%.

All of our tranches of work were adequately reserved to meet the financial outlay. As this was the first year of introducing this measure it has provided us with an opportunity to monitor and review our reserving philosophy in the new financial year.

Data accuracy

This is an enhanced performance measure and applies to key data fields in our claims management system. Data quality is key not just to claims management but also to other areas of our organisation which rely on claims data informing their work. Having good quality, accurate, reliable claims data is essential to the work undertaken by the whole of our organisation. The target was met.



Strategic priority 2 Intelligence

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



Strategic priority 3 Intervention

	Area	Target	Met
Positive feedback from trusts visited on recognition of products.	Safety and Learning	At least 60%	Met
Response to members			
1) 95% response rate to members following a request for contact within five working days.	Safety and Learning	95%	Met
2) Participation in eighteen regional engagement events for members which include two national sharing and learning events.		18 events	Met
3) Eight safety and learning products to be made available for members in 2018/19		8 products	Met
Practitioner Performance Advice education events rated by participants at least four out of five for effectiveness/impact.	Practitioner Performance Advice	90%	Partially met
Requests for advice from Practitioner Performance Advice responded to within two working days (or within an alternative timeframe requested by the employing/contracting organisation).	Practitioner Performance Advice	90%	Met
Assessments and other interventions delivered within target timeframe.	Practitioner Performance Advice	92%	Met

	Area	Target	Met
Assessment and other intervention reports produced/issued within target timeframe.	Practitioner Performance Advice	90%	Met
Percentage of exclusions/suspensions critically reviewed in line with the following timescales: Stage 1: after initial four weeks Stage 2: at three months Stage 3: at six months	Practitioner Performance Advice	90%	Met
Decisions on referrals for assessments and other interventions communicated to the referrer within 13 working days of receipt of all referral information.	Practitioner Performance Advice	90%	Met



Strategic priority 4 Fit-for-purpose

	Area	Target	Met
Indemnity scheme financial spend.	Finance and Corporate Planning	Within 5% of target	Met
Undertake annual customer satisfaction survey to inform service development.	Membership and Stakeholder Engagement	Complete in 2019/20	Met
Target for CNST member participation in our customer satisfaction survey to ensure engaged customer base.	Membership and Stakeholder Engagement	60% of our CNST membership	Met
Evidence of increasing scores covered by annual customer satisfaction surveys year-on-year.	Membership and Stakeholder Engagement	Increasing scores in 50% of subject areas covered	Met
Overall approval rating in the 2019/20 customer satisfaction survey.	All	Overall satisfaction rating continues to increase	Met



Strategic priority 4 Fit-for-purpose (continued)

	Area	Target	Met
Downtime (unavailability between 7am and 7pm) of any IT system.	IT and Facilities	No > 5% of working month	Met
Downtime (unavailability between 7am and 7pm) for the extranet and claims reporting services.	IT and Facilities	No > 2.5% of working month	Met
Critical security patches for externally facing systems to be applied promptly.	IT and Facilities	Within 14 days of issue	Met
Helpdesk to respond to calls within two hours of receipt.	IT and Facilities	90%	Met
Sickness absence rate.	HR&OD	Below that for the national NHS average	Met
Prompt payment of suppliers within 30 days.	Finance and Corporate Planning	95%	Not met

Finance and Corporate Planning key performance indicators

We missed our KPI in relation to the prompt payment of suppliers within 30 days. However, we implemented a new financial accounting system in December 2019 and are developing the purchasing and payments process to make improvements in this area.

Service updates

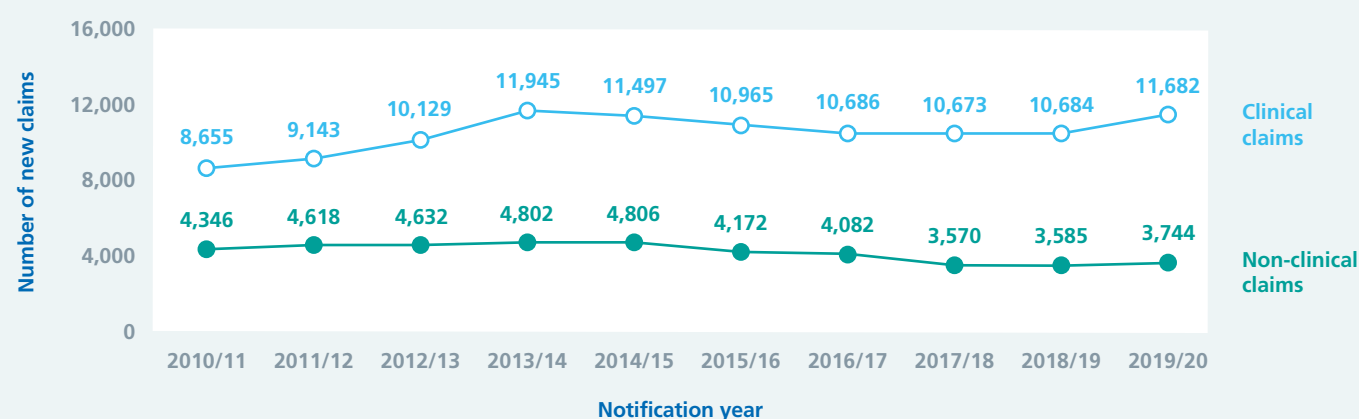
Claims Management

In 2019/20 we have received 11,682 new clinical negligence claims and incidents, an increase of 998 (9.35%) compared to 2018/19.

Our members reporting a higher number of incidents has driven the increase in claims volumes. The reporting of incidents that are likely to lead to a claim being made is aligned to our strategy of becoming more upstream in the investigation and management of certain types of claims.

We received 401 new claims and incidents for the CNSGP scheme for the first time, accounting for 40% of the increase in clinical volumes. Of these 336 were reported incidents, with 65 being actual claims.

Figure 3: The number of new clinical and non-clinical claims and incidents reported in each financial year from 2010/11 to 2019/20³



Compared to 2018/19 we received an increase of 404 reported incidents in our clinical negligence schemes, excluding CNSGP. In 2019/20 these incidents accounted for 19.4% of the overall claims volumes, an increase from 15.4% in 2018/19.

Incidents reported in the gynaecology specialty accounted for 208 of the 404 incidents reported, an increase of 145% compared to 2018/19. The increase is due to a large number of vaginal mesh related incidents⁴ being reported.

In the DHSC clinical scheme we received 119 claims compared to 44 in 2018/19, an increase of 170%. Claims emanating from historic abuse at Aston Hall Hospital account for 93 of the claims reported.

The Early Notification scheme received 57 new claims in 2019/20. We do not include incidents reported under the Early Notification scheme in the new claims volumes given the relatively short period of time for which this scheme has been running and the accelerated nature of reports.

³ The number of clinical claims reported for 2018/19 has increased by six from what was reported last year due to the inclusion of Early Notification claims.

⁴ These claims involve the insertion of tension-free vaginal tape, transobturator tape, transvaginal tension free vaginal tape-obturator or vaginal mesh (vaginal tape or mesh) to treat symptoms of stress urinary incontinence or pelvic organ prolapse and allegations tend to centre around (but not exclusively) failure to obtain adequate consent (e.g. failure to warn of risks of procedures or failure to offer alternative treatment) and/or substandard performance of surgery.

Excluding incidents, Early Notification and CNSGP claims, we saw an increase of 142 (1.53%) new clinical negligence claims in 2019/20, compared to 2018/19.

In addition, we provided oversight of claims managed by two MDOs: MPS and MDDUS, which had entered into arrangements with DHSC over the funding of claims related to incidents prior to 1 April 2019. These cases are not included in the reported numbers.

To better contextualise the number of claims received in-year, it is useful to broadly consider the activity undertaken by the NHS in secondary care. With the caveat in mind that claims received in-year include claims relating to incidents that have occurred in previous years, the volume of NHS activity undertaken (inpatient and outpatient finished consultant episodes, emergency department attendances and ambulance journeys) has steadily increased from close to 110 million to in excess of 135 million episodes between 2013/14 and 2018/19. This is an increase in activity of c25 million episodes or 23% over the period. Over the same period, claims and incidents reported to NHS Resolution reduced from a peak of 11,995 claims to 10,684. Excluding the 401 claims and incidents reported for the new CNSGP scheme in 2019/20, total claims and incidents are still below that peak.

We have also seen an increase in non-clinical negligence claims in 2019/20. We received 3,744 non-clinical negligence claims compared to 3,585 in 2018/19, an increase of 159 claims (4.4%). This is attributable to a rise in the number of orthopaedic injuries in our LTPS scheme, which has gone up by 109 (4.5%) claims. Claims for psychiatric illness and injuries caused to the head have also seen small increases in volume numbers.

Following the abolition of strategic health authorities and primary care trusts on 1 April 2013, NHS Resolution was directed to handle and process claims arising from the liabilities of those organisations, which had subsequently transferred to the Secretary of State. As part of that arrangement, NHS Resolution inherited historic industrial disease claims brought by former NHS workers. These were claims made before the establishment of NHS Resolution in April 1995, and primarily arose from exposure to asbestos, and noise-induced hearing loss. These claims volumes were excluded from Figure 3 because of the distorting effect they would have on NHS Resolution's claims trends, but are shown in Figure 4. The initial spike from the take-on of claims in 2013/14 can be seen, and volumes have been relatively stable in more recent years.

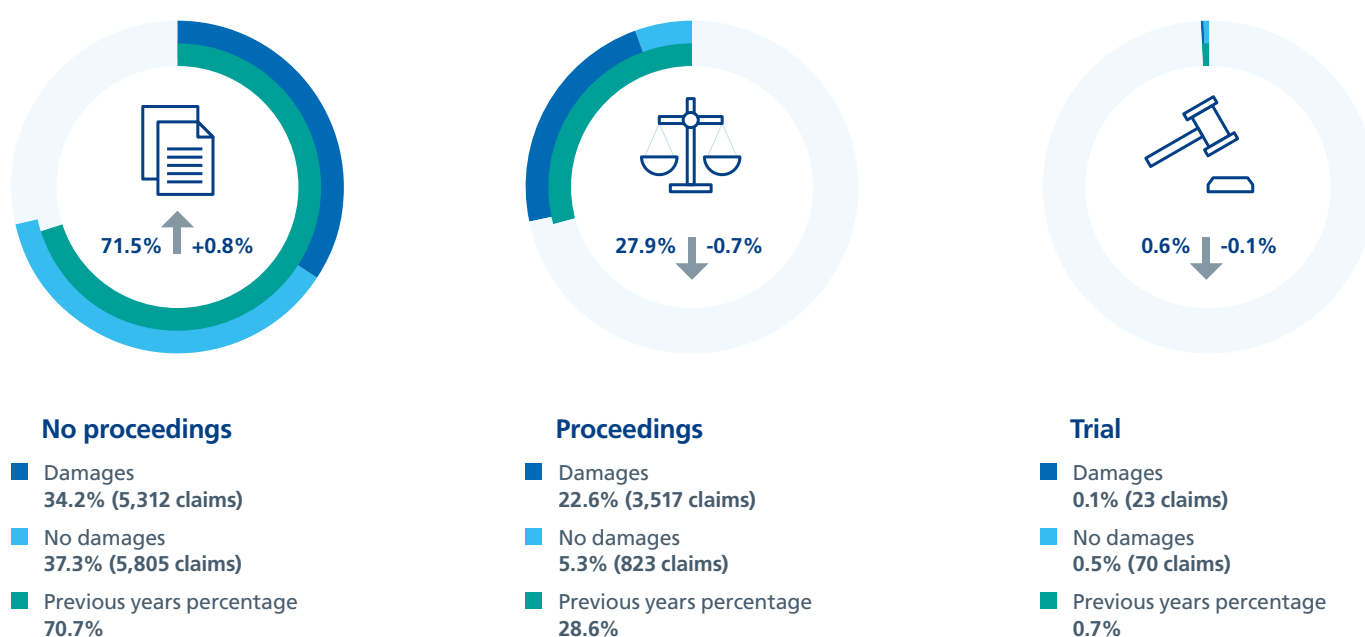
Figure 4: Legacy industrial disease claims (such as for asbestosis and mesothelioma) from 2012 to 2020 dealt with under our DHSC Liability scheme



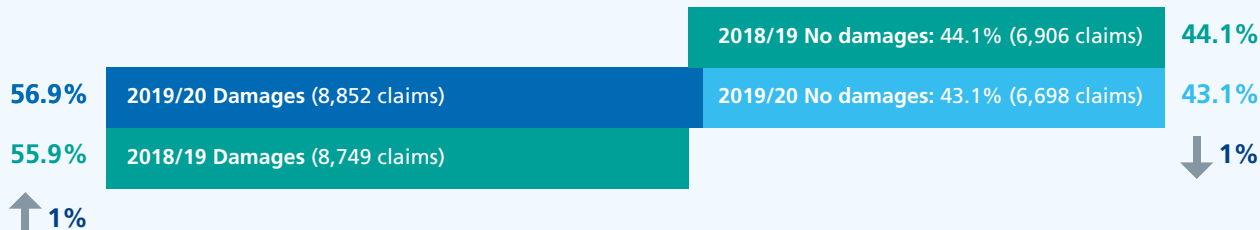
Claims settled with/without formal court proceedings

We settled 273 fewer claims in 2019/20 compared to 2018/19. Two of our claims KPIs directly relate to our strategic ambition to resolve cases fairly. We met our Time to Resolution KPI, which aims to reduce the amount of time taken to resolve a case, once a liability decision has been made, directly contributing to the overall volume of cases settled.

Figure 5: How 15,550 clinical and non-clinical claims were settled⁵ in 2019/20 compared with 15,655 in 2018/19 with an increasing percentage settled without proceedings



Overall claims settlements



⁵This figure refers to settled claims, not closed claims, and includes claims that have been agreed with ongoing periodical payment orders. Settled claims will also include claims where damages have been agreed or successfully defended, and costs have not yet been agreed. These data are a different cohort to closed claims reported elsewhere in this document as they may fall in different years.

Of the 15,550 settled claims in 2019/20, 43.1% settled without damages being paid. This compares to 44.1% in 2018/19. The percentage of claims settling without damages being paid will fluctuate, depending upon the nature of cases that are settled each year. We settle cases in line with our strategic aim to resolve cases fairly, which will result in making payments to a claimant who is entitled to compensation. We settled the majority of claims without formal proceedings being required (71.5%, compared to 70.7% in 2018/19 – see Figure 5). The large majority of claims settled prior to formal legal proceedings being required are managed in-house by our expert teams, with assistance from our legal panel. They generally resolve through negotiation via correspondence, at settlement meetings or a form of dispute resolution, including formal mediation.

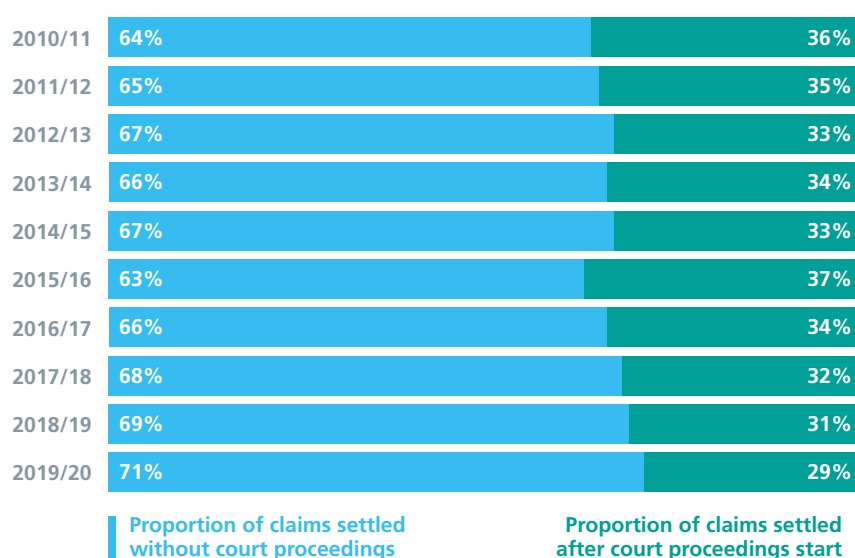
In 2019/20, the closed claims with no payment of damages had a cumulative potential cost to the NHS of £1,551 million. We incurred £17.4 million defending these claims, therefore ensuring a total sum of £1,533 million remained available for the use in frontline services.

We remain committed to trying to keep cases out of formal court proceedings. To assist in achieving this we monitor litigation reduction in our claims KPIs. The target is challenging with a number of factors being outside of our control but we continue to make progress against it.

Just under a third of our claims enter formal legal proceedings. Of those claims that enter formal court proceedings, 79.9% result in some damages being paid out. This number includes claims that require formal court approval, such as infant approvals or where claimants lack capacity or because the claim has been brought close to the expiry of limitation, and where we wish to clarify points of legal principle. Claims may also enter court proceedings due to a dispute over the value of the damages. In such cases we will still make a damages payment, even if we are successful in the dispute over the value of such damages.

Less than 1% of our claims proceed to trial and in the majority of those claims (75.3%) we are successful in achieving judgement in favour of the NHS.

Figure 6: Litigation rate for clinical claims⁶



The percentage of cases settling before formal court proceedings are required has continued to increase, as a result of the actions taken internally to try to avoid litigation. This includes the alternative dispute resolution initiatives that we have established and continue to develop, to promote early settlement prior to formal court proceedings being issued.

⁶The data in this figure relates to clinical claims only and it differs from the earlier Figure 5: Settled claims, which represents both clinical and non-clinical claims.

Closed claims

In 2019/20, we closed a total of 16,378 clinical and non-clinical claims compared to 16,393 in 2018/19. This includes claims closed with and without damages being paid. Cases closed in-year may have had damages settled in previous financial years with costs negotiated following payment of the damages.

Not all of the claims closed this year would have been settled in the same financial year. The nature of claims closed with or without damages will depend upon the portfolio of claims at any given period of time and will show variance in numbers.

Figure 7: The total number of clinical and non-clinical claims closed with and without the payment of damages from 2005/06 to 2019/20

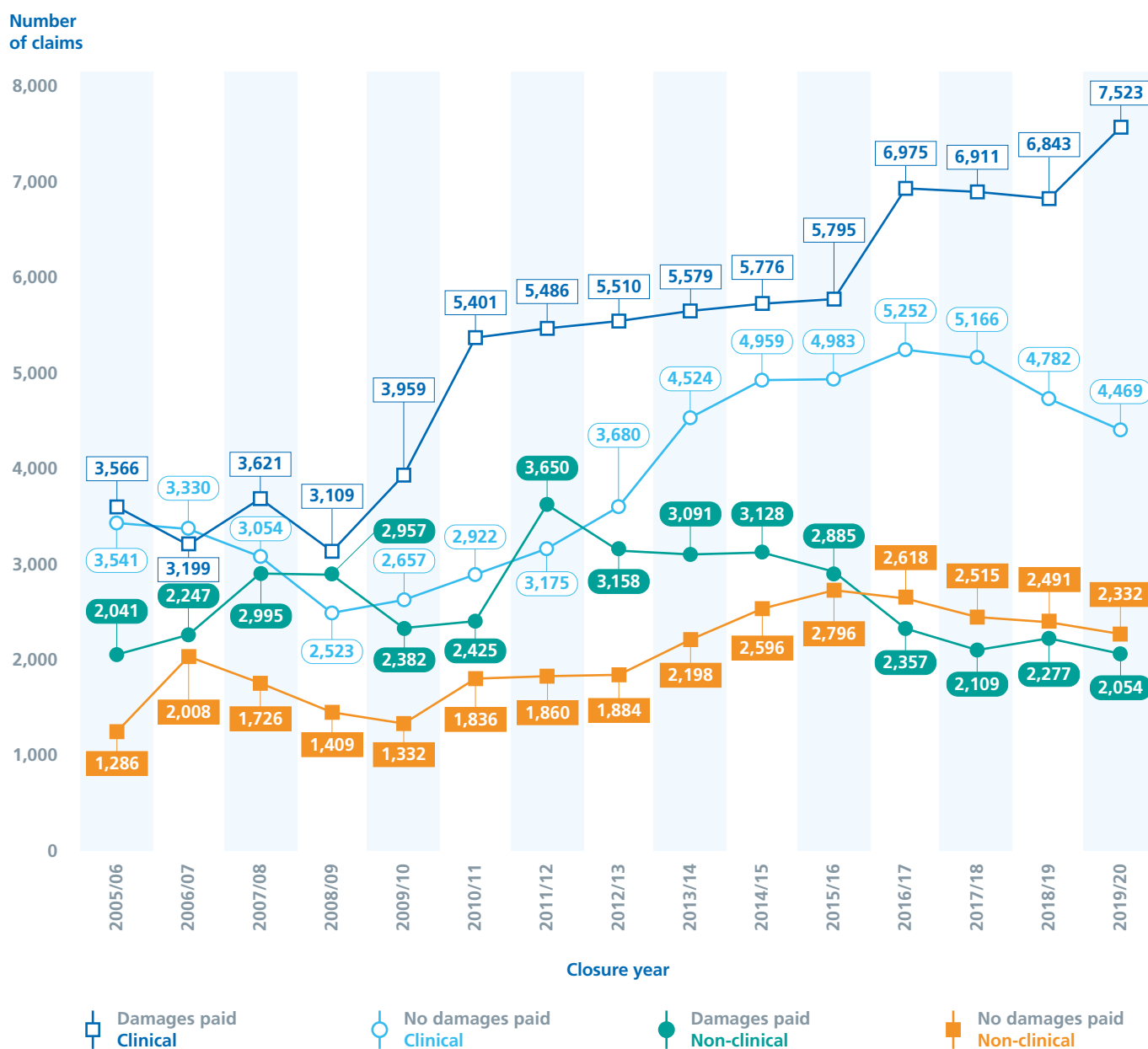
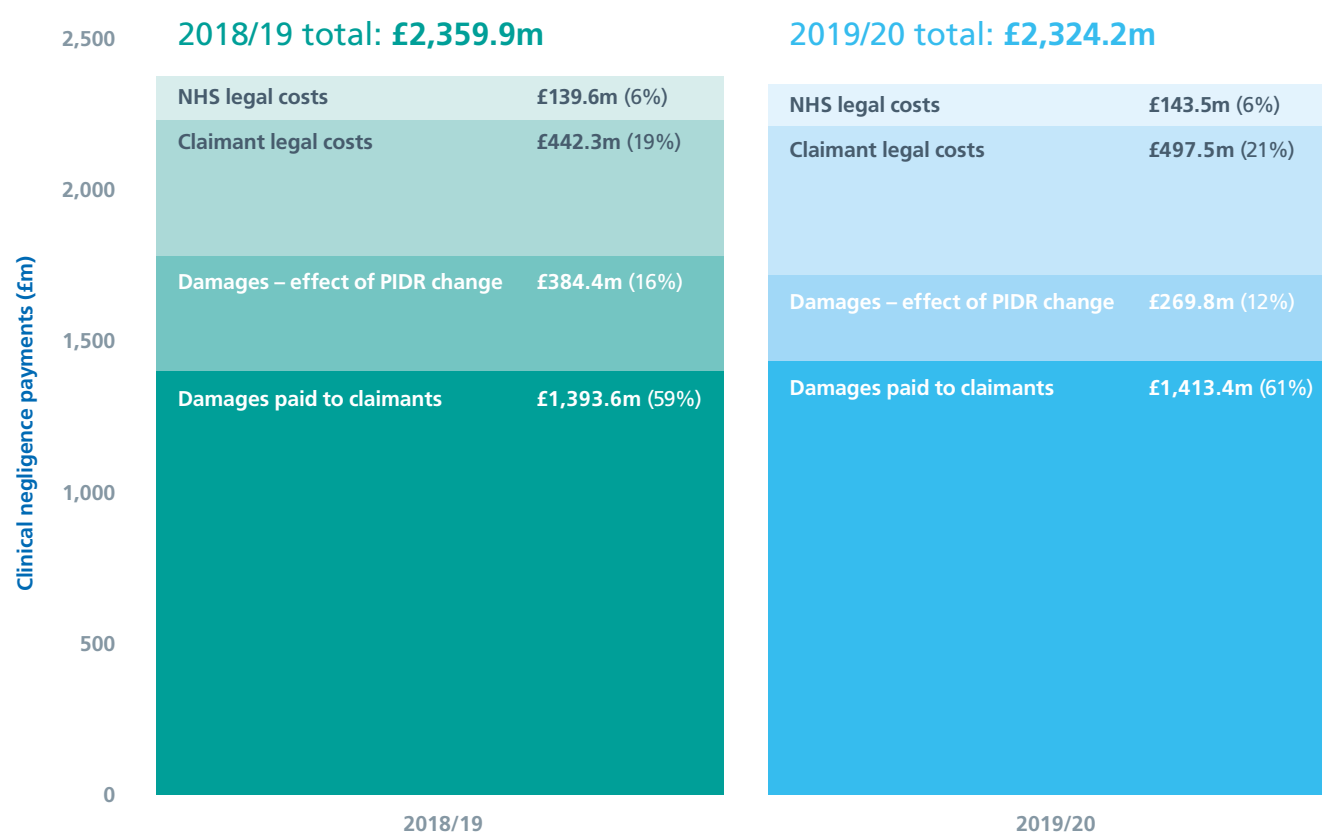


Figure 8: Clinical negligence payments for 2019/20
(including PIDR and expenditure related to CNSGP and ELGP)



Despite the number of claims settled in-year remaining reasonably stable and the proportion of claims settling with damages increasing, the total payments relating to our clinical schemes decreased by £36 million to £2,324.2 million, compared to £2,359.9 million in 2018/19.

Damages paid to claimants including PIDR expenditure decreased from £1,778.0 million in 2018/19 to £1,683.2 million in 2019/20, a decrease of £94.8 million (5.3%). The change to the PIDR in 2019, which affects the value of lump sum settlements to claimants, accounts for virtually all of this decrease.

Damages payments excluding PIDR costs remained at a similar level. However, within this, CNSGP and ELGP, both new in 2019/20, accounted for £40.3 million in damages payments. This resulted in a like-with-like reduction in damages payments, due to a lower volume of payments on high value cases being made in 2019/20 compared to the previous year.

Claimants' legal costs have increased by £55.2 million (12%) from £442.3 million to £497.5 million. Of this, £21 million was incurred on General Practice arrangements in 2019/20. Interim payments for costs, on claims where damages have been agreed, increased by £33.5 million compared to 2018/19. Payments on these cases reduce the liability for interest on costs. NHS legal costs overall have increased by a small margin, £3.9 million (3%).

Figure 9: Payments on clinical claims by financial year from 2013/14 to 2019/20 for our CNST, ELS and Ex-RHA, DHSC clinical schemes (including that attributable to the change in the PIDR) and GPI (CNSGP and ELGP)

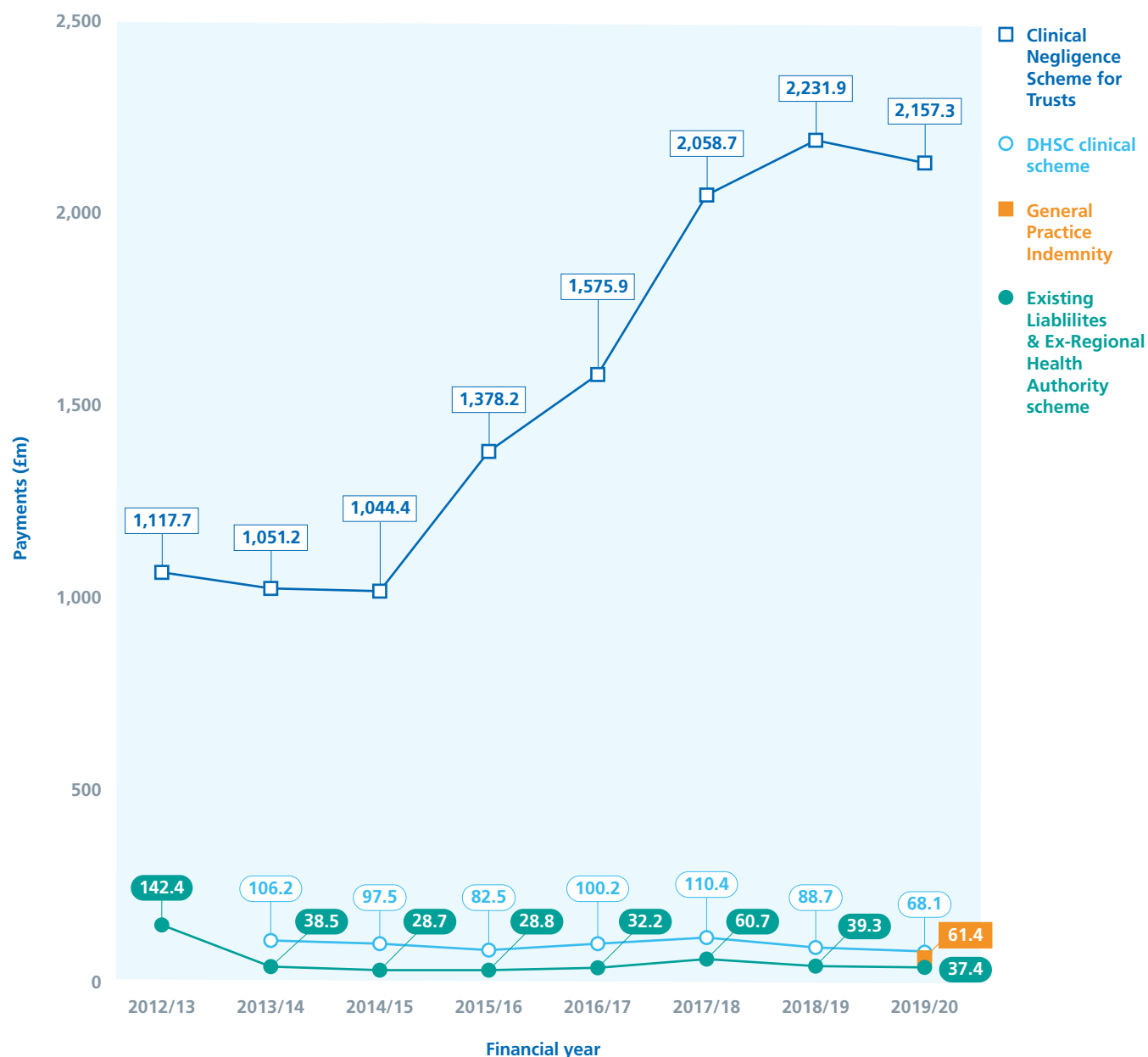


Figure 9 provides a breakdown of spend on clinical claims over eight years by individual scheme, and costs affected by factors discussed above in relation to Figure 8.

Figure 10: The number of CNST and DHSC legacy clinical negligence cases reported by estimated damages range in each financial year from 2014/15 to 2019/20

In 2019/20 we received a lower volume of £2 million+ claims than in the last three financial years. Compared to 2018/19, we received higher volumes of claims in the mid-value tranches. These are estimates of the damages value of claims reported and as they have not been settled these valuations can change.

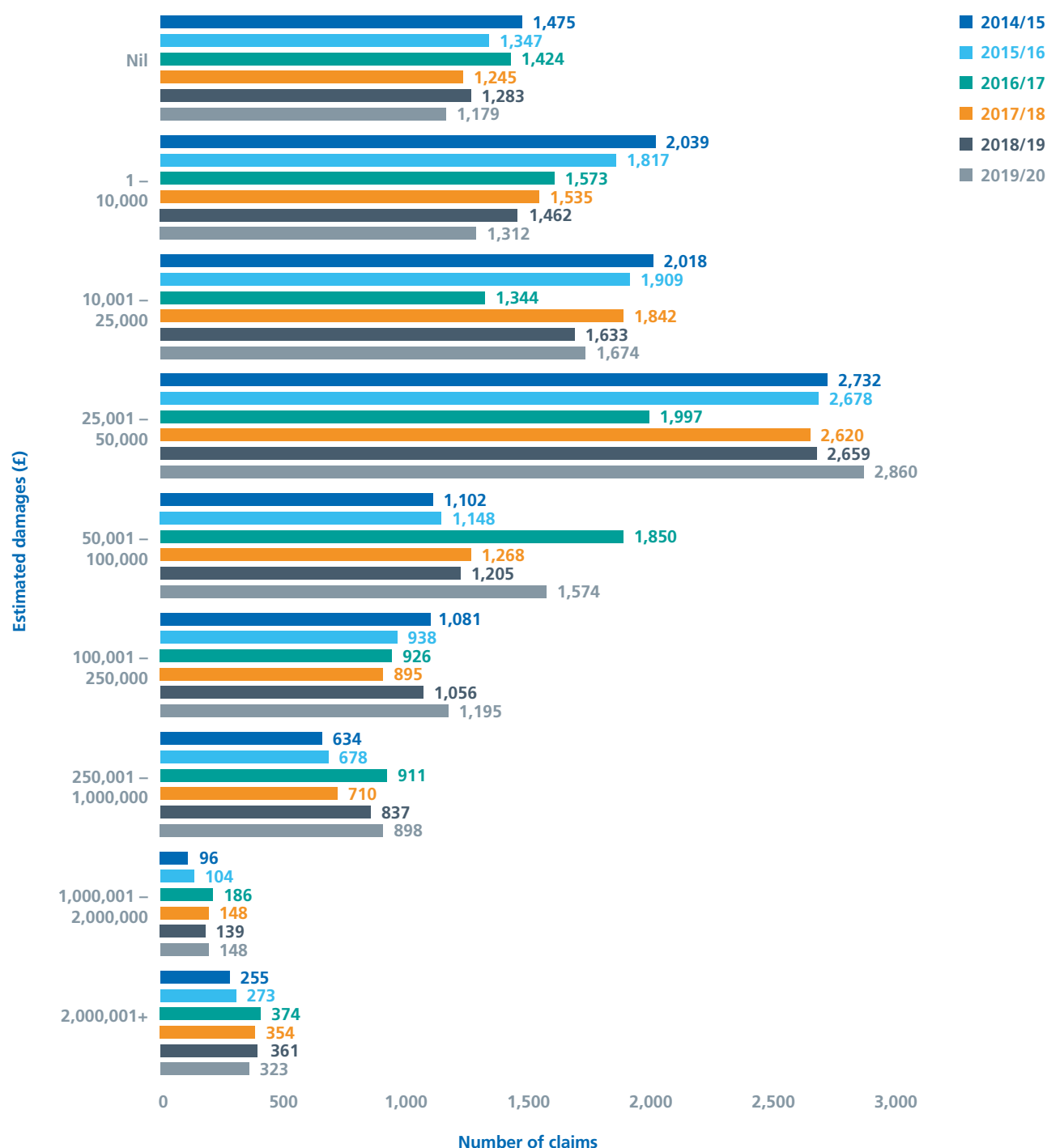


Figure 11: The number of clinical negligence claims reported in 2019/20 by specialty from a total of 11,281⁷

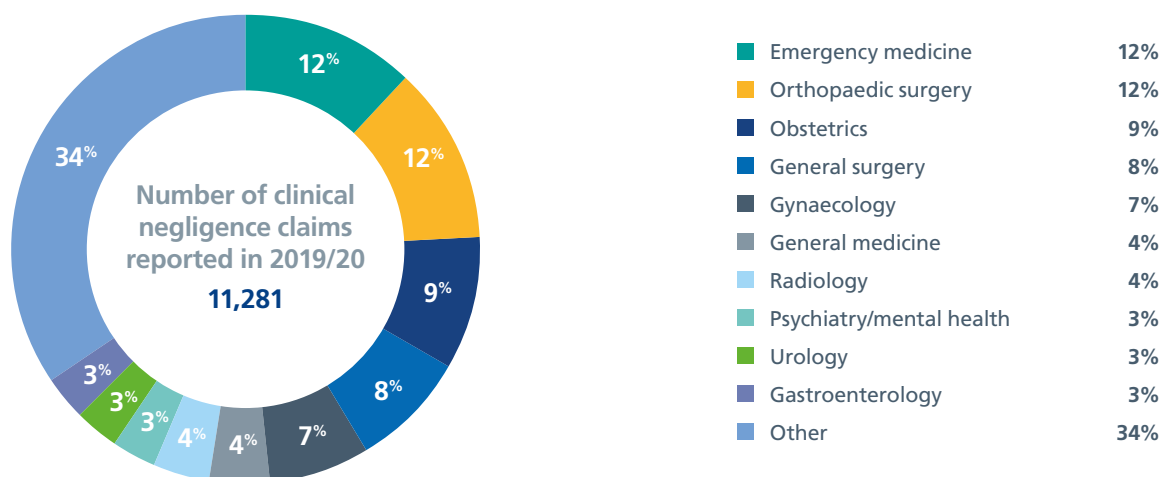
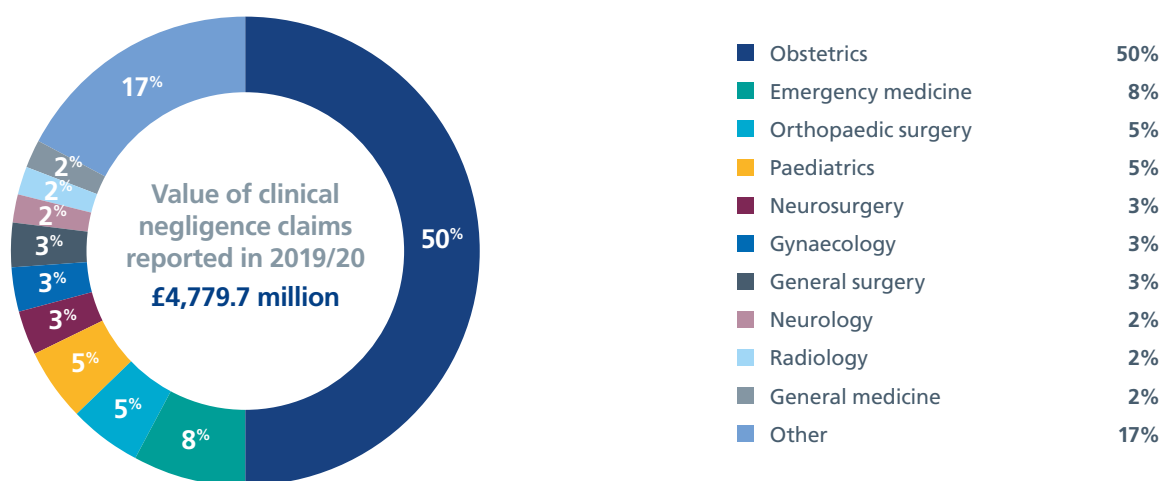


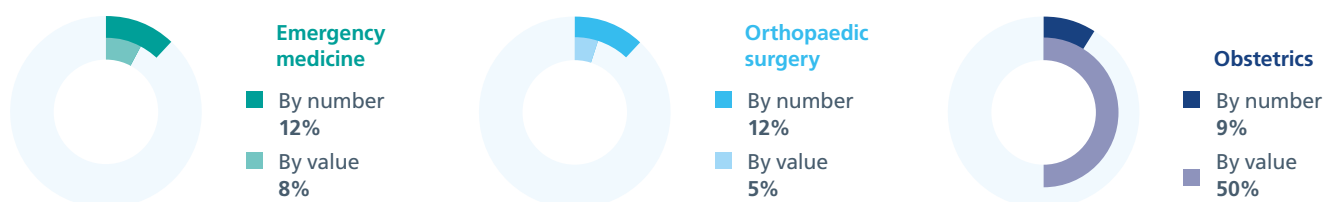
Figure 12: Value⁸ of clinical negligence claims reported in 2019/20 by specialty across all clinical negligence schemes from a total of £4,779.7 million⁹



^{7,9} Figures 11 and 12 exclude 401 claims and incidents related to CNSGP.

