NHS Resolution

Annual report and accounts
2021/22

HC **436**

Advise / Resolve / Learn

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NHS Resolution
Annual report and accounts
2021/22

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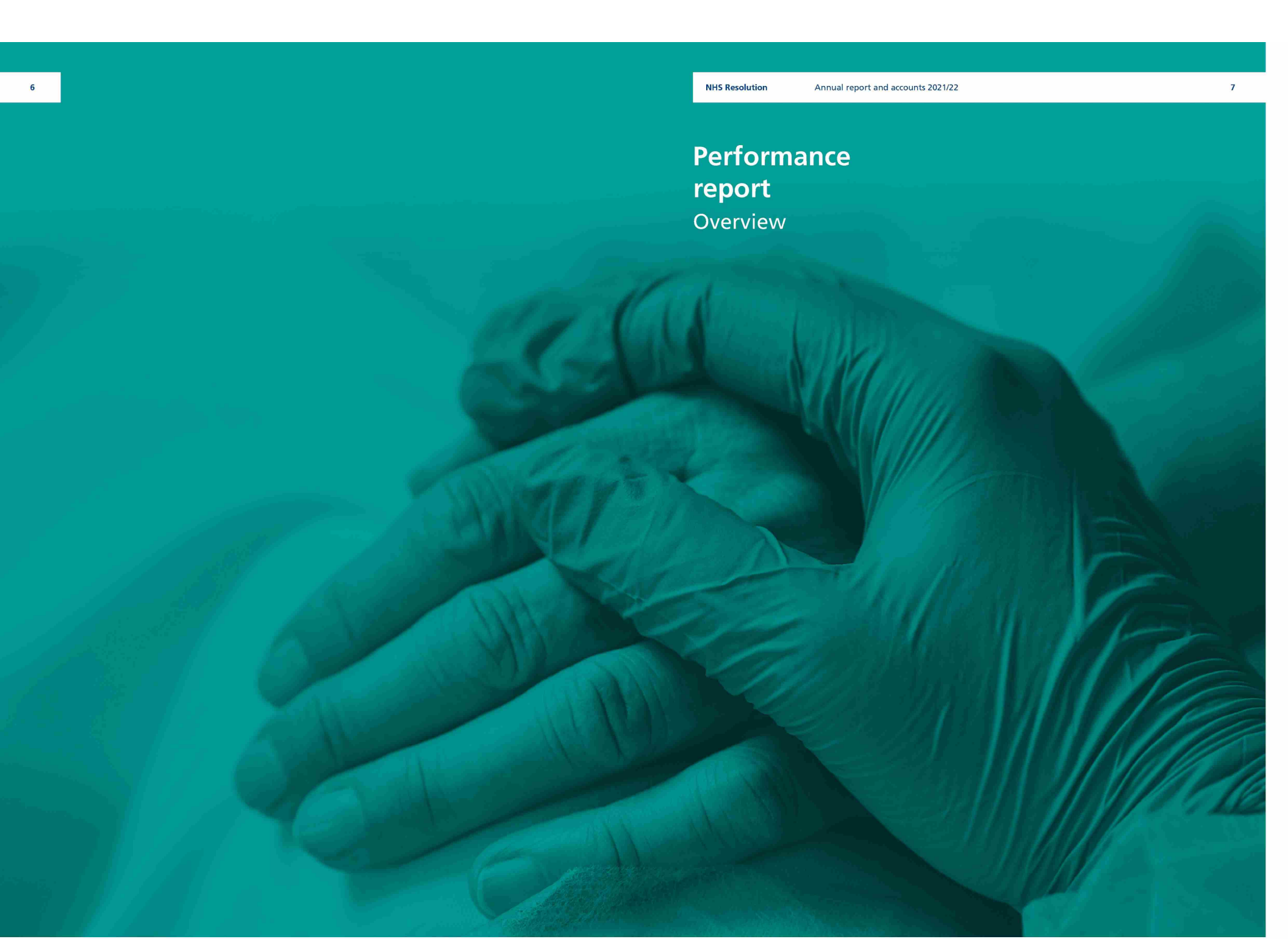


Chair's welcome

2021/22 was a pivotal year for NHS Resolution and the services we provide for the National Health Service and its patients and staff. Against the background of ongoing disruption caused by the Covid-19 pandemic, this year marked the completion of our former five-year strategy, creating a firm foundation for the generation of our approach for the next three-years outlined in *Advise, resolve and learn: Our strategy to 2025*[1].

Mike Pinkerton / Interim Chair

The last five years have seen what was the NHS Litigation Authority (NHSLA) truly develop and change into NHS Resolution, not only in name but in substance. There can be no greater illustration of that than the graph on page 38, which shows a fundamental shift from formal litigation towards non-litigated claim resolution methods, which are invariably less adversarial and often better for patients and staff alike.

By way of a reminder of our journey over the last five years – our strategy was shaped by three key themes:

- **Proactively driving a less adversarial system**
- **Using our expertise and data to improve safety**
- **Delivering greater value**

and delivered by an organisation which capitalised on the synergy generated by the former NHSLA, National Clinical Assessment Service and Family Health Services Appeal Unit becoming integrated as NHS Resolution. A summary of the achievements of that strategy is set out on page 12.

No strategy can predict all events and our five-year programme was influenced by new Government requests (e.g. the general practice indemnity schemes) and the Covid-19 pandemic (for example, the coronavirus indemnity schemes).

Our operating model, partnering with our legal panel, allowed us to flexibly respond to new priorities without significantly affecting progress towards our strategic aims and we took the opportunity to refresh the strategy in 2019 to ensure continued relevance.

Irrespective of all the above achievements, the cost to the public purse of responding to clinical negligence continued to rise over the last year with damages payments under secondary care clinical schemes increasing by 10.3% to £1.775 billion and claimant and NHS legal costs also rising, the latter at a slower rate than the former. The biggest single influence on our provision remains the long-term discount rates set by HM Treasury to place a value in today's prices on payments against claims that we expect to make many years into the future. The 2021 discount rate reductions have increased the forward provision by £42.6 billion to £128.6 billion. This is an accounting provision that will further change with future rate changes. Another important figure to focus on is the provision for CNST for claims arising from incidents in 2021/22, which is £13.3 billion, a figure we have referred to previously as the "annual cost of harm". Removing the effect of the HM Treasury discount rate change translates this figure to £8.7 billion which is comparable to previous years, while remaining a very significant sum.

The key contributor to this is the cost of maternity related claims which make up 62% of secondary care clinical claims by value and 12% by volume, hence our continued focus on supporting improvements in maternity care and the magnification of this priority within our new strategy. Our Early Notification Scheme is providing contemporary safety feedback for the NHS (rather than delayed by several years following a mature claim) and supporting families better with earlier admissions of liability and interim payments where appropriate.

[1] https://resolution.nhs.uk/2022/05/19/nhs-resolution-strategy-to-2025-published/

The Maternity Incentive Scheme continues to mature and develop, driving and assuring the delivery of a range of safety related actions, determined by a multiagency expert group, by all providers.

Also encouraging is that the number of Clinical Negligence Scheme for Trusts (CNST) claims reported to us has remained essentially static over recent years, with a rate reduction when standardised against growing NHS activity. In 2021/22 there was a reduction of 534 clinical claims (or 5%) compared to the previous year. We see this as likely to be related to restrictions caused by the pandemic and we consequently expect to see an increase in levels in future. However, the additional claims impact of actions taken by the NHS to manage the pandemic are difficult to predict and will unfold over time as the average lag from an incident occurring to a claim being lodged is around three years. Our overall clinical claims and incidents reported has sharply increased, but this is predominantly due to NHS Resolution now managing primary care claims that were previously the responsibility of other bodies, which has also required growth in our staff numbers to provide these new, additional services.

Our wider performance analysis is set out from page 29. It identifies that the majority of our key performance indicators have been met and, where they have not been met, provides an explanation as to the reason. Moving forward, we are a growing organisation with new duties added to our portfolio and also major change programmes underway. This combination changes our risk profile and we will mitigate this through further developing our corporate risk management approach. Our governance in-year was enhanced by the institution of a People Committee as a formal sub-committee of the Board, ensuring we have additional scrutiny of people and organisational development matters.

With the pandemic continuing to profoundly affect the NHS and other public services, we did what we could to reduce the burden on NHS staff, while also supporting the health and wellbeing of our own staff while they worked in a number of new ways and latterly in new locations in both London and Leeds. Long-held plans were implemented under our Ways of Working (WoW) programme to improve the working conditions and processes for our staff while reducing the cost and increasing the efficiency of our offices, and were flexible enough to accommodate the now mainstream 'hybrid' approach. Staff transferred to new office locations in both London and Leeds which has enhanced the working environment while also allowing for more efficient working practices and reduced estates 'footprint'.

We were increasingly concerned to understand and amplify the impact of our activities, particularly in Safety and Learning, and commissioned academic partners to help us rigorously evaluate our work. They will report in 2022.

We supported a range of policy developments and inquiries with information and analysis. We await the outcome of the *Fixed recoverable costs in lower value clinical negligence* consultation and also the forthcoming Government consultation on the future of clinical negligence, which is the product of ongoing work across Government departments following the Public Accounts Committee recommendations in November 2017.

In 2021/22 our two major multi-year change programmes began on the ground in earnest, aimed at reforming our claims operating model and aligning us to the new regionalised NHS and social care landscape of integrated care systems and radically replacing our legacy IT systems and enhancing our information capability. The combined and related impacts of these two major change programmes will be a step change in efficiency and effectiveness with better, more informed services for our scheme members and optimal insight delivered for our own use and, perhaps more importantly, in concert with other system partners to drive evidence-based improvement within the NHS.

During the year we had a number of changes to the Board, saying goodbye to our former Chair Martin Thomas and also our longest standing Non-Executive Director Keith Edmonds. We welcomed new non-executive directors, namely Janice Barber and Dame Lesley Regan, who bring a wealth of additional knowledge and experience of legal and clinical areas respectively. I would like to thank all Board colleagues, past and present, for their expertise and contributions which have shaped our strategy and delivery.

I would also like to thank our CEO and Executive Team and our wonderful staff who continued to deliver what was asked of them, and more, in sometimes difficult and challenging circumstances. That also goes for our many partners and not least our Legal Panel, who again had to adapt quickly to new circumstances.

As we look forward to 2022/23 and delivering year one of our new strategy, we have every reason to believe that our progress will continue based on the foundation built over the last five years and we remain ambitious to deliver increasing benefits for the people we serve and for the NHS.

Mike Pinkerton
Interim Chair

Chief Executive's report

2021/22 marks the final year of our five-year strategy, 'Delivering fair resolution and learning from harm', and sets the scene for our strategy for the next three years. Our new strategy sets out how we will continue to build on the progress made and as such it does not represent a fundamental change in direction.

Helen Vernon / Chief Executive

This is because we believe that the central tenet of an upstream approach to resolving the things that are our core business, namely compensation claims, performance concerns and contracting disputes, continues to hold true. Both we and those we work with can have the most impact by learning from what happened to prevent a recurrence and by taking action to prevent an issue escalating unnecessarily into distressing and expensive formal processes.

The issues we deal with are complex and the initiatives we have launched during the last five years have been aimed at long term and sustainable change. We have worked hard to achieve a shift in adversarial environment to one where formal litigation has fallen year on year to an all-time low, and where dispute resolution outside of the court system or other formal processes is no longer exceptional or novel. This has not resulted in a less rigorous approach. As set out at page 36 of this report we continue to resolve a high and increasing number of claims without payment of damages, preserving millions of pounds of public funds, while resolving claims where compensation is due fairly and as quickly as we can. In addition, as we illustrate on pages 40 to 42 of this report, we also continue to bring our more than 25 years' expertise in healthcare claims to the management of cases in the higher courts which determine the boundaries of the law in the future.

We are also more frequently taking the decision to pursue a custodial sentence through contempt of court proceedings for those who bring exaggerated or fabricated claims as described at page 42.

Our Early Notification (EN) Scheme for obstetric cerebral palsy is singled out as an exemplar of our upstream approach and progress is reported from page 30. This is an innovation which aims to demonstrate over time that early intervention can bring benefits for all those affected by negligent care, as well as real time improvements in safety and, ultimately, reductions in associated costs. As the EN Scheme reaches a tipping point, where the cases investigated in the first year would have been expected to reach us under the traditional model, we plan to evaluate the scheme to inform its future development.

As with any strategy, critical to our success has been the need to adapt rapidly to the unexpected. In 2018 we were asked to deliver new indemnity schemes for general practice. At pages 36 and 37 of our report we describe how these new schemes, which involved the Government's acquisition of historical claims as well as responsibility for new ones, have led to a growing portfolio. The main scheme – Clinical Negligence Scheme for General Practice – will, as expected, gather pace as more and more incidents fall within its scope. The general practice schemes are now feeding more substantially into our reporting on clinical claims, providing a more complete picture of clinical negligence in the NHS. For example, at page 36 we illustrate how claims in secondary care have fallen in number (our Clinical Negligence Scheme for Trusts) but how the addition of the new general practice schemes means that our incoming and settled clinical claims numbers are rising overall. This entails increased activity by our organisation, particularly when coupled with the acceleration of investigations under our EN Scheme by several years. We have laid the groundwork to manage this increased workload with a planned expansion of our workforce and two major change programmes in claims management and IT. We aim to make the very most of the opportunities presented by our expanded remit to drive efficiencies and improvements to our services across the board.

The second unexpected development has of course been the Covid-19 pandemic, which has permeated every aspect of our work in 2021/22, ranging from the increased support provided to our own staff described at page 81, to the rapid launch and delivery of new indemnity schemes to respond to the pandemic healthcare arrangements. The pandemic has also caused us to make changes to the way in which we operate and to our services, such as the pause to the Maternity Incentive Scheme to relieve the burden on frontline services. Wherever possible, we have drawn on pandemic arrangements as a way to accelerate change and to innovate. This includes increased collaboration to circumvent constraints in the justice system and the remote delivery of services such as online mediation, the first virtual performance assessments and remote site visits in our Primary Care Appeals service.

A constant, however, has been the continued rise in the costs of compensation claims for clinical negligence. The dominant feature of our accounts this year is the 51% increase in the provision from £85.2 billion[1] to £128.6 billion. This increase is almost entirely due to a downward adjustment in the prescribed HM Treasury discount rate. This is a technical accounting feature but illustrates the sensitivity of our accounts to adjustments in the assumptions used of which this is one number. Claims inflation, in the meantime, has slightly abated, with increasing evidence that the long-term trend is below levels previously assumed. While this is positive news, the overall trajectory remains upwards and of concern. This has recently been examined by the Health and Social Care Select Committee and where Government has announced an intention to consult on a range of approaches to address rising clinical negligence costs. We look forward to continuing to support this work that, as the National Audit Office identified in 2017, is a cross-government matter, which cannot be addressed by NHS Resolution or the Department of Health and Social Care in isolation.

This is another reason why partnership working is so important to us. Nothing that we set out to achieve can be done alone, and in that regard we are indebted to our partners across health and justice who have worked with us to deliver against shared objectives. Our Maternity Incentive Scheme is a great illustration of this, demonstrating how the pricing of indemnity schemes can be called into action to drive improvements in safety which are curated by others such as the royal colleges. We are particularly grateful this year to the members of our new Maternity Voices Partnership who are helping us to develop our services in a way which is better connected with the needs of patients and families. I would also like to thank the clinical staff who have generously given up their time and expertise to inform our work in learning from claims.

Finally, I want to take this opportunity to pay tribute to our incredible staff who go above and beyond every day to deliver to the best of their ability for the NHS and the patients we all work for. I am looking forward to working with them all, and with our partners and sponsoring department, as we enter our new three-year strategy, 'Advise, resolve and learn'.