⁸ This is the total value of the claim including damages, claimant and NHS legal costs and includes both paid and outstanding costs. Valuations are liable to change for any individual claim before settlement.

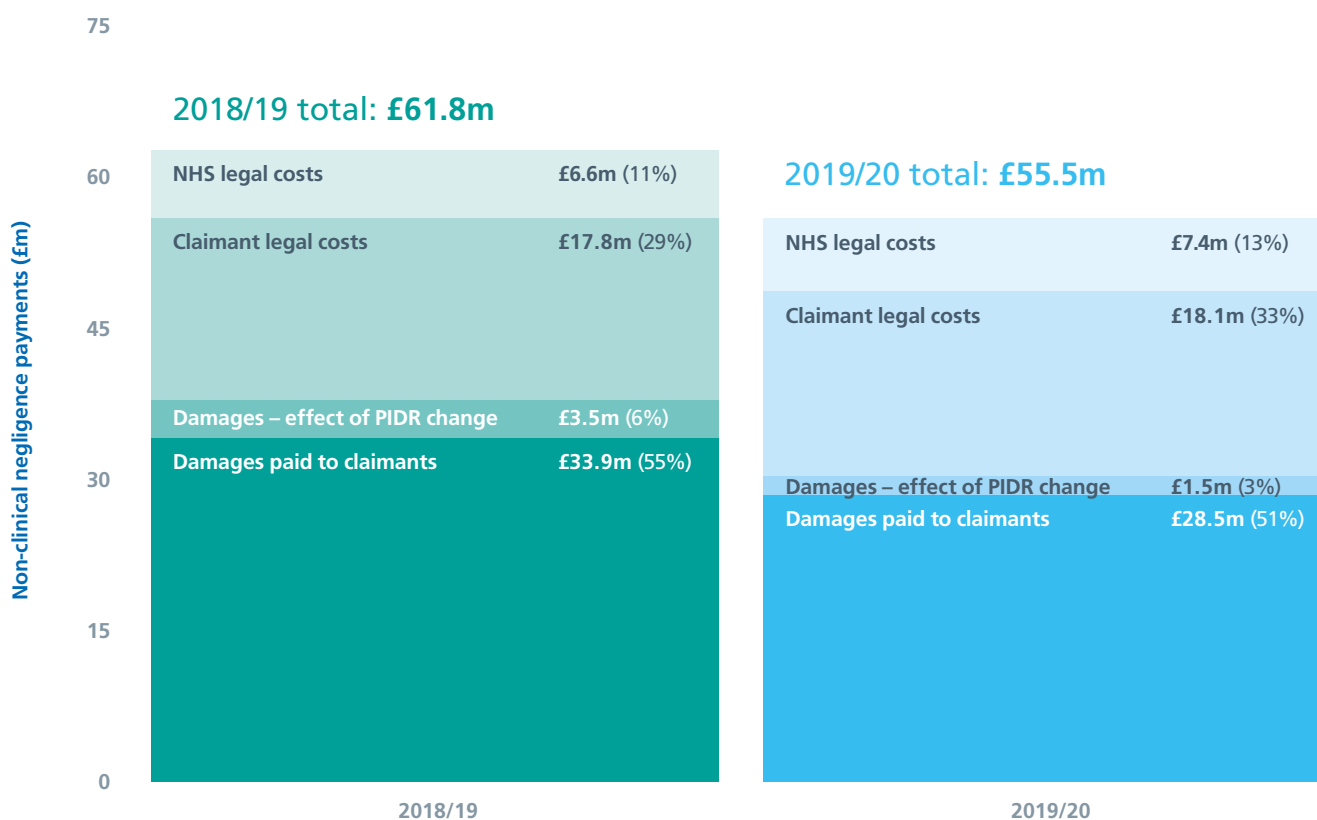
Figure 13: The top three categories of clinical claims received in 2019/20 by value¹⁰ and number



Obstetrics claims remain the largest proportion, 50% of the total estimated value, while only representing 9% of the volume of claims received. Our focus continues to be on maternity claims

because of this. Steps taken to help reduce the likelihood of harm and associated costs include our Early Notification scheme and our maternity incentive scheme.

Figure 14: Non-clinical negligence payments for 2019/20 (including PIDR)



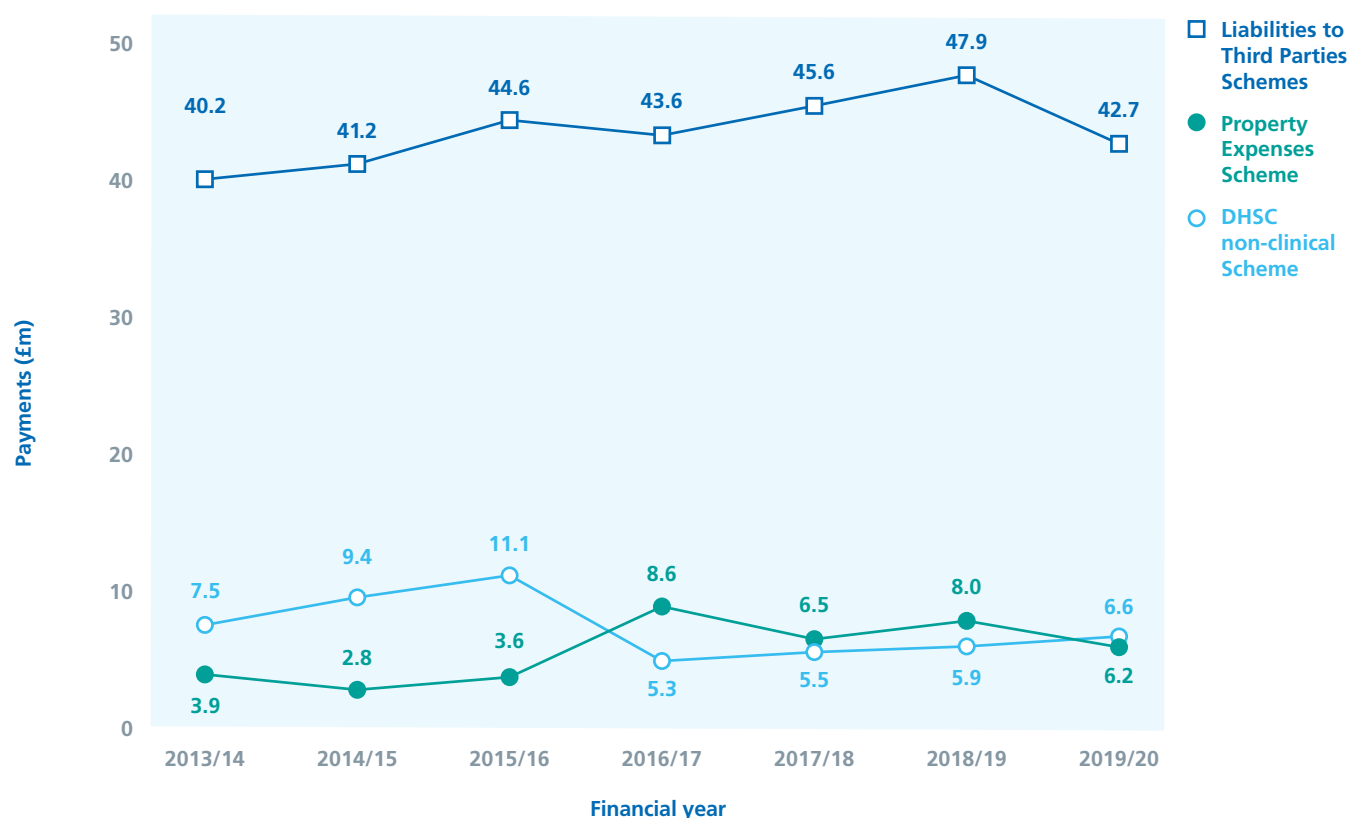
¹⁰ This is the total value of the claim including damages, claimant and NHS legal costs and includes both paid and outstanding costs.

Damages payments made to claimants have decreased by £5.4 million (16%) to £28.5 million in 2019/20. The majority of the decrease relates to the LTPS scheme. In 2018/19 a number of high value settlements contributed to an increase in damages payments compared to 2017/18. The damages payments in 2019/20 have returned to a similar level to those in 2016/17 and 2017/18.

PIDR payments have reduced by £2 million from £3.5 million to £1.5 million in 2019/20 as a result of the change in the PIDR in August 2019. Claimant legal costs have seen a marginal increase of £0.3 million from £17.8 million in 2018/19 to £18.1 million in 2019/20. NHS legal costs have increased from £6.6 million in 2018/19 to £7.4 million in 2019/20.

Orthopaedic injuries account for the largest percentage of non-clinical claims received in 2019/20 at 68%, which is down from 69% in 2018/19.

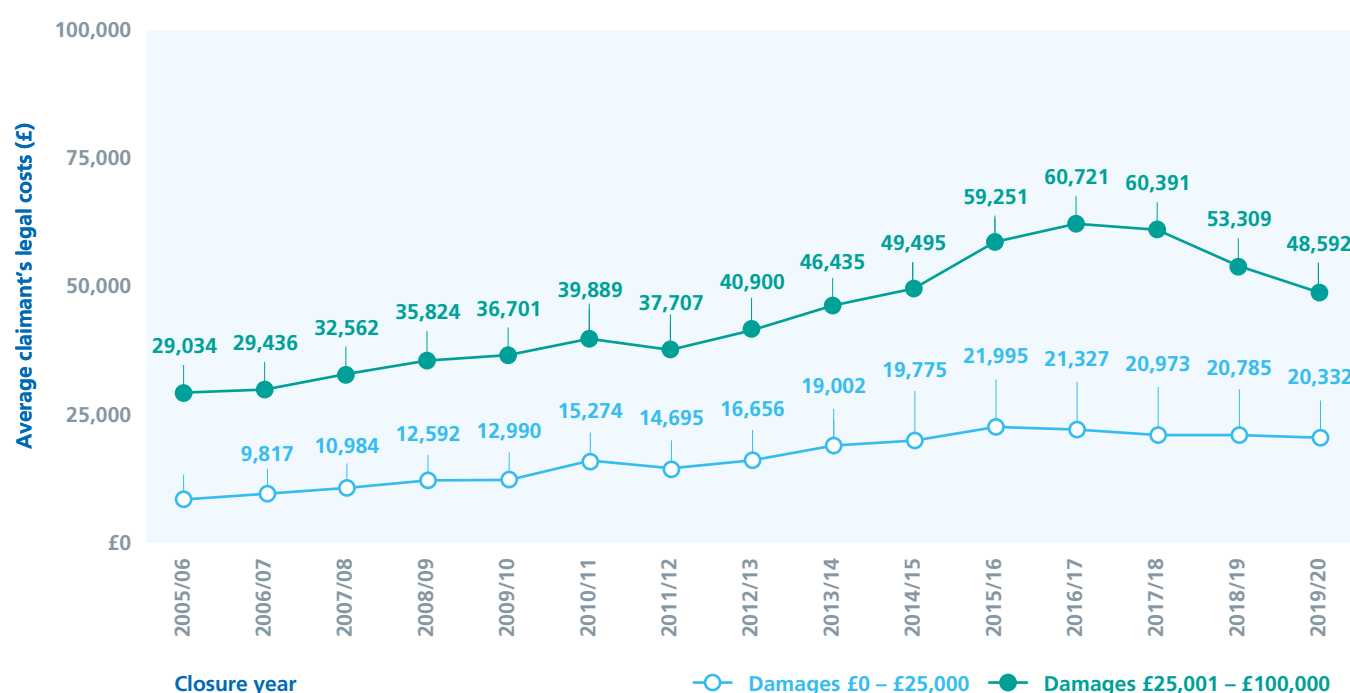
Figure 15: Payments on non-clinical claims by financial year from 2013/14 to 2019/20 for LTPS, PES and DHSC non-clinical schemes (including PIDR)



Our DHSC non-clinical scheme responds to historic liabilities and liabilities inherited by the Secretary of State for Health and Social Care from abolished health service bodies. PES covers first-party losses arising from

damage to NHS property assets. PES expenditure is typically volatile and unpredictable, since the trigger for most claims will be weather-related events.

Figure 16: Average of claimant costs paid on claims where damages are between £1 and £100,000 for claims closed in the financial years from 2005/06 to 2019/20 for all clinical negligence schemes¹¹



The funding of a claim has a direct correlation to the amount of costs paid when a claim is settled. The most frequent type of funding used in the last five financial years is a conditional fee arrangement (CFA), used on 81% of all closed claims up to £25,000, and 83% of all closed claims between £25,000 and £100,000. Following the introduction of LASPO in 2013, changes were made to recoverability of costs associated with a CFA, specifically the success fee.

The primary reason for the decline in the average value of costs paid in closed clinical claims between £25,000 and £100,000 is the change in funding arrangements. In 2017/18 from the 1651 closed claims, 499 (30%) were pre-LASPO CFA funded with the associated ability for a success fee to be recovered from the paying party, increasing the overall cost liability. The percentage of claims closed with

pre-LASPO CFA funding in 2019/20 dropped to 6%, 120 claims from a total of 1926. Claims funded by post-LASPO CFA agreements in the same period (2017/18 – 2019/20) have increased from 52% to 81%. The effects appear to be showing in the reduced average value of claimant costs in the £25,000 - £100,000 cohort since 2017/18. However despite a similar profile of change in funding from pre to post LASPO CFA's in the closed claims up to £25,000, we have not seen the same decline in average costs paid and the overall amount paid out in 2019/20 was on par with amounts paid out in 2016/17.

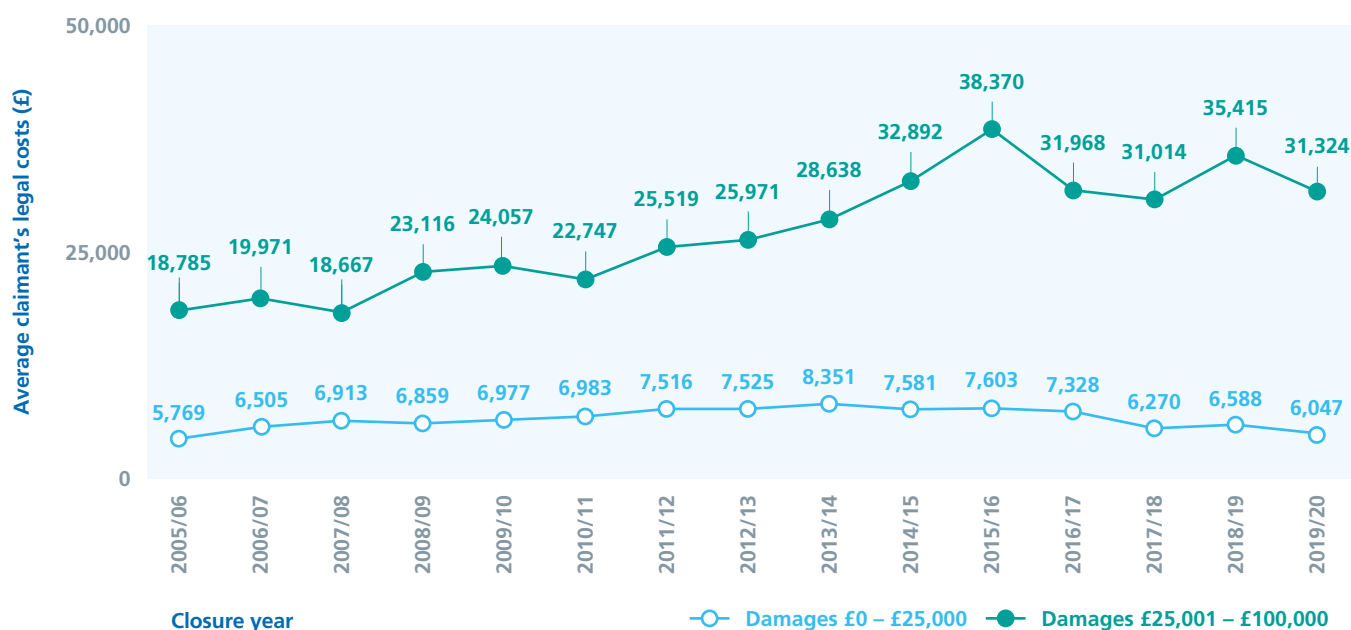
The level of legal costs incurred by the NHS on claims management continues to show a small year on year increase, to be expected this year with the overall increase in new case notifications.

¹¹ Claimant costs and damages as recorded at year end in which the closure occurred.

Non-clinical costs

The number of non-clinical claims closed between £25,000 and £100,000 is far fewer than in the clinical schemes – only 151 in 2019/20 – and therefore the average costs are not affected to the same extent by the funding arrangements.

Figure 17: Average of claimant costs paid on claims where damages are between £1 and £100,000 for claims closed in the financial years from 2005/06 to 2019/20 for all non-clinical negligence schemes¹²



¹² Claimant costs and damages as recorded at year end in which the closure occurred.

Developing legal precedent

CNSGP plus existing liabilities

DHSC, on behalf of the Secretary of State for Health and Social Care, agreed interim arrangements with the MPS and MDDUS in respect of their general practice members and NHS Resolution was directed by the Secretary of State for Health and Social Care to provide oversight of these arrangements for the Secretary of State.

In September 2019, MDDUS agreed interim arrangements with DHSC, under which discretionary indemnity in respect of historical liabilities of MDDUS's general practice members would be provided, from 6 April 2020, by the Government under the newly launched ELSGP. MDDUS implemented part of the overall transaction by means of a Scheme of Arrangement. The scheme will mean that MDDUS's responsibility for providing discretionary indemnity to English general practice members will end on 6 April 2020. On the same date, responsibility for managing existing and new claims against MDDUS's former and current general practice members for historical liabilities within scope of the ELSGP transferred to Government. NHS Resolution has been asked to manage these claims for the Secretary of State.

Currently, the ELSGP only applies to the NHS historical liabilities of general practice members of the MDDUS and responsibility for handling claims in respect of these liabilities lies with Government (in practice, NHS Resolution) since the scheme came into operation on 6 April 2020. Our oversight of the MPS interim arrangements continues throughout 2020/21 and the ELSGP will apply to the NHS historical liabilities of general practice members of the MPS from 1 April 2021. DHSC has not yet reached an agreement with the Medical Defence Union (MDU).

Although the volume of claims notified under the CNSGP in its first year of operation has been relatively low, and in line with projections, we have dealt with over 3,000 individual queries, some of which have required cross-system input. As there is no requirement to register or apply for membership of the CNSGP, it is of vital importance that those

working in general practice understand the contracting arrangements under which they are providing services as indemnity under the scheme is linked to the contract under which services are provided. We have responded to over 80% of queries within the expected five-day turnaround. In addition to publication of scheme rules and reporting guidelines we have supported the general practice community in understanding the changes in indemnity provision through production of a short video that gives a brief overview of what CNSGP is, how it works, what it covers and what it doesn't. We have also produced a series of CNSGP podcasts and videos, provided a 24-hour claims helpline with the support of our legal panel, and are developing a subscriber service to inform interested parties when changes are made.

Due to the comprehensive nature of cover provided under CNSGP, we are working to ensure the scheme keeps pace with wider changes in primary care. We have convened an advisory group made up of representatives from across general practice, building on the excellent work of the General Practice Standing Group – the key stakeholder reference group that has existed throughout the development and life of the scheme. Our engagement approach represents the inclusive nature of coverage under the scheme which includes all those working in general practice, including new and emerging professional groups set out in the LTP.

Given the scale of the change this has represented for general practice, our first year of operation has been primarily focused on raising understanding of the scheme and ensuring it is embedded in the general practice community (more detail in our section on *Regional member events and primary care roadshows* on page 72. Future efforts will be focused on refining our processes and reflecting initial learning. Our general practice indemnity claims teams are made up of experienced case handlers with a range of skills and experience of handling clinical negligence cases for the NHS and general practice.

Dispute resolution

Dispute resolution and the use of mediation are fundamentally aligned to our strategy to reduce the number of claims proceeding into formal litigation. We continue to use, and explore new, dispute resolution initiatives to achieve our strategic aims. We have piloted global dispute resolution meetings with cohorts of specific claims, which has resulted in resolution of multiple cases in a single meeting. This initiative is now being formalised into a business-as-usual process for future use. We have continued to use different forms of dispute resolution including virtual meetings, telephone negotiation and joint settlement meetings to achieve resolution of claims.

Claims mediation

The service is designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims and costs disputes and to avoid the need, expense and potential emotional stress of going to court. An evaluation of the service was undertaken to determine mediation's efficacy as a resolution tool, to understand when mediation is most effective as an intervention and to inform the next mediation procurement exercise.

The evaluation was published in February 2020 and concluded:

- Mediation is an effective forum for claims resolution and provides injured patients and their families with a platform to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution. It allows the opportunity for healthcare providers to hear directly from injured patients on the impact of harm and to provide face-to-face explanations and apologies.
- 74% of cases mediated are settled on the day of mediation or within 28 days of the mediation date.
- The continued focus on mediation and its benefits is driving cultural change in the legal market.

For the full report see <https://resolution.nhs.uk/2020/02/12/mediation-in-healthcare-claims-an-evaluation>

Claims Management mediation panel

NHS Resolution procured a new claims mediation panel following a tendering process in February 2020. All NHS trusts in England are members of NHS Resolution's indemnity schemes, and together with the expansion of our claims service into primary care this puts it in the unique position of being able to use the buying power of the NHS to procure the highest quality mediation services at the lowest possible cost. The procurement comprised of two 'lots' covering mediation services to resolve claims for personal injury and clinical negligence and those arising from claims for legal costs.

Following re-procurement for claims mediation services, contracts were awarded to organisations as below:

- The Centre for Effective Dispute Resolution and Trust Mediation Limited were appointed to deliver mediation services for disputes arising from personal injury and clinical negligence incidents and claims from 1 May 2020
- Costs Alternative Dispute Resolution and St John's Buildings were appointed to mediate disputes arising from the recoverability of legal costs from 1 May 2020.

Mediated claims 2019/20

The period 2019/20 has seen the continued growth of the claims mediation service. A total of **427** cases proceeded to mediation; of these, **81%** of cases settled on the day mediation took place or within 28 days of the mediation (up 7% on 2018/19). We saw an **8%** increase in the use of mediation, rising from 397 cases in 2018/19 to 427 cases in 2019/20. This brings the total of completed mediations that have been undertaken since the inception of the service to 31 March 2020 to **1,033**.

Other forms of dispute resolution

We remain committed to embracing all forms of dispute resolution. We are also working collaboratively with a number of claimant lawyers and other stakeholder groups on initiatives to reduce the number of cases going into formal litigation, to limit the escalation of legal costs and to secure earlier resolution.

Claims Management membership charter

In January this year we published a Claims Management membership charter and engaged with our membership through regional roadshows described on page 72. Written with the input of our members, our case handlers and our legal advisors, the charter provides clarity and brings to life the practical application of our scheme rules. The charter is intended to provide a framework of high level principles for us and our members to ensure we are working together towards fair and efficient resolution of claims, allowing us to provide the best service we can to our members and ensuring we do not duplicate resources when managing claims.

The charter aims to provide a foundation for improvement, in line with our strategy and looking ahead to changes in the way the claims function operates, focusing on member needs, operational efficiency and financial control. It provides consistency for all involved in the claims process. We have over 500 members and it will help ensure all parties are clear about what is expected of each other, including our panel lawyers. It does, however, also allow the flexibility for us to work in different ways on exceptional cases such as class actions, adopting the principles of the charter where possible.

Adapting to meet new demands to ensure we remain fit-for-purpose

Target Operating Model

Following a procurement process we appointed the consultants Deloitte to work with us in reviewing our current claims operating model. The objective of the review was to provide recommendations on all aspects of our current model and recommend a future state operating model, taking into account the changes in our membership with the introduction of CNSGP. The review encompassed a wide range of stakeholders, including DHSC, claimant law firms, our legal panel, members and our own internal staff in all function areas.

A final operating model design was delivered, which recommends some changes in our current processes and new operating methods, which will provide value for money and benefits for all of our stakeholders. It has received board approval to proceed. We engaged with DHSC but due to the Covid-19 pandemic we had to pause the launch of the operating model while we awaited sponsorship approval and couldn't consult fully internally with our staff. We intend to launch the operating model in the next financial year.

Legal costs panel procurement

We procured a new costs panel following a tendering process in February 2020, after working with Crown Commercial Services on the appointment of the Costs Lawyer Services Framework in 2019. The new costs panel allows us to continue to effectively control legal costs expenditure on behalf of our NHS members. The procurement covers two 'lots' comprised of costs lawyer services to resolve costs claims for general litigation, which includes any NHS Resolution personal injury claims (lot 1), and costs lawyer services to resolve costs claims arising from clinical negligence claims (lot 2).

Following procurement for costs lawyers services, contracts were awarded to the below organisations:

Lot 1:

Hill Dickinson LLP and Keoghs

Lot 2:

Hill Dickinson LLP, Acumension Ltd and Keoghs

The legal environment

We manage claims fairly and effectively and continue to develop legal precedents, taking cases to trial or to the higher courts in areas of law which need to be challenged in the broader interests of the NHS, or which require certainty. The law needs to keep pace with the dynamic healthcare environment where groundbreaking advances in science and technology can have a knock-on effect to the cost of clinical negligence. It is important that we defend cases at trial where there has been no negligence and pursue alternative ways (such as mediation) to achieve fair resolution, that do not have to involve a costly legal process, in both financial and emotional terms. We also have a responsibility to challenge excessive claims for damages and costs, in order to preserve funds for NHS care. Testing claims at trial often has wider implications for other, similar cases and so the outcome of a case can either provide an opportunity for others to claim under similar circumstances or deter claims without merit.

Mordel v. Royal Berkshire NHS Foundation Trust (High Court, 8 October 2019 – Jay J.)

This was a claim for ‘wrongful birth’. Ms Mordel, whose first language was Polish although she spoke good English, became pregnant in 2014 and had her booking appointment with a community midwife at her GP’s surgery on 23 June.

She agreed to undergo all six of the standard screening tests, including those for Down’s syndrome during the first trimester. However she was recorded as being “unsure” about any invasive tests (namely diagnostic testing in the event that initial screening indicates more than a 1:150 risk of Down’s).

Initial screening consists of ultrasound testing of the foetal neck (the nuchal translucency test) and a blood serum test of the mother. Ms Mordel saw a sonographer on 22 July for these tests, the latter asking “Do you want the screening for Down’s syndrome?”, to which she answered “no”. Accordingly, those tests were not performed and the sonographer only undertook a maternal ultrasound for dating purposes. She noted in the records “Down’s screening declined”.

Throughout the remaining course of the pregnancy, no Down’s tests were undertaken and the claimant gave birth to a child with Down’s on 25 January 2015. She was extremely upset at this and sued the trust, maintaining that if she had known that her child possessed this condition, she would have had a termination. The trust’s defence was that Ms Mordel unequivocally informed the sonographer that she did not want Down’s testing and that a patient’s wishes must be respected.

Mr Justice Jay found in favour of the claimant. Having heard her give evidence, he concluded that her English was not perfect and although she was reasonably fluent, there were occasions when she failed to understand what was being put to her by counsel, particularly if a question had a degree of nuance or complexity. He decided that the sonographer should have satisfied herself that the patient understood “the essential elements and purposes of scanning for Down’s syndrome”.

He thought the sonographer’s first question was “somewhat abrupt” and that she should have “done more to lay the ground properly”.

He interpreted the claimant’s use of the word “no” as an unreflective response in the heat of the moment. She had not processed the question properly. He accepted Ms Mordel’s explanation that she thought the question meant whether she wanted a child with Down’s. The judge acknowledged that clinicians are not required to “delve into the reasoning processes and motivations” of a patient, but concluded nevertheless that the sonographer had been at fault. Consequently, he held that there had been sub-standard care, for which the trust was liable.

Comment

This might be regarded as a harsh judgement, but it should cause NHS bodies to consider carefully how to deal with patients whose first language is not English. Degrees of fluency vary hugely, of course, and if a patient cannot understand English to any significant extent, a translator may be the only safe option. However, when a patient is apparently quite fluent, the judgement call is more difficult. It is a very fine line between ensuring that the patient has understood the nature of a test (for example) and being overbearing and questioning a patient’s comprehension. In this case the notes clearly revealed that the claimant had agreed to all the routine screening tests so, in the judge’s view, that should have caused the sonographer to ensure the patient had understood the situation clearly, rather than simply noting the position and moving on.

We have discussed this case and learning with the antenatal screening team at Public Health England, and will be working collaboratively with them to share learning from this case.

ZZZ v. Yeovil District Hospital NHS Foundation Trust (High Court, 26 June 2019 – Garnham J.)

A young woman (referred to as XXX) was a rear seat passenger in a car which was involved in a road traffic collision at 09.17 on 27 October 2011.

She was wearing a lap seat belt but nevertheless suffered serious spinal injuries. Insurers for the negligent motorist (ZZZ) settled her claim with a lump sum of £3 million, plus substantial ongoing periodical payments for care and case management. They started contribution proceedings against the trust, alleging that insufficient precautions were taken in the emergency department. This step was taken because shortly after arriving in hospital at roughly 10.15, having been transported from the collision site by ambulance, XXX was able to assist a nurse in removing her trousers and to push her feet against the nurse's hand. However, by 11.15 she could no longer move her legs. At 15.00 a scan revealed a fracture of the lower thoracic spine and severe compromise of the spinal canal and cord. She was referred to a tertiary centre for urgent surgery, but remains seriously disabled.

Ambulance staff, on arrival at the hospital, did not suggest to trust clinicians that they had any concerns about the patient's neck or back and XXX was not on a spinal board. On admission, normal power in both legs was recorded. The patient was placed flat on a trolley on arrival and trust witnesses denied that she ever sat up, as had been alleged. When a doctor needed to examine her back he 'log-rolled' her so as to keep her spine in proper alignment.

Various expert witnesses gave evidence. The neuro-radiologists agreed that the fracture dislocation probably occurred in the collision. Four experts concurred that XXX had suffered a flexion injury leading to a capsular tear which permitted part of the T12 vertebra to move through and over-ride the lower part of T11, causing major dislocation of the spine. T12 also became lodged with more than 50% forward movement over the lower vertebra L1. This was an unstable fracture of the most severe kind. The judge accepted that some spinal function had been retained immediately after the collision. Trust staff were at fault for not making a 'trauma call', under the local protocol, because it had been reported that the combined speed of the vehicles had been 60mph (that in fact turned out to be an over-estimate). Also, there was a breach of

duty in failing to implement a full range of spinal precautions to ensure, so far as possible, no movement to the spine.

However, Mr Justice Garnham held that these breaches did not cause or contribute to the patient's injury. There was no evidence to suggest that XXX's spine was moved to any significant extent during her stay at Yeovil. Rather, he accepted the evidence of two neuro-surgical experts who explained that following initial damage to the spine, swelling of the cord can occur which restricts its supply of oxygen. This results in white cells and other inflammatory material appearing inside the cord. In time, those materials release chemicals which set up secondary damage. This has been recognised since the 1970s.

The initial insult to the cord had been so severe that complete spinal cord injury and subsequent paralysis were inevitable. Medical science could explain why paralysis was not instantaneous. It was therefore wrong to view the trauma as a single event. It continued after the collision because the spine was locked in a contorted and extended position. Chemical changes in the spine continued after the initial impact. Consequently, while two breaches of duty had occurred those had no causative effect. The true cause of the patient's paralysis was damage inflicted in the collision.

Comment

NHS Resolution occasionally sees attempts by insurers to recover monies they have expended in settling a claim against their policyholder. Each one requires careful investigation, not least because there is a need to determine what consequences flowed from the original collision and what (if any) were caused by the alleged clinical negligence. In this case the observed facts appeared to support the insurers' view – namely that XXX had movement below the level of her injury on arrival at hospital. However, expert evidence demonstrated that appearances were deceptive because changes to the spine were continuing, after the collision, which inevitably led to paralysis. Although there were two breaches of duty on the part of clinicians, these had no impact on the eventual outcome.

Thimmaya v. Lancashire Teaching Hospitals NHS Foundation Trust and Mr J. (Manchester County Court, 30 January 2020 – Judge Evans)

This ruling arose out of a claim for allegedly negligent surgery to the neck in 2008. The claimant's surgical expert, Mr J., admitted to the judge mid-trial in 2019 that he did not understand the basis on which a court approached the question of clinical negligence.

That caused the claimant's legal team to abandon her case, leaving NHS Resolution with a substantial legal bill. We decided, after careful consideration, to seek our costs from Mr J. Judge Evans noted that the expert had been "wholly unable to articulate the test to be applied in determining breach of duty in a clinical negligence case", despite having been given a number of opportunities to explain it.

In a statement, Mr J. admitted that he had not been fit at the time of trial to give expert evidence owing to mental health problems. He did not accept that he was unaware of the correct legal test for clinical negligence, but asserted that he had an adverse reaction to questioning from the trust's barrister who reminded him of an interrogator he had previously encountered in Iraq. The judge noted that Mr J., in a joint statement prepared with the trust's expert, referred to "best practice", which is not the legal requirement for avoiding a finding of negligence. She also observed that he had been unable to explain the correct test in a subsequent case, ZZZ, which we report on separately for a different reason. Mr J. had not given counsel's resemblance to a former interrogator as an explanation during the trial in 2019 for his failing.

Since Mr J. had been aware of his mental health issues for a considerable time, and indeed had taken sick leave from his clinical practice in November 2017, he should likewise have pulled out of medico-legal work at the same time. These were significant failings which amounted to "improper, unreasonable or negligent conduct", such that the court had jurisdiction to order costs against him. Mr J. had failed comprehensively in his duties as an expert from November 2017 onwards, and Judge Evans therefore ordered him to meet the trust's legal costs of almost £89,000 incurred from that date.

Comment

We believe that this is the first time in a clinical negligence case that an expert witness has been ordered to pay the costs of the defendant. Any party seeking such an order must overcome the very high hurdle of proving that the expert had acted improperly, negligently or unreasonably. However, if an expert states that he or she does not know the basis on which a court will hold a clinician to have been negligent, that undermines the evidence of the expert completely. This ruling demonstrates that NHS Resolution will take novel steps, if required, to attempt to recover NHS money.

ABC v. St George's University Hospitals NHS Foundation Trust, SW London & St George's Mental Health NHS Trust and Another (High Court, 28 February 2020 – Yip J.)

In 2007 XX, who was ABC's father, killed her mother. He was found guilty of manslaughter by reason of diminished responsibility and made subject to a hospital order under the Mental Health Act.

He was placed at a facility run by the second defendant, where clinicians reached a view that he might be suffering from Huntington's disease, a neurodegenerative disorder of genetic origin. ABC became pregnant in July 2009, shortly after the provisional diagnosis of XX was made. Clinicians asked XX if they could inform his daughters, as they had a 50% chance of inheriting the condition if it was confirmed. XX refused, believing that such knowledge could impact on their decision whether or not to have children.

Consequently, ABC and her sister were not told. Testing in November 2009 confirmed that XX had the condition and he was informed on 10 December that year, by which time ABC was over 24 weeks pregnant. ABC's child was born in April 2010. ABC tested positive for the condition in 2013, so her child has a 50% chance of inheriting it.

In August 2010, a doctor inadvertently revealed to ABC that her father had Huntington's. This caused her great distress and she brought a claim for 'wrongful birth', alleging that doctors should have overridden her father's confidentiality and informed her. Had they done so, she claimed that she would have had a termination. The claim was both in negligence and under the Human Rights Act. It was asserted that the second defendant owed a duty of care to ABC as a patient because she was attending family therapy sessions with them at the relevant time.

The duty of confidentiality is not absolute, and guidance on it is published periodically by the GMC – the relevant editions in this case being 2004 and 2009. The former states that personal information may be published without a patient's consent, and in exceptional cases where the patient has withheld consent, "where the benefit to an individual or to society of the disclosure outweigh the public and the patient's interest in keeping the information confidential".

Yip J. held that since ABC had attended therapy sessions at the second defendant's premises she was owed by them a duty of care as a patient. However, that duty did not extend to releasing to her confidential information about another patient, because that did not arise out of the therapy she was being given.

When considering whether or not to release information to ABC, XX's consultant psychiatrist had consulted a geneticist and other clinicians and had concluded, on balance, that disclosure should not take place. In the case of XX's other daughter, there was a more formal process in that an ethics committee meeting had been convened on 7 October 2010 (ABC was aware of her father's condition two months earlier, but did not inform her sister), and a formal vote was taken, with the majority favouring non-disclosure. The judge was satisfied that an appropriate balancing exercise had been undertaken on both occasions, and that the decisions not to disclose were supported by a responsible body of professional opinion (including experts instructed on behalf of the defendants), even though other responsible clinicians would have disclosed.

The claimant had not demonstrated that the decision was illogical. Yip J. observed that the courts have agreed on occasion that clinicians may owe a duty of care to people other than their patient, but “such a duty is only capable of arising where there is a close proximal relationship between the claimant and the defendant”. There was no such relationship between the geneticists and ABC. However, in the case of the second defendant, proximity and reasonable foreseeability of harm had been established. It was fair and reasonable for the SW London Trust to be expected to balance the risks of disclosure. That balancing had been undertaken appropriately and so the trust was not liable.

Additionally, the judge was not satisfied that, had ABC been informed about the provisional diagnosis in early October 2009, she would have proceeded to termination because (a) the timescale was very tight and (b) she would probably not have had genetic testing then.

Overall, therefore, although SW London Trust owed ABC a duty of care because of the close proximal relationship involved, that duty was to conduct a balancing exercise and the exercise had been undertaken appropriately. There was no such duty on the part of the other defendants. There was no broad duty of care towards all relatives in respect of genetic information.