Helen Vernon
Chief Executive

[1] The opening balance at 1 April 2020 and closing balance at 31 March 2021 have been increased by £2,790 million and £2,457 million respectively to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

Delivery of NHS Resolution's strategy from 2017 to 2022: A summary

Proactively driving a less adversarial system

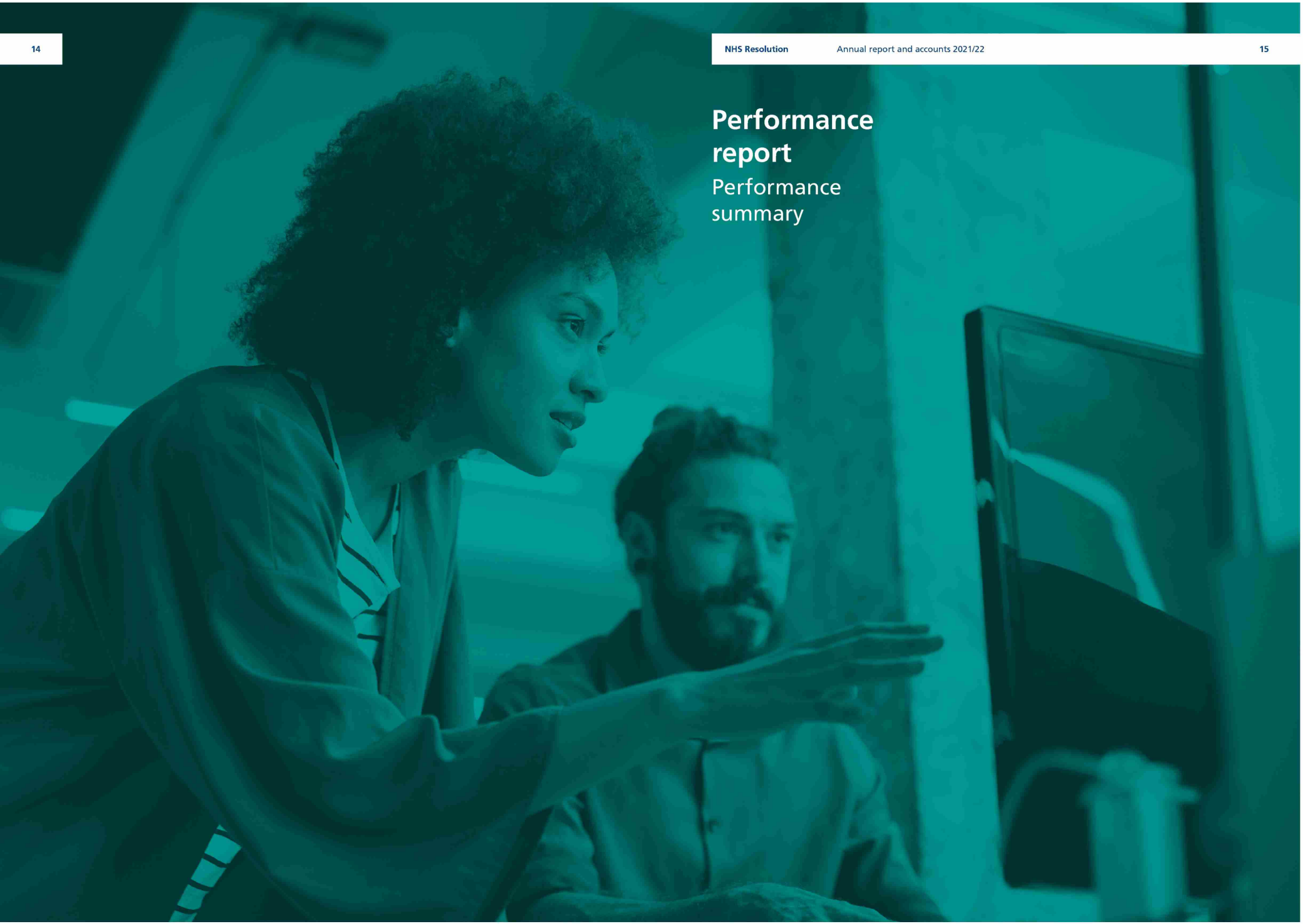
1. **Began** our claims mediation service in December 2016 and by 2018 saw 189 cases mediated against target of 50. Mediation has since dramatically increased in size and scale. Our litigation rate has decreased every year over the strategy period.
2. **Launched** the maternity Early Notification (EN) Scheme in April 2017 to transform the management of complex maternity incidents and related claims, reducing the time from incident to notification from years to weeks and allowing much earlier admissions of liabilities where appropriate as well as provision of financial and other support to families.
3. **Introduced** the Assisted Mediation and Professional Support and Remediation services in 2017 to help clinicians return to safe and effective practice.
4. **Piloted** then instituted team reviews in 2019/20 to reflect and support the reality of modern multidisciplinary care.
5. **Delivered** new assessment models in relation to performance and behaviour of practitioners in 2020/21.
6. **Researched** and published on patients' motivation in bringing claims in 2018/19. This remains a key evidence base for change in the management of the NHS response to harm.
7. **Published** to support more effective local resolution/ management of issues and the development of a just and learning culture in the NHS including:
   - Duty of Candour publications in 2018
   - *Being Fair* in 2019
   - Duty of Candour animation in 2022.

Using our expertise and data to improve safety

8. **Launched** the Maternity Incentive Scheme (MIS) in November 2017 working with the National Maternity Safety Champions and all other key system partners. The MIS has strongly incentivised providers to implement a progressively developing range of actions agreed by maternity experts to be crucial in improving safety.
9. **Partnered** with others to advance maternity safety through engagement with the royal colleges and membership of the Maternity Transformation Programme Board.
10. **Published** a landmark clinically led review of cerebral palsy claims in September 2017: the first time we used our data in collaboration with other parts of the health system. This was followed by the publication of our *Learning from suicide-related claims* report in 2018/19 and the programme continues in 2022 with reports on emergency department themes drawn from our claims information.
11. **Instituted** a Faculty of Learning in 2017 which curates an ever-expanding range of publications, reports and Advice Insights and which also influences face-to-face through provider visits and regional and national events.
12. **Created** the Significant Concerns Framework in 2019/20 which is designed to ensure we are using our information to help identify or validate emergent patient safety concerns.
13. **Shared** enhanced claims scorecards with our NHS trust members from July 2017 onwards to help individual trusts self-identify specialities and issues for improvement.
14. **Improved** our effectiveness by building our business intelligence capacity and capability, implementing a new finance system and recruiting our first Chief Information Officer in 2020. This laid the platform for the start of our Core Systems Programme to replace our legacy systems and modernise our working and data capability in 2021/22.
15. **Collaborated** with Getting It Right First Time (GIRFT) since 2017 to improve safety and increase transparency around our data through the publication of various specialty reports as well as publishing the Learning from Litigation Claims guide in 2021.

Delivering greater value

16. **Prosecuted** a landmark case in 2018 with a claimant being jailed for deliberately attempting to defraud the NHS and deceive the Court. This has since resulted in a number of similar judgements, underlining and promoting our determination to combat claims fraud and exaggeration.
17. **Supported** our staff through focused activity including Investors in People (IIP) Silver accreditation in March 2020 and launch of an equality, diversity and inclusion strategy, refreshed in 2022.
18. **Retained** our ISO 27001 accreditation in **2018/19** and onwards, safeguarding our data.
19. **Implemented** the Clinical Negligence Scheme for General Practice (CNSGP) in April 2019. This has since then progressively integrated clinical indemnity cover for most NHS activities in England under one roof and has been supported by our partnerships with organisations like the Royal College of General Practitioners.
20. **Approved** a business case in 2021 to modernise and improve the efficiency of our claims processes and align them to support the new NHS regional and integrated care landscape over the next three years.
21. **Procured** the Legal Costs Panel in February 2020 and the Legal Panel in December 2021 with new contracts designed to improve effectiveness and reduce costs.
22. **Established** the Clinical Negligence Scheme for Coronavirus (CNSC) and the Coronavirus Temporary Indemnity Scheme (CTIS) at short notice in 2020.
23. **Trained** NHS England staff using principles emerging from panel hearings to reduce preventable disputes developing in 2021.
24. **Brokered** a groundbreaking Covid-19 protocol with claimant representative bodies in 2020 to ensure that patients and NHS staff were not unduly affected by the Covid-19 pandemic with regards to working between claimants and NHS Resolution.
25. **Performed** over 25,000 compliance checks for doctors so they could return to work to support the Covid-19 effort in 2020.
26. **Convened** a maternity safety surveillance group, working with key health system partners to help identify potential trusts of concern during the Covid-19 pandemic in 2020.
27. **Adapted** delivery models using IT for a range of services as a result of the pandemic in 2020/21, some of which are being retained going forwards (e.g. remote claims mediations, educational events and virtual practitioner assessments).



Performance report

Performance summary

Performance summary

This performance summary provides an overview of the work of NHS Resolution, including the key enablers and risks to achieving our objectives and a summary of activities we have undertaken over the past year. In particular, it sets out the activity that meets the six priorities outlined in our Business plan for 2021/22[1]. More detailed information is included in the Performance analysis section (from page 29). Our performance against key performance indicators (KPI) is covered from page 48.

Headlines

In the year 2021/22 we saw a record high in the proportion of 77% of claims settling without court proceedings. This is evidence of our success in keeping claims out of court by using the widest range of approaches to dispute resolution available to us. For example, our Covid-19 Clinical Negligence Protocol, launched in collaboration with claimant lawyers in August 2020, continues to provide impetus to consider alternative means of resolution and avoid litigation. Of the 16,484 settled[2] clinical and non-clinical claims, 48.6% settled without damages.

The volume of clinical negligence claims and reported incidents received in-year increased from 13,351 to 15,078, predominantly due to the continuing maturity of our general practice indemnity books – as we received 3,292 Existing Liability Scheme for General Practice (ELSGP) and 1,502 Clinical Negligence Scheme for General Practice (CNSGP) claims, while volumes fell marginally for the Clinical Negligence Scheme for Trusts (CNST). Alongside this, payments to claimants (damages) increased by 10.3%, while claimant legal costs increased by 5.1%.

Payments for settled claims in 2021/22 increased by £199 million (8.8%) to £2.459 billion.

The overall cost of harm reached £13.3 billion[3] in relation to our CNST, with maternity claims making up 60% of this figure – hence our continued focus on this in our new three-year strategy, the importance of which was yet further emphasised by the Ockenden Report[4].

A stark reminder that although the NHS remains one of the safest healthcare systems in the world within which to give birth, avoidable errors within maternity can have devastating consequences for the child, mother and wider family, as well as the NHS staff involved.

The provision[5] increased by just over half (51%) to £128.6 billion due largely to reductions in HM Treasury long term and very long term discount rates.

Negligence claims form a very small proportion of both the number of incidents and complaints reported in the NHS, and the many millions of individual episodes of care that are delivered by the NHS each year. There are many factors influencing the reasons why individuals bring a claim against the NHS, including factors in the legal market[6]. There is also a significant time lag between an incident occurring and a claim being received – on average 3.1 years. It may also take several years to settle a claim, particularly those high value claims where brain damage has occurred at birth, and payments may be made on those claims many years into the future.

Taken together, this means that what NHS Resolution receives in terms of claims currently is only a very partial indicator of:

- Patient safety in the NHS in past years; and also
- What we can expect to pay out in settlement of those claims in the future.

[1] https://resolution.nhs.uk/wp-content/uploads/2021/06/Business-plan-2021_22.pdf.

[2] Settled claims include claims that have been agreed with ongoing periodical payment orders and claims where damages have been agreed or successfully defended, and costs have yet to be agreed. This differs from closed claims, which do not include claims settled with periodical payment orders.

[3] The overall cost of harm has increased from £7.9 billion last year. The HM Treasury discount rate has had a significant effect, but we estimate that without it, the cost of harm would have increased to £8.7 billion due to the expectation of a higher volume of claims from increased NHS activity.

[4] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review.

[5] The provision is the best estimate of the expenditure required to settle the present obligation at the balance sheet date or transfer to a third party (for claims made and predicated to be made, so called 'incurred but not reported claims'). The figure is updated annually and is an informed estimate that depends on assumptions about future developments and therefore lies within a range of possible results. When considering the provision, it is important to note that if there is a value allocated to a future periodical payment order this will change in response to changing needs and the lifespan of the claimant concerned.

[6] See *Managing the costs of clinical negligence in trusts*, NAO, September 2017.

Who we are and what we do

We are an arm's length body of the Department of Health and Social Care tasked with:

- Providing indemnity to the NHS for the risks involved in delivering healthcare services by:
  - handling compensation claims, keeping patients and healthcare staff out of court wherever possible;
  - ensuring compensation is both fair and timely while combating exaggeration or fraud; and
  - delivering indemnity schemes that meet the continually evolving needs of the healthcare system.
- Delivering expert advice and support on the management of concerns about the performance of doctors, dentists and pharmacists;
- Resolving contracting disputes between primary care contractors and commissioners of primary care, operating independently and transparently to reduce the need for such disputes to be managed via the courts; and
- Using our unique perspective across the causes of claims, performance concerns and contracting disputes to provide insights back to the NHS to help to improve safety and manage risk.

The strategic aims covered by the reporting period of this annual report and accounts for 2020/21 were:

- **Resolution:** Resolve concerns and disputes fairly
- **Intelligence:** Provide analysis and expert knowledge to drive improvement
- **Intervention:** Deliver interventions that improve safety and save money
- **Fit-for-purpose:** Develop people, relationships and infrastructure.

The successful delivery of these strategy aims and those outlined in Advise, resolve and learn: Our strategy to 2025 will see us **contribute** to ensuring **indemnity arrangements are a driver for positive change** across the healthcare system and **reduce**:

- **harm** to patients;
- **distress** caused to both patients and healthcare staff involved when a claim or concern arises; and
- the **costs** required to deliver fair resolution, thereby releasing public funds for other priorities, including healthcare.

Figure 1:
Our strategic aims for 2022–25

New strategic priorities

Priority 1.
Deliver fair resolution.

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

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

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

Priority 3.
Collaborate to improve maternity outcomes.

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

Priority 4.
Invest in our people & systems to transform our business.

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

Our services

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

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

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

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

Enabled by

Finance and Corporate Planning

Digital, Data and Technology

Membership and Stakeholder Engagement

Policy, Strategy and Transformation

Our values

Professional: we are dedicated to providing a professional, high quality service.

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

Ethical: we are committed to acting with honesty, integrity and fairness.

Respectful: we treat people with consideration and respect and encourage supportive, collaborative and inclusive team working.

Operational performance – how we performed against our 2021/22 priorities

Note that our performance with regards to our role in maternity safety is discussed in detail in the Performance analysis from page 29, and is therefore excluded from the following summary.

Priority 1

Deliver the next phase of our strategy to move claims, concerns and disputes into a neutral and less adversarial space

We have expanded the use of alternative dispute resolution initiatives across our core services. The Safety and Learning mediation role, launched in April 2020, has resulted in shared learning from the majority of cases mediated. We have increased our use of resolution (global settlement) meetings which involve parties gathering to discuss, share and agree solutions to progress a claim. These meetings were also convened to discuss a number of claims simultaneously, to save time and resources. 'Stock-take' meetings involved formal meetings with claimant lawyers at fixed stages during a claim in a collaborative approach, and have proved successful in reaching early resolution and reducing costs.

We are continuing to develop the early neutral evaluation tool, which involves appointing an independent evaluator to assess cases in a non-binding and non-prejudicial approach with parties.

In other areas of resolution, we received 798 requests for advice in 2021/22, via our Practitioner Performance Advice service, compared with 805 in the previous year. There was an increase in demand for our behavioural assessments (42 assessments) and action planning remediation services (44 cases), as well as our education programmes. Our Primary Care Appeals service received 128 cases in 2021/22, compared to 113 in 2020/21.

Priority 2

Further develop our new indemnity schemes (for general practice and Covid-19) while using our expertise to support wider improvements, including how healthcare-related claims are managed

In 2021/22 we successfully integrated claims arising from historical liabilities of current and former general practice members in England into our systems, under the ELSGP. We have continued to advise on additional indemnity arrangements in response to the pandemic, including the extensions of the CNSC and CTIS.

In February 2022 we launched our transformational Claims Evolution Programme (CEP). Through it we aim to deliver a single, integrated claims function that provides the best service we can to the NHS. On 1 March 2022 we launched our new, flexible, regionally-focused Legal Panel Service framework, which promotes early investigation, robust decision making and proactive investigations.

In the interests of the wider NHS, we continue to take cases to the higher courts in areas of the law which need to be challenged. Our Primary Care Appeals service has continued to determine complex and technical disputes. During the year there have been two challenges, which are as yet undecided by the Court. The first relates to payments to medical practitioners suspended from the medical performers list in 2015[1]. The second considers the termination of a GP contract without consideration of the Network Contract Directed Enhanced Service scheme.

[1] https://www.gov.uk/government/publications/payments-to-gps-suspended-from-medical-performers-list

Priority 3

Build on our unique role in sharing learning from claims and concerns back to the health system, in particular in relation to the interplay between general practice and secondary care and how to respond when harm occurs

NHS Resolution has a wealth of data which we have used to share intelligence and learning to support reduction of harm, such as claims scorecards, engagement events and thematic reviews. This supports the broader NHS safety architecture to learn from harm through, for example, the reporting of incidents via the National Reporting and Learning System and investigations by trusts and the Healthcare Safety Investigation Branch. A significant amount of work has been undertaken on analysis of the first year of CNSGP as well as further work on learning from claims for lower-limb complications in the diabetic patient. Work continued on the development of our Faculty of Learning[1] and in collaboration with our academic and other partners to develop eLearning tools. We have continued to collaborate with NHS England (which legally merged with NHS Improvement as a result of the Health and Care Act 2022) and have shared data with their Getting It Right First Time (GIRFT) team.

We continued to innovate and develop our Advice and Appeals services. We have redesigned our regionally aligned service delivery in anticipation of integrated care systems (ICS) launching in July 2022. Our Insights series[2] continues to support the healthcare system to better understand, manage and resolve concerns about doctors, dentists or pharmacists. We have enhanced our behavioural assessments, and introduced virtual elements to our clinical performance assessments. New products include an annual activity report for employing organisations, and a 'compassionate conversations' learning programme. Both pilots have been successful and will be rolled out more widely over the course of 2022/23. In response to the Government's response to the independent inquiry report[3] into the issues raised by former surgeon Ian Paterson, we published a suite of resources to help healthcare leaders make the right decisions on exclusions. It was accompanied by a report on *Insights from 10 years of supporting the management of exclusions in England*[4].

Priority 4

Responding to the changing health landscape including reviewing our indemnity scheme pricing and the role of incentives in light of wider system changes

The CNST pricing methodology has incentives built in to reflect the relative claims payments experience of the CNST member. Discussions have been ongoing with NHS England colleagues on how financial incentives through the CNST pricing and funding methodology could be enhanced as the NHS moves to a post Covid-19 financial and operating environment. This includes how to respond to developments in establishing the financial framework for integrated care boards (ICBs). Over the last year, we have worked with policy colleagues from DHSC and NHS England to understand the implications arising from the Health and Care Bill[5] to ensure that our indemnity schemes provide continuity of cover for new and legacy organisations.

We are supporting the Health and Social Care Secretary's technology vision by continuing to redevelop our IT systems and services. This will align to the wider Government Cloud First strategy and, wherever possible, will use existing systems and services on the NHS central platforms. A Court of Appeal ruling on Appeals interest payments has meant that NHS Resolution as an adjudicator now has a power to award interest when it finds that a contractor has been paid the wrong amount. An interim approach to the consideration and award of interest is available on our website[6].

[1] https://resolution.nhs.uk/faculty-of-learning/

[2] https://resolution.nhs.uk/services/practitioner-performance-advice/insights/

[3] https://www.gov.uk/government/publications/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson/government-response-to-the-independent-inquiry-report-into-the-issues-raised-by-former-surgeon-ian-paterson

[4] https://resolution.nhs.uk/resources/insights-from-10-years-of-supporting-the-management-of-exclusions/

[5] Health and Care Act 2022 – Parliamentary Bills – UK Parliament: https://bills.parliament.uk/bills/3022

[6] https://resolution.nhs.uk/wp-content/uploads/2021/03/NHS-Resolution-approach-to-Interest-Payments-FINAL.pdf

Priority 5

Develop and support our people through a period of significant change, building on our Investors in People accreditation, including a renewed focus on equality, diversity and inclusion

We have relocated both our Leeds- and London-based staff into new, flexible Government Hub offices, working in consultation with staff to make sure that we capitalise on opportunities to improve the way that we work across the business. The expansion of our Leeds office supports the Places for Growth Programme[1], aligns with the Government's Levelling Up agenda and supports the Budget 2020 Government commitment to relocating at least 22,000 roles out of London by 2030. This has included building on the positive changes in working practices that were necessitated by the Covid-19 pandemic, such as increasing the use of hybrid work patterns thereby enabling us to recruit more broadly from across the UK. Our ratio of desks to employees is just over four desks per ten employees which meets the Government target of not more than six desks per ten employees and allows for planned growth in staff numbers. We have modernised our internal communications, launching a new intranet, Connect, for staff in July 2021.

To support a consistent and fair approach towards staff in relation to incidents and errors, we are implementing a Just and Learning Culture Charter. Further action is under way to incorporate the values, behaviours framework and the Just and Learning Culture Charter within our policies and procedures. As a result of the ongoing pandemic, 2021/22 continued to be a challenging period for the workforce, both personally and professionally. Our focus has continued primarily on maximising the health and wellbeing (HWB) of our entire workforce in order to support staff to work as productively as possible, while balancing home and family lives. Our health and wellbeing offer for staff was updated and launched on Connect in September 2021. A key part of this offer is a HWB toolkit which provides information on a range of physical, mental and financial health support measures for both staff and managers. We have progressed a significant number of the key priorities from our workforce and organisational development strategy.

Priority 6

Make a step change in our technology and data analytics capabilities and infrastructure

We are developing technology to make sure our data is of the highest quality, more easily manageable and accessible for analysis and provision of insight. We are committed to transparency in our policy to publish data either directly, such as the Annual Report Statistics, or indirectly via system partners such as GIRFT or Model Hospital while adhering to the General Data Protection Regulations (GDPR) framework. We are committed to an ambitious programme of change and growth through implementation of new operational IT systems and infrastructure, and the business model for the Claims Management function. Following our successful Core Systems procurement in August 2021, we are progressing with the development of our new IT platform to streamline our processes, to deliver more efficient services and support our strategic priorities.

We have started work to explore the potential for Artificial Intelligence in relation to claims and have established a Data Science team to deepen our analytical capabilities. Our IT team is now more streamlined and responsive to the ever-evolving threat to cyber and data security. We have adopted some of the NHS Digital sponsored cyber security services, allowing us access to specialist security expertise. We continue to test and independently audit our systems to ensure they meet the highest level of cyber security standards.

[1] https://civilservice.blog.gov.uk/2018/08/30/the-places-for-growth-programme-driving-growth-across-the-uk/

Financial summary

The costs of claims arising from incidents occurring in 2021/22 was estimated to be £13.3 billion for CNST, an increase from the £7.9 billion reported in 2020/21. This increase is mainly due to the change in the HM Treasury discount rates referred to above. However, we have also allowed for an increase in claims volumes as clinical activity has increased since 2020/21 compared to the previous year. As a consequence, without the effect of the discount rate change, we estimate that the annual cost of harm would have been £8.7 billion.

In 2021/22, our clinical schemes underspent by £224 million against budget (compared with £430 million in 2020/21), of which £222 million this year was in respect of CNST. Expenditure on CNST increased by 7% from 2020/21, primarily on high value claims, but the volume and value of claims settlements was lower than assumed in the budget, resulting in the underspend.

Our provision increased by 51% or £43.3 billion to £128.6 billion. Almost all of this is due to the reductions in the HM Treasury long term and very long term discount rates. These discount rates are applied to the amounts expected to be paid out to settle claims in the future in order to give a value in the accounts at today's prices.

As we expect to make payments on clinical negligence claims over the lifetime of claimants' lives, which will be many years into the future, these discount rates can have a significant effect on the value of the provision. However, this is an accounting adjustment and does not affect the underlying amount that will be paid out to settle claims in the short term.

The other factors affecting the value of the provision largely offset each other, but it is worth noting the main trends:

- The provision across all schemes increased due to expected claims from another year's worth of activity by £8.5 billion.
- Our expectations of long term inflation have reduced again. However, this has been partially offset by increases in short term inflation rates.

More information about the changes in the value of the provision and budgetary performance can be found in the Finance report at pages 55 to 63.

Table 1: The year in numbers

Financial element	2020/21 (£ million	2021/22 (£ million)	Change (£ million)	%	
Funding for clinical schemes					
Income from members	2,243.7	2,458.7	215.0	9.6%	^
Funding from DHSC (budget)	418.9	199.8	(219.1)	-52.3%	v
Total funding	**2,662.6**	**2,658.5**	**(4.1)**	**-0.2%**	v
Payments in respect of clinical schemes					
Damages payments to claimants	1,609.8	1,775.3	165.3	10.3%	^
Claimant legal costs	448.1	470.9	22.8	5.1%	^
NHS legal costs	151.4	156.6	5.2	3.4%	^
Total payments	**2,209.3**	**2,402.6**	**193.3**	**8.7%**	^
Funding for non-clinical schemes					
Income from members	65.0	65.9	0.9	1.4%	^
Funding from DHSC (budget)	5.0	7.2	2.2	44.0%	^
Total funding	**70.0**	**73.1**	**3.1**	**4.4%**	^
Payments in respect of non-clinical schemes					
Damages payments to claimants	28.5	32.0	3.5	12.3%	^
Claimant legal costs	16.3	17.3	1.0	6.1%	^
NHS legal costs	5.9	6.3	0.4	6.8%	^
Total payments	**50.7**	**55.6**	**4.3**	**9.7%**	^
NHS Resolution administration of schemes					
Clinical	24.2	32.5	8.3	34.3%	^
Non-clinical	5.1	5.0	(0.1)	-2.0%	v
NHS Resolution other activities					
Income	0.8	0.9	0.1	12.5%	^
Expenditure[1]	6.1	6.7	0.6	9.8%	^
Staff numbers	400	500	100	25.0%	^
Provisions cost of claims restated 2020/21[2]					
Claims provisions expenditure[3]	659	45,766	45,107	6847.5%	^
Of which:					
• Change in discount rate	229	42,623	42,394		^
• Other changes	430	3,143	2,713		^
Provisions for claims restated 2020/21[4]	**85,242**	**128,550**	**43,308**	**50.8%**	^
Capital expenditure	**0.6**	**3.0**	**2.4**	**398.5%**	^

More information on the financial performance of NHS Resolution and its indemnity schemes is provided in the Finance report at pages 55 to 63.

[1] Difference between income and expenditure – see Finance report at pages 55 to 63 for further commentary and explanation.

[2] The provision expense for 2020/21 has been reduced by £333 million to reflect a prior period adjustment in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

[3] Total charge to Statement of Comprehensive Net Expenditure – see Note 7.1 to the accounts for the breakdown and the Finance report section for explanation. The key change year on year is due to the reduction in the HM Treasury long term and very long term discount rates.

[4] The total provision at year end value for 2020/21 has been increased by £2,457 million to reflect a prior period adjustment in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

The environment we work in

When considering our performance it is helpful to understand the environment in which we deliver our work and the risks and issues we face as an organisation.

The legal environment

Cross-government work

We continue to support work across Government to address the challenge of the rising costs of clinical negligence claims.

Fixed recoverable costs

A consultation on the introduction of fixed recoverable costs for lower value clinical negligence claims (generally claims with damages valued at £1,500–£25,000)[1], was conducted by DHSC between 31 January and 24 April 2022. The main objective of the proposal is to provide faster resolution of qualifying claims, with legal costs that are more proportionate to the value of compensation. We have been fully engaged with DHSC on this work and await the outcome of the consultation.

The health landscape

NHS Long Term Plan and Health and Care Act

We continued to prepare for the NHS Long Term Plan commitment via the Health and Care Act 2022 to create more joined-up and coordinated care for patients. We have worked with our system partners to advise on indemnity arrangements for the new integrated care board structures as part of NHS reform and to explore any changes that are required to meet the needs of the changing landscape of healthcare provision. We will also be engaging with ICSs to understand what further support they need from us as they mature. We have also considered this work in light of our commitment to take action on health inequalities.

Health and Social Care Select Committee

In September 2021, we saw the launch of the Health and Social Care Select Committee inquiry into NHS litigation reform. DHSC submitted written evidence to this inquiry focusing on the cost and impact of clinical negligence, developing a learning culture in the NHS, and improving claim resolution. We were a key contributor to this submission. Our Director of Claims Management, Simon Hammond, appeared as a witness for the Committee on 11 January 2022 and our Chief Executive, Helen Vernon, participated in an oral evidence session on 1 February 2022 alongside Maria Caulfield MP, Minister for Patient Safety and Primary Care, and Matthew Style, Director General for NHS Policy and Performance at DHSC. The House of Commons published the *Health and Social Care Committee: NHS litigation reform – Thirteenth Report of Session 2021–22* on 28 April 2022.

We also contributed to the Health and Social Care Select Committee inquiry into the safety of maternity services in England with our Chief Executive, Helen Vernon, who participated in an oral evidence session on Tuesday 3 November 2020. *The Government's response to the Health and Social Care Committee report: Safety of Maternity services in England* published in September 2021.

NHS England's maternity plan

We await with interest the publication of NHS England's follow-on report *Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care*[2], anticipated in the summer of 2022.

[1] https://www.gov.uk/government/consultations/fixed-recoverable-costs-in-lower-value-clinical-negligence-claims

[2] https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/

Key risks and issues

Raising concerns

As an NHS body, patient safety and public protection are of paramount concern. On occasion, we may identify a significant concern and will share information externally, for example with other NHS bodies or those with responsibility for regulation within the healthcare system. This will happen if we see activity which may have caused significant harm or which puts individuals at significant risk due to unsafe clinical practice or conduct that severely compromises the effective delivery of services. In practice, the relevant healthcare provider is likely to be our first point of contact and we may invite them to consider onward referral to other relevant parties (for example, regulators) or seek assurance that they have done so. We operate a Significant Concerns Framework[1] as a guide to addressing those circumstances where a concern about serious harm has arisen, ensuring that confidential information relating to notifications is managed appropriately and within a tightly controlled governance framework, with established escalation arrangements as necessary.

Significant concerns case study[2]

Concerns were raised about a doctor's practice while working at Trust A. There had been delivery of significantly poor care resulting in multiple claims and restrictions placed on the individual's practice. NHS Resolution also identified areas for improvement in relation to Trust A's response to the situation. It was noted that the practitioner had moved to Trust B and it was not clear that Trust A had provided all necessary information regarding the unresolved concerns. Practitioner Performance Advice and Claims Management worked together to support the trusts and help to ensure that information was shared appropriately with Trust B.

Data quality

As interest in clinical negligence and, consequently, our data continues to increase we need to ensure that the data we produce, sometimes at short notice, is accurate and adequately described, to avoid incorrect interpretation. This is challenging given the complexity of data and nuances in the definitions, and we are continually developing our control framework to ensure we capture and maintain accurate and relevant data.

We are committed to transparency in our policy to publish data either directly, such as the Annual Report Statistics, or indirectly via system partners such as GIRFT or the Model Hospital while adhering to the GDPR framework. Our strategy is also to develop the use of technology to make our data more easily manageable and accessible for analysis and provision of insight.