Comment

This was a very sad and probably unique case, which gave rise to an important judicial examination of the tension between a patient’s confidentiality and a relative’s interest in knowing that she might have an inherited disease. The ruling is helpful for the NHS in that it maintains established confidentiality principles, although that is not to undermine its likely effect on ABC. Had it gone the other way, guidance on confidentiality would have needed to be rewritten. The judgement therefore does not alter the law, but rather applies existing principles to very unusual circumstances. Importantly, it states that geneticists do not owe a different duty to that of other clinicians, a possibility raised by the Court of Appeal when allowing the claim to proceed to a full hearing.

Tackling fraud

P v Southport and Ormskirk Hospital NHS Trust (Liverpool County Court, 4 October 2019 – Recorder Alldis)

P attended the emergency department at Southport Hospital on 4 August 2014 with an injury to his left hand (sustained punching a wall). A fracture was suspected and an x-ray performed. This was initially interpreted by a nurse as showing no bony injury. P was advised that he had a soft tissue injury and discharged.

The following day, P's x-rays were reviewed by a radiologist who noted there was suspicion of subluxation/dislocation of the base 5th metacarpal. Unsuccessful attempts were made to contact the claimant by telephone. A letter was sent on 11 September inviting him to re-attend for repeat x-rays if he still had pain or concerns.

P re-attended on 15 September and repeat x-rays suggested a fracture. He was referred to a hand and upper limb surgeon. A CT scan was performed which showed a marked posterior subluxation of the 4th metacarpal joint and moderate posterior fracture of the 5th carpo-metacarpal. The injury was managed conservatively. P alleged that the delay in diagnosis had adverse consequences in terms of his recovery. Breach of duty and some limited causation were admitted.

P alleged he had a dull, aching pain in the left arm which could be anywhere from the two fingers affected spreading into the palm, wrist and left forearm, which ached. The pain throbbed for hours on end and once a week he experienced a shooting pain from the hand up his arm. He alleged he was fearful of knocking his hand or causing further injury to it. He could not lean on his hand or put any weight on it without pain. He barely cooked as he could not cut food or hold heavy pans without pain and claimed £100,000 for the extra cost of convenience food and takeaways. He also alleged he had to drive automatic cars due to the pain of using manual transmission.

A schedule of loss was served totalling £647,507 (including over £320,000 by way of loss of future earnings as a sales executive) plus general damages and some future heads of loss such as pension, psychiatric treatment and the cost of automatic cars.

We received two tip-offs to the effect that P was not as seriously affected as he maintained, one being from his neighbour who provided photographs and a video of the claimant carrying a heavy box and a radiator. This neighbour also gave evidence that he witnessed the claimant cleaning windows and carrying buckets of tiles.

Internet research revealed the claimant participating in Go Ape, an adventure course using ropes high among trees, and a video of him driving a quad bike at speed. Surveillance showed P going about his daily life, including attending work. He was filmed using his injured left hand for various tasks (e.g. holding a mug, writing, using a phone) and there was no indication that he found this painful or difficult.

Attempts to settle the claim at a realistic level failed and the case proceeded to trial. The judge found that the claimant had been malingering and was fundamentally dishonest. This meant that his claim failed entirely even though, had he been honest, he would have been entitled to modest damages for the failed initial diagnosis. We have now commenced committal proceedings against P for contempt of court, which could lead to a prison sentence.

XY v Calderdale & Huddersfield NHS Foundation Trust

XY was a female patient who suffered a delay in diagnosis of cauda equina syndrome allegedly leaving her with severe mobility problems and incontinence.

She valued her claim at over £5.7 million and maintained: "I can only walk very short distances with a walking aid. Within the home, I use two sticks or a walking frame. If I am leaving the house, I need to rely on a manual wheelchair... I cannot stand for long periods. I will never be able to stand in a queue. If I stood up to make a drink, I have to have a trolley with trays on to assist me. A few minutes of slow walking causes me to be exhausted and have to drop back down and gather myself before I can clear my head through the pain".

This account was at odds with our evidence and so surveillance was carried out to establish the validity of the claimant's symptoms. She was seen walking with ease and without aids on a number of occasions. When she visited 'Physiotherapy Works' she parked near the offices and walked slowly with two walking sticks. Following this she drove for an hour to a supermarket where she spent 45 minutes shopping alone with a trolley without using sticks.

Surveillance was also carried out on the day that XY was due to be examined by one of our medical experts. In the morning she was noted to drive for 90 minutes, visit shops without restriction, repeat the physiotherapy ritual and was then driven by a female relative to Scarborough for the appointment. She walked unaided into a hotel and, despite the presence of abundant seating, chose to stand in the queue for reception for 33 minutes, again without aids or any furniture to lean upon. After check-in, XY travelled to the hospital and was pushed in a wheelchair to the appointment and wheeled back out to the car an hour later. The claimant was then seen to walk again and ate some fish and chips at a restaurant on the promenade before taking a 20-minute stroll along the front with her relative. Further observations confirmed an individual with no obvious mobility problems, save for travelling to and from medical appointments.

Surveillance evidence was released to the claimant, who then served a witness statement in response that agreed she had overegged the pudding. Her explanation was that, as no one had listened to the severity of her symptoms when she suffered a delay in diagnosis and treatment, she similarly feared that it was important the experts saw how bad her condition could be so that she was not undercompensated. We agreed a round-table settlement meeting, but on the understanding that we would not be making any financial offers. XY offered to settle at £300,000 but eventually accepted that NHS Resolution would not be willing to settle.

XY ultimately agreed to discontinue her claim and to repay the £70,000 interim payment she had received, which had apparently been spent on holidays, shopping and meals out. She decided to sell her partner's rental property to fund around £60,000 of the debt, with the remainder being paid off on a monthly basis.

Crucially, XY admitted that her claim had been fundamentally dishonest and the case was dismissed by consent. With the Trust's agreement we are issuing contempt of court proceedings against her which, as in the previous case, could lead to a custodial sentence.

Comment

In both cases these claimants substantially exaggerated their injuries for financial gain, despite having otherwise valid claims for lower sums. P failed to receive any damages from NHS Resolution and XY is repaying the interim of £70,000. Both face the prospect of a prison term and a criminal record. The saving to the NHS against damages claimed was over £6.3 million. NHS Resolution will always take a robust line against attempts such as these to defraud the NHS.

Learning from harm

Engagement with partners

The broadened responsibility across secondary and primary care has provided the opportunities to develop new relationships, build closer networks, bring system partners together and share learning to support the ambition to support improvements in safety. Relationships continue to be developed with the Academic Health Science Networks and Health Education England. These relationships support collaborative working with stakeholders and raise awareness of our holistic offer to the system and the CNSGP scheme.

Regional member events and primary care roadshows

As part of our external engagement activities we have run regional events targeted at both the secondary care and primary care communities. We delivered, in conjunction with NHS England and NHS Improvement, seven regional primary care roadshow events over the course of 2019/20. These events were held in Taunton, London, Ipswich, Birmingham, the South East (London), Manchester and Leeds to showcase our services available to providers and commissioners of primary care services, including CNSGP. This was the first time we had delivered such events and provided an opportunity to engage with delegates from across the primary care community, including practice managers, general practitioners, clinical commissioners, and representatives from Local Medical Committees and other healthcare organisations who attended.

Also in 2019/20 we held a series of events targeted at those who work with us on managing claims in NHS secondary care organisations. Events were held in Newcastle, Liverpool, Birmingham, London, Cambridge and Bristol and provided an overview of our services across Claims Management (including non-clinical claims, technical claims and maternity incidents), advice, safety and learning and finance. This was an opportunity for our membership to hear about our focus on improving our processes, such as the launch of our Claims Management membership charter (see page 63), and understanding the link between their claims experience, contributions and how to use learning to improve frontline services.

Maternity

Maternity claims represent around 9% of the total number of clinical negligence claims received by NHS Resolution each year, but are 50% of the total value of new claims. They also relate to 69% of the annual £8.3 billion cost of harm in relation to the

CNST (covering England and secondary care). Incidents occurring in maternity have a significant lifelong impact on affected patients and their families and can also significantly impact on the NHS staff involved.

Figure 18: A comparison of the number and total value¹³ of claims for maternity cerebral palsy/brain damage claims over time across all clinical negligence schemes



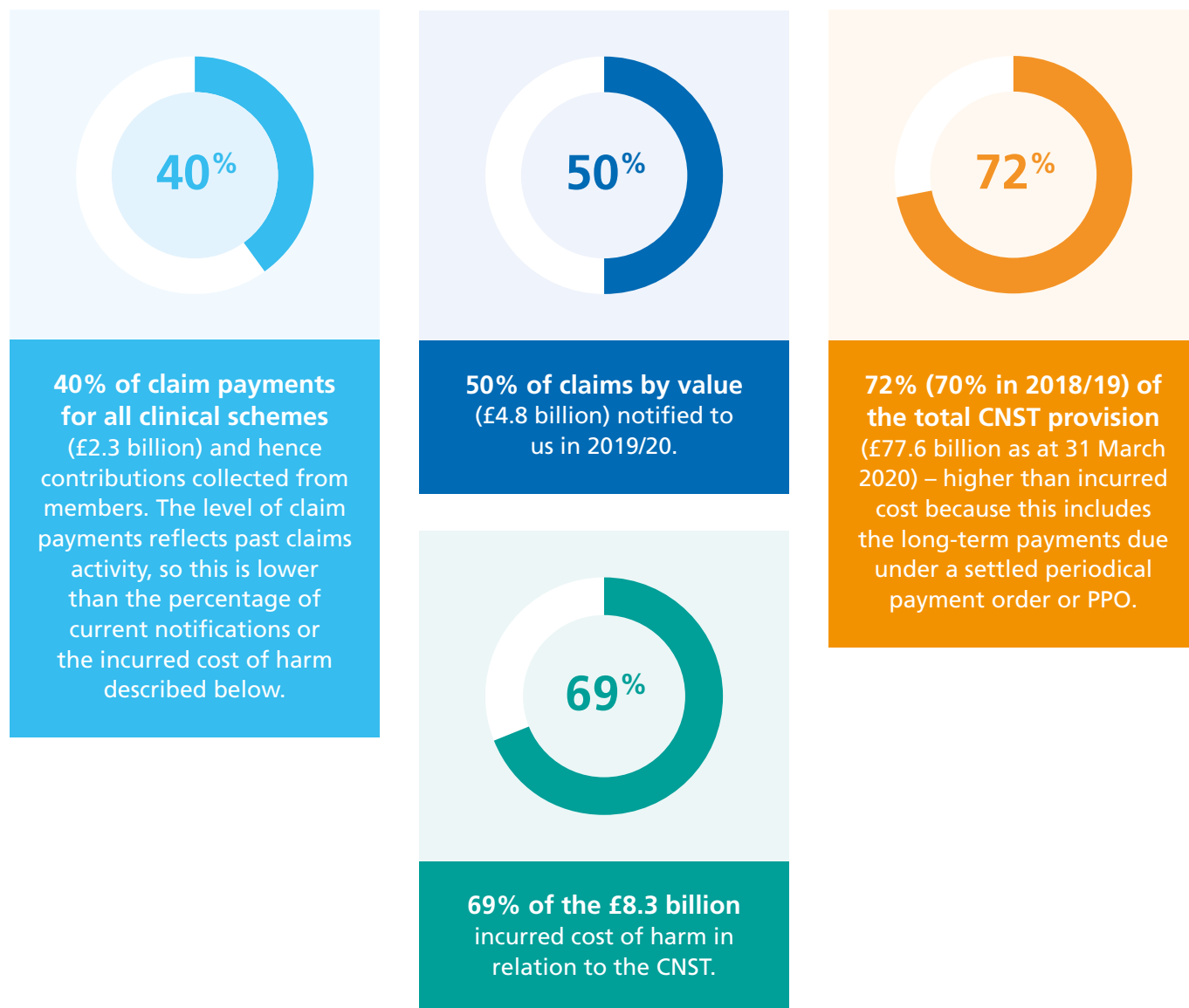
The total value of maternity claims continues to increase, despite a downward trend in claims received since 2016/17¹⁴. Claims volumes have varied historically between 180 and 230 and have been on a downward trajectory in recent years. However, the cost of those claims has steadily risen.

¹³ This is the total value of the claim including damages, claimant and NHS legal costs and includes both paid and outstanding costs. Value of claim is as of last year end (31/3/2020) for all claims, irrespective of the notification year.

¹⁴ In Figure 18 the data reported for recent years has been updated from the 2018/19 report due to the inclusion of Early Notification claims, and updates to data as more information becomes available on cases.

Figure 19: Some headline maternity statistics (as of 2019/20)

Maternity represents...



In maternity, the clinical area with the single highest cost of claims, we are supporting the national ambition to halve maternal and neonatal deaths and significant harm through early notification of incidents.

On 5 December 2019 we held our third national learning event of the year in Birmingham. This was the largest conference delivered by NHS Resolution, attracting over 250 attendees and jointly chaired by Baroness Cumberlege and Sir Cyril Chantler. The programme shared learning back to the NHS, facilitated by maternity related stakeholders including the President of RCOG and the Chief Executive of the Royal College of Midwives.

"Hearing this amazing inspirational person speak at @nhsresolution this year has had a lasting impact on my work and I continue to work with colleagues to imbibe the simple principles of consent inspired by this. Every practicing doctor should hear her talk."

Said a delegate following a talk by Nadine Montgomery

Early Notification scheme

The Early Notification scheme continues to be a flagship of our five-year strategy. In line with reporting guidelines of the RCOG Each Baby Counts criteria, trusts continue to report to the scheme cases in which a baby has a potentially severe brain injury. In September 2019 we published [The Early Notification scheme progress report: collaboration and improved experience for families](#) outlining the progress and learning from cases reported in year one of the scheme from 1 April 2017 to 31 March 2018. The learning was extracted from potentially high-risk cases which had been referred to our panel solicitors for further review. The benefit of analysing high-risk cases ensures that the learning is extracted in a timely manner to feed back into the maternity system to effect change, as well as ensuring that the aims of the scheme are being met.

The findings from the Early Notification progress report demonstrated significant improvements in reducing the time between an incident and admissions of liability being made. At the time of publication, 24 families had received an admission of liability, formal apology and in some cases, financial assistance with their care and other support within 18 months. As of 31 March 2020 there have been 51 admissions of liability*. This short duration is unprecedented for claims related to brain injury and/or cerebral palsy. In addition, the EN progress report outlined six key recommendations to influence change in clinical practice for maternity services. These are: candour, staff support, fetal monitoring, impacted fetal head, maternal deterioration and hyponatraemia.

An illustrative Early Notification case story: Meaningful investigation and response for families to improve insight and care and expedite appropriate compensation

This example¹⁵ relates to a mother who was booked for induction of labour at 38 weeks and a baby who underwent therapeutic cooling. The case met the criteria for reporting¹⁶ to the Early Notification team and was duly reported by the trust.

Following legal and clinical review of the medical records by the Early Notification team, the case was assessed as being suggestive of substandard care with the potential for an early admission of liability to be made.

This was because missed opportunities were identified with regard to undertaking cardiotocography monitoring, which records the fetal heartbeat and uterine contractions during pregnancy (more commonly known as CTG monitoring), and as tests taken after the baby was born indicated that, if CTG monitoring had been undertaken appropriately, it may well have been possible

to identify fetal distress sooner and take steps to minimise this. The baby, sadly, was diagnosed with hypoxic ischemic encephalopathy (HIE) and appeared likely to require ongoing assistance.

The Early Notification team instructed panel solicitors to accelerate liability investigations with the assistance of independent medico-legal experts and the trust.

Following detailed analysis and discussion with the legal and medical experts, the Early Notification team and the trust concluded that the omissions regarding CTG monitoring constituted a breach of duty for legal purposes. It was further agreed that, had CTG monitoring been conducted appropriately, it was more likely than not that concerns with regard to the fetal heart rate would have been identified and escalated sooner, and therefore that delivery of the baby would have occurred sooner. Had this been the case, the permanent neurological injury which

* In addition to the 51 cases that strictly fall within the Early Notification criteria, a further 11 admissions have been made on cases that do not, making a total of 62 admissions of liability. Many of these families are represented by solicitors.

¹⁵ To protect confidentiality, the facts of this case story have been altered from those pertinent to any specific case. It remains a representative example of the work and investigations undertaken by the Early Notification team in collaboration with members and panel firms.

¹⁶ <https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/>

occurred as a result of the hypoxia (a lack of oxygen/ and or blood flow to the baby) sustained by the baby would have been avoided.

In light of these conclusions, a letter was sent to the family admitting liability and offering an early interim damages payment to help address the family's immediate financial needs. The family were signposted to potential sources of legal advice and support and a letter of apology was sent by the trust.

Further investigations are ongoing with regard to baby's condition and prognosis. These investigations are progressing on a collaborative basis with the family's solicitors as baby grows into childhood and ongoing development and care needs become clearer.

The trust was actively involved and updated with regard to the progress of liability investigations and has had the opportunity to reflect on the omissions with CTG monitoring, which occurred on this occasion. In line with the recommendations made within the Early Notification Scheme Progress Report¹⁷, the trust has had the opportunity to consider not only the technical training provided to staff but also the complex socio-technical processes involved with CTG analysis, including human and environmental factors, in order that it might identify any lessons that could be learnt from the specific combination of circumstances and challenges which came together on this case.

The Early Notification team consider that cases such as this demonstrate the spirit of the Scheme which:

- a. Encourages responsible and proportionate investigation and response to potential claims, avoiding duplication of liability investigations between Claimant and Defendant solicitors and experts by investigating proactively, making early admissions of liability where indicated and adopting a collaborative approach when practicable;
- b. Endeavours to provide earlier explanations, apologies and, where appropriate, offers of financial support to families;
- c. Supports trusts with opportunities for reflection, learning and improvement much closer to the point of incident than would usually otherwise be practicable for NHS Resolution in comparable cases investigated via the traditional claims route.

We are actively looking at innovative ways to investigate cerebral palsy cases. Most recently we have looked to streamline the way in which experts review cases in conference resulting in liability determination faster than the traditional approach of reviewing one case at a time. In the upcoming year, we will also be looking at innovative ways of measuring and defining compensation as these babies grow older and require substantial support.

We continue to analyse learning from cases reported into the scheme and work with key stakeholders (such as the RCOG and the Royal College of Midwives). In addition to further support learning from claims, we have produced quarterly case stories which have been developed to support clinical teams to learn from cases reported into the scheme. Themes for case stories respond to emerging themes in maternity services and include [fetal surveillance](#), and cross departmental learning in the form of [learning lessons in maternity from a recent Supreme Court hearing](#). The case stories are designed to be used in mandatory training, in-situ simulation, team meetings and safety huddles.

¹⁷ <https://resolution.nhs.uk/wp-content/uploads/2019/09/NHS-Resolution-Early-Notification-report.pdf>

Hyponatraemia – a maternity story

A mother in her first pregnancy attended the midwifery-led unit in spontaneous labour at term. The midwife assessing her observed that she had a mild tachycardia on admission and encouraged her to drink. The tachycardia settled; however, after a number of hours in labour she was transferred to the labour ward for management of slow progress.

On the labour ward, she was advised to have a syntocinon infusion to augment contractions. An intravenous cannula was inserted and syntocinon and intravenous fluids started. Some variable decelerations of the fetal heart were noted on the cardiotocograph (CTG) and the flow of intravenous fluids was increased. After active pushing for around 30 minutes, the CTG was abnormal and the mother gave her consent for a trial of instrumental birth. In theatre, her behaviour was noted to be unusual, but she was tired and exhausted after a prolonged labour. The baby was delivered by forceps in poor condition; the neonatal team began resuscitation and transferred the baby to the neonatal intensive care unit for ongoing care including therapeutic cooling for seizures.

In maternity recovery, the mother's behaviour became increasingly unusual and a referral to the liaison psychiatry team was made. Approximately an hour after she had given birth, her partner called for help as she began to have a tonic clonic seizure. An arterial blood gas taken following the seizure revealed a sodium level of 117 mmol/l that was confirmed on a venous sample sent to the laboratory. She was transferred to the intensive care unit for ongoing care. Her partner was not sure but thinks she may have drunk at least three litres of water while in labour. This is in addition to the two litres of intravenous fluid on the drug chart from labour ward and theatre. The neonatal team were also informed and a review of the baby's cord gas results revealed a low sodium at birth of 116 mmol/l, but this was not seen previously.

Key points

- All women in labour are at increased risk of hyponatraemia (defined as blood serum sodium < 130 mmol/l), especially dilutional hyponatraemia which is sometimes referred to as water intoxication.
- This is a result of lower baseline serum sodium in pregnancy, impaired ability to excrete water in the third trimester and exposure to the anti-diuretic effect of oxytocin (synthetic and/or endogenous). Excessive oral or intravenous fluid intake exacerbates this, with potentially serious complications for mother and baby.
- Complications of hyponatraemia include headache, agitation, confusion, seizures and death. Vigilance, diagnosis and active management is therefore imperative.
- Water freely crosses the placenta, lowering the infant's blood sodium concentration in tandem with its mother's. Seizures secondary to hyponatraemia in the newborn infant are similar to those caused by hypoxic ischaemic encephalopathy (HIE) and they are likely to receive therapeutic cooling as a result.
- In a recent study (1), 26% of low-risk mothers who received or ingested >2500mls of fluid during labour were hyponatraemic.
- Significant hyponatraemia can be avoided by giving women evidence-based advice on oral fluid intake, careful monitoring of fluid input and output and responding to positive fluid balance.

Resources

1. Moen V, Brudin L, Rundgren M, Irestedt L. *Hyponatraemia complicating labour – rare or unrecognised? A prospective observational study.* BJOG. 2009 116:552–56
2. GAIN *Guideline for the Prevention, Diagnosis and Management of Hyponatraemia in Labour and the Immediate Postpartum Period.* March 2017. ISBN: 978-1-906805-36-4

Maternity incentive scheme

The scheme is now in its third year of operation. The maternity incentive scheme safety actions are designed in partnership with the collaborative advisory group. The ten maternity safety actions provide a contribution to the national ambition to reduce the rate of maternal and neonatal deaths, stillbirths and brain injuries by 20% by 2020.

Year-on-year, the safety actions are revised in line with best practice and are also responsive to emerging themes. For example, for the maternity incentive scheme year three, trusts are required to demonstrate compliance with all five elements of the saving babies lives care bundle version 2, and multidisciplinary training now includes a safety action relating to improving training for neonatal resuscitation and the deteriorating newborn, which was one of the emerging themes from the year one Early Notification scheme report.

In year two, for which we have published the results, hospitals self-certified against the ten actions by completion of a board declaration template, which is then signed by a member of the trust board. As with the process for year one, there was no new funding for this. We collected an additional 10% on top of the maternity component of the CNST contribution to create a £71.87 million fund and

returned that 10% plus a share of the proceeds to those who were successful in all ten actions. Those who were unsuccessful had an opportunity to bid for a payment capped at 30% of their contribution to the fund to help them make progress against the actions they did not meet. In year one (2018), 74 out of 132 (56%) trusts certified as achieving all ten actions. The ten actions remained the same in year two but with added stretch in the required standard of compliance. The results for year two show that 116 out of 130 trusts (89%) certified as having achieved all ten safety actions, which represents a significant uplift on the year one position. (The total number of maternity trusts has reduced from year one due to mergers.) Over the course of the year there have been some revisions to the certifications submitted to us; as a result funds awarded to providers where their certification was revoked (or withdrawn) have been required to return them to us for redistribution to the remaining successful NHS providers.

While it may be challenging to isolate the quantitative impact of the maternity incentive scheme from other maternity initiatives, the scheme has been successful in driving practice improvements. Feedback from participating trusts indicate that the safety actions give greater prominence to the actions required to increase the awareness of maternity safety at board level, and have greater influence for multi-disciplinary working, e.g. across anaesthetic and neonatal services. Over 86% of the trusts reported that as a result of engagement in the maternity incentive scheme there had been improved communication between boards and maternity services, which had resulted in increased support for the implementation of all safety actions. We have published an interim evaluation of the scheme: <https://resolution.nhs.uk/wp-content/uploads/2020/04/Maternity-Incentive-Scheme-evaluation-report.pdf>.

“Transitional care is really supporting mums and babies staying together. Looking at the theme to avoid term admissions can improve safety.”

“Saving babies lives bundle have made us review how we use our resources and we have seen improvements in outcomes.”

Scheme participants

Building in-house expertise in safety and learning

Neonatal coding

We have strengthened our data capture on our claims management system to support thematic analysis of the reasons for neonatal claims.

General practice and diabetes

A practice nurse has been recruited to support learning from CNSGP claims, identifying common themes, and will also support next year's programme of work for a clinical fellow undertaking a thematic review of vascular complications related to management of diabetes.

Sharing the learning and responding to emerging trends

Thematic review

Each year NHS Resolution appoints a clinical fellow to undertake a thematic review of claims related to a particular speciality. This year, in response to emergency department claims representing the highest volume of claims, a thematic review was undertaken to gain greater understanding of the key contributors to this specialty area. The review includes working across the system with a range of key partners and stakeholders to develop the recommendations. The report will be published later this year.

Faculty of Learning

The Faculty of Learning is cross-organisational work which focuses on the intervention aspect of our strategy and business plan. The primary aim is to develop and deliver quality education and training products to support members to improve safety, reduce harm and facilitate better patient and family experience. The Safety and Learning team continue to work with partners to share best practice in learning from claims into one Faculty of Learning to share with the NHS. This year's resources available on our website (resolution.nhs.uk) include the following.

Point of incident resolution

Launch of Being fair: supporting a just and learning culture for staff and patients following incidents

Our ambition to get closer to the point of incident to prevent unnecessary claims has provided opportunity to work with senior health leaders and influencers for the purpose of understanding how care is delivered. Recognising from [commissioned research](#) by the Behavioural Insights Team that sought to explore why people make a claim, there is a need to refocus safety systems, processes and behaviours to ensure responses deliver effective and sustainable reduction in risk and a restorative, just, learning culture. Underpinning this learning is a culture which is kind, respectful and which enables people to speak out openly, and to share issues, concerns and ideas *without judgement*¹⁸.

With our membership we co-created a '*Just and Learning Culture Charter*' to provide guidance for organisations to adapt and adopt key evidence-based safety principles. The charter is also supported by AvMA. The publication aims to dispel many misconceptions about a just and learning culture: that it is 'blame free'; that it is too 'soft' and individuals need to be punished in order to stop making mistakes; and that error or failure can be eliminated. This was launched at the Health Service Journal National Safety congress, and was also highlighted at this event by the Secretary of State for Health and Social Care in his opening address. The guidance has attracted great interest and has been presented at a range of both national and local events as well as a number of webinars.

¹⁸ *Just Culture – restoring trust and accountability in your organization*. Sidney Dekker (2018). CRC Press.

Alan's story – saying sorry

In December 2019 we published our video [Alan's story – saying sorry](#). The video presents a case story of a patient suffering a fall while in hospital.

The film focuses on the immediate response of the staff following the incident. It explores the ways in which patients and their families can be supported when an incident occurs. The film is accompanied by text which provides insight on related claims and presents a series of questions to support staff to consider their own practice and opportunities to develop in such situations.

This resource will stimulate debate among organisations and individuals regarding best practice in supporting patients and families following an incident.

Consent

Nadine's story – consent

In December 2019 we published our video [Nadine's story – consent](#). In the video Nadine Montgomery provides an open and frank account of her pregnancy, labour, the challenges of caring for a child with cerebral palsy and her journey through the legal system which ended at the Supreme Court in 2014.

Nadine discusses the principles of consent and the relationship between clinicians and patients that remain just as relevant today as back in 1999 when she received care. The video is accompanied by two additional short videos that provide context to Nadine's case and advice that can support clinicians in delivering good quality consent. They demonstrate the human harm that can occur in claims. The video is an essential watch for midwives, obstetricians and others involved in maternity care. The importance of gaining thoroughly informed patient consent is paramount.

Learning from inquests

Inquest videos

Following a national mental health event we ran in 2018 we were approached by several senior coroners expressing interest in working with us to support staff called to give evidence at an inquest.

This is because giving evidence can create anxiety and uncertainty, particularly if it is a new experience or it's gone badly in the past. Three short films have been developed which have transferability and support individual situations, offering insights into the whole process from different perspectives. The films seek to dispel misconceptions about the role of the coroner and explain how best a witness can help the coroner and the family of the patient.

Increased engagement with clinicians in member and beneficiary organisations: exploring and understanding claims data

Our Safety and Learning team supports members of our indemnity schemes to better understand their claims risk profiles by raising awareness and supporting their analysis of claims to target their safety activity. Working locally, they can reflect regional and national issues in patient and staff safety, working with a range of partners over the course of the year from both the health and justice sectors. This work has included: individual engagement visits to trusts where claims scorecards are discussed and learning from claims is encouraged, as well as the benefits of triangulating learning from

serious incidents, complaints and claims, facilitating local, regional and national events to help share learning across trusts, regions and the wider NHS and producing products to enhance learning. As part of our external engagement activities the team delivered a range of events in 2019/20. These events included the introduction of webinars and podcasts to extend our engagement with clinicians while bringing them together to share best practice and receive feedback on products and initiatives as well as improving patient safety with the aim of reducing claims against the NHS.

2019 claims scorecard

The 2019 claims scorecard again provided members with a ten-year view (by incident date) of their claims history. This is in response to ongoing feedback from members that this longer timescale provides more opportunity for learning than the previous five-year format. The safety and learning team continues to support members in accessing and utilising their organisation's scorecard(s). The layout and content of the scorecard allows it to be used in a number of ways. The front sheet views allow for easy reporting of the high-level data for an organisation, and the editable charts and tables support identification of themes, while the 'all data' tab provides comprehensive granular data that can be subjected to further analysis to provide insight. Many members have been supported by the safety and learning team to complete triangulation exercises using scorecard claims data combined with member-held data for incidents and complaints. The safety and learning team have continued to promote the scorecard to a diverse audience within member organisations, particularly supporting clinicians to access data relevant to their speciality.

Supporting GIRFT

NHS Resolution works closely with the Getting It Right First Time (GIRFT) programme to improve the quality of care by reducing unwarranted variation across the NHS. This year GIRFT published the first of its best practice guidance which concentrated on high value areas of knee and hip arthroplasty. The Safety and Learning team worked with trusts to help them align their data packs from GIRFT with their claims history on our scorecards, and carried out a series of joint visits to trusts who had either very low or very high volume claims to better understand their practices and processes in this area. The team developed buddying with GIRFT leads in the NHS England and NHS Improvement regions to ensure consistent messaging around the area of claims.

Serving our customers

To determine our customer needs, and to evaluate our success in meeting them, we undertake an annual online survey. We invite members of our indemnity schemes, commissioners, healthcare providers and relevant strategic organisations to share their views on where they feel we are doing well, but importantly also those areas where we could do better. Results from this year's survey, which ran in January and February 2020, show that most customers continue to be satisfied with NHS Resolution, with approximately seven out of ten customers (72%) telling us they are satisfied with the overall service received.

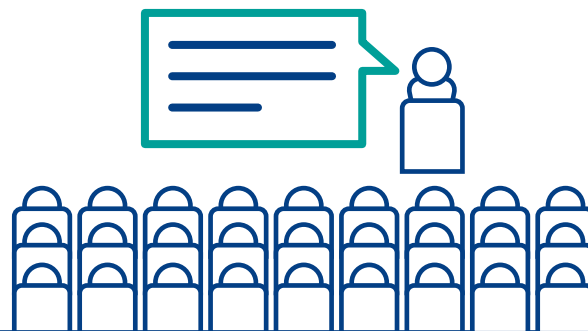
To supplement this quantitative data, we commissioned a series of in-depth interviews to provide richer qualitative feedback from strategic partners and other bodies on our corporate approach and ability to influence the system. Those interviewed reported a positive experience of NHS Resolution with full support for our strategic commitment to early resolution, learning from claims and concerns to drive improvement and reduce the volume and cost of claims. We will carefully consider the combined feedback and use the information to shape any service improvements made as a result.

Practitioner Performance Advice

Headlines



775 cases of advice
(doctors, dentists and pharmacists).



Delivered training for over
600 delegates at public training
workshops, and **48 in-house
workshops**, on how to investigate
and resolve concerns locally about
practitioner performance.

Developing our offer – we have:

- Successfully introduced new assessment models in relation to clinical performance and behaviours
- Piloted an approach to support teams experiencing disruptive behaviours in clinical settings
- Continued the development of the workplace-based assisted mediation model and increased capacity to deliver this service
- Undertaken a comprehensive review of our professional support and remediation service, and identified a number of enhancements
- Piloted Action Learning Circles for case managers and case investigators to support the ongoing development of skills of those carrying out this work

Learning from our experience

Practitioner Performance Advice has continued to provide a case advice service to healthcare employers on the effective local management and resolution of performance concerns about individual doctors, dentists and pharmacists. Over the course of the year, we received 775 new requests for advice on a range of issues relating to individuals' performance, including on matters of clinical capability, performance, workplace behaviour and conduct. This year our services have reached 88% of all secondary care trusts in England across all regions.

Over time, while we are seeing a reduction in the number of new requests for advice we receive each year, in parallel we continue to see take up of our education and learning programmes in line with our ambition to build capability and capacity locally. Eighty-eight per cent of all England-based secondary care organisations accessed our services in 2019/20; this is comparable to the reach we achieved in 2018/19. This suggests that capacity and capability for managing concerns locally is growing, with Practitioner Performance Advice being accessed to support the management and resolution of more complex cases. This is an area that we will seek to understand and explore further going forward.

We are taking steps to strengthen our profile in the primary care sector through proactively increasing our stakeholder engagement and educational reach, as well as closer partnership working with NHS England and NHS Improvement. As in previous years, doctors accounted for the majority of new cases (88%), with 52% of those cases being in relation to clinicians at consultant grade or GP principal level.

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

Case management framework

We developed and launched a case management framework for our Advisers. It sets out the issues to be considered and the expectations regarding case handling by the Advisers at each stage of a case to ensure that our processes, while tailored to the specific circumstances of each case, will still be consistent regardless of which Adviser is appointed. It is not intended to replace an Adviser's discretion or their own judgement in an individual case, but to support their decision making.

Assessment

In 2019/20 we introduced new models of assessment, following a development programme to review and streamline our assessments and to ensure that they meet the needs of our users. We now offer two assessments – one focusing on clinical performance and the other concentrating on the behavioural characteristics of a practitioner. If appropriate, we offer both types of assessment, making our service more targeted and flexible.

In developing the new models, we made a number of efficiencies in our processes. This has reduced the time taken to complete behavioural assessments by 58% and clinical performance assessments by 36%, compared to the closest equivalent assessment models we undertook last year. This has delivered clear benefits for our users in that healthcare organisations are able to take steps more promptly to manage and support practitioners to return to safe and valued practice in the interests of patient care and to achieve resolution earlier.

Professional Support and Remediation

A particular success this year has been the focused action plans we provide for individual practitioners. We have completed 34 plans this year. We work with practitioners who need support to return to clinical practice and our aim is to return practitioners to safe and effective clinical practice at the earliest opportunity. Professional Support and Remediation can also be used where an employing or contracting organisation is seeking to return a practitioner to practice following a period of absence.

Building on feedback from a survey of stakeholder needs, we reviewed the service business model, focusing on improving quality, communication and delivery times for Professional Support and Remediation products. As a result healthcare organisations requesting action plans have benefitted from a decrease in delivery times of 43% compared to 2018/19.

In January 2020 we conducted in-depth interviews with customers to obtain in-depth feedback on our service. A number of interviews were undertaken before the work was placed on hold due to the Covid-19 pandemic.

Interim findings from ten in-depth interviews indicate:

- that medical directors are confident in managing less complex cases at a local level, requesting our support mainly when cases increase in complexity and/or reach the stage of formal action;
- a need for a package services for upcoming medical directors, to prepare and educate them to manage concerns effectively, supporting our work to get upstream and build capacity and capability at local level;
- there is an opportunity for our Advisers to get involved with organisations on a broader agenda (more aligned to the GMC Employer Liaison Adviser approach) across the full range of our services.

Team reviews

This year we have seen a number of cases involving concerns regarding poor working relationships within teams. Such issues are usually longstanding, complex and deeply rooted. Our team review provides employers with a means to understand these types of concerns and identify ways of moving forward in order to restore a working balance to the team environment as soon as possible.

To further develop the service we have started to design a comprehensive training and development programme for our team review facilitators. This will ensure the approach continues to incorporate established contemporary thinking around team behaviours and reflect the unique position we have in supporting employers to manage concerns. Although in the initial stages, further development of the service could lead to the opportunity to assist our users further by carrying out specialist behavioural interventions in cases where a need is identified.

Workplace-based assisted mediation to support the resolution of disputes between practitioners

We have delivered ten assisted mediations, where we bring clinicians together to help them find a mutually acceptable way forward when there are disputes in the workplace.

Significant concerns

Our Practitioner Performance Advice service supports organisations to resolve concerns fairly and share learning. We have made a number of improvements to our service which include strengthening the promotion of information-sharing between organisations in the interests of patient safety.

Education

We continue to see demand for our education services and across the UK we delivered 48 skills-based workshops to over 600 frontline clinicians and healthcare managers on a range of key areas such as case investigation and management, as well as resolving performance concerns. Our national network of [Advisers](#) design and deliver these courses for those managing these difficult areas of performance management. They are delivered on site or via generic sessions which are regularly scheduled.

We saw a 10% decrease in education activity in 2019/20 compared with the previous year and 88% of participants providing feedback rated the impact as four out of five or higher. We also successfully updated our educational materials to reflect changes within the NHS and professional regulation, as well as current best practice and key developments in case law. Of particular significance has been our renewed focus on engagement through Responsible Officer networks, which has afforded a critical platform to maintain our organisational profile and to understand the particular challenges in the wider healthcare system relating to performance management and the differing regional needs of our users. In conjunction with our Safety and Learning service, we have taken the opportunity afforded by Responsible Officer Network meetings to raise the profile of the scorecards providing organisations with information on their claims history and our work with other organisations to promote a just culture.

Action Learning Circles

During 2019/20 Practitioner Performance Advice offered case investigators and case managers working within primary care the opportunity to join an Action Learning Circle. Staff were teamed up with five peers to form a trusted learning group who helped challenge thinking on how to manage day-to-day issues and develop realistic and pragmatic solutions to problems.

Throughout the programme, participants benefit from learning how to:

- articulate a work challenge and explore with peers how the challenge can be resolved
- examine feelings, actions and motives in a safe space to help test potential solutions
- develop second level thinking through a process of constructive exploration and challenge with peers.

Delegates who participated in action learning said that the experience helped them move their case understanding forward and that they had considered cases/problems in a different way.

Learning from exclusions

We commenced a learning exercise to understand more about the national picture on exclusions and how we support the NHS in managing these more complex cases.

Healthcare Professional Alert Notifications

Over the past year we have been working with DHSC to make revisions to the *Directions to the NHS Litigation Authority* to mitigate risks from the changing NHS structure over recent years.

The revisions have now been finalised by:

- Providing a definition of an “organisation which provides services to or on behalf of an NHS body” which allows organisations such as independent sector providers who are contracting with the NHS and locum agencies to make requests for HPANs and for information on active HPANs to be shared with them.
- Clarifying the cascade arrangements for an active HPAN, to reflect the current architecture of the NHS in England.
- Permitting email as a route of communication with the subject of an HPAN.
- Reducing the review period for active HPANs from six months to three months to reflect the reduced timescales for regulators to make an initial consideration of a referral.
- Removing the specific requirement for retention of records for five years and replacing it with “for as long as the Authority considers it necessary to do so” to ensure the retention of HPAN records is consistent with NHS Resolution’s corporate retention policies.

Case study one: Action planning

Practitioner Performance Advice provides action plans to healthcare organisations for practitioners who need support to deliver safe and effective clinical practice. Professional support and remediation can provide support to practitioners returning to work following a prolonged absence, to reskill and/or reintegrate into clinical practice. It can also address performance or behavioural concerns about practitioners. Sometimes these concerns have been identified from one of our own assessments of the practitioner, or our input may follow a local investigation or the involvement of another external body.

Mr A was a consultant surgeon whose practice had been found to be deficient in a number of areas following an internal investigation. As patient safety was the paramount concern, Mr A's clinical practice was restricted and Practitioner Performance Advice was asked by his employing trust to produce an action plan aimed at addressing the following areas of practice:

- operative and technical skills
- infection control
- communication with patients
- leadership skills

An action plan was produced by Practitioner Performance Advice and implemented by Mr A's employer. The plan was designed to deliver sustained improvement and ran for nine months. The plan recommended that Mr A would rebuild his confidence and clinical skills in a supported environment at a placement in a different trust.

As part of the action plan, Mr A was provided with a range of support, including:

- induction phase for the placement
- supervision from an experienced senior consultant
- protected time for regular and structured reflection
- feedback opportunities
- professional development activities
- coaching and mentoring
- formative workplace-based assessments (such as case-based discussion, mini-clinical evaluation exercise and direct observation of procedural skills)

The plan provided a clear phased structure for Mr A's return to work and clinical practice, with defined milestones to facilitate regular performance reviews and to ensure a fair, comprehensive and robustly evidence-based approach to evaluating his progress.

At the conclusion of the programme, Mr A's clinical supervisor reported that Mr A was providing satisfactory care for patients. This enabled his employing trust to make the decision that he was ready to return to his own department.

A shorter three-month follow-up programme, designed by Practitioner Performance Advice, allowed the employing trust to actively manage and support Mr A's reintegration into the department. This plan was also completed successfully and the evidence gathered through both action plans showed that the concerns identified by the internal investigation had been successfully resolved and that Mr A was delivering the level of patient care expected of a consultant in his specialty.

NB: this case study is a composite of real cases with changes made to protect anonymity.

Case study two: Clinical performance assessment

Where there are concerns about a practitioner's clinical practice, Practitioner Performance Advice can carry out a clinical performance assessment. This gives an independent view on the clinical performance of the practitioner, identifying both satisfactory practice and any areas of poor practice, and provides the healthcare organisation and practitioner with a sound basis upon which to bring the case towards a resolution.

Dr X was an associate specialist surgeon. Concerns had been raised by two consultant colleagues about his surgical skills and clinical decision making. Local investigation could not reach a firm conclusion about Dr X's clinical performance, and he was placed under supervision in clinics and in theatre. As a result of the unresolved concerns, the Medical Director contacted Practitioner Performance Advice. She felt that gaining a fair and independent view of Dr X's practice from the supervision may be difficult because Dr X worked in a small, specialised team and there were some interpersonal issues which could affect the impartiality of some of the consultants, as well as Dr X's willingness to accept their opinions. The trust referred Dr X's case to us for consideration and we offered a clinical performance assessment.

Two experienced surgeons were recruited as clinical assessors in Dr X's specialty. They assessed Dr X over the course of four days in the workplace by reviewing a selection of records from Dr X's cases and observing his practice in clinics and theatre. The assessors also conducted a case-based assessment with Dr X, exploring his clinical reasoning and decision making relating to cases seen during the assessment visit.

Practitioner Performance Advice issued a robust evidence-based assessment report to the Trust and Dr X. The report found that Dr X was practising at a satisfactory level across many domains of practice, such as clinical management, record keeping and communication with patients. Dr X's operative skills were of a particularly high standard, and his practice in theatre was generally satisfactory. However, Dr X's assessment of patients in a clinic setting was not at the level expected. His patient histories were not comprehensive and he did not always use appropriate investigations.

Following a post-assessment meeting between the practitioner, Medical Director and Practitioner Performance Advice, the trust relaxed Dr X's supervision in a theatre setting. He remained under additional supervision in clinics, and the trust requested that Practitioner Performance Advice develop an action plan for Dr X to address the areas for development.

As he found the report to be fair and independent, Dr X accepted the findings of the report and was keen to remediate his practice. After working through the action plan for nine months, the trust was satisfied that Dr X was performing at the level they expected of him as an Associate Specialist across all areas of his practice, and concluded the additional supervision.

Primary Care Appeals

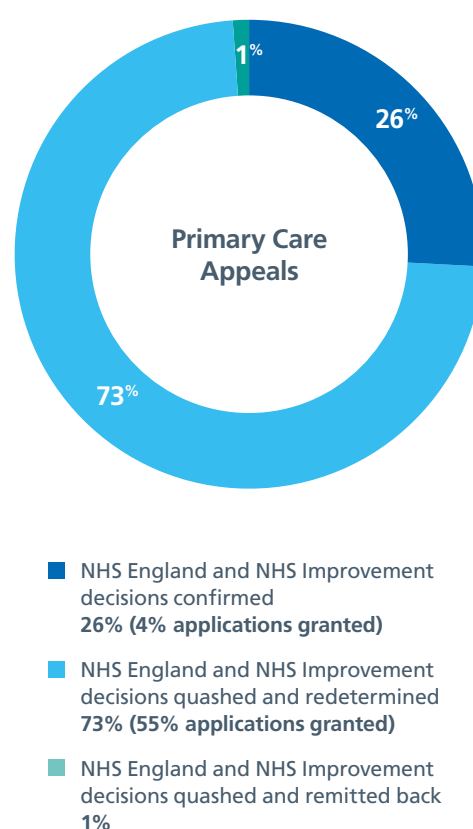
Primary Care Appeals receives and resolves appeals where NHS England and NHS Improvement and primary care contractors or those wishing to provide primary care services cannot reach agreement at local level. In 2019/20 Primary Care Appeals received more appeals and dispute applications than in the previous year.

Pharmaceutical appeals

The number of appeals we received in accordance with Pharmacy Regulations and Overpayment Directions¹⁹ was marginally lower than those we received in the previous year. We resolved appeals on applications from pharmacists to join the Pharmaceutical List (otherwise known as 'market entry'), on applications to change the premises 'listing', on the issuing of breach or remedial notices and on decisions to recover quality overpayments. Overall, we received 162 pharmacy appeals compared with 171 in the last financial year.

Of those pharmacy market entry and change of listing appeals that resulted in the Primary Care Appeals service reaching a substantive resolution (i.e. not withdrawn or summarily dismissed) and which did not require an oral hearing or any external input, 98% were issued within a target of 15 weeks with an average of 11 weeks. For those determinations requiring external input, 70% were issued within 19 weeks with an average of 18 weeks and for those which required an oral hearing, 64% were issued within a target of 25 weeks with an average of 28 weeks. Twenty-two market entry appeals required an oral hearing.

Figure 20: Primary Care Appeals service decisions



¹⁹ NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the National Health Service Litigation Authority (Pharmaceutical Remuneration – Overpayments) (England) Directions 2018

We saw an increase in the number of appeals received regarding decisions of NHS England and NHS Improvement to recover quality payments made to pharmacies (40 compared to 7 in 2018/19). In every appeal substantively resolved (40), we found for NHS England and NHS Improvement.

While it is not appropriate to comment on individual cases in this narrative, it is important for wider learning to use this opportunity to reflect on decisions of interest. In this regard, during the year we resolved the first appeals regarding consolidation applications. These applications enable a person already included in a pharmaceutical list to make an application in respect of the consolidation onto the site ('S1') of listed chemist premises in the area of the relevant Health and Wellbeing Board (HWB) of the provision of pharmaceutical services provided at or from S1 and other listed chemist premises (site) in the area of the HWB. In this regard, NHS England and NHS Improvement (and ourselves on appeal) must refuse a consolidation application if it is satisfied that granting the application would create a gap in pharmaceutical services provision that could be met by a routine application either to meet a current or future need for pharmaceutical services, or to secure improvements, or better access, to pharmaceutical services.

In case 21072²⁰ NHS England and NHS Improvement had refused such an application. On appeal, our Pharmacy Appeals Committee (the Committee) noted that both the HWB and Local Medical Committee objected to the application based on the fact that it

would result in the closure of a 100 hour pharmacy (in a deprived area), causing a reduction in pharmacy opening hours from 100 hours each week to 47.5 hours each week. The applicant had asserted that the demand that the proposed 'closing site' sees during the hours of 6am and 9am and after 6pm was minimal. The Committee had no reason to doubt the applicant's willingness to agree to extend its opening hours if the application were granted, but there was no contractual obligation for it to do so. While the applicant referred to other pharmacies located within close proximity to the closing site, the applicant had not provided any information upon which the Committee could assess access to these pharmacies. The Committee considered that the applicant had not provided sufficient information to support its assertions that the effect of losing these core opening hours on access to and availability of pharmaceutical services was not enough to create a gap of the type referred to in the Regulations. The application was refused on 9 May 2019.

In case 23239²¹, NHS England and NHS Improvement refused the consolidation application. In considering the appeal, the Committee noted that the HWB had failed in its statutory duty to respond to both NHS England and NHS Improvement and NHS Resolution. The Committee proceeded on the basis of the available information, noting that of the nine existing pharmacies within a mile of the closing site, seven are standard 40 hour contractors and two are 100 hour contractors. The two 100 hour contractors provide extensive opening hours over seven days, and four of the 40 hour contractors provide opening hours

²⁰ <https://resolution.nhs.uk/wp-content/uploads/2019/05/21072-Pharmaceutical-Decisions-2013-Reg-26A-Newcastle-upon-Tyne.pdf>

²¹ <https://resolution.nhs.uk/wp-content/uploads/2020/06/23239-Pharmaceutical-Decisions-2013-Reg-26A-Bolton.pdf>

over six days. The Committee noted that the opening hours proposed by the applicant for the 'consolidation site' would remain the same, and that the total number of core opening hours would be the same as the closing site, albeit with a slightly different distribution of the days and times at which these would be provided, and that the consolidation site would be offering more total opening hours than the closing site. The Committee noted NHS England and NHS Improvements' comments that there would be no loss/reduction in terms of services being offered by the applicant in granting the application, and that the applicant has confirmed that there will be no interruption in service provision.

The Committee considered that the wording of Regulation 26A(5)(a) sets a threshold that must be met in order to refuse an application. In order to do so, the decision maker must be satisfied that granting the application "would" create a gap in pharmaceutical services provision that could be met by a routine application. This is a higher standard than would be the case if it stated that the application must be refused if granting it "might", "may" or "could" create such a gap. It suggests that there is at least a high probability, if not a certainty, that granting the application will cause such a gap. Ordinarily, the HWB's comments on whether such a gap would be created, which it is legally obliged to provide, would carry a significant amount of weight on this point. Other interested parties would also be entitled to comment on this issue. However, in this case the HWB had not provided any comments.

The Committee considered that the applicant had addressed the issue of whether or not granting the application would not create a gap in pharmaceutical services provision that could be met by a routine application. In particular, the applicant had referred to the short distance between the 'closing site' and the 'consolidation site', the ease of access between them, the availability of other pharmacies nearby, and had stated that there would be no change in the services provided by granting the application. The Committee noted that the applicant's comments on these points had not been challenged by any other party. The application was granted on 9 January 2020.

Developing our offer

Panel members

A Committee made up of NHS Resolution officers and Appeals Panel Members determines pharmacy market entry and overpayment appeals. These appeals are either determined on the papers or following an oral hearing. In order to support us, we have a pool of twenty panel members from a wide variety of backgrounds who bring key skills to our work, including the ability of adjudicating in quasi-tribunal proceedings, tribunal or similar, a proven ability to consider and understand highly complex information on a wide range of issues and excellent oral and written communication skills and interpersonal skills, including the ability to communicate professionally. Their biographies can be found on our website at <https://resolution.nhs.uk/services/primary-care-appeals/pharmacy-appeal-committee>.

In December 2019 we held our annual staff and panel member event, which was invaluable for providing a forum for discussion and case review. We take this opportunity to thank all our panel members for all their hard work over the year.

Pharmacy Appeals User Group

The Pharmacy Appeals User Group met once during the year. The aim of this group is to consult service users and their representatives on appeals practice and procedure, and on any proposed changes to practice and procedure. Feedback from external group members remains very positive. At its November meeting we updated the group on the restructuring of the Primary Care Appeals team, gave advance sight of three new guidance notes intended for publication in early 2020 and discussed external training requirements for 2020/21. Notes of meetings are available at <https://resolution.nhs.uk/services/primary-care-appeals/pharmacy-appeals-user-group>.

Dispute resolution

There is a mandatory requirement in the Regulations governing medical, dental and ophthalmic services for primary care contractors and NHS England and NHS Improvement to make reasonable efforts to communicate and co-operate with each other with a view to resolving any dispute which arises out of or in connection with the contract before referring the dispute for determination in accordance with the NHS dispute resolution procedure (or, where applicable, before commencing court proceedings).

During the latter part of the year, we received a higher number of applications than normal where local resolution had either not been engaged, had stalled or had not been exhausted. As a result we refused to deal with such disputes unless and until local resolution had been attempted and fully exhausted or where evidence was provided by the applicant demonstrating that the other party was not engaging in the process because, in the opposing party's view, it was fruitless, i.e. both parties were so far apart on the matter in dispute. Disputes relating to GPs and their contracts were again the main source of new applications (46 compared with 25 last year). There were 23 dental disputes and two ophthalmic disputes received, an overall increase of 15% on 2018/19.

Judicial reviews

During the year there was a challenge to our decision to confirm a decision of NHS England and NHS Improvement to terminate a GP contract. We found for NHS England on the basis of patient safety. In March both parties consented to the matter being remitted back to Primary Care Appeals to redetermine.

As reported in 2018/19, there was a challenge to a number of decisions we made under special delegation from the Secretary of State for Health and Social Care regarding Alternative Primary Medical Services Contracts. The judicial review is restricted to whether or not the contractor is entitled to be awarded interest on the monies he is owed. The matter is still ongoing.

Performers Lists notifications and pre-contract checks

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

or proceedings involving the proposed applicants. This process provides a centralised system for the disclosure of relevant information enabling NHS England and NHS Improvement to make informed decisions regarding the suitability of those applying to join the relevant list.

Between 1 April 2019 and 31 March 2020 Primary Care Appeals received notification of 69 suspensions compared to 79 in 2018/19. The breakdown by profession is shown in Figure 21. There were 73 suspensions still in force as at 31 March 2020. There were also 2,485 other decisions under the aforementioned regulations as shown in Figure 22.

Figure 21: Performers Lists/Pharmaceutical List suspensions by profession in 2019/20

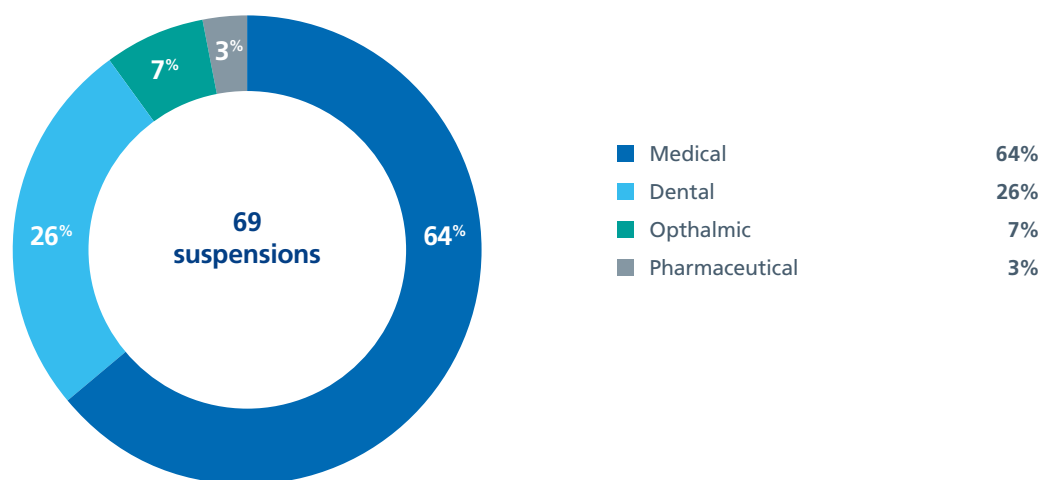
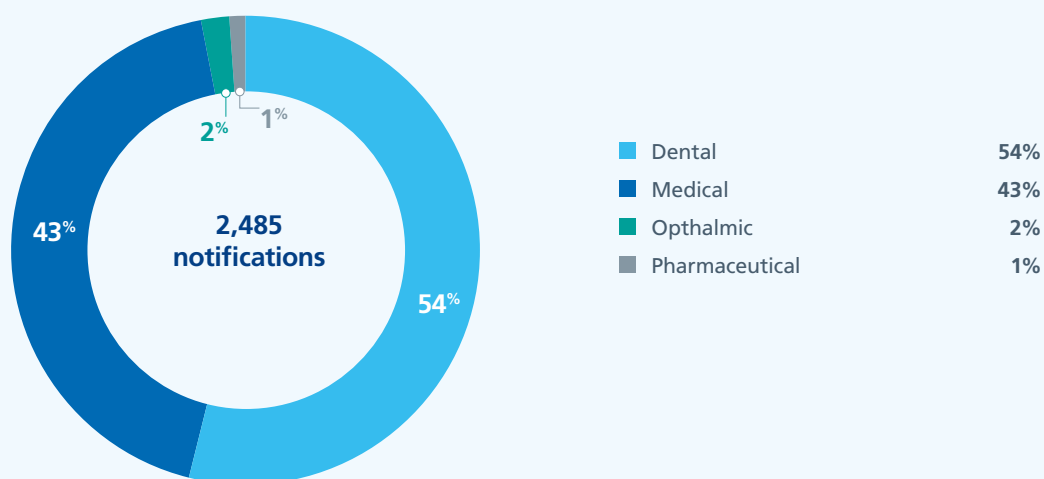


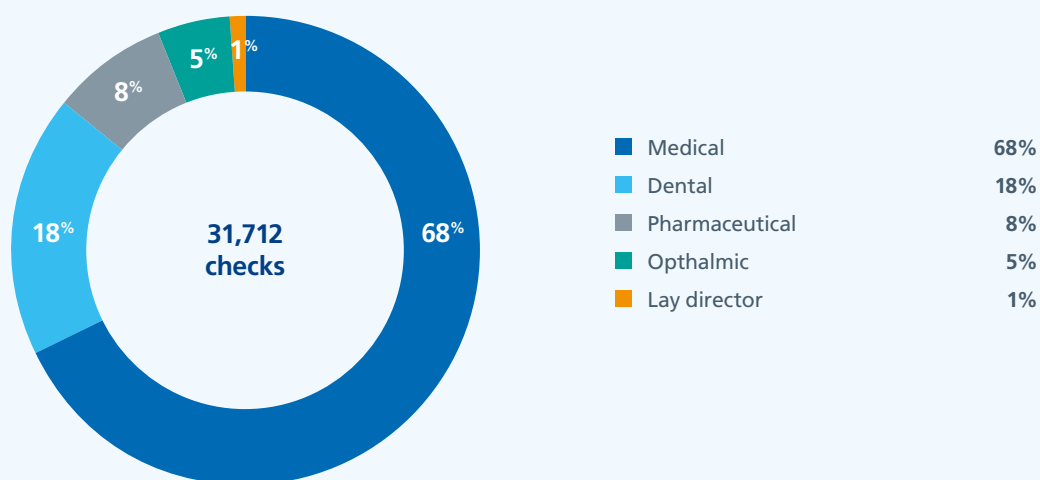
Figure 22: Performers Lists/Pharmaceutical List other notifications by profession in 2019/20



During the year, Primary Care Appeals received 31,712 requests for information compared to 2018/19 (27,982) using our secure, online checking system, which provided immediate clearance for 98% of checks.

The remaining 2% were referred to Primary Care Appeals for further analysis before disclosure. The breakdown of checks by profession is shown in Figure 23.

Figure 23: Performers Lists/Pharmaceutical List checks by profession/type in 2019/20



An example of considering multiple applications to open an NHS community pharmacy which would confer significant benefits

It was common ground between the three applicants that there should be a pharmacy for the patients of Basingstoke and in particular those in or near to Popley. The applicants argued that there was not a reasonable choice for patients and that there was difficulty in access. None of the applicants suggested that all three applications should be granted. All three applicants submitted that their own application best met the criteria under Regulation 18(2).

A comparison of the three applications would follow an assessment of the scheme of Regulation 18(2) and allow the Pharmacy Appeals Committee (the Committee) to assess the relative merits of each application to be weighed against the other.

The Committee had regard to the judgement of Mr Justice Kerr, R (*on the application of Rushport Advisory LLP*) [2016], and the comments made on granting multiple applications to the same site. The Committee considered that granting more than one application, where there was no evidence that more than one grant was required, could lead to over-provision of NHS pharmaceutical services at the expense of the public purse. The Committee therefore proceeded on the assumption that only one grant was necessary to secure improvements or better access. After considering the relative merits of each application, the Committee would therefore determine which application should be granted.

Applicants 1 and 2 placed greater reliance on the residential areas to the south of Popley Way. Applicant 3 placed emphasis on the residents to the north of Popley Way and the new-build premises. It was apparent to the Committee that the premises to the south of Popley Way were more likely to be dwellings with less affluent patients. The homes immediately north of Popley Way were slightly better quality and those further north/west of applicant 3's location were generally of a higher quality.

The Committee considered access, deprivation and the fact that a pharmacy had existed at/near to two of the applications and that while that may have provided convenience, it was satisfied that a pharmacy at the surgery was used because patients needed it and/or they exercised a reasonable choice. In assessing the 'draw' to applicant 3's location, it was concluded there would be little reason for residents to the south of Popley Way to travel to this location. The lack of facilities and the journey were more likely to be a disincentive and/or barrier to accessing pharmaceutical services. Having come to the above conclusions the Committee was satisfied that a pharmacy to the south of Popley Way (applicant 1 or 2) in the more deprived area close to where patients would be attending their GP surgery would be of significant benefit to significantly more local residents.

On the matter of which of the two applications should be granted, applicant 2 offered one more weekday core hour (1pm–2pm) and a supplementary hour on Saturday (1pm–2pm). However, the Committee found no suggestion that a large cohort of patients, or patients in work or with particular illnesses, attended during the lunch hour and in this respect the apparent benefit had the appearance of a paper exercise rather than a properly researched benefit. In other respects both providers offered the same or similar services.

Crucially, applicant 1 was supported by the GPs and managers at the surgery whose pharmacist partner had been working with each other and their planning for this joint venture was at an advanced stage. They had secured premises with a long-term lease and were in a position to set up the new pharmacy within a short period of time. They had a shared vision for the future provision of integrated services. In contrast, the surgery and/or the landlord of the premises had had no such discussions with applicant 2. As a result applicant 1 was granted.

A fit-for-purpose organisation

Throughout the year we have continued to plan for and make innovations and improvements in the way we deliver our operations to make sure that we are as efficient and effective as possible.

The way we work

Ways of Working

As part of the government hub strategy we are due to relocate from Buckingham Palace Road into a London-based hub during 2021. We are working closely with our staff to create a more agile work culture in line with the government smarter working policy and engaging with the Places for Growth Programme: driving growth across the UK. To support this policy we have also expanded our office space in Leeds, moving to a new office at Arena Point. This has allowed us to increase our recruitment activities outside of London and establish and extend our Claims Management service there.

We also need to further modify our ways of working to better align to wider NHS and central government objectives around smart working and estate cost management. Our Ways of Working programme seeks to ensure our work environment will be inspiring, innovative and productive, supported by reliable technology, enabling us to choose smarter work styles which have been co-designed with staff and support our growing organisation. This will enable us to deliver our strategy, encourage a more inclusive and collaborative culture and provide the best service to our stakeholders, members and customers. The programme began this year, extensively invoking co-design across the organisation, and will continue at pace in the year ahead.



New approaches to training and talent management

As an organisation we are committed to investment in staff development and the creation of career progression pathways in order to 'grow our own' talent.

Apprenticeship scheme

In August 2019, we launched a junior case manager apprenticeship programme, which is an entry-level opportunity to join the Claims Management team as a claims handler under a supportive coaching, mentoring and training programme. The programme is part of our ongoing commitment to investing in staff development and in creating career progression pathways to grow our own talent. We welcomed our first team of junior case managers on 18 November 2019. Our current cohort of junior case managers are undertaking the Insurance Professional Level 4 Apprenticeship. This combines practical on-the-job training while studying with an external training provider, leading to a CII Diploma in Insurance, which will be awarded upon the successful completion of the training. At the same time the junior case managers will work closely with our claims teams, handling cases with support, allowing them to put their training directly into practice. After completion of training the junior case managers will have the opportunity to progress to interview for the role of case manager.

Talent management framework/staff development

In line with our strategic focus, we continue to develop a talent management framework to attract, identify, develop and retain future leaders in order to nurture our people and deliver our business aims. In addition to the delivery of our leadership programme and ongoing technical training, we have conducted a comprehensive training needs analysis with a key focus on competencies and behaviours, aligned with our values. Training and developmental matrices have been created on a role-by-role basis, defining the requirements of each role and the training and the support available to maximise potential and to support our handlers to take a more customer and patient-focused approach. A key component of this has been enabling our claims handlers to take a more compassionate and personalised approach in their dealings with patients, through specialist training in empathic communication. Because of the nature of our work, our staff are sometimes on the receiving end of distressing and emotional communications. We continue to provide guidance and training for our staff to be able to handle these situations with sensitivity, at the same time providing support to underpin staff wellbeing.

Systems

Core systems review

Since the launch of our five-year strategy in 2017, we have been reviewing our information needs to meet our strategic priorities and how our current systems meet these. Extensive work has taken place to understand and document our business requirements. In 2019/20 we finished the discovery phase of the core system review and undertook a round of technical consultancy with Deloitte to recommend the best course of action for the organisation and the potential costs. The recommendation was to replace the core case management and document management systems and to implement new customer relationship management and business intelligence tools, which was agreed in principle by the NHS Resolution Board. As a result, we are developing a business case for funding for investment in core operating and support systems, with a view to implement the project over the next two years. In 2020/21 we aim to complete the approvals process and go to market for the new solutions.

A new finance system

During the year we implemented a new finance system with an improved interface with our claims management system to enable efficient processing of claims payments. The software has sufficient flexibility to evolve alongside our corporate needs. We have successfully implemented phase one of the system and are continuing with a second phase to allow the organisation to fully realise the benefits, which include driving through improvements in prompt payments, further training of staff on the purchasing process and implementation of an online expenses module.

Accessibility

In order to be compliant with the *Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018*, we undertook an accessibility review of our website in January/February 2020. Our accessibility review involved live testing with a sample of users with a range of impairments. As a result, we will be taking a number of recommended steps from the report to make minor improvements to improve user experience. We are committed to updating our accessibility statement and publishing the results of the review and the subsequent roadmap of improvements. In future all new developments to the website will be built with accessibility in mind from the outset and be appropriately tested before release.

IT security

We continue to utilise the Protective Domain Name Service (PDNS) provided by the National Cyber Security Centre (NCSC) and have extended its use to our Crown Commercial Services sourced Datacentres. We are working with NCSC and NHS Digital to seek further enhancements to this service and extend to our mobile devices to address some of the challenges that are posed by an agile workforce.

We have adopted and applied metrics to ensure that all NHS Digital issued CareCERT bulletins are reviewed and appropriate controls are implemented by our IT team and continue to meet these targets.

Sustainability report

NHS Resolution's main activities are run from two offices: Buckingham Palace Road, London, and Arena Point, Leeds. A move took place to larger premises in Leeds in April 2019 to accommodate the expansion of the Claims function as NHS Resolution's remit has expanded with the introduction of general practice indemnity arrangements. Both are leased as serviced offices with the landlord taking primary responsibility for providing gas, electricity, water and waste services. The service charges are built into the lease terms. This means our direct influence on energy, water and waste management is limited and therefore much of our work around sustainability is through our commitment to the wider government initiatives around smarter working, Places for Growth and the hub strategy.

In 2019/20 our IT team migrated the remainder of our IT systems to a data centre provider under a Crown Commercial Service framework, thereby substantially reducing localised energy and IT infrastructure costs. Our long-term IT plans include further cloud adoption to produce further efficiencies and better alignment with the wider government Internet First policy.

We actively promote smarter working and are redesigning our IT systems to better support this. We have flexible working arrangements in place and operate a ratio of 7 desks for 10 members of staff at the London office.

We have an ongoing initiative to work 'paperlite' and are working with our suppliers and panel firms to encourage this approach more widely. This reduces printing and the need for physical records, printer toner and their associated storage; we recycle unwanted IT equipment within the wider NHS where possible.

Climate change and rural proofing

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

Greenhouse gas (GHG) emissions

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

The scope types are:

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

Table 2: GHG emissions

GHG emissions: tonnes CO ²		2019/20	2018/19	2017/18
Gross emissions for scopes 1 and 2	As occupiers of serviced offices, we do not have any energy usage under scopes 1 and 2			
Gross emissions for scope 3	Electricity	48	52	107
	Gas	19	18	18
	Business travel	38	44	24

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

Table 3: Energy consumption

Scope 3 – Building energy consumption	2019/20		2018/19		2017/18	
	Quantity (MWh)	Cost (£)	Quantity (MWh)	Cost (£)	Quantity (MWh)	Cost (£)
Electricity	188	23,566	184	22,411	304	38,113
Natural gas	103	4,603	99	4,460	98	4,351

For 2019/20 the energy consumption data for Buckingham Palace Road is based on estimates as the landlord was not able to access the data. For all years energy consumption and cost is calculated as 10% of the whole building usage for Buckingham Palace Road – this is based on the floor area occupied by NHS Resolution.

Table 4: Travel

Scope 3 – Business travel	2019/20		2018/19		2017/18	
	Miles	Cost (£)	Miles	Cost (£)	Miles	Cost (£)
Road	47,890	29,399	42,966	23,624	46,203	25,874
Air	49,553	14,100	43,683	11,356	42,873	12,510
Rail	371,925	162,886	290,131	115,979	333,172	112,160

Table 5: Waste

Waste	2019/20		2018/19		2017/18	
	Quantity (tonnes)	Cost (£)	Quantity (tonnes)	Cost (£)	Quantity (tonnes)	Cost (£)
	12.8	549	14.6	1,805	12.7	£1,563

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

Table 6: Use of finite resources

Waste	2019/20		2018/19		2017/18	
	Quantity	Cost (£)	Quantity	Cost (£)	Quantity	Cost (£)
Water consumption	1,561 m ³	3,680	1,343 m ³	3,233	1,400 m ³	3,370
Administrative paper	1,805 reams A4 equivalent	4,099	2,500 reams A4 equivalent	5,570	2,655 reams A4 equivalent	6,662

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

The figures for energy usage, waste and water include Arena Point, Leeds, in 2019/20 for the first time as we took up full occupancy of the space in April 2019.

Finance report

Headlines



The **provision for the liabilities** arising from claims has increased by £0.7 billion from £83.4 billion to £84.1 billion. NHS Resolution's longstanding schemes reduced by £0.6 billion offset by an increase of £1.3 billion in relation to general practice indemnity liabilities recognised for the first time.



The total value of **clinical negligence claims** under the CNST scheme incurred as a result of incidents in 2019/20 was £8.3 billion, down from £8.8 billion the previous year.



The **cost of settling claims** in 2019/20 reduced by £103 million, to £2.3 billion on longstanding schemes. An additional £61.4 million was spent on settling general practice claims.



Administration costs increased by £5.0 million (19.2%) to £30.8 million. £3.2 million of this increase related to general practice claims administration.



Budget position

- Department Expenditure Limit (DEL) £96 million under budget
- Annually Managed Expenditure (AME) £5.6 billion under budget.

The two key aspects to NHS Resolution's financial activities are the provision for liabilities arising from incidents which have already happened, and in-year budgetary performance.

The overall financial picture this year shows that outlook for claims activity has improved, with inflationary expectations reducing. The cost of settling claims in-year has reduced due to the change in the PIDR from minus 0.75% to minus 0.25% on 5 August 2019, although this has been partly offset by new costs arising from the introduction of general practice indemnity arrangements.

These improvements in trends overall are reflected in the reduction in the estimated value of incidents arising from the clinical activity covered by our CNST scheme from £8.8 billion in 2018/19 to £8.3 billion in 2019/20 (see Note 2.1 to the accounts). This represents the cost of claims, both those received, and those expected to be received in the future, from incidents in 2019/20. The reduction is due to the combination of factors explained after Figure 24. The provision for liabilities has increased slightly from £83.4 billion at 31 March 2019 by £0.7 billion, to £84.1 billion at the end of this financial year, including £1.3 billion of liabilities arising from the general practice indemnity

arrangements put in place during the financial year. Liabilities for longstanding NHS Resolution schemes have reduced in value by £0.6 billion due to continued favourable trends in underlying assumptions and the change in the PIDR.

The provision is the value of liabilities arising from incidents that occurred before 31 March 2020 at current prices, both in relation to claims received and our estimate of claims that we are likely to receive in the future from those incidents which have occurred but have yet to be reported as claims (incurred but not reported, IBNR).

Figure 24: Change in NHS Resolution provisions for all schemes

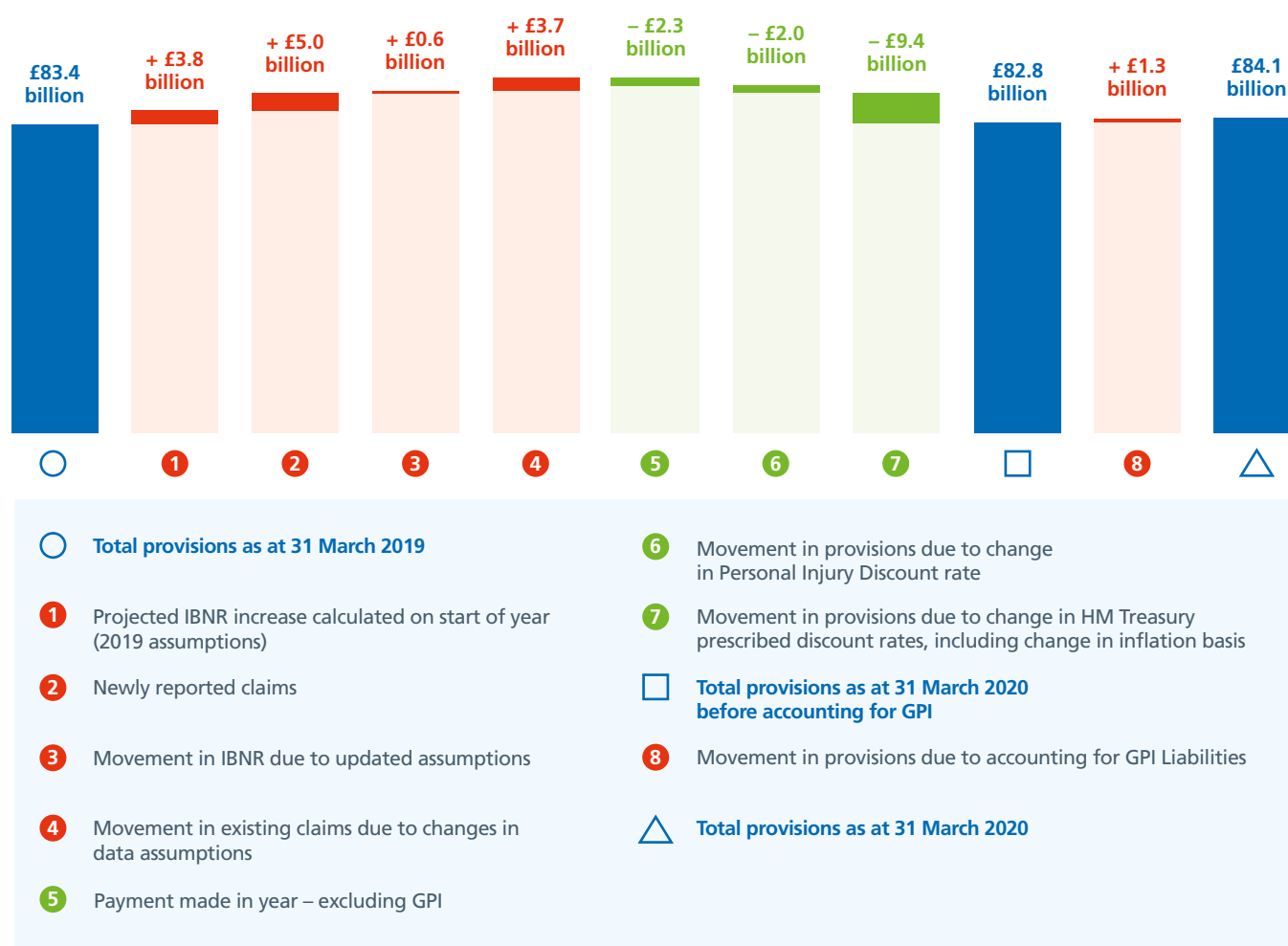


Figure 24 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

Items 1 and 2

Liabilities from another year's worth of activity for all schemes for all incident years are £8.8 billion.

The value of known claims received during 2019/20 was £5 billion, £1.3 billion more than in 2018/19.

This increase is driven by a higher volume of clinical claims received, with a greater proportion being of a high value.

Item 3

Shows an increase of £0.6 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this increase in the IBNR are:

- An increase of £1.2 billion relates to a small decrease in the probability of successfully defending claims assumptions despite slightly reduced claims volumes
- A fall of £0.6 billion due to reductions in average costs of claims assumptions.