Policy environment

We operate in a dynamic policy environment and our Policy, Strategy and Transformation team is tasked with identifying emerging issues and considering their potential impact on our ability to meet our strategic objectives. We work closely with DHSC and other arm's length bodies (ALBs) across a range of policy issues, contributing our data and expertise as appropriate. Key areas of focus for 2021/22 have included the pandemic, maternity and complaints policy. We also continue to work with the Government on clinical negligence policy, supporting the consultation on *Fixed recoverable costs in low value clinical negligence claims* and the broader work around the costs of clinical negligence. Our latest consultation responses can be found on our website[3].

[1] https://resolution.nhs.uk/how-we-use-your-data/

[2] This is an illustrative, composite case study (to preserve confidentiality).

[3] https://resolution.nhs.uk/category/consultations/

IT infrastructure

We have concluded our discovery phase of our Core Systems Programme and are now progressing with the detailed design and development of our new platform. The Core Systems Programme operates under our established programme governance framework and includes a steering group and a programme assurance committee consisting of representatives across the organisation who will consider risks, issues and benefits arising from the programme. In addition, we are seeking input from colleagues across the system to support our core system transformation programme as part of our user research. The programme has received NHSX (now NHS England Transformation Directorate) Assurance Board approval and will follow the NHS approvals process.

Cyber security

Our IT team is constantly striving to keep pace with the ever-evolving threat to cyber and data security. We have adopted NHS Digital sponsored cyber security services, allowing us access to specialist security expertise at no additional cost. Additionally we have a specific key performance indicator around our response times to alerts from the NHS Digital CareCERT team. As a result of these changes our security stance along with its supporting administrative processes is more streamlined and responsive. We have successfully maintained our Cyber Security Essentials Plus certification as well as passing our ISO 27001 surveillance audit. We have continued our programme of penetration and vulnerability testing along with a review and independent audit against the National Cyber Security Centre (NCSC) 14 cloud principles. Our Board, as well as our Audit and Risk Committee, are fully appraised of emerging threats and our approach to dealing with them.

Fraud

The risk of fraud is ever-present. With support from our local counter-fraud specialist providers, and participation in DHSC's Counter Fraud Liaison Group, we continually review and monitor potential threats, provide awareness training to staff and undertake proactive exercises to detect potential fraud and improve our control framework. Genuine claimants have nothing to fear; however, where there is evidence of a fabricated or exaggerated claim we will continue to take steps to protect public funds and to pursue a custodial sentence. Please see our case stories on exaggerated and false claims as examples of how we handle cases of this nature on page 40 for more information.

Challenges to our delivery

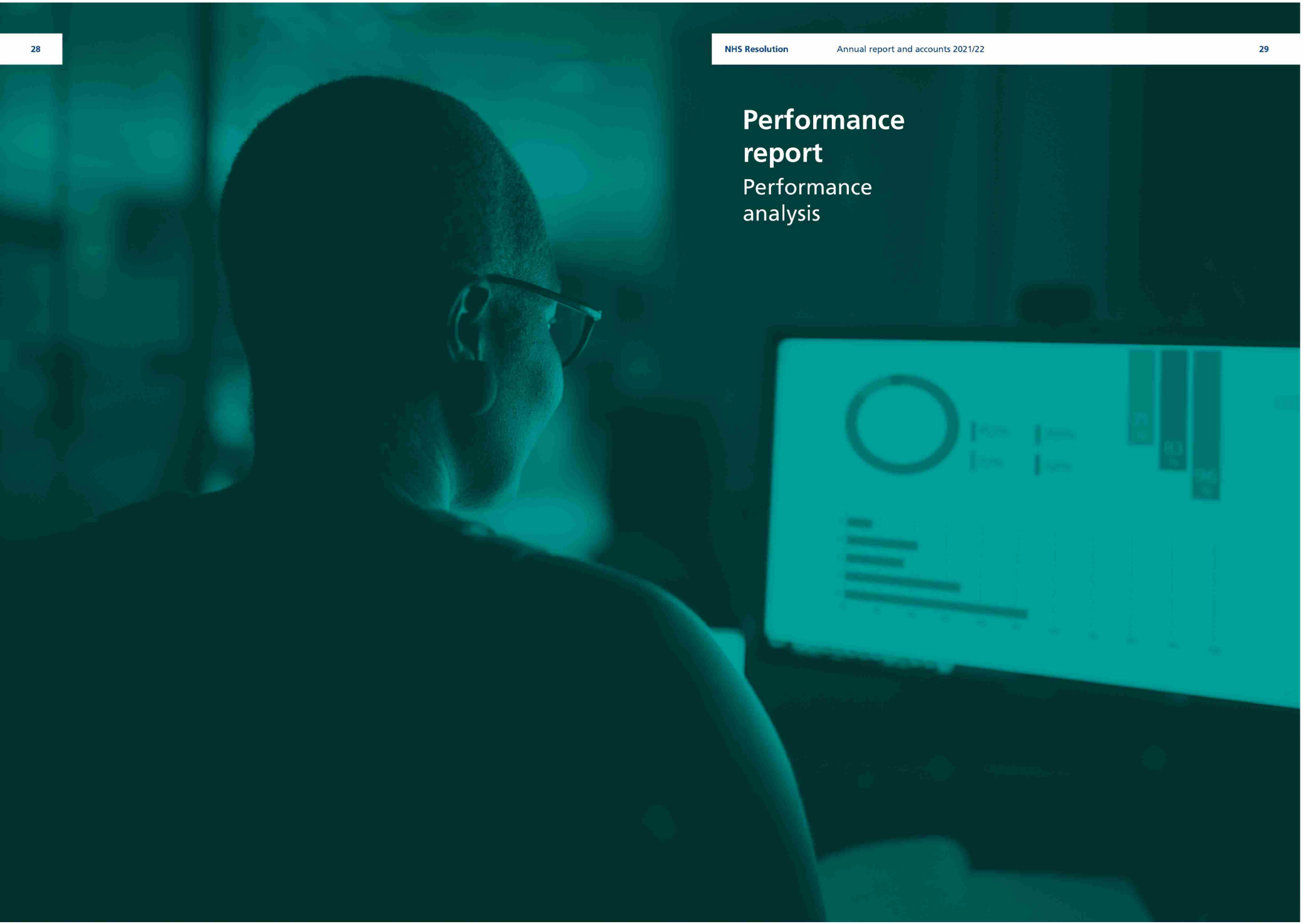
What did not go as well, took longer than expected or changed direction during the year?

- **Core systems and service development**
  We encountered delays in initiating our two main change programmes (the Core Systems Programme and the Claims Evolution Programme) due to the time required to secure the necessary business case approvals. Having received the approvals, we initiated both programmes in 2021/22 with both due to deliver first steps in 2022/23 with further iterations in the future.
- **Healthcare Professional Alert Notices and Performers Lists Checks**
  We are responsible for the management of the Healthcare Professional Alert Notices (HPANs) system. This is a system through which notices are issued by us to inform NHS bodies and others about health professionals who may pose a significant risk of harm to patients, staff or the public. We had hoped to launch a new platform in 2021/22 to support this service. However, while we continue to provide a pre-employment check service, the development of new technology to improve the ease of access to this service has been brought into our Core Systems Programme.
- **Maternity Incentive Scheme**
  NHS Resolution and the Collaborative Advisory Group (the group of experts from across the maternity system who support us with this work) took the decision to pause year four of the MIS to take into account the impact of Covid-19 on trusts' ability to achieve the scheme's safety actions. We listened to our members, and adapted and revised the MIS, while reinforcing the key principles of the scheme which was relaunched on 3 May 2022.

Going concern

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

Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements of 31 March 2022.

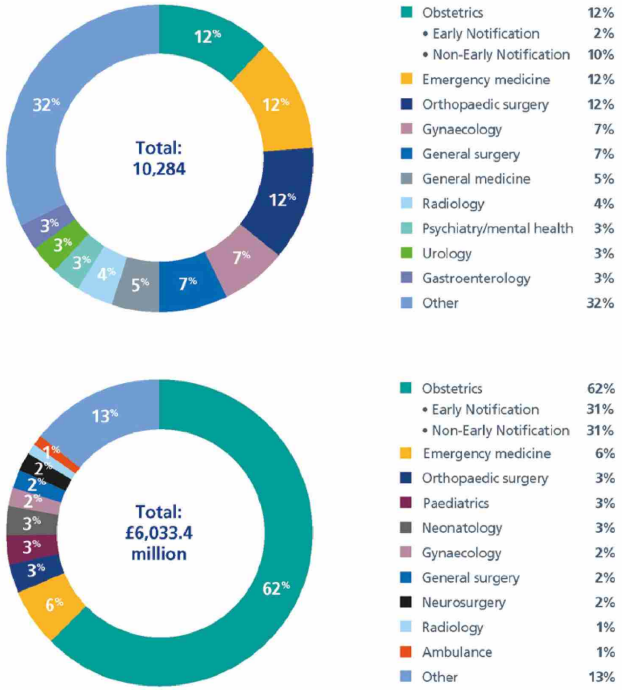


Performance report

Performance analysis

Our continued focus on making maternity care safer

Figure 2:
The percentage of clinical negligence claims reported in 2021/22 by specialty, with a breakdown by volume (total 10,284 claims) and by value (total £6,033.4 million)



Obstetrics	12%
• Early Notification	2%
• Non-Early Notification	10%
Emergency medicine	12%
Orthopaedic surgery	12%
Gynaecology	7%
General surgery	7%
General medicine	5%
Radiology	4%
Psychiatry/mental health	3%
Urology	3%
Gastroenterology	3%
Other	32%

Obstetrics	62%
• Early Notification	31%
• Non-Early Notification	31%
Emergency medicine	6%
Orthopaedic surgery	3%
Paediatrics	3%
Neonatology	3%
Gynaecology	2%
General surgery	2%
Neurosurgery	2%
Radiology	1%
Ambulance	1%
Other	13%

There were 1,243 obstetrics claims in 2021/22, accounting for 12% of all clinical negligence claims by volume, placing maternity-related claims among the top three specialities by volume, alongside emergency medicine and orthopaedic surgery.

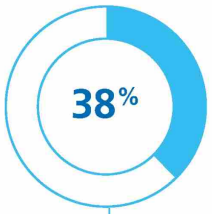
Obstetrics claims accounted for 62% of all clinical claims by value received in the year, highlighting the underlying impact of the financial costs of maternity indemnity payments, alongside the impact of harm on patients, families and healthcare staff.

Of the £13.3 billion annual cost of harm incurred though CNST, maternity claims accounted for 60% in 2021/22.

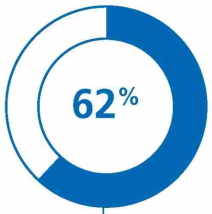
Settling maternity claims

Damages awards for maternity claims are often made by way of a periodical payment order, meaning a lump sum is paid out upon settlement and then annual payments for the remainder of the harmed patient's life. This provides the claimant, and their family, with the security of regular payments for care packages and other required assistance. For maternity claims involving harm to a baby it may take many years to assess the full extent of the harm caused, as the needs of the child cannot be fully assessed until developmental milestones have been reached. Such claims also require court approval of the award of damages. For this reason the average time between notification of a maternity claim and settlement is 5.8 years, 2.7 years longer than the average clinical negligence claim.

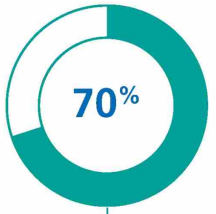
Figure 3:
Some maternity statistics as of 28 March 2022



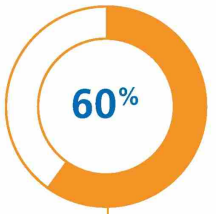
38% of total clinical negligence **payments** (£2.4 billion) and hence contributions collected from members. The level of claim payments reflects past claims activity, so this is lower than the percentage of current notification or incurred cost of harm described below. Slightly reduced from 40% last year.



62% of claims by **value** (£6 billion) notified to us in 2021/22.



70% of the total clinical negligence **provision** (£128.2 billion). Slightly increased from 68% last year.



60% of the **total clinical negligence cost of harm** (£13.6 billion).

Given these figures, maternity continues to be a central plank of our strategic focus as we transition from our previous five-year strategy (spanning 2017 to 2022) to a new three-year strategy (2022 to 2025). We remain committed to the aim of our previous strategy to 'provide analysis and expert knowledge to the healthcare and civil justice systems, to drive improvement'.

Figure 4:
The **number** of maternity cerebral palsy/brain damage claims received over time across all clinical negligence schemes[1]

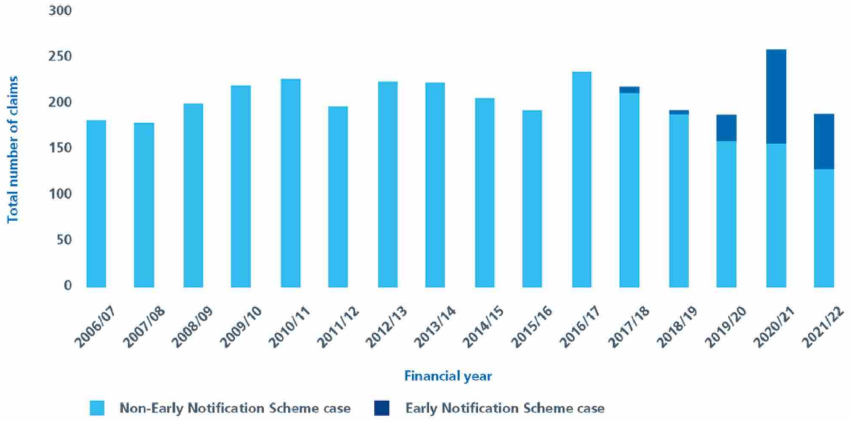


Figure 5:
The **total value** of maternity cerebral palsy/brain damage claims received over time across all clinical negligence schemes

[1] The numbers of confirmed cerebral palsy/brain damaged baby claims will not directly align with the number of EN cases, as the baby may be too young to diagnose at the point of becoming an EN case and indeed incidents of potential harm may not ultimately translate into clinical negligence cases.

The growth in obstetrics claims volumes over the past three years is due to the impact of trusts reporting cerebral palsy/brain damage claims earlier through our EN Scheme. The scheme, established in 2017, allows us to investigate potential eligibility for compensation and to take action to reduce legal costs while improving the experience for the patient's family and affected staff.

The impact of the Early Notification Scheme can be seen when looking at the recent value of maternity claims.

The scheme has already achieved reductions in the time between an incident occurring, an investigation into eligibility for compensation initiated, and admissions of liability being made. Seeking early notification of maternity incidents means that NHS Resolution can proactively investigate liability sooner, while trusts are encouraged to be open about incidents, be candid with families and maximise opportunities to learn from them.

What is the Early Notification (EN) Scheme?

It is a key initiative towards achieving the delivery of safer maternity care, providing a more rapid, caring response to families in cases of severe harm, and supporting a learning culture. The scheme proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm. We do this by requiring our CNST members to notify us of maternity incidents which meet a certain clinical definition.

It is designed to do two main things:

- To speed up investigations into whether or not a baby is entitled to receive compensation by investigating cases proactively, being open about our conclusions and signposting families to appropriate sources of advice and support; and
- To help ensure that steps are taken to learn from things that have gone wrong to improve maternity care as well as sharing good practice.

Early admissions

During the past five years we have been able to make a significant number of early admissions[1]. As the volume of admissions increases, so does the number of interim payments made. There are now some children, due to their age and the length of time the scheme has been running, for whom we are able to fully quantify their needs. This has led to an increase in the value of the payments made, while simultaneously reducing the impact of inflation on these claims. This has resulted in an increase in damages payments under the scheme from £3.2 million last year to £10.2 million this year.

Implementing a more focused approach

From 1 April 2021, our EN Scheme moved to an 'outcome-first' approach. The criteria for an investigation was narrowed to babies who have an abnormal MRI scan where there is evidence of changes in relation to intrapartum hypoxic ischaemic encephalopathy (HIE). This ensures the scheme focuses on those babies who have suffered harm and where there is potential for complex care needs and a high value financial compensation payment.

The new approach has led to a reduction in duplication with the Healthcare Safety Investigation Branch (HSIB) and has enabled trusts to focus on liaison with HSIB and the family. To progress the liability investigation (the legal investigation into clinical negligence) by the EN Scheme, a decision was made to focus only on those incidents where HSIB had completed their investigation.

[1] An admission is an acknowledgement of legal liability for substandard care.

The development of the EN Scheme reflects our expertise in managing clinical negligence claims, which is increasingly underpinned by analysing and sharing key learnings from our work. In 2021/22 we started work on a second report into the evolution and impact of the EN Scheme (to be published in summer 2022), which provided the basis for sharing learning with system partners and staff in member trusts through case stories reflected in this report. We also established a Maternity Voices Advisory Group in 2021/22, giving families an opportunity to advise on the future development of the EN Scheme. The group was a strategic response to the ambition in the National Patient Safety Strategy that encouraged organisations and service users to work in partnership to improve quality and safety.

We continue to collaborate with strategic partners, including through the Maternity Incentive Scheme, to help support safer maternity care. Results for year three of the scheme were encouraging, with 95 maternity trusts (out of 122 eligible trusts) achieving all ten safety actions.

What is the Maternity Incentive Scheme?

The Maternity Incentive Scheme is a collaboration by NHS Resolution and the national maternity safety champions in partnership with the Collaborative Advisory Group (CAG). The CAG was established by NHS Resolution to bring together other arm's length bodies and the royal colleges to support improvements in maternity and neonatal services. Members of the group include: the Department of Health and Social Care, NHS Digital[1], NHS England, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Royal College of Anaesthetists, the Care Quality Commission (CQC) and Healthcare Safety Investigation Branch (HSIB).

The scheme works by drawing an additional 10% of a trust's calculated maternity contribution via our CNST maternity pricing. Trusts that can demonstrate they have achieved all of the ten safety actions recover the element of their contribution to the incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions do not recover their contribution, but may be eligible for a smaller discretionary payment to help them make progress against any actions they have not achieved.

Trust submissions are checked against CQC findings and a range of external verification points: these include referencing MBRRACE-UK data, submissions to the Maternity Services Data Set and against the National Neonatal Research Database (NNRD), and EN Scheme notifications to HSIB. We contact trusts[2] where there are concerns about their scheme's declaration for reverification or recertification.

The launch of year four of the scheme was challenging due to Covid-19, and to support trusts in December 2021 it was paused with a requirement for trusts to continue to apply the principles of the MIS. The scheme was relaunched in May 2022 with revisions of the safety actions and their deadlines, with consideration to the findings of the Ockenden Report.

The year 2021/22 concluded with the publication of the final Ockenden report – final: Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. We welcomed the findings and actions proposed by Donna Ockenden's review and we committed to continuing our work to help ensure that all maternity services are of the highest possible quality for all patients. NHS Resolution will respond to this report with plans to review our procedures and practice.

[1] NHS England have now created a Transformation Directorate, incorporating NHSX and NHS Digital.
[2] https://bit.ly/3NOTxof

We highlighted key elements in our 2022–25 strategy in our response, not least the focus on further collaboration to improve maternity outcomes and our ongoing support to the National Maternity Safety Ambition. Our new strategy contains a specific strategic aim to support this:

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

We will report our progress against this strategic aim over the next three years.

We regularly collaborate and share learning with maternity stakeholders, including CQC, GIRFT, NHS England and the royal colleges – for example, we collaborated with GIRFT to share data on claims costs with trusts with a view to influencing safer clinical practice.

Going forward, we recognise our evolving role in driving improvements to the safety culture of the NHS more broadly. We will continue to explore how we further build on work with key partners to make greater use of our data and how we work in partnership with others to identify future priorities for learning. We have embedded these ambitions in our existing work and in our new three-year strategy.

Working across the healthcare system to further improve safety in the NHS

As highlighted in the Chair's welcome, we reached the end of our five-year strategy in March 2022 and achieved a significant amount. The five-year strategy covered the two-year pandemic towards the end of that period. There was a huge amount of change across the health and care systems caused by the pandemic and our new strategy provides an opportunity for us to take stock of our progress in supporting a safer NHS.

We opted for a new strategy covering a three-year period as this is long enough to enable some medium to long term planning, gives us some stability and enables us to set out a direction of travel over the period. A three-year period is also short enough to accommodate the likelihood of further changes, and for our priorities and objectives to accommodate those changes. We anticipate concluding two major change programmes during this timeframe, one to transform our core technology and data systems, and another to update our claims management processes and procedures to meet the changing needs of the system, including the introduction of integrated care boards from July 2022.

Looking ahead, key areas of our focus will include:

Fair resolution: We continue our strategic focus on improving the way compensation is delivered when something goes wrong, by adopting innovative approaches to keep cases out of costly litigation and by supporting DHSC more broadly to address the challenge of the rising cost of clinical negligence, supporting ongoing work across Government. We also continue to support DHSC with the development of their Patient Safety Action Plan, with their response to the Health and Social Care Committee's report into NHS litigation reform (2022) and other initiatives.

Just and learning culture: NHS Resolution are committed to working with our system partners to create a just and learning culture in the NHS. Creating a positive culture can play a role in tackling a variety of workplace issues, such as retention, and is a key to improving patient safety.

Practitioner Performance Advice: Our Advice service works to help ensure that the NHS workforce is supported and that concerns are resolved to preserve resources for patient care. Recognising that the data gathered by Advice might provide useful learning for the system, especially in terms of the management of the workforce, we have identified opportunities to expand our insights function within Advice.

Received claims

The total of new clinical negligence claims and reported incidents reached 15,078 in 2021/22, up 13% on the previous year (13,351). The bulk take-on of general practice indemnity claims for pre-1 April 2019 incidents from medical defence organisations is the most significant driver of this increase. A total of 2,005 ELSGP claims were migrated from Medical Protection Society (MPS) in 2021/22. However, our CNSGP scheme for incidents from 1 April 2019 continues to mature, with 1,502 claims received in 2021/22 compared to 973 in the previous year. In contrast, the number of new claims added to our CNST book fell for the third year running. In 2021/22, new CNST claims totalled 10,226 (10,760 in 2020/21 and 11,145 in 2019/20).

The increase in clinical claims from 13,351 in 2020/21 to 15,078 in 2021/22 were in the main due to:

- 1,730 more ELSGP claims,
- 529 more CNSGP claims,
- 534 fewer CNST claims.

It is too early to determine the impact from Covid-19 on future claims volumes and values due to normal time-lags in claims being lodged – averaging 3.1 years. We continue to monitor the potential impact of future Covid-19 related claims associated with risks arising from delayed or missed treatments, and recovery in NHS activity rates, while adjusting future claims projections. In 2021/22, we received 22 claims related to Covid-19 under CNSC, an increase of just 15 from seven in the previous year, and it is therefore too early to draw conclusions about future trends related to these claims given their low volumes to date.

For our non-clinical Liabilities to Third Parties Scheme (LTPS), claims have risen this year by 378 to 3,074 compared with the previous year (2,696); however, they remain lower than pre-pandemic levels (3,669 in 2019/20).

Closed claims

We closed 17,539[2] clinical and non-clinical claims in 2021/22 (compared with 15,395 in 2020/21), with total payments of £2.459 billion (£2.260 billion). Of these claims, 9,305 were closed with damages (8,412) while 8,234 claims were closed without damages (6,983). Overall, 893 more claims were closed with damages than in the previous year.

Of clinical claims, 6,514 were closed without damages, an increase of 1,435 over the previous year (5,079); of non-clinical claims, 1,720 were closed without damages (compared with 1,907 in 2020/21).

There was overall an increase in the number of clinical claims closed both with and without damages paid compared with last year, across all schemes. Across the clinical portfolio (excluding general practice indemnity, GPI) the numbers were comparable to pre-pandemic levels – 4,289 closed without damages this year compared with 4,265 in 2019/20. As expected, a greater number of cases were closed across the GPI book this year, linked to the increased numbers of cases within both CNSGP and ELSGP. Across the non-clinical claims portfolio we have seen a steady decrease in cases closed overall, and specifically without damages, since 2017/18.

Of the clinical claims closed, 11,514 were on our CNST book and 2,658 on our general practice indemnity book, reflecting work to close inactive claims transferred to us after April 2019. We closed 594 new ELSGP claims as a result of investigations to establish whether they are likely to proceed. Our experience to date suggests that a higher proportion of GPI claims may close more quickly as a result.

Figure 6:
The number of new clinical and non-clinical claims and incidents reported in each financial year from 2012/13 to 2021/22[1]

[1] The data for previous years has been restated and now includes a change to the 2013/14 data for 153 DHSC non-clinical claims which were incorrectly excluded as legacy industrial disease claims. In 2020/21 an additional 722 ELSGP clinical claims have now been included which were omitted in error in the 2020/21 Annual report and accounts.

[2] The data for previous years has been restated for historical claims received under our ELSGP. 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.

Figure 7:
The total number of clinical claims closed by scheme demonstrating the effect of our new general practice indemnity schemes

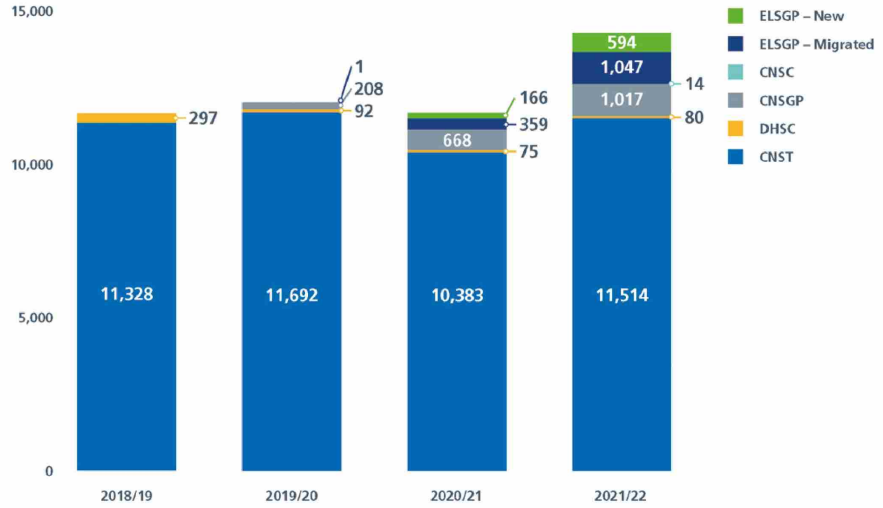
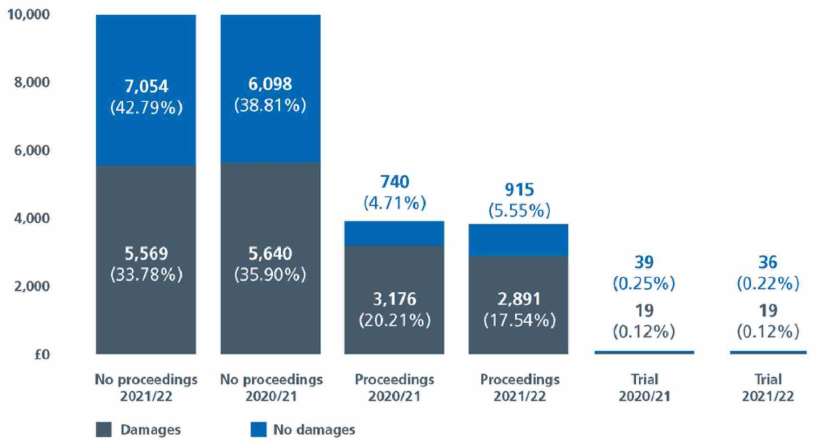


Figure 8:
16,484 clinical and non-clinical claims were settled in 2021/22 compared with 15,712 in 2020/21 with an increasing percentage settled without proceedings[1]



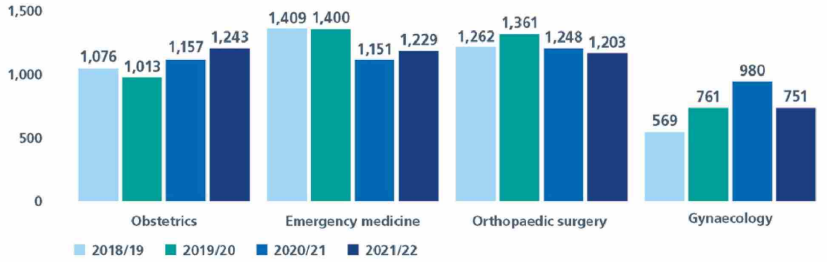
A total of 12,623 claims were settled without proceedings in 2021/22 (compared with 11,738 in 2020/21). This reflects an ongoing improvement in our litigation rate over the medium-term, settling more claims before formal court proceedings are required, based on our deployment of dispute resolution techniques, such as mediation and more collaboration with claimant lawyers. This has been achieved without compromising the rigour of our investigation of eligibility for compensation. Indeed, for clinical claims, the percentage of claims that have resolved without damages being paid has increased from 43.7% (2020/21) to 48.5% (2021/22). This includes claims managed under our CNSGP and ELSGP schemes, which have different approaches to the triaging of claims. Excluding those schemes, the percentage of clinical claims that have resolved without damages being paid has increased from 36% (2020/21) to 41% (2021/22).

Figure 9:
Litigation rate for clinical claims (2017/18 to 2021/22)

[1] The number of claims with and without proceedings will differ from those reported in 2020/21 as we have retrospectively incorporated historical claims received under our ELSGP.

In 2021/22, 77% of claims were settled without litigation, the highest ever volume achieved, reflecting our ambitions to keep patients and healthcare staff out of litigation wherever possible. The percentage of claims that have litigated continues to reduce, down from 26% (2020/21) to 23% (2021/22). We continue to deliver fair resolution of cases in line with our strategic priorities, considering the merits of each case and compensating harmed individuals where negligence is found. Where claims have entered litigation, which is unavoidable in some cases, for instance approval of a child's damages award, the percentage of litigated claims that have resolved without an award of damages has increased from 19% (2020/21) to 24% (2021/22). For clinical claims only, the number of litigated claims that have resolved without an award of damages has increased from 19% (2020/21) to 25% (2021/22).

Figure 10:
The top four categories of clinical claims received each year from 2018/19 to 2021/22 by number



Alongside obstetrics claims, which increased to 1,243 (1,157), emergency medicine claims increased to 1,229 (1,151 while orthopaedic surgery claims decreased to 1,203 (1,248). Over the medium term, obstetrics claims have become the largest volume received by speciality.

Managing claims fairly and effectively and developing legal precedent

We continue to develop legal precedent, 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. 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.

Cases of note

Khan v. Meadows (Supreme Court, 18 June 2021)

This case concerns the scope of a medical practitioner's duty when consulted about a specific issue.

Ms Meadows became aware that she might be a carrier of the haemophilia gene when her nephew was born in 2006 and diagnosed with haemophilia. She wished to avoid having a child with the condition and so consulted her GP. The GP, Dr Khan, arranged blood tests to establish whether she had haemophilia – the results were normal. However, the GP failed to advise her that these tests could not confirm whether she was a carrier of the gene.

Thinking that all was well, Ms Meadows became pregnant in 2010. Her son developed severe haemophilia. She claimed that had she been given correct advice, she would have chosen a termination. As well as haemophilia, her son has the unrelated condition of autism. Dr Khan admitted liability for the losses arising from haemophilia but not those resulting from autism, which in monetary terms were much higher.