Item 4

The liability has increased by £3.7 billion in respect of changes in assumptions affecting known claims:

- A net increase of £4 billion relates to claims that were open at 31 March 2019 and remain open at 31 March 2020. This is due to reserve values, estimated settlement year and probability of success of individual claims being revised as more information becomes available
- A decrease of £281 million in the liability relates to claims closed during the year, either at a lower value than expected, or where the claim was repudiated.

Item 5

£2.3 billion was paid out during the financial year to settle claims. This is lower than the amount we receive in claims from another year's worth of activity (Items 1 and 2) partly because we generally settle high value cases where ongoing care is a feature, with a periodical payment order (PPO). This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2014/15), the number of PPOs in payment was 1,634 with £138 million paid out that year, and a whole life value of £4.6 billion. At the end of this financial year, the equivalent figures were 2,318, £271 million and £18.7 billion respectively. Many of those types of cases involve long life expectancy, so the liability will continue to grow for some time, as each year we add another year's worth of activity to the existing claims book.

Item 6

The provision has decreased by £2 billion due to the increase in the PIDR from minus 0.75% to minus 0.25% in August 2019. The decrease in the provision value is relatively small because the PIDR is used in the calculation of certain elements of lump sum damages payments, while a significant proportion of the provision relates to structured settlement payments (i.e. regular payments to claimants continuing for life under a PPO and, to a lesser extent, legal costs, which are not affected by the PIDR).

Item 7

The largest element of the change in the provision is a reduction of £9.4 billion (of which £6.1 billion relates to IBNR and £3.3 billion to known claims) due to changes in financial assumptions. HM Treasury discount rates (which are applied to give liabilities expected to be settled in the future a value at today's prices) have changed very little for this financial year.

However, the inflation rates used to adjust observed claims inflation assumptions for future expectations in inflation have changed in two ways:

- Around 61% of the £9.4 billion movement reflects reductions in inflationary expectations over the year. The expected difference between past and future increases in the Retail Prices Index (RPI), which has previously been used to adjust observed claims inflation rates, has reduced from 0.6% in 2018/19 to 0.35% in 2019/20
- The remaining portion relates to a refinement in the derivation of financial assumptions in response to developments during 2019 about the future calculation of the RPI. During 2019, the UK Statistics Authority announced that it intended to consult on changes to the calculation of RPI. In view of the increased likelihood that the future calculation of RPI will be inconsistent with its past measurement, this adjustment for any differences in general inflation has been derived this year relative to the Office for Budget Responsibility (OBR) Consumer Prices Index (CPI) projections set out in the HM Treasury guidance on calculating general provisions. The OBR CPI projections are broadly in line with recent past CPI inflation suggesting that no adjustment to the claims inflation assumption is required (compared to a 0.35% adjustment if we had continued to use RPI for this purpose).

This has had such a big impact because claims liabilities are estimated to settle many years into the future: small changes in inflation can result in a large change in the value of the provision.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. Resulting small changes in assumptions as well as changes to discount rates reflecting the financial/market environment, as described above, can have significant impacts on the provision valuation from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail at Note 7.2 on page 186 in the Notes to the accounts section of this report.

In-year financial performance

The settlement and administration of indemnity schemes is funded by a combination of contributions from members (NHS and independent sector providers of health care, clinical commissioning groups and other DHSC ALBs), and financing from DHSC. General practice indemnity costs are funded out of the budget held by NHS England and NHS Improvement for the NHS via DHSC financing.

DHSC sets a budget in respect of this financing on a DEL basis. The DEL is a HM Treasury budgetary control²², which covers income and spending on general administration costs, e.g. salaries and goods and services, but also the settlement (utilisation) of the provisions in the financial year. This is different to the increase in the provision that is recorded in the Statement of Comprehensive Net Expenditure, which is classified as AME in the HM Treasury budgetary controls framework.

The public sector funding regime does not require NHS Resolution to have sufficient assets to cover the

long-term liabilities as these will be financed through government borrowing and taxation at the time they become due for settlement. Therefore, NHS Resolution only collects the cash needed to settle claims in the financial year in question.

The PIDR, which is used by the courts to place a current value on claims settlements where there is an element of future loss, changed in August 2019 resulting in a reduction in the cost of in-year settlements compared to the previous financial year. However this has still added £271 million to the cost of settlements compared to when the rate was set at 2.5% prior to March 2017. Additional funding has continued to be provided during 2019/20 for this by DHSC rather than passing on costs to scheme members.

Expenditure on clinical schemes against income and budget set by DHSC is shown in Table 7. These costs include NHS Resolution's own administration costs.

Table 7: Clinical schemes financial performance

	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	Percentage under / (over)spend
Member funded – CNST	1,951	1,913	38	2%
PIDR funding – CNST	295	260	35	12%
DHSC funded schemes	117	95	22	18%
PIDR funding – DHSC schemes	17	10	7	41%
General Practice Indemnity arrangements	58	65	(7)	(11%)
Total clinical schemes	2,438	2,343	95	4%

²² HM Treasury Consolidated Budgeting Guidance can be found at <https://www.gov.uk/government/publications/consolidated-budgeting-guidance-2017-to-2018>.

Contributions from members for our largest scheme, CNST, decreased by 2.1% from 2018/19, while expenditure increased by 2% on the member-funded element of costs, resulting in a small (£38 million/2%) underspend.

During the year expenditure on damages on clinical schemes reduced by £20 million compared to the previous year. This excludes PIDR costs and £40 million spent on settling general practice indemnity claims. This is a change in pattern from previous years where growth in these costs has been running at over £100 million per year.

The year-on-year reduction has been observed primarily in high value claims with total reserve estimates of over £4 million. In addition, damages payments for PPO claims have also reduced.

As can be seen from Figure 9 (the year-on-year comparison of clinical costs), claimant legal costs have increased by £55 million/12%. Of this, £21 million related to general practice indemnity arrangements recognised for the first time, and the remainder related to an increase in interim payments.

Table 8: Non-clinical schemes financial performance

	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	Percentage under / (over)spend
Member funded – LTPS	46	46	0	0%
PIDR funding – LTPS	2	1	1	50%
Member funded schemes – PES	6	6	(0)	(0%)
DHSC funded scheme	4	6	(2)	(50%)
PIDR funding – DHSC scheme	1	0	1	100%
Total non-clinical schemes	59	59	(0)	(0%)

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

DHSC-funded schemes cover claims arising from organisations that are no longer in existence. Claims numbers reported, damages and legal costs have all reduced. The exception to this trend is PPO costs which have increased as the larger value cases tend to be settled on this basis. Notwithstanding

inflationary pressures, we would expect the costs arising under these schemes to reduce over time as existing claims are settled, and the likelihood of new claims diminishes.

This is the first year of operation of indemnity arrangements for general practice. It is expected that the volume of claims and costs for the CNSGP scheme (for liabilities from 1 April 2019) will increase over time, while existing liabilities decrease as new claims volumes reduce and claims are settled.

NHS Resolution also has a budget for AME. This is to cover expenditure on volatile or difficult-to-manage budget items, and is set on an annual basis.

NHS Resolution's AME expenditure is in respect of the net movement in provisions for all of the indemnity schemes, i.e. the change in the provision less any provisions settled in the year. Performance against budget is forecast in line with the Parliamentary timetable, but this is before the work on setting the key assumptions from observed experience has commenced. Prudent estimates in relation to key potential variables are therefore used to inform the budget, in discussion with DHSC and HM Treasury.

As noted above, some favourable movements in key assumptions, most significantly financial assumptions in relation to future inflation rates, have had a positive impact on AME expenditure this year, contributing to a £5.6 billion underspend.

Table 9: Annually Managed Expenditure

	(£m)	(£m)
Budget		6,300
Expenditure		
Cost of new claims provision	12,439	
Change in discount rate	(9,832)	
Settlement of provisions	(2,380)	
Total expenditure		678
Under / (over spend)		5,622

Administration costs

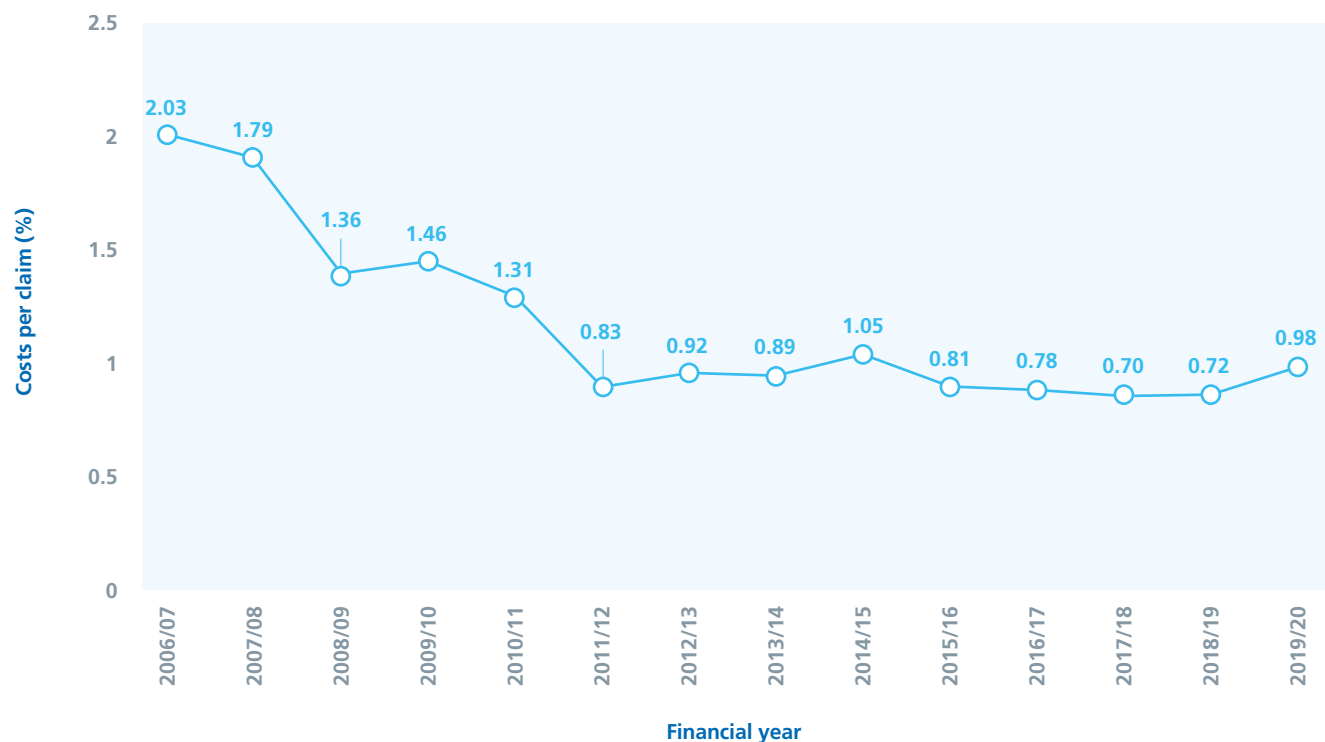
Administration costs for all of our activities (including the costs of administering member-funded schemes and General Practice indemnity arrangements which have been allocated to the scheme DEL budgets above) have increased by £5 million (19.2%) to £30.8 million. This primarily relates to staffing costs, as full-time equivalent staff numbers have increased by 35 (12%) to 328. We have expanded our management team at deputy director level to lead our expanded operations and enhance our succession planning arrangements.

Investment in our change programme has also increased, with independent advice being brought in to key projects to support the development of our plans for infrastructure and operational transformation.

In addition, this year we have generated £1.0 million (£1.1 million in 2018/19) of income from commercial activity, primarily in respect of education activities and services to other national governments delivered by our Practitioner Performance Advice service. These activities made a small loss of £23k (2%) during the year.

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

Figure 25: Administration spend as a percentage of annual total claims settlement costs



As a proportion of the value of total claims settlements, administration costs have increased from 0.72% to 0.98%. This reflects the increase in administration costs, but also the reduction in claims settlement costs experienced this year, despite having expanded our operations to include indemnity for general practice.

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

Capital

The budget for capital purchases for the year was £1,390k, and total spend for the year was £645k, an underspend of £745k. The underspend is due in part to the decision to engage consultancy advice on the review of our core IT systems – the budget estimate allowed for some implementation costs during the year which consequently did not take place. We also reviewed other projects during the year which did not proceed in line with the expectations in the budget.

Cash

The cash balance at the start of the year was £182 million. This had arisen because of underspends in recent years on the schemes we operate, primarily on CNST, as described earlier in this report.

The balance has reduced to £120 million by the end of the year despite incurring a further underspend on clinical schemes. We have discussed with DHSC the options for utilising cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. In these circumstances, we have agreed with DHSC to utilise cash balances to fund PIDR costs in relation to each of the schemes up to the limit of cash available. DEL budgetary cover has been provided by DHSC as described above.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2019/20.



Helen Vernon

Chief Executive and Accounting Officer

Date: Wednesday 8 July 2020



Accountability report

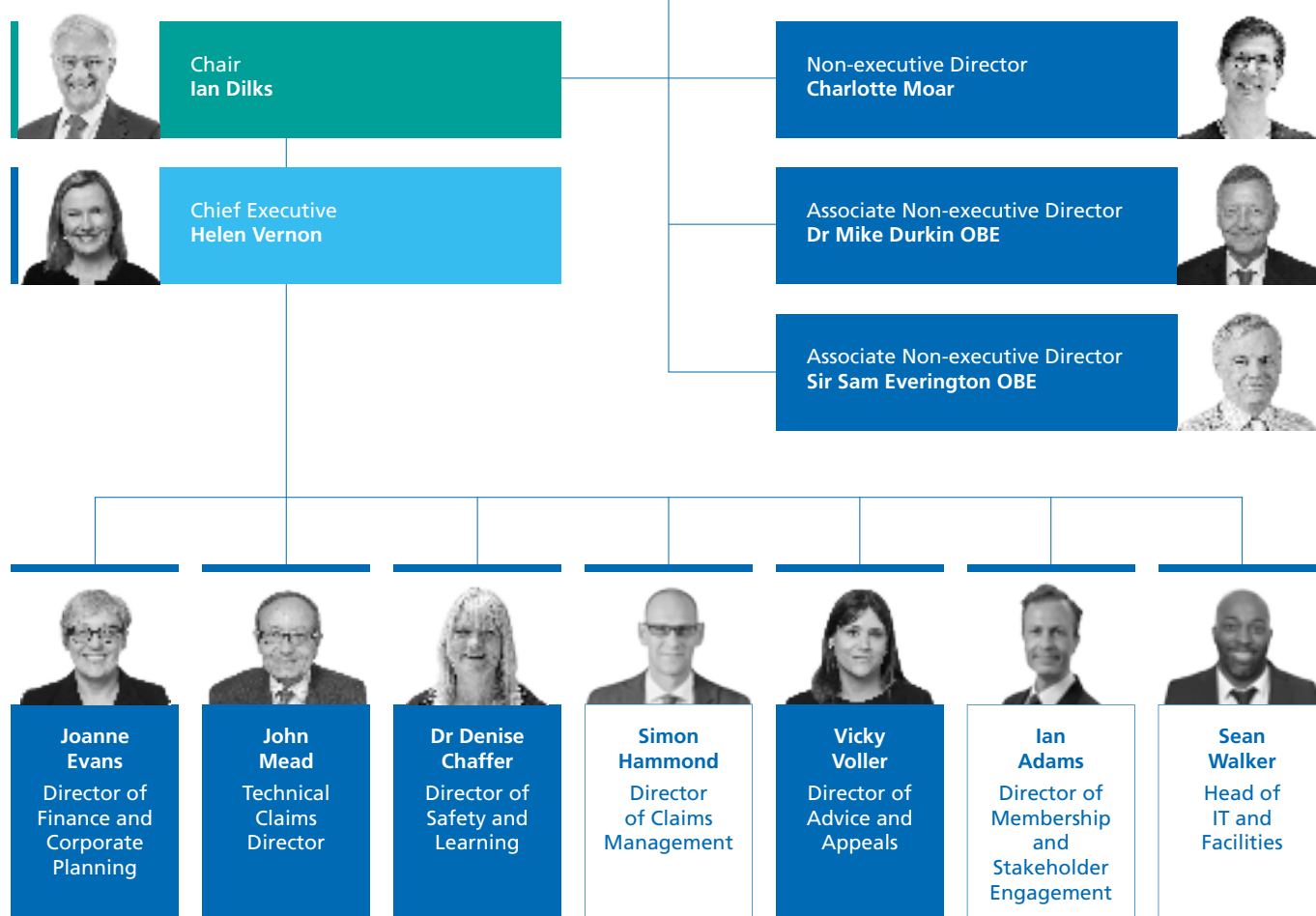
Corporate Governance Report

Directors' report

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

Figure 26: Who we are

 Board members
  Board members
  Non-board members



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

Statement of Accounting Officer's responsibilities

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

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

- observe the Accounts Direction issued by the Secretary of State for Health and Social Care, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the annual report and accounts as a whole is fair, balanced and understandable and take personal responsibility for the annual report and accounts and the judgements required for determining that it is fair, balanced and understandable.

The Accounting Officer of DHSC has designated the Chief Executive as Accounting Officer of NHS Resolution. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding NHS Resolution's assets, are set out in *Managing Public Money* published by the HM Treasury.

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

Governance Statement

Scope of responsibility

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

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

- compliance with and delivery against NHS Resolution's 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
- NHS Resolution's operational and financial systems.

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

NHS Resolution's PEER values

Professional

We are dedicated to providing a professional, high-quality service, working flexibly to find effective and efficient solutions.

Expert

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

Ethical

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

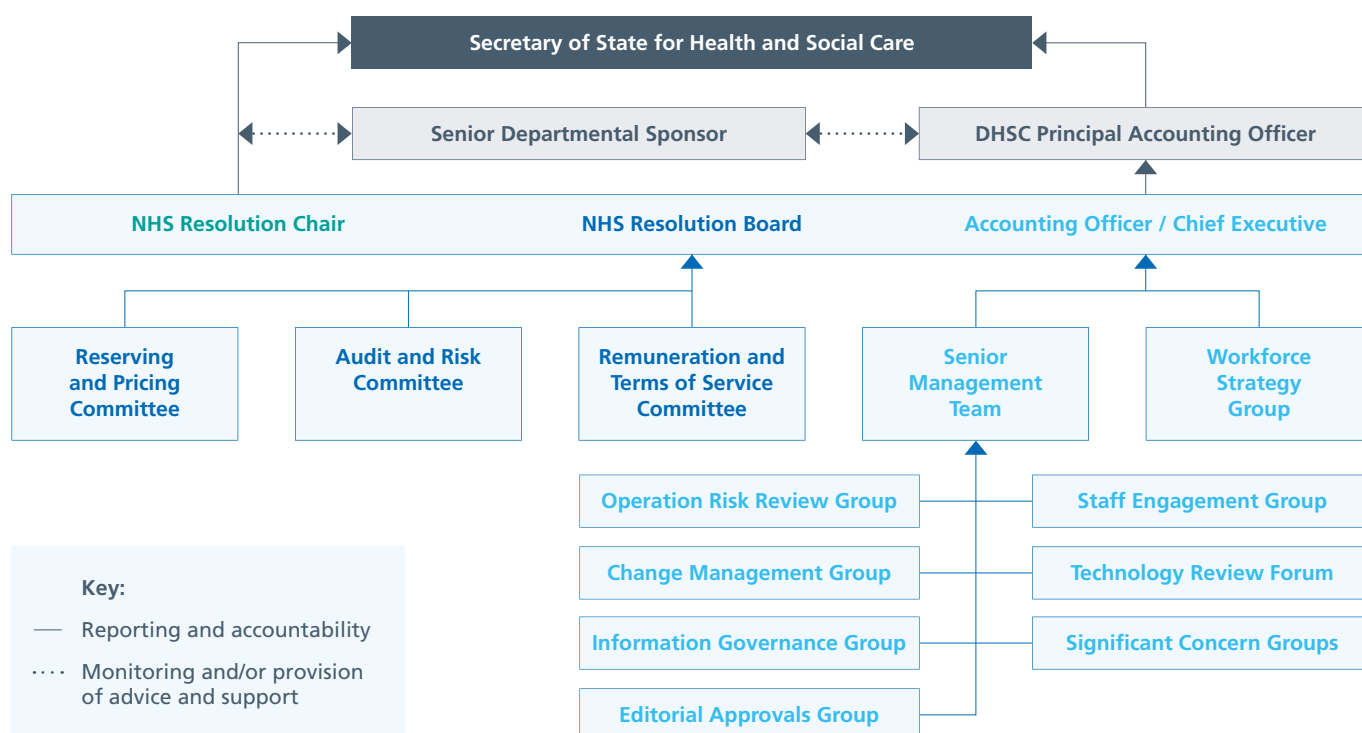
Respectful

We treat people with consideration and respect, and encourage supporting, collaborative and inclusive team working.

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

The governance framework and structures

Figure 27: NHS Resolution governance structure and subgroups reporting to the SMT



The NHS Resolution Board

As of 31 March 2020 the Board consisted of the non-executive Chair, four non-executive members and four executive members. There are also two associate non-executive and one associate director.

Mike Pinkerton was reappointed for a period of three years with effect from 16 January 2020. Mike Durkin's appointment as Associate Non-executive Director was extended for a further 12 months with effect from 1 July 2019. Both appointments provide continuity for the NHS Resolution Board.

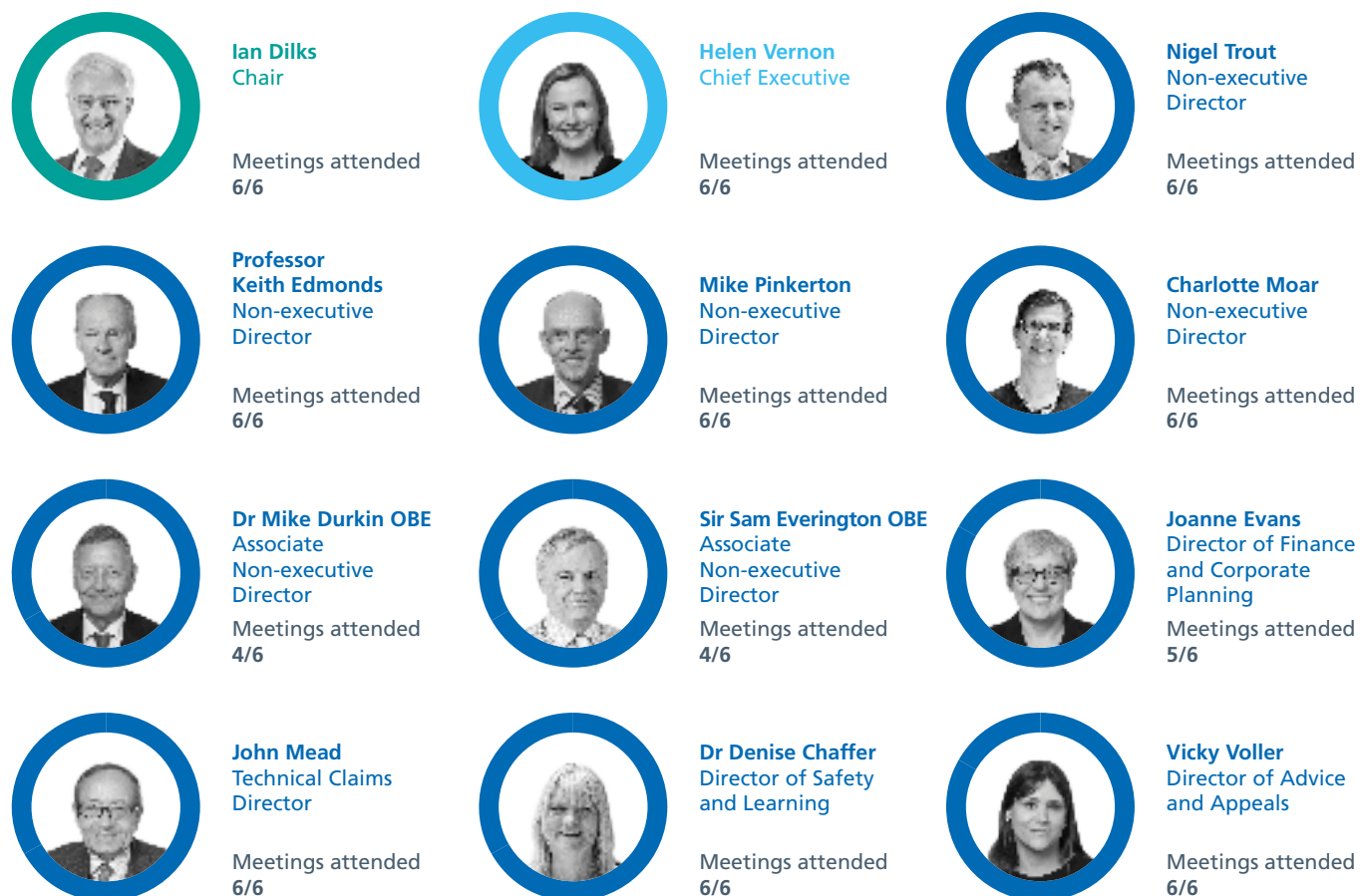
There is also the option of appointing between three and five non-executive directors and executive directors.

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

I report on the organisation's performance to the Board and to DHSC on a regular basis in accordance with the Framework Agreement with DHSC. Financial risk is considered by the Reserving and Pricing Committee (RPC) and SMT, both of which I chair, and is also reported on to the Board and DHSC. Variations from anticipated performance are, where appropriate, accompanied by reports from the Audit and Risk Committee (ARC) and/or Senior Management Team (SMT), to give me, the Board and, where appropriate, DHSC, assurance on progress and the action being taken. The Board regularly reviews these reports to ensure it remains satisfied regarding the quality of information, and also that it is relevant and sufficient to inform the business of the Board. For example, the Board requested a report on the principles governing the re-tender of the contract for legal services.

During the period from 1 April 2019 to 31 March 2020 our Board met on six occasions and attendance details are as follows.

Figure 28: Board meeting attendance



Over the year some of the topics considered at the Board meetings included:

Figure 29: Frequency of key matters discussed through the year at Board meetings



Compliance with the corporate governance code

While we are not required to comply with the UK Corporate Governance Code, the Board and its Committees has due regard to the principles set out in the Code. Effectiveness reviews of the Board and ARC Committee take the Code into account.

Board effectiveness

A Board Effectiveness review carried out in 2019 by an independent facilitator concluded the Board had a clear sense of common purpose, and agreed the areas of further growth for NHS Resolution. The Board are taking forward an action plan for the areas of further development which include:

- leading the evolution of our culture to support our role as a 'system leader' in reducing claims costs by taking an holistic approach to drivers of cost such as patient safety; and
- confirming that the Board's governance structure fully supports its work as a high-performing team to oversee delivery of the five-year strategy across the whole primary and secondary patient pathway.

The Board updated this review at the end of the year, using a framework agreed in 2019, which confirmed that the Board continues to be effective, complies with all relevant guidance and has made progress in the areas identified last year where improvements could be made.

Committees of the Board

The Board is supported by three committees which were established to enable the Board and myself as Accounting Officer to discharge our responsibilities and to ensure that effective financial stewardship and internal controls are in place. A review of the terms of reference for the three committees was carried out in 2019/20 to assure their fitness-for-purpose.

Audit and Risk Committee

The ARC supports me and the Board in our responsibilities on matters related to internal and external audit, corporate governance, anti-fraud policies, internal control and risk management, and the NHS Resolution's annual report and accounts.

The ARC is chaired by a non-executive director, and is supported in delivery of its function by internal and external auditors. The ARC is attended regularly by a representative of DHSC. The Chair of DHSC's ARC attended the ARC meeting in June 2019. In 2019/20 there was a change of non-executive director to the membership. There was no gap in the membership, therefore this change had no impact on the function of the Committee. ARC has two independent lay members.

Table 10: Audit and Risk Committee meeting attendance

Name	Post	Meetings attended
Charlotte Moar	Non-executive Director and Chair of ARC	4/4
Keith Edmonds (last meeting was 16 October 2019)	Non-executive Director	3/3
Mike Pinkerton (first meeting was 16 October 2019)	Non-executive Director	2/2
Charles Bellringer	Independent Lay Member	3/4
Julia Wortley	Independent Lay Member	4/4

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

- Reviewing the Annual report and accounts including the governance statement.
- Scrutinising risks which are outside the risk appetite statement and reviewing plans and timescales to redress these.
- Receiving updates on incidents and the overall position in relation to cyber security.
- Deep dives into particular areas of risk including general practice indemnity, Practitioner Performance Advice, the implementation of the new finance system, contract management of the core claims system and cyber security.
- Receiving updates on progress towards achieving and sustaining ISO 27001 and other information governance requirements as well as reports on health and safety and freedom to speak up compliance.
- Reviewing the Standing Financial Instructions and Standing Orders and recommending them to the Board.
- Through the Chair of the Committee, scrutinising the arrangements for providing DHSC with forecasts for the AME budget.
- Requesting assurance that NHS Resolution had arrangements in place to ensure compliance with all DHSC regulations. Work to produce a comprehensive list of these is complete and an assurance mapping is now underway.

ARC effectiveness

In December 2019 ARC members and other key attendees completed a self-effectiveness questionnaire. The results indicated that there was a clear understanding of the ARC's role, the agendas were structured, there was challenge in relation to the risk framework and there was effective engagement with internal and external audit. The opportunities to build further effectiveness were in relation to the balance of challenge and support, wider use of assurance mapping, and consideration of the focus of discussion for ARC and Board reporting in relation to risks, key controls and treatment plans in line with the risk appetite. An action plan will be developed during 2020/21.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee whose role includes the determination of the remuneration, benefits and terms of services of all posts covered by the Pay Framework for Executive and Senior Managers (ESM). All meetings were quorate. The committee fulfilled its responsibilities in line with its terms of reference. Further detail in relation to remuneration can be found on page 134 and in the financial statements section from page 159.

Reserving and Pricing Committee

I chair an internal RPC with membership comprised of the Director of Finance and Corporate Planning, Director of Claims, Head of Reserving and Pricing and a non-executive director, currently our Chair. The Committee is attended by our actuarial advisers from the Government Actuary's Department. During the year, the Government Actuary declared a conflict as he was acting as the advisor to the Lord Chancellor and withdrew from RPC meetings during the period that work was underway to set the PIDR.

The Committee meets regularly in order to:

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

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

I, Martin Clarke, am Government Actuary and a Fellow of the Institute and Faculty of Actuaries.

In my opinion, the IBNR provisions for NHS Resolution as at 31 March 2020 to be included in NHS Resolution's report and accounts have been calculated using an appropriate actuarial methodology and assumptions which are within a reasonable range, given the purpose of the calculation and taking into account discussions held with NHS Resolution's Reserving and Pricing Committee. The actuarial assumptions were selected on a best estimate basis, with explicit adjustment for risk and uncertainty included within the claims inflation assumption. There are no such margins included elsewhere in the assumptions. I have calculated the IBNR provisions to be £46,536 million for all schemes combined (including Existing Liabilities for General Practice indemnity claims, ELGP) as at 31 March 2020 using the method and assumptions selected by NHS Resolution. This opinion statement should be considered in the context of my advice to the Reserving and Pricing Committee.

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

Senior Management Team

The Senior Management Team (SMT) includes directors and heads of the operating areas in the organisation. SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which SMT oversight or approval is required, including resource management and planning, governance arrangements, complaints and stakeholder management. The SMT reviews particular areas of NHS Resolution's activity or areas of development and considers any changes in the external environment that may have an impact on NHS Resolution and its services.

There are regular risk review sessions to ensure we have controls and treatments in place to mitigate risks and bring them within appetite. During the year, SMT held a series of sessions to review and refresh the five-year strategy as well as producing a business plan for 2020/21. I report on the work of the SMT to the Board and hold members of the SMT to account for delivering against agreed objectives which are linked to delivery of NHS Resolution's strategy and business plan.

Table 11: SMT subgroups

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

The control environment

The system of internal control is designed to eliminate risk, where possible, and manage residual risk to a reasonable level, rather than to eliminate all risk of failure to achieve objectives. Therefore, it provides a reasonable and not absolute assurance of effectiveness. The top five key risks to our organisation are set out as follows with some of the key controls we have in place to manage those risks.

Capacity to handle risk

Through our risk management framework we regularly considered the risks and issues that could have an impact on the achievement of our business objectives. This included consideration of the controls we have in place to mitigate those risks and then, where required, develop plans to bring those risks within appetite. Within the framework we have a strategic risk register which reflects those risks that could have an impact on the delivery of our strategy; this is reviewed regularly by SMT. ORG are charged with the review of corporate operational risks that may impact the delivery of our business plan as well as business-as-usual matters.

Risk reporting and escalation is set out in our risk management policy and procedure which is published on our website: <https://resolution.nhs.uk/governance-policies/risk-management>

Table 12: Our top five risks linked to strategic aims and the controls in place to mitigate them

Strategic aim	Identify Risk identified as potential threat (or opportunity) to the achievement of NHS Resolution objectives	Risk management Key controls in place to mitigate the risk
All strategic aims	IT infrastructure NHS Resolution's core systems become obsolete.	- Core Systems Review Project Board - Core systems review undertaken and consultancy expertise commissioned to advise on the risks and future state architecture.
All strategic aims	Cyber security Data security and integrity is compromised, for example: through cyber-attack or unauthorised/inappropriate disclosure of data.	- IT policies and procedures in place - System controls including firewalls - IG group review metrics for virus incident log - IG group review incidents and take forward learning - IG reports to SMT, ARC and the Board - External company carry out regular penetration tests and report findings and improvements - Internal audit reviews and deep dives - ISO 27001 certification - Cyber Essentials Plus audit and certification.
All strategic aims	Responding to the pace of change Fail to recognise and respond to changes in the environment in which NHS Resolution operates.	- Set up of Policy, Strategy and Transformation team to horizon scan and provide resource to support policy development - SMT strategy session discussions of emerging topics - Membership of Cross Government Strategy steering committee and working group - Monitoring and evaluation of developments in models of care - Monitoring and evaluation of the maternity incentive scheme.
All strategic aims	Failure to deliver core business and change projects because of the scale of transformational activity underway.	- SMT and Board overview of transformation proposals - ORG review of delivery against business plan - CMG oversight of programme and portfolio delivery.
Help the system, organisations and individuals identify and address issues. Work in partnership with other ALBs, NHS trusts, patients and healthcare staff to improve the way in which the NHS responds to incidents.	Raising concerns Failure to appropriately act on significant concerns where we identify through our work that patient/staff safety and public protection are or have the potential to be compromised.	- Early Notification scheme launched for maternity - Incentivisation of members to identify concerns early - Significant Concerns Group and frameworks in place.

Through the regular review of the risk register and the assessment of the controls and required treatments, we were able to assess how treatment plans have contributed to any reduction of risk impact and/or likelihood of occurrence. We also considered changes to description of the risks to ensure they reflect the environment we operate in and are within our control, one such risk being failure to recognise and respond to changes in the environment in which we operate.

Where key issues have arisen we considered whether the current controls in place could be strengthened to reduce the likelihood of a reoccurrence and major impact on the organisation. One issue that arose in 2019/20 that required immediate action was the occurrence of system bugs following an IT development deployment. While the system issues did not result in incorrect information being made available to users of our services, there was an impact from the operational effort required to address the system bugs. It was recognised that improvements were required in the model of delivery of IT development work set out in the contract with the supplier. To support us with this we commissioned independent consultancy to review the current contract, which has resulted in a new way of working with the supplier.

Risk appetite

The Board have developed and continue to review the statement of risk appetite. The Board's approach is to minimise its exposure to risk in relation to the delivery of its operations and compliance with good standards of governance. The Board is prepared to accept a greater degree of risk in relation to our position and role in the health system, given the increasingly financially challenging environment the NHS is operating within and the need to work with other organisations to address this challenge on several fronts.

As an organisation we recognise that the introduction of new technology presents clear opportunities to adapt and develop services within the NHS. With this comes different risks to which we need to respond and consider mitigations. To support this we will continue to work with our strategic partners including NHSX and NHS Digital.

Management assurance

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

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.

Table 13: Internal Audit carried out eight reviews in the financial year

Audit title	Assurance
Strategic and corporate planning	Moderate
Business continuity	Moderate
Key financial controls	Moderate
HR key controls	Moderate
Practitioner Performance Advice	Moderate
Data quality	Moderate
Technology change	Moderate
General practice indemnity	Substantial
Follow up of outstanding internal audit recommendations	Reasonable progress
The Head of Internal Audit gave moderate assurance to the Accounting Officer that NHS Resolution has had adequate and effective systems of control, governance and risk management in place for the reporting year 2019/20.	

Performance and financial controls

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

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

Anti-fraud, bribery and corruption

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of our work inevitably focuses our attention on the risk of fraudulent claims being brought against our members, and we take a zero-tolerance stance towards fraud and bribery. We have in place an up-to-date Anti-fraud, bribery & corruption policy and procedure advising staff on how to recognise and deal with potential instances of fraud and bribery. We continue to have in place a counter fraud team who work in accordance with the NHS Counter Fraud Authority Standards for Providers to prevent, deter, detect and investigate fraud and bribery.

During 2019/20 we have also worked closely with our colleagues in the NHS Counter Fraud Authority, DHSC and the Cabinet Office in the adoption of the Government Counter Fraud Functional Standard GovS013.

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

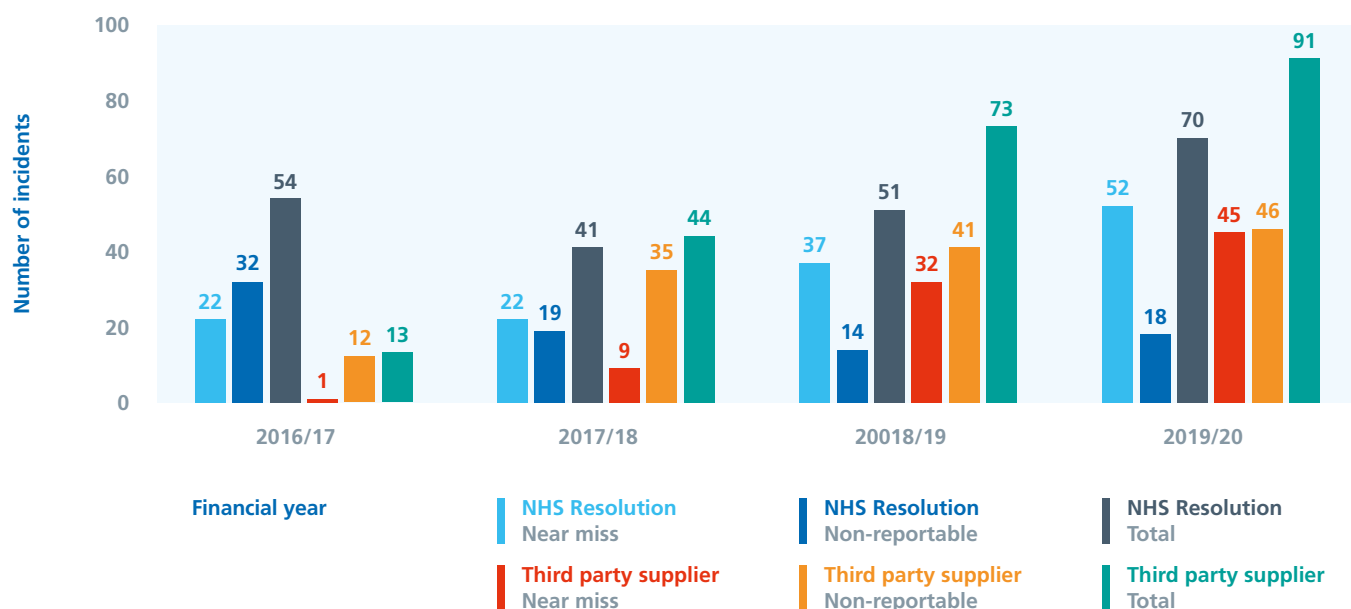
Business continuity

Effective business continuity arrangements are a key control to ensure we can respond to and recover from major operating disruptions which would seriously impact the organisation's ability to conduct its critical business operations for a significant period of time. During the year we have continued to maintain, develop and test our business continuity plans with external expert support, and activated those procedures to prepare for and respond to the current Covid-19 pandemic. As a result our business operations were successfully transferred to a fully remote working basis.

Information security and governance

We have maintained ISO 27001 information security certification which provides evidence that we have an effective information security management system. We have also achieved Cyber Essential Plus certification which is a UK government scheme of good practice in information security. We are committed to minimising the risks associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to information governance. During the year, we submitted our annual return on the NHS Digital Information Governance toolkit and as part of this 96% of staff completed and passed our mandatory bespoke IG eLearning training.

Figure 30: Information governance incidents reported between 2016/17 and 2019/20 by severity



During this year, there were 70 information governance incidents recorded by NHS Resolution, of which 52 were 'near misses'. A 'near miss' is defined as an incident that did not lead to harm, loss or damage, but could have done, and is reported in order that we can learn from the near miss occurrence.

We have as previously recorded separately information governance incidents notified to us by third party suppliers of which 45 were 'near misses'. They are reported separately where they are data controllers in their own right and we are notified when that is the case so that we can identify any remedial action to be taken and learning to be followed up through contractual arrangements. We are working with our third party suppliers to ensure root cause analysis and learning from incidents is taken forward so as to ensure mitigations are put in place to reduce the risk of such incidents occurring in the future. NHS Resolution did not have any incidents during this period which required reporting to the Information Commissioner.

The figures show a steady increase in reported near misses, which is perhaps a reflection of the continuing awareness of information security being embedded within business operations. We do not, however, wish to be complacent and do continue to learn from and encourage reporting and use examples from our incidents to shape future information governance learning, which is a mandatory requirement for all staff and Board members.

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

Responding to members of the public

Effective processes were in place throughout the year, which ensured a swift response to all public enquiries, correspondence, parliamentary questions and issues raised under Freedom of Information, Data Protection (DPA) legislation and complaints. NHS Resolution received 337 requests, ranging from journalists to clinicians and members of the public, which is almost the same in number from last year (338). The majority (75%) of these requests relate to our claims and we have published responses on our disclosure log: <https://resolution.nhs.uk/freedom-of-information>

We have also logged a large number of queries (384) from the members of our indemnity schemes for data during this period, either where we are assisting them to support FOI requests to them, or because they are seeking data to support learning. We have also updated our factsheets and our publication scheme to assist the public to find information about our organisation and our activities.

- https://resolution.nhs.uk/resources/?fwpr_resources_type=factsheet
- <https://resolution.nhs.uk/wp-content/uploads/2020/04/Freedom-of-Information-Publication-scheme.pdf>

We seek to be open and in the majority of cases we do provide disclosure of information in full, unless to do so would be to increase the risk of identifying claimants or others who trust us with their sensitive health information. Among the small number of cases in which we have withheld some information as part of the disclosure, two cases were reported to the Information Commissioner during this period, and our decisions to withhold information were upheld (on legal and confidentiality grounds).

Going forward, we are also undertaking further work to publish more regular reporting of data that are being commonly requested.

Data Protection Requests

NHS Resolution receives two types of requests under the DPA: Subject Access Requests (SARs) giving individuals the right to request any information held about themselves; and requests for information for the prevention and detection of crime. During this period we received 89 SAR requests, which is a small increase from last year (78), half of which relate to Practitioner Performance Advice (51%). The remaining are requests for information for our claims function, our corporate functions or where members of the public have requested information that is not held by NHS Resolution.

We received 15 requests for information for the prevention and detection of crime, ranging from the police to other insurers.

Complaints and feedback

From 1 April 2019 to 31 March 2020 we received 33 complaints, which were reviewed through our formal complaints policy, of which eight were partially or totally upheld. This compares to 49 complaints logged in 2018/19. These numbers remain small relative to the volume of activity across the organisation. There have been no complaints escalated from our reviews that were referred to the Parliamentary and Health Service Ombudsman (PHSO). We do, however, take all complaints seriously.

The reduction in numbers of complaints escalated under the complaints policy we have seen during this period may be a reflection of us seeking to review complaints in a number of ways, and not just use one formal route to address concerns. An example of this is that a number of complaints relate to matters arising from the negotiation in relation to a claim. Rather than raising expectations by directing these complaints to a route which is not designed to resolve claims, we are addressing these issues through our Claims Management team responding directly to those service users, whereas previously we would try to pursue a standard route for resolving all complaints. This is in keeping with considering how best we can resolve concerns or address feedback.

During this period we have also reviewed our complaints policy in line with work undertaken by the PHSO and collaborated with the aim of improving the consistency of complaints handling. We are continuing with work to consider how we may best capture learning from all our complaints whether they are locally addressed or through our formal complaints route. Complaints are reported to our SMT and Board.

Freedom to Speak Up

We have a Freedom to Speak Up policy and have in place three Freedom to Speak Up Champions as well as a non-executive director who is the Freedom to Speak Up Officer. Over the past year the champions have used opportunities to promote the speak-up function to our staff as well as promote associated topics with real relevance to the wider speak-up community.

While there were not a significant number of Freedom to Speak Up events raised, there had been a number of conversations which highlighted some themes of concerns.

These were addressed by:

- agreeing the local application of PEER values
- liaising with SEG to consider what can be done to ensure people are recognised by name
- liaising with HR/OD to ensure the consistent application of policies.

General levels of awareness of the Speak-Up Guardians and the role they play has increased over the last year. To further the progress made, there is commitment from the Guardians, supported by SMT and ORG, to do more to embed the principles of speaking up into the culture of the organisation. The Freedom to Speak Up policy is currently under review to ensure it is consistently applied and is effective for all staff.

Health and safety

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures. Staff are required to participate in the training provided to ensure awareness. We continue to engage a health and safety adviser to review our progress against the previous year's assessment of all aspects of health and safety legislation. We have achieved a 99% rating through the work that has taken place and have actions in place to address two medium rated recommendations.

Respect for human rights

NHS Resolution fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play both in combatting it and supporting victims. In particular, we are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to date include:

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 Freedom to Speak Up – Raising Concerns policies additionally give a platform for our employees to raise concerns about poor working practices.
- We have been using social media to raise awareness and there has since been investment in training to ensure front-line practitioners are aware of and able to respond to incidents of modern slavery within care settings.

Procurement and our supply chain

- Our procurement approach follows the Crown Commercial Service standard and includes a mandatory exclusion question regarding the Modern Slavery Act 2015.
- When procuring goods and services, we additionally apply NHS Terms and Conditions. This requires suppliers to comply with relevant legislation.

NHS Pension scheme regulations

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

Procurement and contracting

We have annual plans in place to ensure that acquisitions for goods and services are supported through a robust procurement process and are completed in compliance with Public Procurement Regulations. All procurement is considered in terms of business need and is the most economically advantageous for us. We continue to develop and embed best practice in contract management to ensure we achieve good value for money on the contracts we enter into.

Statutory functions

We commissioned a piece of work to ensure compliance with all relevant statutory regulations that NHS Resolution should be functioning under and an assurance mapping exercise is being taken forward. This gives me as AO 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 us 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, and that they are in line with the recommendations as set out in the Harris Review.

In summary, I am satisfied that the framework of governance, risk management and system of internal controls are adequate and have been effectively maintained throughout 2019/20.

Remuneration and staff report

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee (the 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 (ESM). The Committee was established by NHS Resolution's Board which determines its terms of reference and met five times during the 2019/20 year. All meetings were quorate.

Figure 31: Remuneration and Terms of Service Committee meeting attendance



The Committee approved a 12-month extension of an existing Associate Non-executive Director position with effect from 1 July 2019. The annual Directors' performance reviews, presented by the Chief Executive who was in attendance, were

considered and noted by the Committee. The 2019/20 annual pay award and performance related payments were determined by the Committee based on guidance provided by DHSC and approved.

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

- Approval to extend an existing temporary additional responsibilities allowance (TARA) for an executive director to March 2020
- The performance and objectives of the Chief Executive
- Approval of the Chief Executive's salary
- Approval of management's proposed response to a staff issue
- Approval of a new ESM Grade 1 position – chief information officer and associated changes to SMT reporting lines (subject to consultation)
- Approval of a joint ESM post between NHS Resolution and DHSC
- Approval of dual office working arrangements for a director
- Approval of national clinical advisor roles including:
 - General practice advisers
 - Consultant radiologist
 - National obstetrics clinical adviser (extension to existing secondment).

The Committee considered its performance in 2019 as satisfactory and concluded that it had discharged its obligations as set out in the terms of reference. The Committee also considered that the terms of reference remain appropriate and fit for purpose.

Remuneration policy

NHS Resolution is bound by the NHS terms and conditions of service (known as Agenda for Change). With the exception of the directors who are paid in accordance with *DHSC pay framework for executive and senior managers in ALBs*, all staff are paid in accordance with Agenda for Change. During 2019/20, NHS Resolution introduced the use of the national medical and dental pay and terms and condition of service, for those positions which are deemed necessary to have a current licence to practise and/or professional membership with an appropriate body. We currently have one staff member employed under the medical and dental terms and conditions of service.

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

Full detail on the medical and dental pay and terms and conditions of service can be found on the [NHS Employers website](#). The relevant NHS Resolution policies applied during the financial year in relation to salaries were the Recruitment and selection policy and procedure (HR16) and the national NHS terms and conditions of service noted above. Allowances to staff in payment during the year other than basic salary were high cost area supplement, recruitment and retention payments (RRP), and on-call allowances for information systems and governance staff.

Remuneration for directors

The following tables provide the contractual salary and pension details of those senior managers and non-executive directors who had control over the major activities of NHS Resolution during 2019/20. Tables 14, 15 and 16 are subject to audit. There were no changes to our Board membership throughout 2019/20.

Table 14: Executive and non-executive director salaries and allowances for 2019/20

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension- related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Ian Dilks Chair	60–65	0	0	N/A	N/A	60–65
Helen Vernon¹ Chief Executive	150–155	0	5–10	0	47.5–50	205–210
Joanne Evans Director of Finance and Corporate Planning	120–125	14,800	0–5	0	27.5–30	170–175
Denise Chaffer Director of Safety and Learning	110–115	0	5–10	0	0	115–120
Vicky Voller² Director of Advice and Appeals	105–110	0	0	0	30–32.5	135–140
Keith Edmonds Non-executive Member	5–10	0	N/A	N/A	N/A	5–10
Charlotte Moar³ Non-executive Member	10–15	1,400	N/A	N/A	N/A	10–15
Mike Pinkerton⁴ Non-executive Member	5–10	3,700	N/A	N/A	N/A	10–15

Name and title	Salary	Expense payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension-related benefits	Total
	(£000s)		(£000s)	(£000s)	(£000s)	(£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Nigel Trout Non-executive Member	5–10	0	N/A	N/A	N/A	5–10
Mike Durkin⁵ Associate Non-executive Member	5-10	1,500	N/A	N/A	N/A	5–10
Sam Everington Associate Non-executive Member	5-10	0	N/A	N/A	N/A	5–10

¹ Helen Vernon had a pay increase in year and therefore full year equivalent salary is in the band £155-160k.

² Vicky Voller's post title changed to Director of Advice and Appeals from 13 December 2019.

³ Charlotte Moar is also the Chair of the ARC.

⁴ Mike Pinkerton was reappointed for a period of three years with effect from 16 January 2020.

⁵ Mike Durkin's appointment as Associate Non-executive Director was extended for a further 12 months with effect from 1 July 2019.

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

Travel and accommodation costs have been incurred by the Executive Director for journeys between the Leeds and London base following the opening of an expanded Leeds office and the relocation of that Director to Leeds.

Table 15: Executive and non-executive director salaries and allowances for 2018/19

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension- related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Ian Dilks Chair	60–65	0	0	N/A	N/A	60–65
Helen Vernon Chief Executive	145–150	0	5–10	0	20–22.5	175–180
Joanne Evans Director of Finance and Corporate Planning	120–125	0	0–5	0	27.5–30	150–155
Denise Chaffer Director of Safety and Learning	110–115	0	0	0	0	110–115
Vicky Voller¹ Director of Advice and Appeals	65–70	0	0	0	17.5–20	85–90
Keith Edmonds Non-executive Member	5–10	0	N/A	N/A	N/A	5–10
Charlotte Moar² Non-executive Member	10–15	0	N/A	N/A	N/A	10–15
Mike Pinkerton³ Non-executive Member	5–10	0	N/A	N/A	N/A	5–10

Name and title	Salary	Expense payments	Performance pay and bonuses	Long-term performance pay and bonuses	All pension-related benefits	Total
	(£000s)		(£000s)	(£000s)	(£000s)	(£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Nigel Trout Non-executive Member	5–10	0	N/A	N/A	N/A	5–10
Mike Durkin⁴ Associate Non-executive Member	5–10	1	N/A	N/A	N/A	5–10
Sam Everington⁵ Associate Non-executive Member	5–10	0	N/A	N/A	N/A	5–10

¹ Vicky Voller's post title initially changed to Director of Practitioner Performance Advice from July 2018 and then to Director of Advice and Appeals from 13 December 2019. Vicky Voller's full year equivalent salary is in the band £100k–105k.

² Charlotte Moar is also the Chair of the ARC.

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

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

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

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

Pension entitlements for executive directors

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

Table 16: Pension entitlements for executive directors

Name and title	Real increase in pension at age 60 (£000s)	Real increase in pension lump sum at age 60 (£000s)	Total accrued pension at age 60 at 31 March 2020 (£000s)	Lump sum at age 60 related to accrued pension at 31 March 2020 (£000s)
	bands of £2,500	bands of £2,500	bands of £5,000	bands of £5,000
Helen Vernon Chief Executive	2.5–5	0–2.5	40–45	80–85
Joanne Evans Director of Finance and Corporate Planning	0–2.5	0	10–15	0
Vicky Voller Director of Advice and Appeals	0–2.5	0–2.5	20–25	40–45
Denise Chaffer Director of Safety and Learning	0–2.5	0–2.5	40–45	125–130
	Cash equivalent transfer value at 31 March 2020 (£000s)	Cash equivalent transfer value at 31 March 2019 (£000s)	Real increase in cash equivalent transfer value (£000s)	Employer's contribution to stakeholder pension (£000s)
Helen Vernon Chief Executive	714	642	37	22
Joanne Evans Director of Finance and Corporate Planning	135	98	16	17
Vicky Voller Director of Advice and Appeals	329	294	14	15
Denise Chaffer Director of Safety and Learning	0	0	0	16

Cash equivalent transfer values

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

There were no early retirements or other exit arrangements for directors during the reporting period. This is subject to audit and uses common market valuation factors for the start and end of the period.

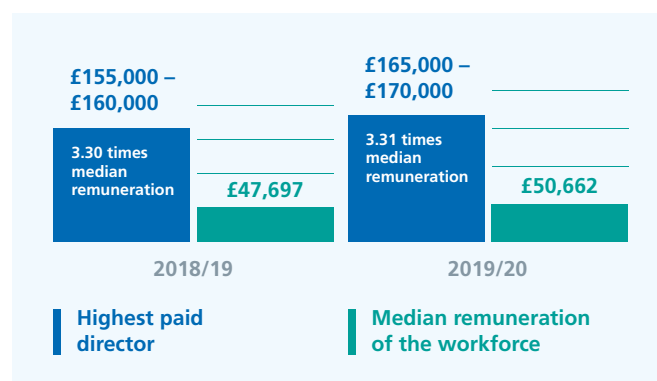
Payments to past directors

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

Fair pay disclosure

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

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



The banded remuneration of the highest-paid director in NHS Resolution in the financial year 2019/20 was £165,000–£170,000 (2018/19, £155,000–£160,000). This was 3.31 times (2018/19, 3.30) the median remuneration of the workforce, which was £50,662 (2018/19, £47,697).

In 2019/20, no employees received remuneration in excess of the highest-paid director (2018/19, was also zero). Remuneration ranged from £21,089 to £167,458 (2018/19 £20,150 to £156,559).

The fair pay disclosures are subject to audit.

Staff report

The implementation of CNSGP and the ongoing expansion of our Leeds based staff have both contributed to the continued growth of the organisation's establishment. NHS Resolution has seen an increase of 10.7% on the average full-time equivalent (FTE) staff in post, up from 293 in 2018/19 to 328 in 2019/20. While increasing our budgeted establishment and headcount we have reduced our level of annual staff turnover to 8.1%, down from just under 12% in 2018/19.

We have developed our existing equality and diversity reporting processes to reflect the geographical characteristics of both our London and Leeds based

workforce. This was also a key feature included in our recently developed equality, diversity and inclusion agenda. Throughout 2019/20 we have continued to support our workforce in a vast range of personal and professional development opportunities both internally and externally. Our ongoing commitment to people management excellence has been recognised by the silver level Investors in People (IIP) award, which was obtained as part of our re-accreditation process in early 2020.

Tables 17 and 18 set out staff costs and average staff numbers, which are subject to audit.

Table 17: Staff costs for 2018/19 and 2019/20

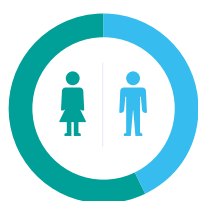
Staff costs	Permanently employed staff (£000s)	Other (£000s)	2019/20 Total (£000s)	2018/19 Total (£000s)
Salaries and wages	16,991	828	17,819	14,328
Social security costs	1,802	0	1,802	1,542
Employer contributions to NHS Pensions	1,862	0	1,862	1,680
NEST pension contributions	3	0	3	2
Apprenticeship levy	66	0	66	53
Total	20,724	828	21,552	17,605

Table 18: Average full-time equivalent staff numbers

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other*	2019/20 Total	2018/19 Total
Total	313	15	328	293

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

As at 31 March 2020...



Of the seven executive and senior managers, three were **male (43%)** and four were **female (57%)**



The gender split ratio for the whole of NHS Resolution was **male (37%)** and **female (63%)**

The organisation regularly reports to the Board the details of its workforce gender by pay band including executive and senior managers.

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

Figure 32: Headcount by gender and grade

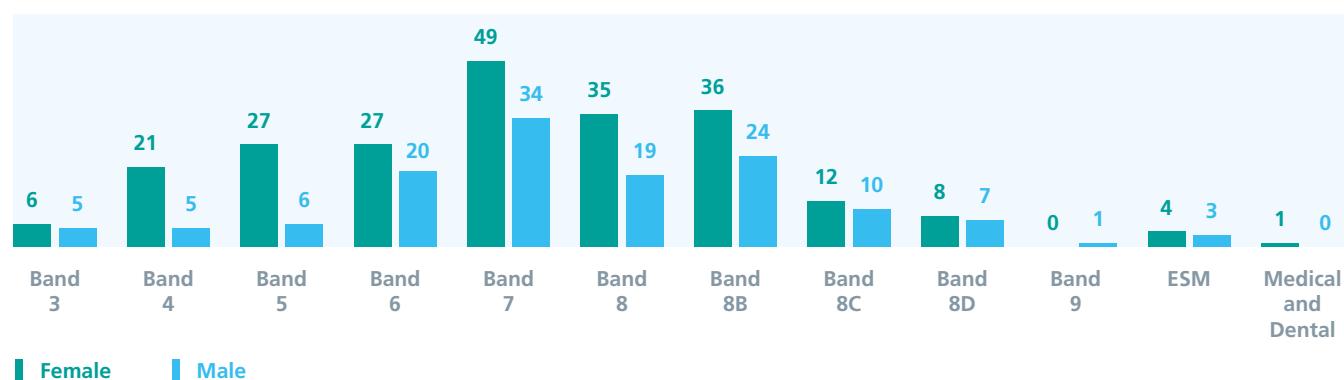


Figure 33: Workforce – disability²³

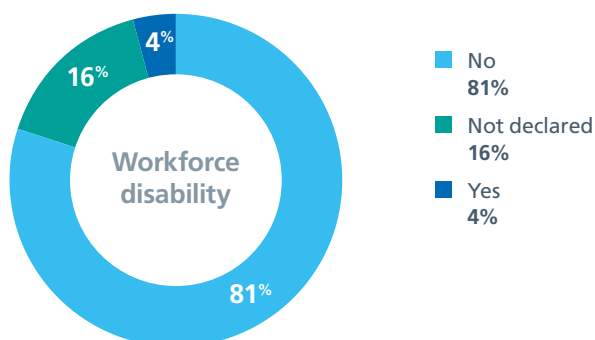


Figure 34: Workforce – sexual orientation

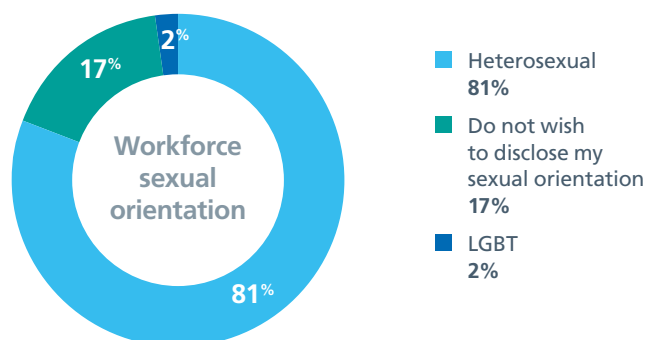


Figure 35: Workforce – religion/belief²⁴

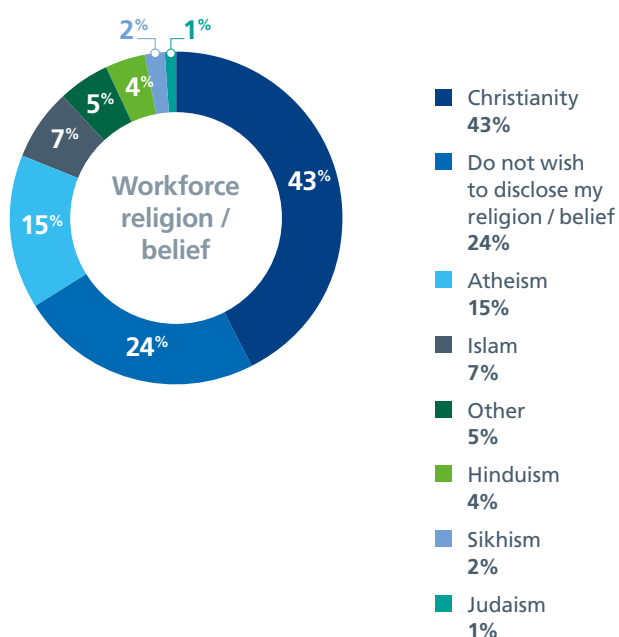
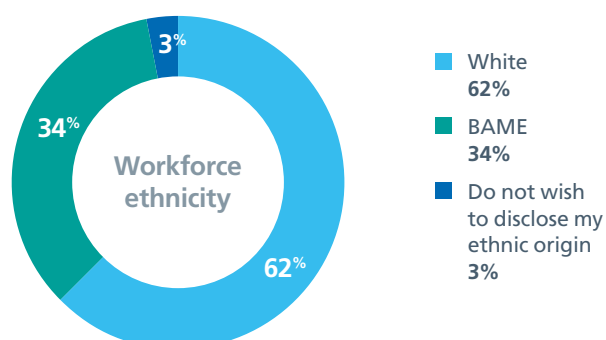


Figure 36: Workforce – ethnicity (organisational profile)²⁵



²³ Note: numbers add up to 101% due to rounding.

²⁴ Note: numbers add up to 101% due to rounding.

²⁵ Note: total is 99% due to rounding.

²⁶ MINDFUL EMPLOYER® is an NHS initiative run by Workways, a service of Devon Partnership NHS Trust, to help support employers to support mental wellbeing at work.

Disability

NHS Resolution has signed up to the Government's 'Disability Confident Scheme', which replaces the previous 'Two Ticks – Positive About Disabled People Scheme'. We remain a member of the Mindful Employer Charter²⁶, which is intended to support the organisation in attracting a more diverse workforce.

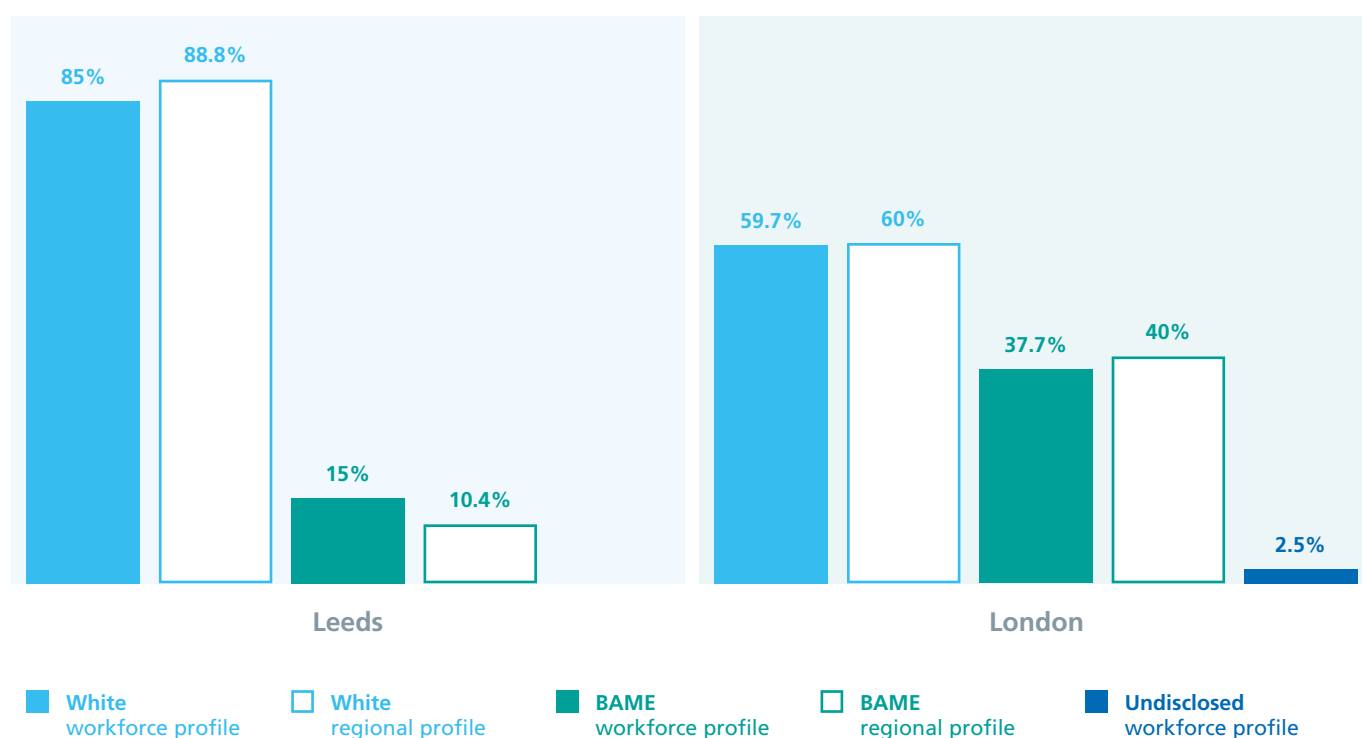
The percentage of applicants during 2019/20 who identified themselves as having a disability and who were offered an interview was 34%. This was higher than the percentage of applicants who did not declare themselves as having a disability, which was 26%. When considering the percentage of appointments made from the number of applications received, this was 2.2% for those who considered themselves as having a disability and 2.9% for those who did not. The percentage of those who did not wish to disclose this information was 5.8%.

Ethnicity

The proportion of Black, Asian and Minority Ethnic (BAME) employees has increased to 35% in 2019/20 (previously 33%). As we continue to grow our workforce in Leeds, it is important that we understand our regional figures and how these align to the local population.

Figure 37 shows the current workforce profile against the regional profile information. These figures are based on the 2011 census data. NHS Resolution's workforce profile is aligned to the regional figures with a noted higher representation in Leeds. It is, however, important to note that the Leeds figures are based on a small number of staff.

Figure 37: Workforce – ethnicity (Leeds* & London against the regional figures)



* For the Leeds regional census data 0.8% categorised themselves as 'other' and are not included in this figure.

Although closely aligned to the regional figures, we still show a slight underrepresentation of BAME staff in London. In contrast, we employ a higher number of BAME staff in Leeds when compared to the regional figures.

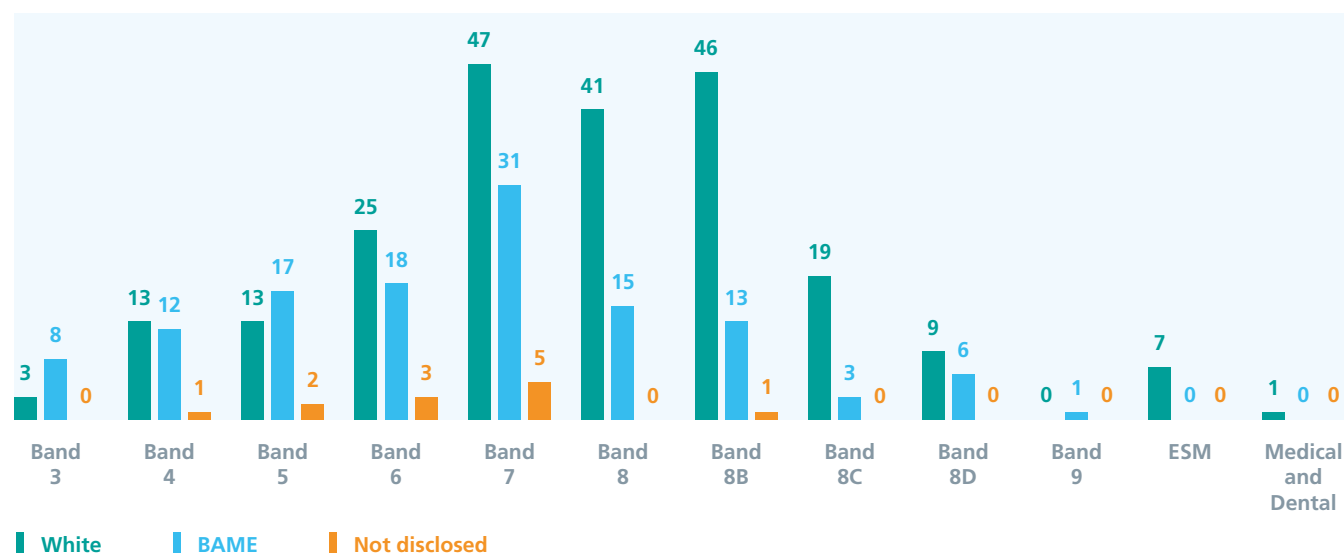
The organisation continues to provide regular reports to the Board, detailing its workforce ethnicity by pay band including senior managers. There are some noted areas of under- and overrepresentation of BAME staff as detailed in Figure 38.

While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is a clear underrepresentation of BAME staff at the ESM level. This is consistent with the national data around the lack of BAME staff at senior level within the NHS (Kline, March 2014) and industry in general. The information also shows that there is an overrepresentation of BAME staff within the lower pay bands.

However, as part of our equality, diversity and inclusion agenda the organisation has already taken a number of steps in order to start addressing these areas including:

- Promoting and supporting access to leadership development for all levels of staff
- Promoting and supporting external leadership development opportunities aimed specifically at BAME staff, i.e. Ready now programme and Stepping up programme
- Supporting the implementation of the Junior Case Manager apprenticeships, which is a positive step in supporting career progression for BAME groups.

Figure 38: Headcount by ethnicity



Sickness absence

As at 31 March 2020, NHS Resolution's 12 month cumulative sickness absence rate was 1.54%. This is below the national NHS national average for England and for other similar national NHS organisations. We have improved the quality of the sickness absence data recorded, and continue to provide our Board with oversight of our absence management processes. Overall we ensure that the required level of support is provided to our workforce while supporting our managers in the management of both informal and formal cases.

Off-payroll engagements

As of 31 March 2020, NHS Resolution has five off-payroll appointments costing more than £245 per day and that are likely to last longer than six months. These appointments were all new engagements within the reporting period. The appropriate pre-placement checks were completed for these and for all of the off-payroll engagements, with the required assurances obtained to confirm these placements were assessed to ensure that the appropriate tax and national insurance arrangements were in place as they were not covered by IR35²⁷.

Table 19: For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2020	5
Of which:	
No. that have existed for less than one year at time of reporting.	5
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

²⁷ IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

Table 20: For all new off-payroll engagements, or those that reached six months in duration between 1 April 2019 and 31 March 2020, for more than £245 per day and that last for longer than six months

New engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020.	6
Of which:	
No. assessed as caught by IR35.	0
No. assessed as not caught by IR35.	6
No. engaged directly (via PSC contracted to department) and are on the departmental payroll.	0
No. of engagements reassessed for consistency/assurance purposes during the year.	0
No. of engagements that saw a change to IR35 status following the consistency review.	0

Table 21: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020s

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

Exit packages

There were no compulsory or voluntary redundancies during the 2019/20 financial year. This is subject to audit.

Trade Union Regulations 2017

The Trade Union (Facilities Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require relevant public sector organisations to report on the trade union facility time in their organisation. The following tables detail the number of union officials within NHS Resolution, the percentage of their time spent on facilities time, the percentage of pay bill spent on facilities time and the percentage of paid trade union activities. This covers the period 1 April 2019 to 31 March 2020.

Table 22: Relevant union officials

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

Table 23: Percentage of time spent on facility time

Percentage of time	No. of employees
0%	0
1–50%	1
51–99%	0
100%	0

Table 24: Percentage of pay bill spent on facility time

Total cost of facility time	£4,650.70
Total pay bill	£21,752,005
Percentage of the total pay bill spent on facility time, calculated as: <i>(total cost of facility time ÷ total pay bill) x 100</i>	0.02%

Table 25: Paid trade union activities

Hours spent by employees who were relevant union officials during 2019/20 on paid trade union activities, as a percentage of total paid facility time hours.	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: <i>(total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100</i>	0%

People

The year 2019/20 has been very productive and successful in respect of our workforce and organisational development activities, which have supported the delivery of the organisation's annual business plan and strategic priorities.

In March 2020, following a re-accreditation process, we were successfully awarded silver level Investors in People (IIP) accreditation. This is a fantastic achievement by the organisation, which recognises the significant amount of effort and investment made in order to ensure that we are supporting, developing, engaging and leading our workforce in a collective and collaborative way. The work delivered in line with our Workforce and Organisational Development Strategy has made a positive impact in so many ways and the IIP silver award recognises this and our ongoing commitment to people management excellence.

Our approach has ensured that we have developed an engaged and effective workforce which has the resilience to respond positively to the current pandemic and associated revised ways of working. In order to maximise our support to staff and their families, we reviewed and where appropriate adjusted a number of our HR policies and procedures, developed a health and wellbeing toolkit for staff and put together a range of support measures for staff and managers in relation to dealing with and managing bereavements. Our approach ensured that staff were able to maintain business-as-usual activities, while keeping safe and well during a rather difficult and challenging period.

There have been a considerable number of staff engagement activities throughout the year, the most notable being the delivery of year two of our leadership development programme, full details of which are noted below. Other staff engagement activities have seen the level of completion of our staff annual appraisals increasing to 95% in 2019 up from 90% in 2018 and a positive response rate of 68% to the staff survey undertaken as part of the IIP assessment process.

We have progressed a significant number of the key priorities noted in our workforce and organisational development strategy. Activities delivered throughout 2019/20 include the following.

Equality, diversity and inclusion

Throughout 2019/20 and in collaboration with our staff we developed an equality, diversity and inclusion (EDI) agenda.

As noted in our *Equality, diversity and inclusion policy and procedure* and our *Workforce Organisational Development Strategy*, “NHS Resolution is committed to embedding equality, diversity and inclusion across the organisation” ensuring that fair treatment and social inclusion are at the heart of everything we do.

It is the organisation’s intention to create an environment where staff respect and value each other’s diversity in order to support the delivery of its strategy and business plan. As an NHS arm’s length body (ALB), it is imperative NHS Resolution shows transparency and embraces the core values of the NHS, which are respect, dignity, compassion and inclusion. The latter refers to a commitment to treat everyone with respect and significance, celebrating and valuing difference of lived experience.

This EDI agenda sets out our intended actions and areas of focus in order to ensure NHS Resolution has a culture where individual differences and diversity are welcomed. We will achieve this through:

- Promoting equal rights and opportunities
- Pro-actively tackling discrimination or disadvantage in all its forms
- Creating an open and inclusive culture where equality, diversity and inclusion can be comfortably discussed
- Having an inclusive and diverse workforce, to reflect the rich diversity of London and Leeds
- Developing a behaviours framework which underpins the organisation’s PEER values.

In order to ensure that NHS Resolution continues with the work and initiatives already in place in relation to EDI, an action plan has been developed setting out its intended areas of focus to cover the period 2020–2022. The action plan considers each of the protected characteristics and covers three primary areas:

- Recruitment, selection and on-boarding.
- Leadership and talent management.
- Capacity and capability.

Our vision for each of these areas are:

Recruitment, selection and on-boarding

To ensure the organisation is able to reach underrepresented groups, and identify and remove any barriers preventing people from these groups seeking, applying and successfully obtaining employment within NHS Resolution. To create an environment where we can attract, recruit and retain staff from all communities, with the ultimate aim of creating an inclusive and diverse workforce, which represents the population we serve.