The Supreme Court had to decide whether Dr Khan was responsible for the financial consequences of the autism. Using the example of a commercial case decided by the House of Lords in 1997, a key question was "what, if any, risks of harm did the defendant owe a duty of care to protect the claimant against?" This was important because the law does not impose responsibility on a defendant for everything which follows from his or her act or omission, even if it is wrongful.

In this case the patient approached her GP surgery specifically to know if she was a carrier of the haemophilia gene. Although there was a causal link between the admitted negligence of Dr Khan and the birth of the child, that was not relevant to the scope of his duty. The law did not impose on Dr Khan any duty in relation to unrelated risks that might arise in pregnancy. It followed that he was liable only for the costs associated with haemophilia.

Comment

This is a very important ruling from the Supreme Court. Those acting for the mother argued that if it wasn't for the doctor's negligence, her child would not have been born and therefore the defendant should be responsible for the financial consequences of all his disabilities. The Court ruled that this was the wrong way to look at the situation. The GP had not been consulted about autism, which is a risk resulting from any pregnancy. Consequently, he did not owe a duty of care in that regard. It is a principle which can be applied to other clinical negligence cases.

Walsh (deceased) v. Northumbria Healthcare NHS Foundation Trust (Newcastle County Court, 19 May 2021 – Judge Freedman)

In 2017 Mr Walsh took his own life by running onto a major road into the path of oncoming traffic. It was alleged that security staff had been negligent and that this led to his death.

Mr Walsh had no history of psychiatric illness, but on 23 January 2017 he had struck one of his children and as a result was required to leave the family home. He then took an overdose of paracetamol, and did so again on 4 February. He was taken by ambulance to hospital and after initial assessment was sent for a psychiatric review. An hour later he told a physician's assistant that because the hospital was not doing anything to help him he was going to kill himself. He ran towards an area with easy access to the main road. Security officers were summoned and were able bring him back to the building. He then had a cigarette outside the entrance and returned to the emergency department, accompanied by the guards. He asked for water. One of the guards went to the cooler and at that point the patient made his escape. Unfortunately, the guards could not catch him and he ran into the path of approaching vehicles.

It was claimed that the guards had failed to take appropriate care of the patient and it was foreseeable that if a door were left unattended even for a brief time Mr Walsh might escape. Judge Freedman noted that the patient had not been detained under the Mental Health Act 1983 and therefore there was no statutory power to confine him to hospital. While there was a risk of the deceased absconding, the function of the security officers was not to detain him in the conventional sense but rather to take reasonable steps to prevent him from leaving. In the short period prior to him running away, there was nothing in his demeanour to suggest he was contemplating an escape. On the contrary, the evidence suggested he was calm and co-operative. It was reasonable for one of the guards to respond to the request for water. To hold guards negligent in such circumstances would be to impose an intolerably high burden upon them. The guards had not been negligent and, in any event, causation had not been demonstrated because it was probable that Mr Walsh would have found another opportunity to end his life within a short time, even if he had been restrained on this occasion.

Comment

This was a very sad case, but it is important to bear in mind that the patient was not detained under the Mental Health Act. The claim sought to place an unreasonably high burden upon the guards who had no immediate reason to think the patient was going to escape and were performing an act of kindness for him. This is a notable ruling, although as it is a County Court judgment it is not binding on other judges. It is clear from the decision that the duty of security guards in such circumstances is one of reasonable care and no higher.

Paul v. Royal Wolverhampton NHS Trust; Polmear v. Royal Cornwall NHS Trust; Purchase v. Ahmed (Court of Appeal, 13 January 2022)

Introduction

These three cases all involved similar issues concerning secondary victims of alleged clinical negligence. A secondary victim is not someone to whom the defendant owed a direct duty of care in the circumstances (the primary victim), but rather a person who witnessed the accident or event involving the primary victim or who came upon its consequences shortly afterwards. The Court had to decide whether, on the facts of each case, secondary victims might be able to recover damages. This ruling was not about whether the clinicians involved had been negligent.

Detail

Mr Paul, who suffered from type 2 diabetes, was admitted to hospital on 9 November 2012 complaining of chest and jaw pain. He was treated for acute coronary symptoms and discharged on 12 November. On 26 January 2014, some 14 months later, he had a heart attack while shopping with his family and died shortly afterwards. His young daughters witnessed his collapse and suffered psychiatric trauma. It was alleged that Mr Paul should have been given a coronary angiogram by the hospital in November 2012, which would have revealed coronary artery disease.

Esmee Polmear, aged 7, was referred by her GP to the trust following episodes of not being able to breathe and turning blue. The reviewing paediatrician concluded in January 2015 that her symptoms were likely to be related to exertion, with nothing to suggest an underlying heart problem. However, on 1 July 2015, over five months later, Esmee felt unwell on a school trip. Her parents agreed to bring her back but when they reached her she was lying on the ground with a staff member giving mouth-to-mouth resuscitation. She was not breathing and died shortly afterwards. Both parents suffered post-traumatic stress disorder. The trust admitted negligence by failing to diagnose Esmee's underlying condition.

Ms Purchase visited her GP in January 2013 with acute sinusitis. Afterwards she continued to feel unwell and by 4 April she was weak, dizzy and had difficulty breathing. Her mother took her to an out-of-hours GP, who made a diagnosis of respiratory tract infection with pleuritic pain, oral thrush and depression. He prescribed antibiotics and antidepressants. However, her condition remained unaltered. On 7 April, three days later, her mother returned home to find Ms Purchase lying motionless on her bed, staring at the ceiling, although she looked alive. She was then joined by her other daughter and ex-husband. A 999 operator advised the family to give cardio-pulmonary resuscitation pending arrival of an ambulance. This proved unsuccessful, and paramedics could not achieve any improvement. Ms Purchase died. Her mother sustained post-traumatic stress disorder, severe chronic anxiety and ongoing depression. She alleged that the GP had failed properly to assess and treat her daughter's symptoms.

The Court reviewed the leading court decisions on secondary victims. On behalf of the claimants it was argued that the "event" which caused the trauma to secondary victims need not occur at the same time as the original negligence. However, the Court concluded that it was bound by its own previous decision in Taylor v. A. Novo (2013), where a mother suffered an accident at work when shelving fell onto her. Three weeks later she collapsed and died at home, witnessed by her daughter, who was held unable to recover damages from her mother's employers for psychiatric trauma.

The Court stated that for a secondary victim to recover against a defendant whose clinical negligence had caused the primary victim injury, the horrific event "cannot be a separate event removed in time from the negligence". Consequently, these claims could not succeed. However, the Court of Appeal regarded this area of the law as being suitable for review by the Supreme Court and therefore gave the claimants permission to appeal.

Comment

These are all deeply tragic cases, and everyone will feel huge sympathy for the secondary victims. However, as the House of Lords made clear in the leading cases of Alcock, which dealt with the Hillsborough disaster, there must be boundaries to recoverability by those who are not primary victims. Without them, defendants would potentially be exposed to large numbers of claims arising from one act of negligence. Judges must determine where those boundaries should be set. While it might well be foreseeable that failure to diagnose a heart condition could lead to the patient collapsing and dying, witnessed by family members who suffer psychiatric trauma as a result, that does not necessarily mean that the witnesses can recover damages. We must anticipate a definitive ruling from the Supreme Court, perhaps in 2023, which will have important implications for both relatives and the NHS.

Exaggerated and false claims

We assess all claims on their merits and readily pay those where liability is established. Occasionally, we come across cases where there has been serious exaggeration of symptoms or an attempt to manufacture a claim, and we adopt a very firm line with these in order to preserve scarce NHS funds and discourage similar attempts. Two such instances resulted in custodial outcomes during the year.

In the case of D, the claimant had a genuine clinical negligence claim for failure to prevent the development of cauda equina syndrome. This was worth around £60,000. However, he asserted that he was much more seriously disabled than he actually was and submitted a claim for circa £2 million, attested by a statement of truth. He maintained he could walk only 100 yards, using two sticks. Surveillance demonstrated that D could in fact walk without any aids, and both lift and move boxes without apparent discomfort. We sought the Court's permission to commence committal proceedings against D for contempt of court. After a number of attempts at evasion, including feigning illness, D eventually accepted that he had been in contempt by making false statements for pecuniary gain. In July 2021 Judge Lickley QC sentenced D to 29 weeks in prison for contempt of court, observing:

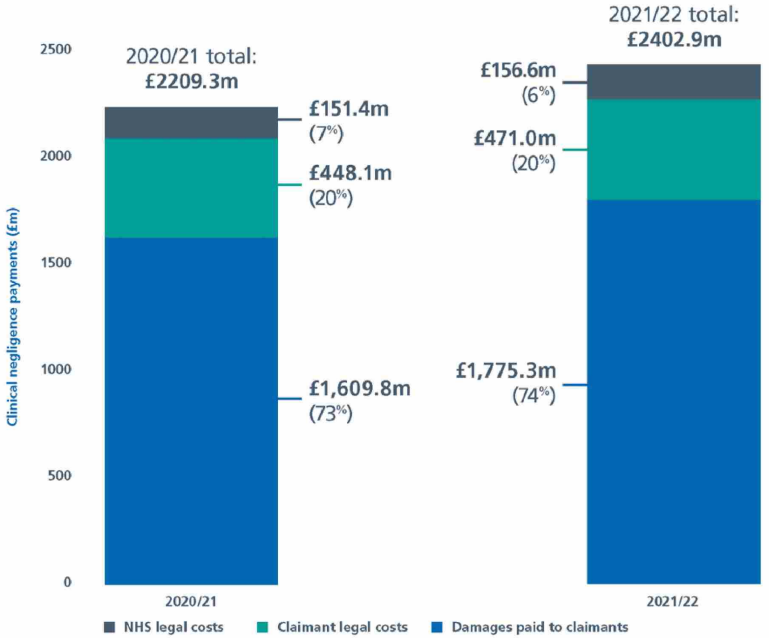
"people who try to cheat their way to compensation should be punished by way of custodial sentence", and D's actions "were so serious that only an immediate custodial sentence was appropriate".

W, who was a security guard at an NHS trust, alleged he had slipped on cardboard left in a changing area at the hospital. The claim appeared genuine and was settled for just over £5,000. However, shortly afterwards, evidence came to light from W's ex-partner in the form of text messages which appeared to show that the accident had been staged. Fortunately, W's solicitors had not passed on the settlement to him and returned the money. We made an application to the Court, jointly with the trust, to seek a finding of contempt. Shortly before the hearing in November 2021, W accepted he had been in contempt. Judge Anne Whyte QC found that W's representations had been both frequent and dishonest. The relative financial modesty of the claim did not remove the seriousness of the contempt. W had misled a public body and wasted NHS funds. She therefore sentenced W to a prison term of seven months.

Comment

While the prison sentences received were relatively similar, the financial sums differed greatly between these cases. However, in criminal sentencing, specific discounts are applied for different types of mitigation such as admissions and remorse, and therefore the sentences are not directly comparable. The overall message from these cases is nevertheless very clear – NHS Resolution will not hesitate to seek the imposition of a prison sentence if individuals bring greatly exaggerated or fabricated claims.

Figure 11:
Clinical negligence payments for 2021/22



Payments

Payments against all our clinical schemes for 2021/22 (2020/21) were £2,402.9 million (£2,209.3 million) in total – which comprised damages paid to claimants of £1,775.3 million (£1,609.8 million), claimant legal costs of £471 million (£448.1 million) and NHS legal costs of £156.6 million (£151.4 million). The increase in NHS legal costs can be in part attributed to increased spending on the general practice indemnity schemes, mainly ELSGP, since the migration of the claims previously managed by MPS (+£8.1 million/161%).

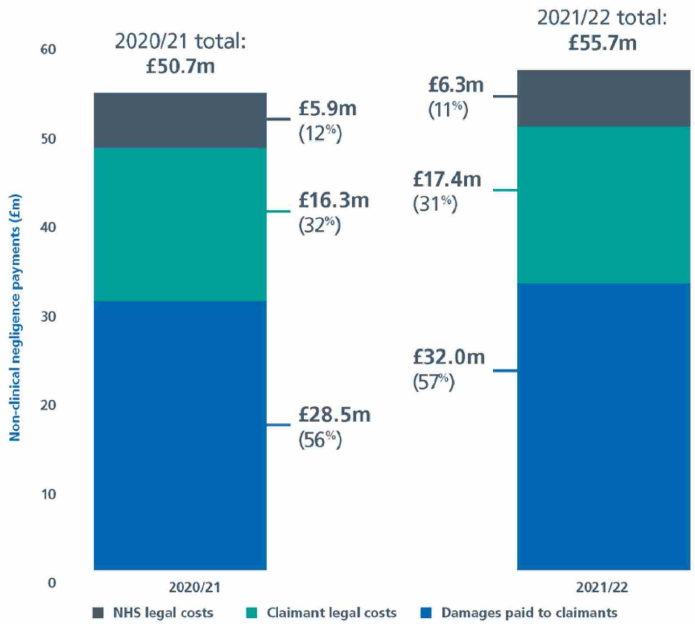
Payments on CNST claims increased by £152.8 million (7%) to £2,213.9 million from 2020/21. This increase was primarily in damages and claimant legal costs payments against high value (more than £3.5 million) claims.

Payments made on the DHSC clinical scheme increased to £82.8 million in 2021/22 (£61.6 million in 2020/21). A number of high value claims fell due for settlement in this year, as expected.

Payments made on behalf of GPI increased: £85.0 million in 2021/22 (£62.4 million), reflecting the continuing maturing of our GPI claims book.

Payments for our Existing Liabilities Scheme and Ex-Regional Health Authority Scheme decreased to £21.2 million in 2021/21 (£24.3 million).

Figure 12:
Non-clinical negligence payments for 2021/22



Payments against all our non-clinical schemes totalled £55.7 million in 2021/22 (£50.7 million) – which comprised damages paid to claimants of £32.0 million (£28.5 million), claimant legal costs of £17.4 million (£16.3 million) and our legal costs of £6.3 million (£5.9 million).

Figure 13:
Payments on clinical claims by financial year from 2013/14 to 2021/22 for our CNST

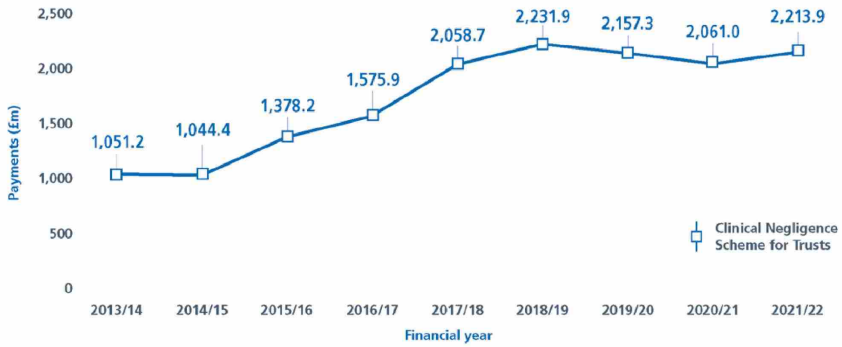
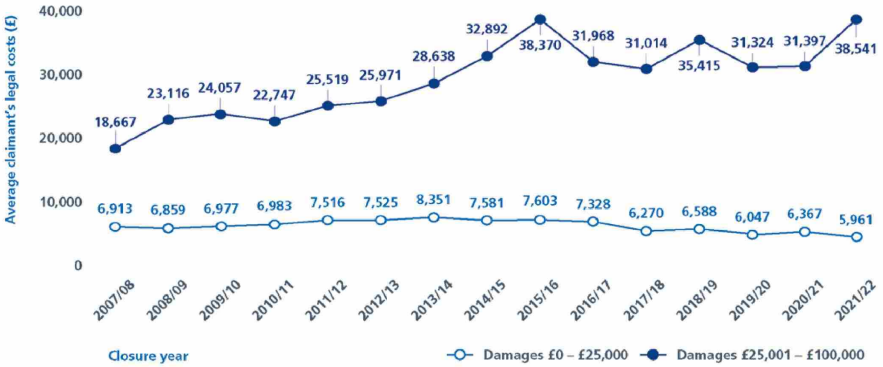


Figure 14:
Average of claimant costs paid on claims where damages are between £1 and £100,000 for claims closed in the financial years from 2007/08 to 2021/22 for all clinical negligence schemes[1]

Across all claims settled, there was a steady increase over previous years in average claimant legal costs for claims involving damages up to £25,000; there was also an increase over the past year of claimant legal costs for claims involving damages between £25,001 and £100,000. These average costs were, respectively, £23,250 in 2021/22 (£21,609) and £52,953 (£48,361).