Leadership and talent management

We will continue developing an environment that supports all staff to realise their individual potential, particularly those employees from underrepresented groups. This will ensure that all development opportunities are promoted, encouraged and supported for all staff, enabling them to become the next generation of leaders.

Capacity and capability

To create an environment of transparency and openness where staff feel safe to explore and have difficult conversations on issues that affect them. Ensuring that the organisation continues to develop their EDI agenda in order to establish a diverse workforce that represents the population and client base we serve.

Leadership development

Following completion of the final Leadership module in 2019, the evaluation and lessons learned from all previous cohorts was presented to our SMT. Working with a range of colleagues across the organisation, we have set out and discussed our recommendations on the key components of our next leadership programme. A draft programme is now in place and will be presented to SMT in June 2020. It is anticipated that our next leadership programme will commence from September 2020.

Succession planning

Throughout 2019/20 the organisation has continued to establish and is recruiting to a number of further deputy director positions. The introduction of these roles since 2018/19 has ensured that the organisation is appropriately resourced to deliver its strategic intentions including the implementation of the CNSGP. During 2019 we received approval from DHSC to appoint to a chief information officer post; this will further strengthen our ability to deliver our business strategy while offering more career development opportunities. The introduction of these roles supports the succession plans for our senior business critical roles while offering better career pathways within a majority of our services.

An update on the succession plans for each of our executive and senior manager (ESM) positions was presented to our Remuneration Committee in January 2020. Our talent pipeline for each directorate is underpinned by individual career conversations, intentions and aspirations, which continue to be held outside of the annual appraisal process.

We have maintained our membership with the Health and Care Leaders Scheme (HCLS) and continued to offer and access various external leadership development opportunities which include the Ready Now, Stepping Up, Leaders 2025 and Nye Bevan programmes. In addition, we are working towards the creation of an ALB reciprocal mentoring programme to support the purpose of the network which is “to ensure we take a strategic approach to talent, management and development and work with our stakeholders to help build an increasingly confident, capable and motivated workforce across the national health and care system”. This has been agreed by the HCLS Talent Board and associated costs of this platform will be met by the membership fees from the HCLS.

Coaching and mentoring

We provide an offer of internal and external coaching and mentoring opportunities for staff which supports their ongoing personal and professional development, as well as the launch of a ‘return to work’ mentoring scheme as part of our wider equality, diversity and inclusion action plan.

Gender pay gap

In February 2020, in accordance with the requirements under the Equality Act 2010, NHS Resolution published its third gender pay gap report. The report was published on the GOV.UK website in advance of the April 2020 deadline. NHS Resolution reported a mean gender pay gap of 7%, up slightly from 6% in the previous year.

While the overall rate has marginally increased, the organisation has seen a positive increase in the number of female employees in the upper pay quartile, which has increased by a further 3% in 2019. As in 2018, the only employees who received bonus pay in 2019 were female, which means there was no pay gap to report in this regard.

Over the 12 month reporting period, NHS Resolution has appointed twice as many females into senior roles than males. Similarly, we have increased the number of roles within bands 2 to 6, which have been filled predominantly by females. The organisation is delighted that a majority of these vacancies have been filled by female employees (67%); however, because a majority of these new hires are in the lower pay grades, in the short term the organisation will see a slight increase in our gender pay gap figures.

Over the past 12 months we have:

- Made available a 'Return to Work' mentorship programme, aimed at those returning from a period of maternity/adoption leave.
- Completed the second wave of our leadership programme which covers all levels of staff, in order to equip employees with the essential insights, knowledge and skills to directly improve career aspirations and promotion opportunities.
- Successfully rolled out an apprenticeship programme within our Claims Management function, which supports individuals developing from band 5 to band 7 roles in a period of 24 months. The programme is accessible for staff in lower bands from across the organisation as well as external appointments.
- Since March and following a formal job evaluation process, our band 2 positions have been re-evaluated to band 3.

Parliamentary accountability and audit report

The following disclosures are subject to audit

Losses and special payments

We wrote off £348,850 of debt in 2019/20, there were no losses or special payments over £300,000 in 2018/19.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES schemes, are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy at Note 1.3 to the accounts on page 167. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the accounts on page 176.

Expenditure on consultancy

Expenditure incurred on consultancy in 2019/20 was £364,000. Of this £125,000 was in relation to the review of the claims function target operating model and £175,000 on the core systems review. There was no expenditure on consultancy in 2018/19.

Publicity and advertising

Publicity and advertising spend for the year was £67,462. This compares to £100,711 in the previous year.

Regularity of expenditure – gifts

We have not received or made any gifts where the value exceeded £300,000. Staff are required to declare gifts in line with NHS Resolution's Hospitality and Gifts Policy and Procedure (HR04).

Indemnity Scheme Cover for NHS Resolution

For 2019/20, NHS Resolution was covered under both LTPS and PES.

Remote contingent liabilities

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

Disclosures in relation to liabilities arising from the Covid-19 pandemic have been made in Notes 7 and 8 to the accounts.

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2019/20.



Helen Vernon

Chief Executive and Accounting Officer

Date: Wednesday 8 July 2020

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

Opinion on financial statements

I certify that I have audited the financial statements of NHS Litigation Authority (herein referred to as NHS Resolution) for the year ended 31 March 2020 under the National Health Service Act 2006. The financial statements comprise: the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion:

- the financial statements give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2020 and of its net expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

Without qualifying my opinion, I draw attention to the disclosures made in note 7 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 7, given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by NHS Resolution.

Opinion on regularity

In my opinion, in all material respects the income and expenditure recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

Basis of opinions

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

Conclusions relating to going concern

I have nothing to report in respect of the following matters in relation to which the ISAs (UK) require me to report to you where:

- NHS Resolution's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- NHS Resolution has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about NHS Resolution's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Responsibilities of the Accounting Officer for the financial statements

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

- Conclude on the appropriateness of NHS Resolution's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on NHS Resolution's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my report. However, future events or conditions may cause NHS Resolution to cease to continue as a going concern.

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

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

Other information

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

Opinion on other matters

In my opinion:

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

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Gareth Davies

Comptroller and Auditor General

Date: 9 July 2020

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 2020

	Notes	31 March 2020 (£000s)	31 March 2019 (£000s)
Other operating income	3	(2,004,401)	(2,053,909)
Total operating income		(2,004,401)	(2,053,909)
Staff costs	2	21,552	17,605
Purchase of goods and services	2	6,915	5,907
Depreciation and impairment charges	2	840	820
Provision expense	7	2,549,542	8,386,821
Other operating expenditure	2	1,577	1,503
Total operating expenditure		2,580,426	8,412,656
Net operating expenditure		576,025	6,358,747
Finance expenditure	7	507,878	422,465
Net expenditure for the year		1,083,903	6,781,212
Other comprehensive net expenditure		0	0
Comprehensive net expenditure for the year		£1,083,903	6,781,212

The Notes on pages 166 to 213 form part of these financial statements.

Statement of financial position as at 31 March 2020

	Notes	31 March 2020 (£000s)	31 March 2019 (£000s)
Non-current assets			
Property, plant and equipment		1,407	1,972
Intangible assets		1,354	984
Total non-current assets		2,761	2,956
Current assets			
Trade and other receivables	4	27,560	15,652
Cash and cash equivalents	5	120,691	182,092
Total current assets		148,251	197,744
Total assets		151,012	200,700
Current liabilities			
Trade and other payables	6	(96,407)	(78,850)
Provisions for liabilities and charges – known claims	7	(2,783,788)	(2,476,653)
Total current liabilities		(2,880,195)	(2,555,503)
Total assets less current liabilities		(2,729,183)	(2,354,803)
Non-current liabilities			
Provisions for liabilities and charges – known claims	7	(34,733,478)	(32,920,914)
Provisions for liabilities and charges – IBNR	7	(46,536,000)	(47,978,000)
Total non-current liabilities		(81,269,478)	(80,898,914)
Total assets less liabilities		(83,998,661)	(83,253,717)
Taxpayers' equity			
General fund		5,873	3,821
ELS reserve		(1,305,942)	(1,447,553)
Ex-RHA reserve		(65,457)	(73,492)
DHSC clinical reserve		(3,480,036)	(3,903,402)
DHSC non-clinical reserve		(101,309)	(111,409)
ELGP		(1,000,437)	–
CNSGP		(306,740)	–
CNST reserve		(77,592,849)	(77,565,305)
PES reserve		(5,850)	(4,974)
LTPS reserve		(145,914)	(151,403)
Total taxpayers' equity		(83,998,661)	(83,253,717)

The General Fund and individual scheme reserves are used to account for all financial resources. See the Understanding our indemnity schemes section for a brief description of each scheme to which the reserves relate. The Board approved a recommendation on 6 July 2020 that the financial statements from page 159 should be signed by the Accounting Officer and these were signed by Helen Vernon on 8 July 2020.

The Notes on pages 166 to 213 form part of these financial statements.



Helen Vernon
Chief Executive and Accounting Officer
Date: Wednesday 8 July 2020



Statement of cash flows for the year ended 31 March 2020

	Notes	31 March 2020 (£000s)	31 March 2019 (£000s)
Cash flows from operating activities			
Net expenditure		(1,083,903)	(6,781,212)
Other cash flow adjustments	2	840	820
(Increase) / decrease in receivables	4	(11,908)	(371)
Increase / (decrease) in payables	6	17,557	40,270
Increase / (decrease) in provisions	7	677,699	6,387,616
Net cash (outflow) from operating activities		(399,715)	(352,877)
Cash flows from investing activities			
Purchase of property, plant and equipment		(40)	(943)
Purchase of intangible assets		(631)	(518)
Asset write-off		26	0
Net cash (outflow) from investing activities		(645)	(1,461)
Cash flows from financing activities			
Net Parliamentary funding		338,959	148,119
Net financing		338,959	148,119
Net (decrease)/increase in cash and cash equivalents		(61,401)	(206,219)
Cash and cash equivalents at the beginning of the period		182,092	388,311
Cash and cash equivalents at the end of the period	5	120,691	182,092

The Notes on pages 166 to 213 form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2020

	Notes	General Fund (£000s)	ELS Reserve (£000s)	Ex-RHAs Reserve (£000s)	DHSC clinical Reserve (£000s)	DHSC non-clinical Reserve (£000s)	ELGP Reserve (£000s)	CNSGP Reserve (£000s)	CNST Reserve (£000s)	PES Reserve (£000s)	LTPS Reserve (£000s)	Total Reserves (£000s)
Balance at 31 March 2018		1,930	(1,446,402)	(74,118)	(3,872,347)	(98,558)	0	0	(70,979,436)	(6,819)	(144,874)	(76,620,624)
Changes in taxpayers' equity for 2018/19												
Net expenditure for the year		(7,228)	(30,151)	(374)	(131,055)	(21,851)	0	0	(6,585,869)	1,845	(6,529)	(6,781,212)
Total recognised income and expense as at 2018/19		(5,298)	(1,476,553)	(74,492)	(4,003,402)	(120,409)	0	0	(77,565,305)	(4,974)	(151,403)	(83,401,836)
Net Parliamentary funding		9,119	29,000	1,000	100,000	9,000	0	0	0	0	0	148,119
Balance at 31 March 2019		3,821	(1,447,553)	(73,492)	(3,903,402)	(111,409)	0	0	(77,565,305)	(4,974)	(151,403)	(83,253,717)
Changes in taxpayers' equity for 2019/20												
Expenditure												
Authority and claims administration	2	(6,913)	(137)	(9)	(464)	(135)	(3,137)	(32)	(15,658)	(61)	(4,338)	(30,884)
(Increase) / decrease in provision for known claims	7	0	50,748	4,044	177,830	(4,765)	(448,800)	(1,208)	(4,232,145)	(5,881)	(39,243)	(4,499,420)
(Increase) / decrease in the provision for IBNR	7	0	59,000	3,000	162,000	11,000	(612,000)	(306,000)	2,123,000	(1,000)	3,000	1,442,000
		(6,913)	109,611	7,035	339,366	6,100	(1,063,937)	(307,240)	(2,124,803)	(6,942)	(40,581)	(3,088,304)
Income												
Scheme and other income	3	1,006	0	0	0	0	0	0	1,951,259	6,066	46,070	2,004,401
Total recognised income and expense for 2019/20		(5,907)	109,611	7,035	339,366	6,100	(1,063,937)	(307,240)	(173,544)	(876)	5,489	(1,083,903)
Net Parliamentary funding ¹		7,959	32,000	1,000	84,000	4,000	63,500	500	146,000	0	0	338,959
Balance at 31 March 2020		5,873	(1,305,942)	(65,457)	(3,480,036)	(101,309)	(1,000,437)	(306,740)	(77,592,849)	(5,850)	(145,914)	(83,998,661)

¹ The Net Parliamentary funding represents the cash drawdown of £338,959 million in 2019/20 for DHSC-funded indemnity schemes and administration costs. The Notes on pages 166 to 213 form part of these financial statements.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2019/20 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRSs) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of NHS Resolution for the purpose of giving a true and fair view has been selected. The particular policies adopted by NHS Resolution are described in the following text. They have been applied consistently in dealing with items that are considered material to the accounts.

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

1.1 Accounting conventions

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

1.2 Early adoption of standards, amendments and interpretations

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

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

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

The following have not been adopted early in these accounts:

IFRS 16 Leases

The effective date is for accounting periods beginning on or after 1 January 2019, but this has been deferred in an update to the FReM due to Covid-19, with a new effective date for accounting periods beginning on or after 1 January 2021.

IFRS 17 Insurance Contracts

The effective date is for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM.

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. This funds the ELS, Ex-RHA, DHSC clinical and DHSC liabilities schemes, the additional costs of the personal injury discount rate arising from the change in the rate announced by the Lord Chancellor in March 2017, and some administration costs. In addition, from 1 April 2019, NHS Resolution received funding from NHS England and NHS Improvement via DHSC for the administration of General Practice indemnity arrangements, as directed by the Secretary of State. Parliamentary funding is recognised in the financial period in which it is received.

The operating income disclosed in Note 3 to the accounts is that which relates directly to the operating activities of NHS Resolution. NHS Resolution currently has the following income streams, the accounting treatment of which have been assessed against the requirements of IFRS15 Revenue 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, which their authorising legislation gives them the right to collect. This is deemed, per the FReM adaptation of IFRS15, to constitute a contractual arrangement between NHS Resolution and its scheme members. The period of cover is annual, commencing on 1 April each year (contracts do not span financial years). Invoices are raised yearly, quarterly, over 10 months and monthly according to the contract agreed with each member. Revenue is recognised in our accounts in equal monthly instalments over the term of the yearly contract, as NHS Resolution's performance obligations are fulfilled.
- Revenue from contracts in relation to professional services: Invoices are raised either yearly or quarterly as per the agreed contract. Regardless of the timing on raising invoices for payment, we recognise revenue in equal instalments over the accounting year, as performance obligations within the contractual agreements are fulfilled.
- Revenue from contracts in relation to training courses: We only recognise revenue in this category after the training has taken place; which is the point at which NHS Resolution's performance obligations are assessed to have been fulfilled.

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 Clinical Negligence Schemes for Trusts (CNST).

Where a trust has successfully demonstrated achievement against the 10 safety actions, it will recover its element of CNST contribution that went 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 all actions.

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

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

The provisions of the NHS Pensions Scheme cover past and present employees. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The NHS Pension scheme is a defined benefit scheme which is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, 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.

There are two NHS pension schemes: the 1995/2008 scheme and the 2015 scheme. The employer contribution rate for the period 1 April 2019 to 31 March 2023 is 20.68% of pensionable pay for both the 1995/2008 scheme and the 2015 scheme. The employer contribution rate is set through a process known as the scheme valuation. A scheme valuation is carried out every four years and it measures the full cost of paying pension benefits to current pensioners. The most recent 2016 scheme valuation identified the need to increase the employer contribution from 14.3% to 20.68% (including a levy of 0.08% for scheme administration) from 1 April 2019. The expected contribution for 2020/21 is £3.76 million.

NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Pension Scheme, NHS Resolution used an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations.

NEST is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2019/20 were £6,136 up to £50,000. Total contributions are 8%, with employee contributions at 4%, employer contributions at 3% and government contributions (tax relief) at 1%.

More details on NEST can be found on the NEST website www.nestpensions.org.uk/schemeweb/nest/aboutnest.

1.6 Short-term employee benefits

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

1.7 Provisions and Contingent Liabilities

NHS Resolution provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using the HM Treasury's discount rate.

In November 2017, following consultation with HM Treasury, the Financial Reporting Advisory Board (FRAB) recommended that nominal discount rates should be applied to general provisions rather than the real discount rates previously applied to an inflation rate. This change did not require a restatement of prior year balances as this was a change in accounting estimates and not a policy change.

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

NHS Resolution was commissioned to deliver a new future liability scheme called Clinical Negligence Scheme for General Practice (CNSGP), established on 1 April 2019 for claims arising from incidents on or after that date. In addition, NHS Resolution was directed to provide management and oversight of arrangements resulting from a transfer of in-scope liabilities from Medical Defence Organisations (MDOs) to the DHSC Group. All of these arrangements are funded out of the budget for the NHS managed by NHS England and NHS Improvement which comes to NHS Resolution via DHSC financing. Accounting treatment for CNSGP has been reviewed and will be accounted for under IAS 37, in line with the treatment of other NHS Resolution indemnity schemes.

In relation to the transfer of assets and liabilities to the DHSC Group from the medical defence organisations, these are accounted for under IFRS 3 Business Combinations. This requires the subsequent measurement of assets and liabilities acquired in accordance with other applicable IFRS. NHS Resolution has a management and oversight role in relation to in-scope claims, flowing from the directions from DHSC, and accounts for these liabilities under IAS 37.

NHS Resolution does not consider that any of our indemnity schemes or management and oversight of General Practice claims fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because significant insurance risk is passed back to the members of risk-pooling schemes through annual contributions, to the GP Contract funding held by NHS England transferred via DHSC as provision of financing, or directly to DHSC through the provision of financing.

The difference between the gross value of claims and the probable cost of each claim as calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in Note 8.

Resolution of claims is difficult to predict as many factors can lead to delay during the settlement process while emerging evidence can alter valuation, and thus NHS Resolution makes a best estimate regarding the likely year of settlement and expected value of the claim against each notified claim. These estimates are reviewed throughout the life of the claim and amended to reflect variations in expectations, which inevitably alter the value provided.



1.8 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 as against £170,644 recognised in 2018/19

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 in Note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. The judgements that have the most significant effect on the amounts recognised in the financial statements relate to the calculation of the provisions for known claims and for IBNR, as explained in Note 7.2.

1.11 IFRS 8 – operating segments

NHS Resolution has one reportable segment under IFRS 8, income and expenditure are disaggregated by different scheme types in the Statement of Changes in Taxpayers' Equity.

2. Expenditure

	Notes	31 March 2020 (£000s)	31 March 2019 (£000s)
Non-executive Members' remuneration¹		203	123
Other salaries and wages²			
Salaries and wages		17,819	14,328
Social security costs		1,802	1,542
Pension costs		1,865	1,682
Apprenticeship levy		66	53
Education, training and conferences		126	154
Establishment expenses		1,393	1,001
Hire and operating lease rental			
Land and buildings		528	1,061
Lease cars		4	9
Photocopiers		(1)	25
Franking machine		18	2
Vending machine		11	3
Insurance		200	227
Transport (business travel)		250	156
Premises and fixed plant		3,494	2,820
External contractors			
Actuary's advice		847	734
Primary Care Appeals advisory expenditure		42	39

¹ Non-executive members' remuneration of £203k includes £71k in relation to Chairman's pay. The equivalent of £71k in 2018/19 was included in other salaries and wages.

² Additional explanations can be found in Remuneration and staff report in the Accountability report section.

Expenditure continued	Notes	31 March 2020 (£000s)	31 March 2019 (£000s)
Consultancy		364	0
External corporate legal fees ³		284	221
Practitioner Performance Advice assessment expenditure		102	239
Practitioner Performance Advice professional services		(2)	9
Other		367	349
Auditor's remuneration: audit fees⁴		175	154
Internal audit fees		69	74
Bank charges and interest		18	10
		30,044	25,015
Depreciation		584	633
Amortisation		256	187
		840	820
		30,884	25,835
Other finance costs – unwinding of discount	7	507,878	422,465
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	7	7,284,312	5,518,713
Change in the discount rate⁵	7	(9,381,770)	269,108
Increase / (decrease) in the provision for IBNR	7	4,647,000	2,599,000
		3,057,420	8,809,286
Total Expenditure⁶		3,088,304	8,835,121

³ External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included within Note 7 Provisions.

⁴ NHS Resolution did not make any payments to its auditors for non-audit work.

⁵ The discount rates used are mandated by HM Treasury and are set out at Note 7.3 to the accounts.

⁶ Of the £3,088 million total expenditure for 2019/20, £5.8 million is shown as administration expenditure in DHSC consolidated group accounts

2.1 Analysis of the provision expense

2019/20	CNST (£000s)	CNSGP (£000s)	ELGP (£000s)	LTPS (£000s)	PES (£000s)	DHSC clinical (£000s)	ELS (£000s)	Ex-RHA (£000s)	DHSC non-clinical (£000s)	Total (£000s)
2019/20 incidents										
Known claims	80,715	1,208	0	6,468	3,398	0	0	0	5	91,794
IBNR	8,223,841	306,000	0	27,026	3,340	0	0	0	0	8,560,207
Total 2019/20	8,304,556	307,208	0	33,494	6,738	0	0	0	5	8,652,001
Prior years incidents										
Known claims	4,151,430	0	448,800	32,775	2,483	(177,830)	(50,748)	(4,044)	4,760	4,407,626
IBNR	(10,346,841)	0	612,000	(30,026)	(2,340)	(162,000)	(59,000)	(3,000)	(11,000)	(10,002,207)
Total prior years	(6,195,411)	0	1,060,800	2,749	143	(339,830)	(109,748)	(7,044)	(6,240)	(5,594,581)
Total	2,109,145	307,208	1,060,800	36,243	6,881	(339,830)	(109,748)	(7,044)	(6,235)	3,057,420

2018/19	CNST (£000s)	CNSGP (£000s)	ELGP (£000s)	LTPS (£000s)	PES (£000s)	DHSC clinical (£000s)	ELS (£000s)	Ex-RHA (£000s)	DHSC non-clinical (£000s)	Total (£000s)
2018/19 incidents										
Known claims	42,634	0	0	5,844	5,661	0	0	0	0	54,089
IBNR	8,778,354	0	0	30,056	2,528	0	0	0	0	8,810,938
Total 2018/19	8,820,988	0	0	35,900	8,139	0	0	0	0	8,865,027
Prior years incidents										
Known claims	5,710,994	0	0	34,476	2,985	221,630	23,026	(1,634)	1,720	5,993,197
IBNR	(5,965,354)	0	0	(20,056)	(1,528)	(91,000)	7,000	2,000	20,000	(6,048,938)
Total prior years	(254,360)	0	0	14,420	1,457	130,630	30,026	366	21,720	(55,741)
Total	8,566,628	0	0	50,320	9,596	130,630	30,026	366	21,720	8,809,286

Note 2.1 provides an analysis of the provision expense charged to the Statement of Net Comprehensive Expenditure in the reporting year. The cost of claims arising from incidents happening in the reporting year is shown by individual indemnity scheme or

arrangement, and totals £8.652 billion across all schemes in 2019/20. The prior year's incidents figures in the tables show the impact of changes on provisions that have been recognised in previous reporting years, and total a reduction

of £5.595 billion across all schemes in 2019/20. These changes stem from updates to individual known claims reserve values and probabilities, and changes to IBNR assumptions, as more information becomes available through the passage of time.

The equivalent figures for 2018/19 are an increase of £8.865 billion and a reduction of £0.055 billion, respectively.

The approach taken to valuing the provision is shown at Note 7.2.

3. Operating income

	2019/20 (£000s)	2018/19 (£000s)
CNST contributions	1,951,259	1,993,516
LTPS contributions	46,070	47,806
PES contributions	6,066	11,500
Practitioner Performance Advice	1,006	1,054
Other income	0	33
Total	2,004,401	2,053,909

4. Receivables

	Ex-RHA (£000s)	ELS (£000s)	DHSC clinical (£000s)	DHSC non-clinical (£000s)	ELGP (£000s)	CNSGP (£000s)	CNST (£000s)	PES (£000s)	LTPS (£000s)	Admin (£000s)	Total 31 March 2020 (£000s)	Total 31 March 2019 (£000s)
NHS receivables – revenue	0	0	0	0	0	0	2,369	121	4,076	392	6,958	4,285
Expected credit loss	0	0	0	0	0	0	0	0	0	0	0	(171)
Accrued income	0	0	0	0	0	0	0	0	0	0	0	0
Prepayments	39	635	1,806	0	0	0	935	0	0	666	4,081	3,485
Other receivables	0	211	119	32	5,703	0	9,200	7	267	982	16,521	8,053
Total	39	846	1,925	32	5,703	0	12,504	128	4,343	2,040	27,560	15,652

5. Cash and cash equivalents

	Ex-RHA	ELS	ELGP	CNSGP	CNST	PES	LTPS	Admin	Total 31 March 2020 (£000s)	Total 31 March 2019 (£000s)
	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)		
At 1 April 2019	952	20,265	0	0	114,311	6,408	39,143	1,013	182,092	388,311
Change during the year	(852)	7,684	6,565	409	(80,879)	(119)	2,149	3,642	(61,401)	(206,219)
At 31 March 2020 ¹	100	27,949	6,565	409	33,432	6,289	41,292	4,655	120,691	182,092

6. Trade payables and other current liabilities

	ELS	DHSC clinical	DHSC non-clinical	ELGP	CNSGP	CNST	PES	LTPS	Admin	Total 31 March 2020 (£000s)	Total 31 March 2019 (£000s)
	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)		
NHS payables revenue	0	0	0	0	0	0	0	321	13	334	174
Prepaid income	2,208	0	0	0	0	3,133	0	0	92	5,433	5,473
Accruals	21	121	160	2,392	2	10,799	9	872	1,463	15,839	18,333
Other payables	99	322	1,531	20,357	3	51,371	0	305	813	74,801	54,870
Total	2,328	443	1,691	22,749	5	65,303	9	1,498	2,381	96,407	78,850

¹ All cash balances are held in Government Banking Service accounts.

7. Provisions for liabilities and charges

	Ex-RHA (£000s)	ELS (£000s)	DHSC clinical (£000s)	DHSC non-clinical (£000s)	ELGP (£000s)	CNSGP (£000s)	CNST (£000s)	PES (£000s)	LTPS (£000s)	Total (£000s)
Opening provision for known claims	62,317	1,198,889	2,927,385	12,714	0	0	31,091,984	9,981	94,297	35,397,567
Opening provisions for IBNR	11,000	258,000	1,007,000	108,000	0	0	46,514,000	4,000	76,000	47,978,000
Total provisions as at 1 April 2019	73,317	1,456,889	3,934,385	120,714	0	0	77,605,984	13,981	170,297	83,375,567
Movement in known claims										
Provided in the year	652	70,484	160,489	7,298	448,800	1,208	9,279,404	8,166	118,606	10,095,107
Provision not required written back	(550)	(33,749)	(158,115)	(2,520)	0	0	(2,534,702)	(2,283)	(78,876)	(2,810,795)
Unwinding of discount	1,161	21,525	51,153	21	0	0	433,972	0	46	507,878
Change in discount rate ¹	(5,307)	(109,008)	(231,357)	(34)	0	0	(2,946,529)	(2)	(533)	(3,292,770)
Provisions utilised in the year	(1,262)	(36,180)	(68,084)	(6,560)	(61,325)	(59)	(2,157,341)	(6,250)	(42,660)	(2,379,721)
Movement in known claims	(5,306)	(86,928)	(245,914)	(1,795)	387,475	1,149	2,074,804	(369)	(3,417)	2,119,699
Movement in IBNR										
Change in discount rate ¹	(1,000)	(16,000)	(69,000)	(3,000)	0	0	(6,000,000)	0	0	(6,089,000)
Provided in the year	(2,000)	(43,000)	(93,000)	(8,000)	612,000	306,000	3,877,000	1,000	(3,000)	4,647,000
Movement in IBNR	(3,000)	(59,000)	(162,000)	(11,000)	612,000	306,000	(2,123,000)	1,000	(3,000)	(1,442,000)
Closing provision for known claims	57,011	1,111,961	2,681,471	10,919	387,475	1,149	33,166,788	9,612	90,880	37,517,266
Closing provisions for IBNR	8,000	199,000	845,000	97,000	612,000	306,000	44,391,000	5,000	73,000	46,536,000
Total provision as at 31 March 2020	65,011	1,310,961	3,526,471	107,919	999,475	307,149	77,557,788	14,612	163,880	84,053,266
Analysis of expected timing of discounted cash flows²										
Not later than one year	998	37,905	97,755	3,990	131,961	2,466	2,443,875	7,980	56,858	2,783,788
Later than one year and not later than five years	3,940	150,819	349,686	15,758	384,040	70,702	11,206,499	6,632	107,022	12,295,098
Later than five years	60,073	1,122,237	3,079,030	88,171	483,474	233,981	63,907,414	0	0	68,974,380
Total provision as at 31 March 2020	65,011	1,310,961	3,526,471	107,919	999,475	307,149	77,557,788	14,612	163,880	84,053,266

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

¹ The change in discount rate represents the change in provision as a result of a change in the discount rates set by HM Treasury and financial assumptions on future inflation rates relative to past rates. The total change in provision due to the change in discount rates and financial assumptions is £9,379 million (£3,291 million for known claims and £6,089 million for IBNR). Further details are in Note 7.2 Explanatory notes.

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

Provisions for liabilities and charges (prior year)

	Ex-RHA (£000s)	ELS (£000s)	DHSC clinical (£000s)	DHSC non-clinical (£000s)	CNST (£000s)	PES (£000s)	LTPS (£000s)	Total (£000s)
Opening provision for known claims	65,114	1,213,983	2,794,434	16,935	27,570,260	9,348	101,877	31,771,951
Opening provisions for IBNR	9,000	251,000	1,098,000	88,000	43,701,000	3,000	66,000	45,216,000
Total provisions as at 1 April 2018	74,114	1,464,983	3,892,434	104,935	71,271,260	12,348	167,877	76,987,951
Movement in known claims								
Provided in the year	145	44,958	234,253	9,848	7,374,294	11,767	67,480	7,742,745
Provision not required written back	(3,210)	(46,419)	(70,608)	(8,142)	(2,065,906)	(3,166)	(26,581)	(2,224,032)
Unwinding of discount	1,150	20,434	45,512	25	355,288	1	55	422,465
Change in discount rate ¹	281	4,053	12,473	(11)	89,952	(6)	(634)	106,108
Provisions utilised in the year	(1,163)	(38,120)	(88,679)	(5,941)	(2,231,904)	(7,963)	(47,900)	(2,421,670)
Movement in known claims	(2,797)	(15,094)	132,951	(4,221)	3,521,724	633	(7,580)	3,625,616
Movement in IBNR								
Change in discount rate ¹	0	1,000	1,000	1,000	160,000	0	0	163,000
Provided in the year	2,000	6,000	(92,000)	19,000	2,653,000	1,000	10,000	2,599,000
Movement in IBNR	2,000	7,000	(91,000)	20,000	2,813,000	1,000	10,000	2,762,000
Closing provision for known claims	62,317	1,198,889	2,927,385	12,714	31,091,984	9,981	94,297	35,397,567
Closing provisions for IBNR	11,000	258,000	1,007,000	108,000	46,514,000	4,000	76,000	47,978,000
Total provision as at 31 March 2019	73,317	1,456,889	3,934,385	120,714	77,605,984	13,981	170,297	83,375,567
Analysis of expected timing of discounted cash flows²								
Not later than one year	1,096	35,863	95,635	3,986	2,291,259	5,977	42,837	2,476,653
Later than one year and not later than five years	3,618	133,936	333,430	15,641	11,243,062	8,004	127,460	11,865,151
Later than five years	68,603	1,287,090	3,505,320	101,087	64,071,663	0	0	69,033,763
	73,317	1,456,889	3,934,385	120,714	77,605,984	13,981	170,297	83,375,567

7.1 Reconciliation of Note 7 to Statement of comprehensive net expenditure

	Ex-RHA	ELS	DHSC clinical	DHSC non-clinical	ELGP	CNSGP	CNST	PES	LTPS	Total
	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)
Unwinding of discount / finance charge	1,161	21,525	51,153	21	0	0	433,972	0	46	507,878
Increase in known claims provision	652	70,484	160,489	7,298	448,800	1,208	9,279,404	8,166	118,606	10,095,107
Provision not required written back	(550)	(33,749)	(158,115)	(2,520)	0	0	(2,534,702)	(2,283)	(78,876)	(2,810,795)
Change in discount rate (known claims and IBNR)	(6,307)	(125,008)	(300,357)	(3,034)	0	0	(8,946,529)	(2)	(533)	(9,381,770)
Increase / (decrease) in provision for IBNR	(2,000)	(43,000)	(93,000)	(8,000)	612,000	306,000	3,877,000	1,000	(3,000)	4,647,000
Provision expense charged to Statement of comprehensive net expenditure	(8,205)	(131,273)	(390,983)	(6,256)	1,060,800	307,208	1,675,173	6,881	36,197	2,549,542
Total charge to Statement of comprehensive net expenditure	(7,044)	(109,748)	(339,830)	(6,235)	1,060,800	307,208	2,109,145	6,881	36,243	3,057,420

7.2 Explanatory notes

Nature of the obligation

NHS Resolution administers indemnity cover for clinical negligence and non-clinical claims under nine 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:

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

Indemnity arrangements for coronavirus

A new scheme, the Clinical Negligence Scheme for Coronavirus (CNSC), was launched on 3 April 2020 in response to the need for government to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the coronavirus pandemic, for example the purchase of services/healthcare capacity from independent sector healthcare providers. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related activities are covered by CNSC. This is where the Secretary of State has exercised the discretion under section 11 of the Coronavirus Act 2020 or prior to the commencement of that section, under general powers, to provide indemnity for clinical negligence.

Liabilities arising from healthcare provision in relation to the pandemic that have existing

cover arrangements in place i.e. through CNST, CNSGP, and LTPS, will continue to be covered under those arrangements. This includes the provision of additional health care capacity through the Nightingale hospitals, the recall of retired or ex-NHS staff and general practitioners, and volunteer personnel.

No provision is made in the 2019/20 financial accounts for additional liabilities arising under these indemnity arrangements. This is due to the proximity of these activities to year end where the volume of Covid-19 related hospital admissions increased during March 2020, and elective activity was scaled back/cancelled from 17th March.

The effect on clinical claims volumes resulting from the reduction in elective surgery and attendances for standard procedures due to the response to the pandemic will be more significant for activity in 2020/21, and will not be seen for several years due to the time lags between incidents, claims, and ultimately their settlement. There may also be an increase in claims with causes related directly or indirectly to the healthcare provision during the pandemic, which again, may not present until some time in the future.

The pattern of claims in the LTPS non-clinical scheme may also change. Non-clinical claims tend to present more quickly after the incident date than clinical claims, and have historically been of a lower value on average. The LTPS scheme is of a much smaller scale than clinical claims – during 2019/20 the value of new claims received was £59 million, and £48 million was paid out to settle claims.

The majority (approximately 70%) of the CNST provision is as a result of claims arising from the brain damage of babies at birth from negligent care. The Early Notification scheme requires the notification by providers of maternity care of cases where there is a risk of brain damage at birth. The number of cases reported to the scheme was lower for March 2020 compared to the same time in previous years. However, this may be due to extended time lags in reporting of incidents because of the impact

of the pandemic on frontline priorities, and also because of the changes in reporting requirements for the maternity incentive and Early Notification schemes during March and April 2020 respectively.

At this stage, it is therefore too early to assess whether there will be a change in the level of risk in relation to brain damage at birth cases, the most significant factor in the provision valuation.

Consequently, it is considered that the likely impact of the pandemic on the incidence of claims on or before 31 March 2020 is immaterial to the 2019/20 accounts.

Although Covid-19 could impact future claims behaviour, it is within the range of uncertainty considered when estimating the IBNR provision. This note provides more information on the impact of different claims patterns and assumptions on the provision. We will monitor and consider the changes in the healthcare environment through the Reserving and Pricing Committee in relation to updating our valuation of liabilities arising from claims for the 2020/21 financial year.

Scope of the schemes and arrangements

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

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

Clinical Negligence Scheme for Trusts (CNST)

This scheme provides indemnity cover to providers of NHS services, NHS commissioners, and DHSC arm's length bodies for claims arising from incidents involving clinical negligence. Contributions are collected from members to make settlements and administer claims on their behalf.

The scheme has been operating since 1 April 1995, and claims are included in the provision where:

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

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

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

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

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

Provisions for GP Indemnity

Clinical Negligence Scheme for General Practice

This scheme was launched on 1 April 2019 to provide cover for incidents from that date arising from NHS services commissioned by NHS England and Clinical Commissioning Groups primarily to the provision of primary medical services under general practice contacts.

The scheme is funded out of the budget NHS England and NHS Improvement hold for the NHS, and is received as financing via DHSC.

Existing Liabilities for General Practice

During 2019, the Secretary of State entered into interim arrangements with two Medical Defence Organisations in relation to indemnity being provided in due course by the state, for tortious NHS liabilities of the MDOs' general practice members (i.e. liabilities arising from incidents prior to 1 April 2019): Medical Protection Society (MPS) on 3 April 2019, and Medical and Dental Defence Union of Scotland (MDDUS) on 23 September 2019. The legal responsibility for providing indemnity and managing claims remained with the MDOs during the financial year. NHS Resolution was directed by the Secretary of State to oversee the management of claims by the MDOs under the interim arrangements to ensure value for money was being delivered, and account for the liabilities for claims within scope. Since the establishment of the ELSGP, indemnity for the historical liabilities within scope of the interim arrangements with MDDUS has been provided under the ELSGP.

The scheme is funded out of the budget NHS England and NHS Improvement hold for the NHS, and is received as financing via DHSC.

On 6 April 2020, claims handling responsibility for claims relating to the liabilities within scope of the interim arrangements transferred to DHSC. NHS Resolution has been directed by Secretary of State to administer these claims under the new Existing Liabilities Scheme for

General Practice (ELSGP). The substance of the accounting for the MDDUS claims will continue as for 2019/20, i.e. under IAS 37 Provisions, Contingent Liabilities and Contingent Assets.