The increase in average claimant legal costs for cases where damages settled between £25,001 and £100,000 has been affected by a reduction in the number of cases that settled without the requirement to pay claimant costs (12 cases in 2021/22 compared to 24 in the previous year). These were typically property damages expense claims. Average damages paid have increased slightly between 2020/21 and 2021/22. This may reflect an increase in the complexity of cases settled during the financial year, driving an increase in claimant legal costs.

Figure 15:
Average of claimant costs paid on claims where damages are between £1 and £100,000 for claims closed in the financial years from 2007/08 to 2021/22 for all non-clinical negligence schemes



For non-clinical claims involving damages up to £25,000, average claimant costs reduced over the long term (£8,351 in 2013/14) to £5,961 in 2021/22. This reflects the impact of a fixed payments schedule for these claims that was introduced in 2013.

[1] There has been a restatement of the data for 2020/21 with the small number of claims closing that had not been reflected last year so the stated average has changed slightly.

Key performance indicators

Our KPIs provide an objective assessment of our operational performance and cover all areas of our operations.

We annually review these to help us to continuously develop our services. At a high level, our KPIs provide assurance to our Board and to DHSC that we are conducting our business as intended and as we are funded for.

Our KPIs are agreed by our Board and DHSC and published annually via our business plan. This annual report addresses performance against our 2021/22 business plan. The target measures for some of our internal claims KPIs are confidential as publication could prejudice the effective management of claims.

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

Resolution

No.	KPI description	Area	Target	Met
1	To respond to a letter of claim involving a clinical/non-clinical matter within the pre-action protocol period	Claims	Internal	Not met
2	To respond to a letter of claim within the timeframe agreed between the parties	Claims	Internal	Met
3	Time to resolution from claims decision to agreement of damages	Claims	Internal	Not met
4	The volume of cases that are repudiated initially with a subsequent payment agreed	Claims	Internal	Met
5	Reduction in the volume of cases which enter formal court proceedings	Claims	Internal	Met
6	The movement in the financial reserves placed on a claim is managed within a target range	Claims	Internal	Met
7	Data accuracy	Claims	Internal	Met
8	'First step' letters sent out within seven days of receiving the appeal or dispute	Appeals	90%	Met
9	Appeals or disputes where 14 or more days' notice of hearing has been given	Appeals	100%	Met
10	Appeals where decision maker agreed with recommendation of case manager	Appeals	80%	Met
11	Outcome of quality audits for appeals and dispute files	Appeals	90%	Met
12	Average number of weeks taken to resolve appeals and disputes – internal input only	Appeals	15 weeks	Met
13	Average number of weeks taken to resolve appeals and disputes – additional input	Appeals	19 weeks	Met
14	Average number of weeks taken to resolve appeals and disputes – oral hearing	Appeals	25 weeks	Not met
15	Average number of weeks taken to resolve disputes – current market rent valuation input required	Appeals	33 weeks	Not met

Intelligence

No.	KPI description	Area	Target	Met
16	Healthcare Professional Alert Notices issued/released (where justified) within target working days	Advice	90%	Met
17	Healthcare Professional Alert Notices revoked (where justified) within seven working days	Advice	90%	Met

Intervention

No.	KPI description	Area	Target	Met
18	Positive feedback from scheme members and beneficiaries visited on recognition of products	Safety & Learning	At least 60%	Met
19	Response to scheme members and beneficiaries bulleted as below			Met
19a	• 95% response rate to scheme members and beneficiaries following a request for contact within three working days	Safety & Learning	95%	Met
19b	• Participation in 18 regional engagement events for scheme members and beneficiaries which include two national sharing and learning events	Safety & Learning	18 events	Met
19c	• Eight safety and learning products to be made available for scheme members and beneficiaries	Safety & Learning	8 products	Met
20	Advice education events rated by participants at least four out of five for effectiveness/impact	Advice	90%	Not met (89%)
21	Requests for advice from our Advice service responded to within two working days (or within an alternative timeframe requested by the employing/contracting organisation)	Advice	90%	Met
22	Assessments and other interventions delivered within the target timeframe	Advice	90%	Met
23	Assessment and other intervention reports produced/issued within the target timeframe	Advice	90%	Met
24	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	Advice	90%	Not met (89%)
25	Decisions on referrals for assessments and other interventions communicated to the referrer within 13 working days of receipt of all referral information	Advice	90%	Met

Fit-for-purpose

No.	KPI description	Area	Target	Met
26	Accuracy of budget and in-year financial management of NHS Resolution's indemnity schemes	Finance	Between 95% and 100% of in-year target	Not met
27a	Undertake annual customer satisfaction survey to inform service development	Membership and Stakeholder Engagement	Complete in 2021/22	Not met
27b	Indemnity scheme member participation in our member satisfaction survey to ensure engaged member base	Membership and Stakeholder Engagement	60% of our CNST1 and LTPS2 indemnity scheme members	Not applicable
27c	Evidence of increasing scores covered by annual customer satisfaction surveys year on year	All	Increasing scores in 50% of subject areas covered	
27d	Overall approval rating in the 2020/21 customer satisfaction survey	All	60%	
28	Availability of core systems	Digital, Data and Technology (DDaT)	95%	Met
29	Availability of extranet and claims reporting services	DDaT	97.5% in core hours	Met
30	Respond to critical security alerts (NHS Digital CareCERT)	DDaT	Within 24 hours of receipt	Met
31	Helpdesk to respond to calls within two hours of receipt	DDaT	90%	Met
32	Vacancy rate	All	<10%	Not met
33	Uptake of annual staff appraisals	All	90%	Met
34	Engagement for the staff survey	All	>75%	Not met
35	Voluntary turnover of staff during six-month probationary period	All	<15%	Not met
36	Prompt payment of suppliers within 30 days	Finance and Corporate Planning	95%	Not met

Claims KPI framework

Despite the ongoing impact of Covid-19, we have maintained a good service overall. Through the year, the pandemic has continued to have a significant impact on the healthcare providers we indemnify, with the priority being the frontline response. Access to healthcare professionals to provide expert and factual input into claims has been constrained. This has resulted in challenges in fully meeting a small number of our KPIs, specifically the time to respond to a formal claim for compensation.

A more detailed analysis of KPIs that were unmet

KPIs 1 and 2 – Response time to a formal claim for compensation

We missed the KPI relating to meeting protocol timescales where the pandemic limited the availability of healthcare professionals to provide expert opinions, for example. In the lower value tranches the target was missed by 20% and a 10% reduction from the previous year. Performance was stronger in the higher value tranches (cases valued above £100,000) where the target was missed by 2%. However, we exceeded our target by 6% for the KPI measuring our response to an agreed timeframe between the parties.

KPI 3 – Time to resolution

We did not meet our KPI that measures the time between a decision being made on whether to admit liability and payment of any agreed compensation. This KPI requires a year-on-year reduction in time to resolution to meet its target. This year, the time taken from admission of liability to settlement increased by over 10% compared with the previous year. Again, this KPI relies on the input of healthcare professionals to advise on ongoing, past and future needs, particularly in higher value cases, to assess the value of compensation.

KPI 14 – Time taken to resolve appeals and disputes (oral hearing)

This metric includes hearings delayed due to the Covid-19 pandemic during the January 2021 lockdown. Had this not been the case the average time would be 23 weeks and within target.

KPI 15 – Time taken to resolve disputes (current market rent valuation input required)

Turnaround time was influenced by one exceptional case which experienced a number of delays – if this one case were excluded, we would have met our target.

KPI 20 – Advice education events

89% of education events have received a score of four out of a possible five during this financial year. Five events fell below the KPI.

KPI 24 – Critically reviewed exclusions and suspensions

89% of exclusions in secondary care (118 out of 133 cases) in England were reviewed by the Advice service within the target timeframe. In the 15 cases where a review was not undertaken within the required timeframe, this was either due to the healthcare organisation being unavailable to complete the review or due to administrative oversight. In all cases, these reviews have now taken place.

KPI 26 – Accuracy of budget and in-year financial management

NHS Resolution underspent by £238.6 million (8.7%) across revenue budgets, with £222 million against our largest indemnity scheme, CNST. The budget for 2021/22 was set in summer 2020, when the ongoing impact of the pandemic was unknown. The underspend was due to settlement of fewer than expected high value claims, and lower than expected inflation in claims settlements. However, expenditure on CNST claims has increased by £158.4 million (7.6%) since 2020/21, with an increase in payments on high value claims being the main element. This will also be influenced by the mix of claims falling due for payment.

KPI 27a–d – Our annual customer satisfaction survey

In response to the pandemic, we suspended our membership satisfaction survey, given pressures on the NHS frontline due to Covid-19. However, in 2021/22 we undertook a series of 'deep dive' interviews with strategic partners, conducted by an independent market research agency, in order to gain feedback on our impact among these stakeholders.

KPI 32 – Vacancy rates

As at 31 March 2022 our vacancy rate was 24.3%. This vacancy rate has remained high due to a delay in approval of our Claims Evolution Programme business case.

KPI 34 – Engagement with our staff survey

Despite the response rate being lower than our previous survey, due to the increase in our headcount figures, more staff actually completed the survey this year. Our response rate, 62.8%, remained above the national average response rate.

KPI 35 – Voluntary turnover of staff

18% of our overall voluntary turnover was from staff within their probation period.

KPI 36 – Prompt payment of suppliers

Performance against the prompt payment of suppliers metric continues to be below the 95% target at 90%, but has improved since 2020/21 as the finance system implemented in December 2019 has bedded in and incremental process improvements have been made.

An organisation fit for its purpose

Sustainability report

NHS Resolution's main activities have been run from two offices: 10 South Colonnade, Canary Wharf, London, and Arena Point and then moving to 7–8 Wellington Place in Leeds from February 2022. Both offices 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 for smarter working, such as the Places for Growth programme and the Hub Network strategy.

Migrating IT systems into the cloud has progressed even further this year. Smarter, agile working means that localised energy use is reduced to minimal levels across both London and Leeds sites. This is a positive step towards more efficient, sustainable systems and technologies. IT hardware is recycled as a best practice through internal NHS channels.

Our initiative to work 'paperlite' has been achieved through the new Ways of Working programme, the pandemic and the development of new software technologies that have allowed us to become less dependent on multifunctional devices and retain physical records, and their associated storage.

Our London office – 10 South Colonnade – has a comprehensive sustainability and net zero strategy in place led by the Government Property Agency (GPA). All governing body tenants collaborate on a regular basis to discuss initiatives and the building's environmental performance and compliance objectives as part of a Sustainability Development Forum which feeds into the wider Government action plan on sustainability.

The Leeds office has just moved to new offices at 7–8 Wellington Place under the responsibility of HMRC and has a similar make-up to the London office. The building is under two years old and uses newer, efficient sustainable technologies in construction, mechanical and electrical, and fixtures and fittings.

Climate change and rural proofing

We have assessed the potential impact of climate change as "low" on our operations. Our facilities and technology strategy has been to leverage wider government provided services, as evidenced by our location strategy, and NHS provided platforms and services where possible, as evidenced by our Technology strategy. This will mitigate any potential impacts of climate change.

In terms of commitment towards Net Zero, we are committed to supporting the NHS ambition of achieving a Net Zero NHS by reviewing the emissions we have direct control over and those that we are able to influence. In 2021/22 the senior management team supported the set up of a Net Zero and Sustainability Network with staff to put together proposals which would move NHS Resolution towards the NHS Net Zero goal by 2040.

Greenhouse gas (GHG) emissions

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

- **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		2021/22	2020/21	2019/20	2018/19	2017/18
Gross emissions for scopes 1 and 2	Combined tCO2e from gas and electricity	553.49	N/A	N/A	N/A	N/A
Gross emissions for scope 3	Energy from waste tCO2e	1.93	N/A	N/A	N/A	N/A
	Business travel	5	2	38	44	24

Given the NHS Resolution office move we are now able to calculate GHG emissions using monthly data received from GPA.

Table 3: Energy consumption

Scope 3 – Building energy consumption	2021/22		2020/21		2019/20		2018/19		2017/18	
	Qty (MWh)	Cost (£)	Qty (MWh)	Cost (£)	Qty (MWh)	Cost (£)	Qty (MWh)[1]	Cost (£)	Qty (MWh)	Cost (£)
Electricity	252	49,308	144	17,581	188	23,566	184	22,411	304	38,113
Natural gas	10	1,260	58	2,590	103	4,603	99	4,460	98	4,351

Energy consumption was lower in previous years due to the pandemic and home working. Costs are now higher due to the return to office and NHS Resolution's move to new premises where the allocation of energy costs is calculated differently.

Table 4: Travel

Scope 3 – Business travel	2021/22		2020/21		2019/20		2018/19		2017/18	
	Miles	Cost (£)	Miles	Cost (£)	Miles	Cost (£)	Miles	Cost (£)	Miles	Cost (£)
Road	8,080	4,976	9,465	5,622	47,890	29,399	42,966	23,624	46,203	25,874
Air	0	0	0	0	49,553	14,100	43,683	11,356	42,873	12,510
Rail	39,817	15,049	6,015	1,573	371,925	162,886	290,131	115,979	333,172	112,160

[1] Tonnes of CO_2 equivalent (tCO_2e)

Table 5: Waste

Waste	2021/22		2020/21		2019/20		2018/19		2017/18	
	Qty (tonnes)	Cost (£)	Qty (tonnes)	Cost (£)	Qty (tonnes)	Cost (£)	Qty (tonnes)	Cost (£)	Qty (tonnes)	Cost (£)
	6	702	5.19	639	12.8	549	14.6	1,805	12.7	1,563

Table 6: Use of finite resources

Waste	2021/22		2020/21		2019/20		2018/19		2017/18	
	Qty	Cost (£)	Qty	Cost (£)	Qty	Cost (£)	Qty	Cost (£)	Qty	Cost (£)
Water consumption	367.5 m^3	934	339 m^3	815	1,561 m^3	3,680	1,343 m^3	3,233	1,400 m^3	3,370
Administrative paper[1]	20 reams of A4	49	80 reams of A4	178	1,805 reams of A4	4,099	2,500 reams of A4	5,570	2,655 reams of A4	6,662

Water consumption was lower in the previous years due to the pandemic and home working. Costs are now returning to a more normal level due to the return to office and NHS Resolution's move to new premises where the allocation of water consumption costs is calculated differently.

[1] Paper use is paper purchased for home workers' printers only. Paper usage for outsourced printing of collateral has not been included.

Finance report

Headlines in numbers

- The provision for the liabilities arising from claims has increased by £43.4 billion (50.8%) from £85.2 billion to £128.6 billion, primarily due to a technical accounting change affecting the provision.
- The total value of clinical negligence claims under the CNST scheme incurred as a result of incidents in 2021/22 was £13.3 billion, up from £7.9 billion the previous year. The change in the long term discount rates set by HM Treasury has significantly affected this value, increasing it from £8.7 billion based on the previous set of discount rates.
- Payments for settling claims in 2021/22 increased by £199 million (8.8%), to £2.459 billion.
- Administration costs increased by £8.8 million (25%) to £44.2 million.
- Budget position:
  - Department Expenditure Limit (DEL) £239 million (8.7%) under budget.
  - Annually Managed Expenditure (AME) £2.63 billion (5.7%) 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 which includes both scheme payments and our administration costs.