Assumption of liabilities upon cessation

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

Process and methodology for setting the provision

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

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

One of the key assumptions used in the production of the estimates reported is outside the formal control of NHS Resolution, as HM Treasury prescribes the discount rates to be used in calculating the provisions. There are other factors that influence the provision that are also outside NHS Resolution's control; for example, patients (and their legal representatives) have an element of control over the timing of the reporting of claims. The Reserving and Pricing Committee keeps all of the factors affecting the calculation of provisions under review to ensure that the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

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

Known claims

The provision is based on the case estimates of individual reported claims received by NHS Resolution. The case estimates are adjusted for the case handlers' estimated probability of each claim being successful, for expected future claims inflation to settlement, for the likelihood that they will go on to settle as structured settlements – with part of the claim paid over the life of the claimant as a periodical payment order (PPO) rather than purely as a lump sum – and for the assumed additional cost if the case were to settle as a PPO.

For ELGP, because case estimates have not been set by NHS Resolution, adjustments have been made to the valuation to reflect historical differences in ultimate settlement costs compared with earlier case estimates. The resulting adjusted claim values are then discounted for the time value of money (at the Treasury-prescribed rates) to give a present value at the accounting date.

Settled PPOs

The Settled PPO model carries out projections on an individual claim-by-claim basis and then aggregates the results. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation).

A probability of survival is then applied to each projected payment and provides a weighting that allows for the relative chance of each payment being made. This forms the cash flows. The longevity of the cash flows is consequently determined by the probabilities of survival. The probabilities of survival for each year for each claim are calculated by the model using mortality tables.

IBNR

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

The steps to arrive at an estimate are:

- A characteristic pattern of claims reporting from claim incident year is identified to determine the ultimate number of claims that are expected to arise from incidents that have occurred in each past year up to the accounting date. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.
- Assumptions are then made about the average claim sizes for different types of claim. Adjustments are made to these assumed claim sizes to allow for expected future claims inflation.
- By combining the average claim sizes with the claim numbers and patterns for the reporting to payment time lag appropriately, a projection is made for the total value of claim payments for IBNR claims in each future year.
- For claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows, based on mortality assumptions derived from the settled PPO claims. Lump sum settlements are assumed to be paid out in full around settlement time.
- The final step in the process is to calculate the present value of the projected future cash flows (using the HM Treasury-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.
- For CNST, ELS and DHSC Clinical Liabilities, these calculations are carried out separately for damages, NHS legal costs and claimant costs, and for PPO and non-PPO type claims.
- For CNSGP, approximate methods have been used based on the estimated costs of ELGP claims in view of the limited data available on CNSGP claims development since the introduction of the scheme in April 2019.



7.3 Key assumptions and areas of uncertainty

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

The following table shows the key assumptions used to determine the CNST IBNR provision, as the CNST IBNR provision is the largest single element of total provisions, and therefore where uncertainty has the greatest effect. For each assumption, the degree of uncertainty in the assumption and the impact of the assumption on the level of provisions has been categorised subjectively as 'high', 'medium' or 'low'. Where appropriate the same assumptions are used for the CNST settled PPOs and known claims provisions.

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

The legal environment is a particular area of uncertainty. There have been a number of recent consultations that might impact the schemes' provisions in the future (such as 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims' issued by DHSC).

The provisions have been valued using the current Personal Injury Discount Rate (PIDR) of minus 0.25%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR. As there is no certainty on the outcomes of future reviews, no adjustments have been made to the IBNR for the potential effects of such changes at this stage.

Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes	Change in assumption between 31 March 2019 and 31 March 2020	Effect of change (CNST)
Ultimate number of claims	Derived from past claim numbers and development patterns	Medium	High	Both the expected number of future PPO claims and non-PPO claims assumptions have reduced slightly	+\$1.2bn (combined effect with probability of paying damages)
Propensity to settle as PPO	Value threshold derived from recent years' settled claims data	Medium	Medium	A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has reduced from \$3.5m to \$3.3m	Impact intertwined with changes in average costs and number of claims
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High	The average costs per claims assumption for non-PPO claims has increased slightly. The average costs assumption for PPO claims has reduced slightly	-\$0.6bn (with speciality adjustment)
Claims inflation	Derived from past settled claims	High	High	The inflation assumption for non-PPO damages has decreased by 0.6% from the previous year. The inflation assumption for PPO damages has also reduced by 0.6%. Both include a 0.3% pa margin for risk and uncertainty	-\$6.0bn (combined effect with HM Treasury nominal discount rates and ASHE)
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium	The change in the assumptions for both non-PPO and PPO claims has increased by 1%	+\$1.2bn (combined effect with ultimate number of claims)
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)	Lag range from 2.8 to 7.7 years, remaining the same at the lower end of the range and increased by 0.2 years at the higher end of the range	+\$0.1bn
Cash flow pattern for PPO payments	Based on analysis of past settled PPO claims	Medium	Low	Expected future lifetime of PPO claimants at settlement has remained the same (37 years).	No impact
Nominal discount rates	HM Treasury prescribed	Prescribed	High	Short- and medium-term rates have reduced by 0.25% and 0.59% respectively. The long-term rate remains unchanged	-\$6.0bn (combined effect with claims inflation and ASHE)
ASHE 6115 (80th percentile)	Based on earnings increases relative to CPI over the longer term	Medium	High	The financial assumptions basis has changed from RPI at +0.75% to CPI at +2.0%.	-\$6.0bn (combined effect with HM Treasury nominal discount rates and claims inflation)

The impacts of the various assumptions can be found detailed in Figure 39: CNST IBNR sensitivities as at 31 March 2020 (page 198).

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

Clinical negligence claims can take a number of years to be reported following the incident that gives rise to the claim.

The IBNR provision depends on an assumed time lag pattern for how claims are reported to NHS Resolution following the incident. If the true pattern of reporting is faster than that assumed, this may mean that the number of IBNR claims has been overestimated, and vice versa. Changing trends in this pattern over time, for example as a result of changes to the legal environment, increased awareness of the availability of compensation and a lack of past data preceding the formation of NHS Resolution, increases the uncertainty in this assumption.

The number of clinical claims reported to NHS Resolution continues to level off. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in past claim trends. The coronavirus outbreak, for example, may have an impact on the volume and nature of claims received in the future due to the significant reduction in accident and emergency attendances and elective procedures, and the volume of patients suffering with Covid-19.

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

The IBNR provisions are subject to considerable uncertainty. At a high level, the method used to calculate the provisions assumes that future experience will be in line with past experience. In particular, the provisions are calculated on the basis of the current legal and claims environment, including the current PIDR. The recent PIDR changes in March 2017 and August 2019 contribute to the inherent uncertainty in the calculation of the

provisions. For example, changes in the PIDR have the potential to impact claimant behaviour, the propensity for claims to settle as PPOs or the balance between the lump sum and structured settlement parts of claims settling as PPOs. In addition, the application of a discount rate with a minus value affects the calculation of accommodation costs under *Roberts v. Johnstone*.

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

The HM Treasury PES discount rate note from December 2019 (which specifies the financial assumptions to be used for valuing provisions at March 2020) states that all cash flows should be assumed to increase in line with the OBR CPI forecasts unless certain conditions are met for this assumption to be rebutted. These conditions are set out in Paragraph 34 of Annex B to the HM Treasury PES note.

For NHS Resolution's IBNR provisions, these conditions have been met:

Condition 1

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

Condition 2

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

Condition 3

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

As a result the claims inflation assumptions are derived by:

- First, looking at nominal increases in average claim costs over past years by reserving segment,
- Then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past, and
- Finally, adding an explicit adjustment for the risk and uncertainty inherent in the provisions (0.3% a year, unchanged from last year).

The second element has been amended this year to reflect price inflation measured using the CPI rather than the RPI. This change is in response to expected future changes to the calculation of RPI and therefore the likelihood is that future RPI increases could differ from past rates because of methodological reasons as well as underlying differences in inflation.

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

The majority of PPOs have payments linked to the retail price index (RPI) and/or ASHE 6115 (a wage inflation index) and the future rates of increase in these indices are uncertain. In particular, the Government and UK Statistics Authority are currently consulting on proposals to change the calculation of the RPI. Further, ASHE 6115 relates specifically to care and home workers and external factors impacting this market in recent years have increased the uncertainty in setting this assumption.

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

The provisions in respect of GP indemnity claims rely on historical claims data provided by organisation with different claims processes and systems. This, together with any changes in claims development following the recent changes in these arrangements, contributes to the uncertainty inherent in these provisions.

CNST IBNR sensitivities as at 31 March 2020

The IBNR provisions are sensitive to the assumptions used to varying degrees. The CNST IBNR provision is the single largest element within the total provision. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision.

The following sections indicate the impacts on the CNST IBNR provision of using different assumptions in two different ways. The reasonable range results are intended to illustrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision. For this assessment, a number of assumptions are varied together but the variations are limited to those that could have reasonably been chosen based on the same analysis of past data.

The sensitivity analysis shown subsequently indicates how wider variations in individual assumptions would affect the provision. This demonstrates the extent to which plausible differences between the assumptions chosen and actual future experience could affect future years' provisions and the ultimate costs of settling claims.

Reasonable range of results

The provision in the accounts is based on a set of chosen assumptions. It is possible to have a range of different results if a different set of assumptions had been chosen.

A reasonable range of results follows, based on assumptions which, considering the historical data analysed and the approach used, could have reasonably been selected in lieu of the chosen assumptions. The reasonable range illustrates the potential outcome if different conclusions had been reached based on the same data. Although it should be noted that this in itself does not reflect the potential uncertainty in the assumptions underpinning the provision as future experience may differ to the past, changes may occur in the claims and legal environment, and the modelling approach may not be a perfect representation of real life.

CNST IBNR reasonable range

	Value	Difference to accounts estimate
Baseline CNST IBNR	£44.4bn	
Reasonable upper range	£51.8bn	16.7%
Reasonable lower range	£38.2bn	-14.0%

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

- The estimate for numbers of PPO damages claims for the incident years 2015/16 onwards;
- The probability of defence for PPO type claims;
- The average cost for PPO damages;
- PPO damages claims inflation;
- The creation to settlement lag for PPO claims.

In summary, the provision in the accounts for CNST IBNR could have been reasonably set at a value between £38.2 billion and £51.8 billion, if the same data, method and approach were used, but different reasonable assumptions were selected on the basis of the past data. This is compared to the accounts estimate of £44.4 billion.

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

Sensitivity analysis

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

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

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

Figure 39: CNST IBNR sensitivities as at 31 March 2020

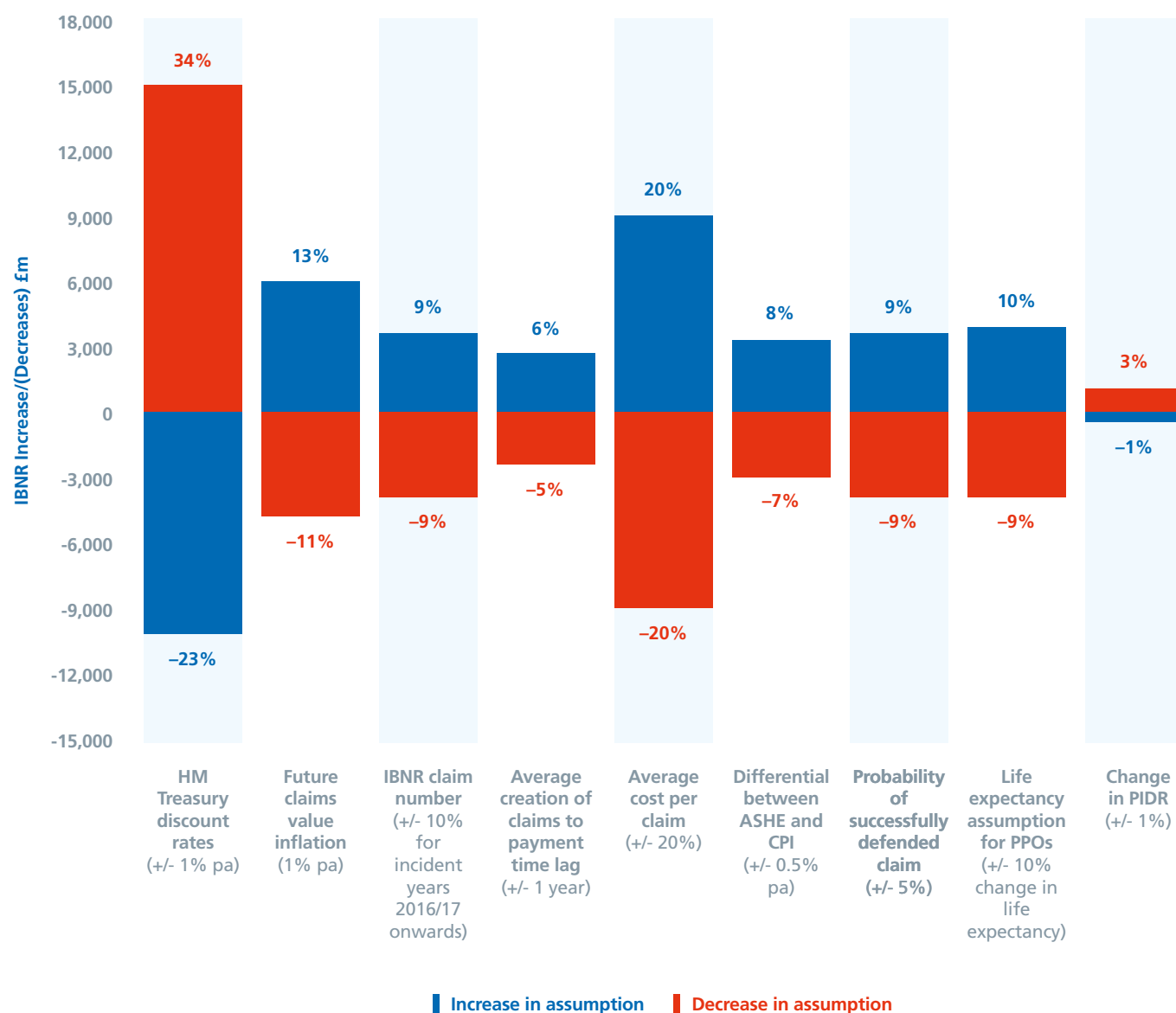


Figure 39 sets out both the value and percentage impact of variations in the key assumptions within the CNST IBNR estimate, which are also explained in the remainder of this note.

Sensitivity of estimated CNST IBNR provision as at 31 March 2020 to movements in the HM Treasury tiered nominal discount rates

Since 2018/19, HM Treasury specifies PES discount rates in nominal terms.

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

		31/03/2020 nominal rates (%pa)	31/03/2019 nominal rates (%pa)
Short term	(<5 years)	0.51%	0.76%
Medium term	(5-10 years)	0.55%	1.14%
Long term	(10-40 years)	1.99%	1.99%
Very long term	(over 40 years)	1.99%	1.99%

Figure 40: Sensitivity of the CNST IBNR provision to changes in the nominal discount rates assumption (£ billion, by change in discount rate from base assumption)

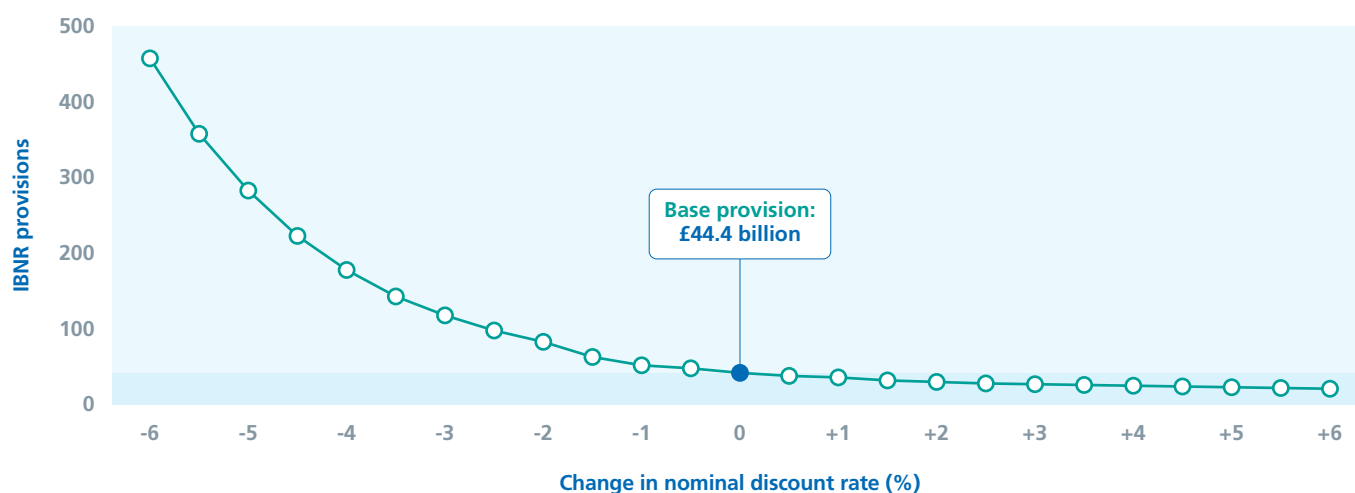


Figure 40 is based on adjusting the nominal discount rate by the increments shown. A change in the nominal interest rate of +1% would represent short-, medium- and long-term nominal interest rates of 1.51%, 1.55% and 2.99%, respectively. As a result of the range of the increments analysed (and, for example, the long-term nominal interest rate of 1.99%), results to the left of the graph imply a negative nominal discount rate.

For the clinical schemes, the changes in discount rates this year have had a relatively small impact on the IBNR provisions. This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than 10 years' time and the long-term discount rate hasn't changed since last year.

Sensitivity to future claims value inflation assumption

Figure 41: CNST IBNR (£bn) adjusted by claims inflation

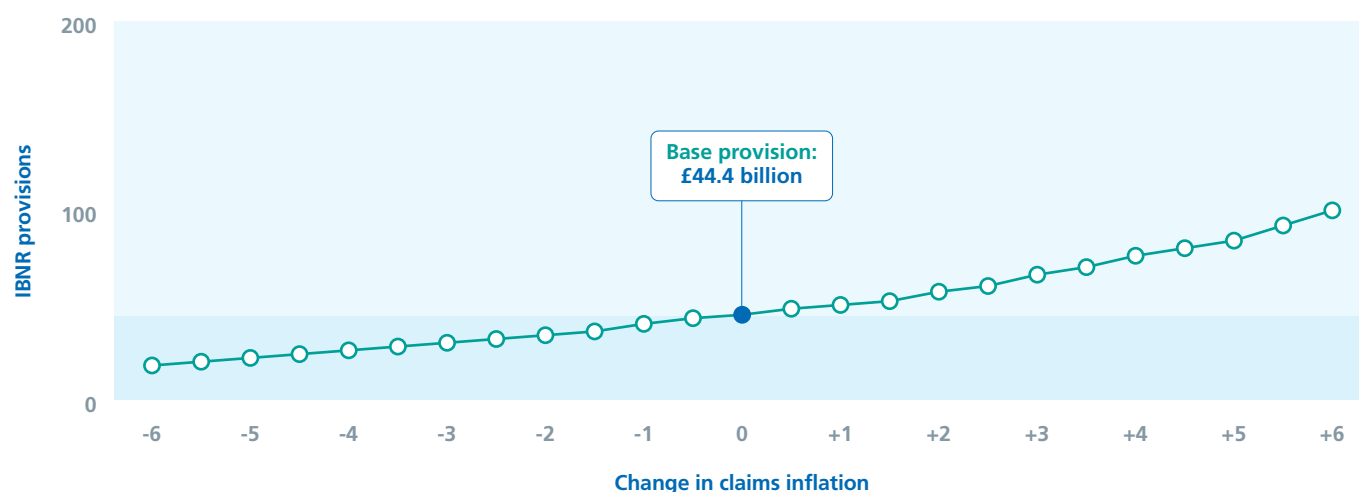
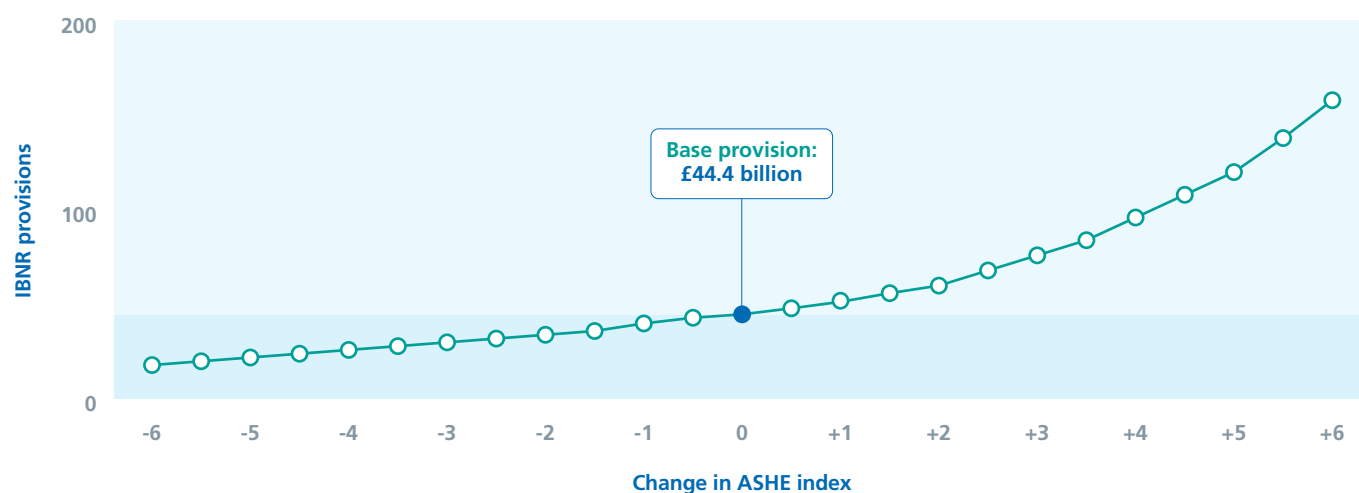


Figure 41 shows the impact of changes in the ASHE assumption to the IBNR provisions. Applying an ASHE assumption of 2.5% rather than the 4.0% rate selected by NHS Resolution could result in reductions in the CNST IBNR provisions up to around £8bn.

Sensitivity to differential between ASHE and CPI

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The current assumption is that the rate of inflation in carers' wages is 2% higher than CPI price inflation each year. The graph shows the effect on the value of the CNST IBNR provision where this differential is varied and as the following chart shows, this is a non-linear relationship. An additional +/- 0.5% difference between ASHE and CPI will either increase the provision by 8% or reduce it by 7% respectively.

Figure 42: CNST IBNR (£bn) adjusted by ASHE index



Known claims sensitivities

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

Settled PPOs represent 50% of the value of the known claims provision and are typically high value cases, and the long-term nature of them mean they are highly sensitive to changes in key assumptions. The following tables show the effect on the valuation if different rates and assumptions were applied for HM Treasury discount rates, the differential between CPI and annual hourly earnings (ASHE), and life expectancy.

HM Treasury discount rate assumptions

Due to the long-term nature of PPOs, where PPO claims can be expected to continue for 50 years or longer, the PPO element of the provision is very sensitive to changes in the HM Treasury-prescribed discount rate, especially the long-term discount rate. As shown above in the discussion of the CNST IBNR provision sensitivity, the relationship between the value of the provision and the effect of changes in the discount rate is not a proportionate one. A reduction of 1% in the discount rates will increase the PPO element of the CNST provision by 38%, but a 1% increase will reduce the provision by 25%.

Provision for settled PPOs at 31 March 2020

HM Treasury discount rate	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
All rates -1% pa	25,529	21,097	1,350	3,004	75	2	1
Base assumption	18,659	15,270	1,014	2,315	57	2	1
All rates +1% pa	14,163	11,493	785	1,837	45	2	1

Percentage change to provision

HM Treasury discount rate	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -1% pa	37%	38%	33%	30%	32%	-8%	21%
Base assumption	0%	0%	0%	0%	0%	0%	0%
All rates +1% pa	-24%	-25%	-23%	-21%	-22%	-8%	21%

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

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. It is currently assumed that the rate of inflation in carers' wages is 2% higher than CPI annually. The following table shows the effect on the value of the PPO element of the schemes' provisions where this differential is varied. An additional +/- 0.5% difference between ASHE and CPI will either increase the CNST PPO provision by 16% or reduce it by 13% respectively.

Provision for settled PPOs at 31 March 2020

Differential between CPI and ASHE	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
All rates -0.5%	16,338	13,270	913	2,101	51	2	1
Base assumption: 0.25% pa	18,659	15,270	1,014	2,315	57	2	1
All rates +0.5%	21,478	17,706	1,135	2,570	64	2	1

Percentage change to provision

Differential between CPI and ASHE	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -0.5%	-12%	-13%	-10%	-9%	-11%	-8%	21%
Base assumption: 0.25% pa	0%	0%	0%	0%	0%	0%	0%
All rates +0.5%	15%	16%	12%	11%	13%	7%	21%

Life expectancy assumptions

The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Where the life expectancy of individual claimants at settlement is increased by 10%, the provision for CNST PPOs will increase by 18%. A 10% reduction in life expectancy will reduce the CNST provision by 16%.

Provision for settled PPOs at 31 March 2020

Life expectancy of claimants	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
Life expectancy -10%	15,649	12,808	849	1,942	47	2	1
Base assumption:	18,659	15,270	1,014	2,315	57	2	1
Life expectancy +10%	21,996	18,006	1,196	2,724	67	2	1

Percentage change to provision

Life expectancy of claimants	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
Life expectancy -10%	-16%	-16%	-16%	-16%	-17%	-12%	21%
Base assumption:	0%	0%	0%	0%	0%	0%	0%
Life expectancy +10%	18%	18%	18%	18%	18%	-8%	21%

Sensitivity of outstanding claims to key assumptions excluding CNSGP and ELGP

Outstanding claims represent 50% of the known claims provision. The following tables show the effect on the valuation if different assumptions were applied in relation to the HM Treasury discount rates, the differential between CPI and annual hourly earnings (ASHE), life expectancy and the claims inflation assumptions.

This is the first year the CNSGP and ELGP schemes are recognised in the accounts and so have been excluded from the sensitivity analysis at this point. The shorter-term nature of such liabilities means they are less sensitive to changes in assumptions when compared to established clinical schemes, especially given that GP indemnity claims have historically settled as lump sum awards rather than PPOs and it is PPOs that are most sensitive to the key assumptions because of their long-term nature.

HM Treasury discount rate assumptions

The following table shows the impact of adjusting the HM Treasury prescribed nominal discount rates by +1% and -1% on known claims. Payments expected to be made in the distant future are more significantly impacted by changes to the discount rates. In general, the clinical schemes are more sensitive to changes to the discount rates due to the long-term payment profile of the claims. In particular, claims that are expected to settle as PPOs can have payments that are expected to be made over 50 years into the future, so even small changes to the discount rates can significantly impact the value of these claims in current prices. A reduction of 1% in the discount rates will increase the PPO element of the CNST provision by 24%, but a 1% increase will reduce the provision by 16%.

Provision for outstanding claims at 31 March 2020

HM Treasury discount rate	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -1%	22,842	22,145	124	463	0	90	10	10
Base assumption	18,471	17,897	98	367	0	89	10	10
All rates +1%	15,486	14,991	81	306	0	88	10	10

Percentage change to provision

HM Treasury discount rate	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	PES	DHSC non-clinical
All rates -1%	24%	24%	26%	26%	0%	2%	0%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%	0%
All rates +1%	-16%	-16%	-18%	-17%	0%	-1%	0%	0%

Differential between CPI and ASHE

The ASHE index is commonly used to determine the size of future structured settlement payments for PPOs. The value of claims contained in the known provision that is expected to settle as PPOs in the future is sensitive to the future ASHE assumption. The future ASHE assumption is set in relation to CPI (CPI + 2%).

The following table shows the effect on the value of the outstanding claims in the known claims provision of changes to the future ASHE assumption. An additional +/- 0.5% per annum difference between CPI and ASHE will either increase the value of the CNST outstanding claims in the known claims provision by 10% or reduce it by 8%, respectively.

Provision for outstanding claims at 31 March 2020

Differential between CPI and ASHE	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -0.5%	16,958	16,430	89	331	0	88	10	10
Base assumption	18,471	17,897	98	367	0	89	10	10
All rates +0.5%	20,277	19,655	109	404	0	89	10	10

Percentage change to provision

Differential between CPI and ASHE	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	PES	DHSC non-clinical
All rates -0.5%	-8%	-8%	-9%	-10%	0%	-1%	0%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%	0%
All rates +0.5%	-10%	10%	11%	10%	0%	0%	0%	0%

Life expectancy assumptions

The value of claims contained in the known provision that is expected to settle as PPOs in the future is sensitive to changes to the life expectancy of claimants.

The following table illustrates the effect on the value of the outstanding claims in the known claims provision of changes to claimant's life expectancies. Where the life expectancies of individual claimants at settlement are increased by 10%, the value of the CNST outstanding claims in the known claims provision would be expected to increase by 10%. A 10% reduction in life expectancies would be expected to reduce the provision by 9%.

Provision for outstanding claims at 31 March 2020

Life expectancy of claimants	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
Life expectancy -10%	16,840	16,315	88	328	0	89	10	10
Base assumption	18,471	17,897	98	367	0	89	10	10
Life expectancy +10%	20,277	19,655	109	404	0	89	10	10

Percentage change to provision

Life expectancy of claimants	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	PES	DHSC non-clinical
Life expectancy -10%	-9%	-9%	-10%	-11%	0%	0%	0%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%	0%
Life expectancy +10%	10%	10%	11%	10%	0%	0%	0%	0%

Changes to claims inflation

The following table shows the effect on the value of outstanding claims in the known claims provision of a +/- 1% change to the claims inflation assumptions. An increase of 1% to the claims inflation assumptions will increase the value of the CNST outstanding claims in the known claims provision by 1% per annum, and a 1% reduction per annum will reduce the provision by 1%.

Provision for outstanding claims at 31 March 2020

Change in claims inflation	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -1%	18,244	17,678	98	359	0	89	10	10
Base assumption	18,471	17,897	98	367	0	89	10	10
All rates +1%	18,699	18,122	98	370	0	89	10	10

Percentage change to provision

Change in claims inflation	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	PES	DHSC non-clinical
All rates -1%	-1%	-1%	0%	-2%	0%	0%	0%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%	0%
All rates +1%	1%	1%	0%	1%	0%	0%	0%	0%

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 additional claims payments to those already provided for. These amounts are not included in the accounts but shown as a Note to the financial statements because a transfer of economic benefit 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 provision 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).

Ex-RHA	ELS	DHSC clinical	DHSC non-clinical	ELGP	CNSGP	CNST	PES	LTPS	Total
(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)	(£m)

Contingent liability as at 31 March 2020

16,000	496,782	942,028	90,854	1,048,000	349,033	45,319,186	7,100	129,394	48,398,377
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Contingent liability as at 31 March 2019

22,081	675,258	1,077,652	102,773	0	0	47,546,614	7,137	138,175	49,570,690
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As a result of the dissolution of NHS primary care trusts and strategic health authorities (on 1 April 2013), NHS Resolution has taken on responsibility for any outstanding criminal liabilities, on behalf of the Secretary of State for Health and Social Care. Any valid claims arising from the activities of those organisations will be dealt with by NHS Resolution and funded in full by DHSC.

As referred to in Note 7.2, a new scheme – Clinical Negligence Scheme for Coronavirus – has been launched from 3 April 2020. No provisions have been made for any liabilities arising from incidents within scope of the scheme prior to this date as it is considered to be immaterial to the 2019/20 accounts. Similarly, the value of any contingent liability related to Covid-19 in the 2019/20 accounts is considered to be immaterial.

9. Commitments under operating leases

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

Land and buildings		2019/20 (£000s)	2018/19 (£000s)
Amounts payable:	Within 1 year	1,228	1,117
	Between 1 and 5 years	0	1,105
	After 5 years	0	0
		1,228	2,222
Other leases:	Within 1 year	7	32
	Between 1 and 5 years	0	0
	After 5 years	0	0
		7	32

10. Related parties

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

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

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below. The remuneration for executive and non-executive directors for the roles they perform for NHS Resolution is disclosed in the Remuneration and staff report on page 134.

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

Name and position in NHS Resolution	Party	Nature of relationship	Payments to related organisation (£000s)	Receipts from related organisation (£000s)	Amount owed to related organisation (£000s)	Amount due from related organisation (£000s)
Denise Chaffer Director of Safety and Learning	Epsom and St Helier NHS Trust	Midwife	–	14,714	–	22
	Croydon University NHS Trust	Partner is a Consultant Radiologist	–	13,790	–	33
Sam Everington Associate Non-executive Member	East London Foundation Trust	Non-executive Director	–	1,104	–	28
	Tower Hamlets CCG	Chair Wife is a Board Member	–	– 8	–	–
Helen Vernon Chief Executive	Tameside and Glossop NHS Trust	Brother is a Consultant Geriatrician	–	8,162	–	11
	NHS England	Brother is National Clinical Director for Older People and Person Centered Integrated Care ¹	–	9,924	–	2,001
	Manchester University NHS Foundation Trust	Brother is a Consultant Geriatrician ¹	–	33,717	–	31

¹ Left both employments 31 January 2020

11. Financial instruments

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

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

As the majority of NHS Resolution's income comes from contracts with other NHS bodies, NHS Resolution has low exposure to credit risk. The maximum exposures are in receivables from customers, as disclosed in Note 4: Receivables.

12. Events after the reporting period

Subsequent to the Balance Sheet date, NHS Resolution is operating two new indemnity schemes.

A new scheme, the Clinical Negligence Scheme for Coronavirus (CNSC), was launched on 3 April 2020 in response to the need for government to provide indemnity cover for clinical negligence arising from the NHS healthcare arrangements put in place to respond to the coronavirus pandemic, for example the purchase of services/healthcare capacity from independent sector healthcare providers. This is where no existing indemnity or insurance arrangements cover the clinical negligence. Any clinical negligence liabilities arising prior to or after this date from these coronavirus-related NHS activities are covered by CNSC by direction from Secretary of State under section 11 of the Coronavirus Act 2020 or, prior to the commencement of that section, under general powers to provide indemnity for clinical negligence.

On the 6 April 2020 DHSC introduced the Existing Liabilities Scheme for General Practice (ELSGP) to be administered by NHS Resolution on behalf of the Secretary of State. Claims arising from the historical liabilities within scope of the interim arrangements with the MDDUS have, from that date, been handled by NHS Resolution on behalf of the Secretary of State. Claims for liabilities within scope of the interim arrangements with MPS will be handled under the ELSGP from the start of the next financial year.

The provision assumptions on all relevant schemes will be reviewed in 2020/21 in light of Covid-19.

These financial statements were authorised for issue on the date that the Comptroller and Auditor General certified the accounts.

Glossary

ALB

Arm's length body.

AvMA

Action against Medical Accidents
(<https://www.avma.org.uk>)

CCGs

Clinical commissioning groups have taken over commissioning from primary care trusts.

CFA

Conditional fee arrangement: a type of funding agreement between claimant lawyers and their clients.

CNSGP

Clinical Negligence Scheme for General Practice.

CNSC

Clinical Negligence Scheme for Coronavirus.

CNST

The Clinical Negligence Scheme for Trusts indemnifies members for clinical negligence claims.

CPI

Consumer Price Index.

DHSC

Department of Health and Social Care.

HM Treasury discount rates

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

Duty of candour

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

ELGP

Existing Liabilities for General Practice. The Secretary of State has agreed interim arrangements with two Medical Defence Organisations, Medical Protection Society, and Medical and Dental Defence Union of Scotland, in relation to NHS historical liabilities arising from general practice incidents that occurred prior to 1 April 2019. NHS Resolution carries out the Secretary of State's oversight responsibilities under those interim

arrangements in relation to the management of claims for the liabilities within scope of the arrangements. The costs are funded out of the budget for the NHS held by NHS England and NHS Improvement, which are transferred to NHS Resolution via financing from DHSC.

ELS

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

ELSGP

Existing Liabilities Scheme for General Practice - covers NHS historical liability claims of general practice members of MDOs that enter into interim arrangements in respect of such liabilities. Liabilities within scope of the interim arrangements with the Medical Protection Society (MPS) will be covered under the ELSGP from 1 April 2021. Those within scope of the arrangements with the Medical and Dental Defence Union of Scotland (MDDUS) are covered under the ELSGP since 6 April 2020.

Ex-RHA

The Ex-Regional Health Authorities Scheme is funded by DHSC and is a clinical negligence claims scheme that indemnifies the liabilities of former regional health authorities.

Extranet

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

FHSAU

Family Health Services Appeal Unit, now known as Primary Care Appeals.

GIRFT

Getting It Right First Time
(<https://gettingitrightfirsttime.co.uk>)

HPAN

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

IBNR

Incurred but not reported claims; claims that may be brought in the future.

LASPO

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

Legal costs

Amounts paid out by NHS Resolution in legal costs for claims resolved: including NHS legal and claimant costs, this can include expert and counsel's fees as well as court costs.

LTPS

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

MDDUS

Medical and Dental Defence Union of Scotland is a mutual defence organisation offering access to expert medico-legal and dento-legal advice and professional indemnity for doctors, dentists and other healthcare professionals across the UK (www.mddus.com).

MDO

Medical Defence Organisation provides professional indemnity insurance alongside other member services.

MDU

Medical Defence Union indemnifies doctors for incidents arising from their clinical care of patients (www.themdu.com).

Member

NHS Resolution is a membership organisation comprising NHS trusts, CCGs, independent healthcare providers to the NHS and other government agencies related to healthcare.

MPS

Medical Protection Society is a not-for-profit protection organisation for doctors, dentists and healthcare professionals (www.medicalprotection.org).

NCAS

The National Clinical Assessment Service helps resolve concerns about the professional practice of individual doctors, dentists and pharmacists in the UK. Now known as Practitioner Performance Advice.

NHS LA

National Health Service Litigation Authority, the legal name of NHS Resolution.

NRLS

The National Reporting and Learning System was established in 2003, and is a system that enables patient safety incident reports to be submitted to a national database. These data are then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

OBR

Office for Budget Responsibility.

PCTs

Primary Care Trusts. Local NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

PES

The Property Expenses Scheme indemnifies NHS members for property claims.

PIDR

Personal injury discount rate.

PNA

Pharmaceutical needs assessment.

PPO

A periodical payment order is a court order that grants the claimant a lump sum payment followed by regular payments over the life of claimant.

RPI

Retail Price Index.

SHAs

Strategic Health Authorities. Regional NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

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ISBN: 978-1-5286-1997-4 CCS: CCS0620708408 Published: July 2020



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