Year-end provisions

The provision is the value of liabilities arising from incidents that occurred before 31 March 2022 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).

The provision has increased by £43.4 billion (50.8%) to £128.6 billion. The most significant factor, accounting for £42.6 billion of this change, is the reduction in the long term and very long term discount rates set by HM Treasury. The discount rate is designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today's prices. It tells us how much we would need to pay out if we settled all of those future obligations today. In accordance with International Financial Reporting Standards, HM Treasury has applied market rates which reflect the low cost of borrowing to Government in determining the long term discount rate. Note 7.3 to the accounts shows how the rates have changed, with the most significant changes being the reduction in the nominal long term (10 to 40 years) and very long term (over 40 years) rates from 1.99% to 0.95% and 0.66% respectively.

A significant proportion of the provisions are expected to be settled over the longer term. Consequently, these reductions in the long term rates have had a considerable impact on the value of the provision. However, this is an accounting judgement that does not change the underlying future payments that will be incurred in meeting the obligations arising from claims when they fall due in the short term.

Aside from this factor, the increase in the provision from another year's worth of activity has been broadly offset by favourable movements in assumptions in relation to claims inflation. Claims settlements have, in recent years, not risen as fast as historical patterns have suggested, and we have reduced the claims inflation assumption again for the 2021/22 financial year. However, it is important to recognise that the cost of clinical negligence across the NHS in-year continues to be significant. The estimated cost of incidents arising from the clinical activity in 2021/22 covered by our CNST scheme was £13.3 billion (see Note 2.1 to the accounts). This figure is materially higher than the £7.9 billion reported in 2020/21 – reflecting:

- the change in the HM Treasury long term discount rates, which places a much higher value on projected claims costs; and
- the assumption that clinical activity would have increased in 2021/22 compared with 2020/21 where activity would have been impacted by the pandemic. We estimate that the annual cost of incidents would have been £8.7 billion without the impact of the change in discount rates.

The estimated impact of Covid-19 on the provision continues to be limited because:

- the vaccination programme was successful in reducing the impact on NHS activity in 2021/22;
- the impact of Covid-19 is largely on incidents which have occurred in the last two financial years and the majority of the provision relates to incidents before this; and
- the majority of the provision relates to maternity claims (70%) and the evidence available to date suggests that the number of claims to expect for 2021/22 will be similar to previous years.

Where Covid-19 does affect the provision, there are two partly offsetting factors: expected lower claim numbers from lower clinical activity, particularly for non maternity activity in 2020/21, offset by new risks and potential sources of claims.

Lower activity in 2020/21 reduces the IBNR provisions across CNST and CNSGP by around £0.3 billion. This is offset by the IBNR provision for new Covid-19 risks and potential claims which is £1.3 billion, hence the net impact of Covid-19 is to increase the provision across all schemes by around £1.0 billion. This compares to a net impact of Covid-19 of £0.5 billion across all schemes last year. The main driver of the increase relative to 2020/21 is the higher number of assumed claims in relation to the indirect impacts of Covid-19 of delays, cancellations and misdiagnosis reflecting longer waiting lists.

Given the time lag in reporting claims there have only been a small number of Covid-19 related claims reported to date. Given the lack of historical claims data the high-level approach adopted to quantifying the impact of Covid-19 on the provisions is discussed in detail in Note 7.2 to the accounts.

Figure 16:
Change in NHS Resolution provisions for all schemes

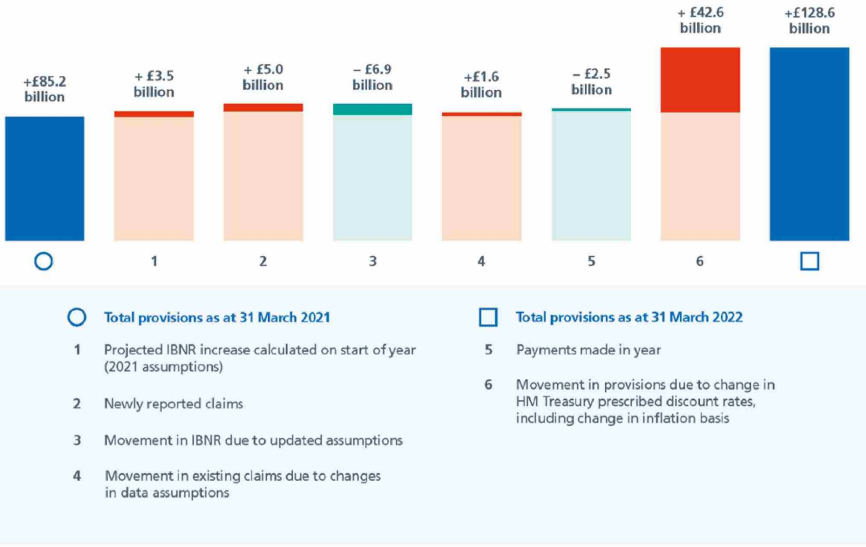


Figure 16 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

The provision at 31 March 2021 has been increased by £2.457 billion from £82.785 billion to £85.242 billion to reflect a prior period adjustment to the known claims provision. Further details are provided at Item 4 below, and at Note 7.4 to the accounts.

Items 1 and 2: Liabilities from another year's worth of activity for all schemes for all incident years are £8.5 billion.

Item 3: shows a decrease of £6.9 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease are in the CNST IBNR, which is the most material component with a £6.2 billion reduction:

- A decrease of £5.7 billion for inflation and average cost assumptions. In general, the average cost of claims in recent years has not risen by as much as the inflation assumptions made in previous years. This is particularly the case for periodical payment order (PPO) damage payments which make up the majority of the IBNR provision. The gross reductions in the CNST IBNR are £4 billion for changes in long term inflation assumptions and £4.5 billion for changes in the average cost per claim assumptions. However, an adjustment has been made to short-term inflation assumptions in line with current economic conditions. This has increased the CNST IBNR by £2.8 billion.
- A decrease of £2.3 billion as a result of removing the risk and uncertainty margin. NHS Resolution has been continually refining its reserving methodology. This is to develop a best estimate of the provision. We seek to address the risk and uncertainty in the provision through the discussion of sensitivities and reasonable range in Note 7.3 to the accounts.
- A decrease of £0.2 billion for the change in assumption for projected number of successful claims. This includes refinements to the methodology in respect of estimating the number of potential PPOs. We separately project claims that are expected to be notified under the EN Scheme, as this scheme is expected to accelerate the reporting of many PPO claims. This refinement reduces the IBNR but is offset by an increase in the number of assumed PPOs for non-EN claims, following recent claims reporting experience. Taken together, the assumed number of claims increases the CNST IBNR by £1.6 billion. Also included in this impact is the change in the assumed probability of the claims settling with damages payable – which by itself decreases the CNST IBNR by £1.8 billion.

- An increase of £2 billion in respect of lag and payment patterns and updated mortality assumptions in respect of potential PPO claims.

There has been an overall increase of £0.5 billion (from the net £0.5 billion provided for in 2020/21) for the assessed impact of Covid-19 on the provisions. This primarily reflects slightly higher NHS activity in 2020/21 than was estimated last year (which is therefore expected to increase the number of clinical claims), and an increase in the number of claims owing to delays, cancellations and misdiagnosis reflecting longer waiting lists.

The remaining decrease of £1.2 billion relates to the effects of assumptions changes on IBNR for the other indemnity schemes (including a net decrease of £14 million for the effect of Covid-19 on the risk of claims covered by other schemes).

Item 4: The liability has increased by £1.6 billion in respect of changes in assumptions affecting known claims. The known claims provision is impacted by the changes in inflation and Annual Survey for Hours and Earnings (ASHE) assumptions.

- A net increase of £2.8billion relates to claims that were open at 31 March 2021 and remain open at 31 March 2022. 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 £1.6 billion in the liability relates to claims closed during the year, either at a lower value than expected, or where the claim was repudiated.

An adjustment to the known claims provision has been introduced to allow for the difference between the value of claims expected to settle within one year of the balance sheet date based on individual claims data, and an actuarial view of the timing of cashflows based on historical claims settlement patterns.

The settlement date for individual claims is used in the known claims provision calculation to determine the rate of inflation and discounting to be applied. The Covid-19 pandemic has increased the uncertainty over when claims are likely to settle. NHS Resolution experienced an unexpected £120 million (5%) reduction in claims payments in 2020/21 at the height of the pandemic, but payments have increased by £199 million (9%) in 2021/22.

In 2021/22 we have seen an increase in both the volume and value of claims in our claims data with settlement dates in the near term. This reflects that claims management has been disrupted over the last two years.

As a result of this review, we have concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time, as it gives a better estimate of the known claims provision.

Applying an actuarial view of the timing of cashflows to the known claims provision has resulted in an adjustment to the known claims provision of £2.8 billion in 2021/22. This is partially offset by the restatement of the opening provision of £2.4 billion.

Item 5: £2.5 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. This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2016/17 financial year), the number of PPOs in payment was 1,826 with £179 million paid out that year, and a whole life value of £12 billion. At the end of this financial year (2021/22), the equivalent figures were 2,530, £336 million and £29.5 billion respectively.

Item 6: There is a significant increase in the provision of £42.6 billion due to the reductions in the long term and very long term discount rates specified for use by HM Treasury, which has been discussed at page 55 of the Finance report. This includes a £1.7 billion increase arising from the adjustment made to the known claims provision in respect of timing of cashflows as set out at Item 4 above.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the legal environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. Resulting small changes in assumptions as well as changes to discount rates reflecting the financial/market environment, as described above, can have significant impacts on the provision from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail at Note 7.2 on page 134 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 healthcare, clinical commissioning groups and other DHSC ALBs), and financing from DHSC. General practice indemnity (GPI) costs are funded out of the budget held by NHS England for the NHS, via DHSC financing.

DHSC sets a budget in respect of this financing on a Departmental Expenditure Limits (DEL) basis. The DEL is a HM Treasury budgetary control[1], 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.

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 by Government 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.

Indemnity schemes in-year financial position

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

Clinical scheme	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	2021/22 Percentage under / (over)spend	2020/21 Expenditure (£ million)
Member funded – CNST	2,459	2,237	222	9%	2,079
DHSC funded schemes	114	104	10	9%	86
GPI	86	94	(8)	-9%	67
CNSC	1	0	0	52%	0
Total clinical schemes	**2,659**	**2,435**	**224**	**8%**	**2,233**

CNST is our largest scheme and has the majority of the underspend against budget. In recognition of the slowing of claims inflation rates, total funding for CNST for 2021/22 was held at the same level as the previous financial year. The 2021/22 budget was set in the summer of 2020 when the full extent of the pandemic, and the consequent impact on claims payments on 2020/21 DEL expenditure, was unknown.

Payments on CNST claims and scheme administration increased year on year by £158 million (8%), compared to a year-on-year reduction of £94 million (4%) between 2019/20 and 2020/21. Nevertheless, this increase still resulted in a £222 million (9%) underspend against the CNST collect as the assumptions for the volume and value of high-value claims settlements in particular did not occur to the extent expected.

The year-on-year increase in CNST spending has been driven by a £177 million (19%) increase in spending on claims valued at over £3.5 million, primarily in damages payments, and with the majority of the total increase of £17 million in claimant legal costs being against this tranche of claims. This is influenced by the mix of claims coming due for settlement in the year.

NHS legal costs of CNST have reduced by £2.8 million year on year. Expenditure on nil damages value claims has reduced by £8 million, partially offset by increases in spending on claims valued at over £100,000.

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

The Early Notification Scheme within CNST is still very much in its early stages of development. The scheme proactively investigates specific brain injuries at birth for the purposes of determining if negligence has caused the harm. It usually takes on average until a child is aged around 11 to understand the full extent of injury and the consequent level of care needed. However, as we continue to refine and streamline the scheme, and by targeting our investigations, this has resulted in an 8% reduction in NHS legal costs to £4 million on EN cases. The value of damages payments on the EN Scheme has increased from £3.2 million in 2020/21 to £10.2 million as the scheme aims to support families in real time. Claimant legal costs have also increased from £0.4 million to £1.9 million as claims are now progressing.

Expenditure on DHSC and GPI schemes also increased year on year. A number of high value claims settled against the DHSC clinical scheme in 2021/22 as expected, driving the increase in spending.

The budget for GPI schemes was set during the financial year on the basis of a run rate for expenditure for the first half of the financial year. However, the rate of expenditure on claims settlements increased unexpectedly in the second half of the year as claims were expedited. This overspend was contained within the total level of financing that DHSC provides to NHS Resolution for all of the schemes it funds.

Very few claims have been received for the CNSC indemnity scheme set up as part of the response to Covid-19. £28,000 has been spent on NHS legal costs, with a further £236,000 spent on administration costs (including corporate overhead costs).

Table 8: Non-clinical schemes financial performance

Non-clinical scheme	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	2021/22 Percentage under / (over)spend	2020/21 Expenditure (£ million)
Member funded – LTPS	57	49	8	14%	45
Member funded – PES	9	4	5	51%	3
DHSC funded scheme	7	7	0	4%	7
CTIS	0	0	0	0%	0
Total non-clinical schemes	**73**	**61**	**13**	**17%**	**56**

Expenditure on LTPS has increased by £4 million (9%) compared to last year and by £2 million (5%) compared with 2019/20. Despite this increase in expenditure we still experienced an £8 million (14%) underspend against the LTPS collect which was set in the summer of 2020. The year-on-year increase in payments is across all elements of the budget, with the biggest increase in damages spend (£3.6 million). The overall increase in payments year on year has been mainly driven by a £3.5 million increase in spend on high-value claims.

Expenditure on PES is volatile and it is difficult to predict due to the nature of claims received under this scheme.

No claims have been received for the Coronavirus Temporary Indemnity Scheme (CTIS), and £79,000 has been spent on administration (including corporate overhead costs).

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

NHS Resolution's AME 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 (see Item 3 under Figure 16), some favourable movements in key assumptions, most significantly financial assumptions in relation to future inflation rates, have had a positive impact on AME this year. However, the impact of the HM Treasury discount rate changes (Item 6 under Figure 16) was underestimated in the budget. A gross adjustment of £4,612 million was applied to the 2021/22 known claims provision to align expected settlement timings with an actuarial view of timing of cashflows (Item 4 under Figure 16). This is partially offset by the increase of £2,457 million of the provision at 31 March 2021.

The net effect of these factors has resulted in an underspend on the AME budget of £2,630 million. However, there is no specific budgetary cover provided for the prior year adjustment of £2,457 million, and this has been reported to DHSC as a budgetary breach.

Table 9: Annually Managed Expenditure

Annually Managed Expenditure	(£m)	(£m)
Budget		45,938
Expenditure		
Net cost of new claims provisions	3,143	
Change in discount rate	42,623	
Settlement of provisions	(2,458)	
Total expenditure		**43,308**
Under/(overspend)		**2,630**

Administration costs in-year financial performance

Administration costs for all of our activities (including the costs of administering member-funded schemes and GPI arrangements which have been allocated to the scheme DEL budgets above) have increased by £8.8 million (25%) to £44.2 million. This primarily relates to staffing costs, as average full-time equivalent staff numbers have increased by 92 (23%) to 492. The costs of a further eight full-time equivalent staff were charged to capital projects bringing our total to 500 full-time equivalent staff members.

In addition, this year we have generated £935k (£759k in 2020/21) of income from commercial activity in respect of activities and services to other national governments delivered by our Practitioner Performance Advice service. These activities made a surplus of £142k (15%) during the year as we have adapted to remote delivery of educational services through the pandemic.

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.

As a proportion of the value of total claims settlements, administration costs have increased from 1.28% to 1.50%. Administration costs have increased at a faster rate than claims payments.

We have continued to expand our operations this year to handle the historical claims taken on from MPS in April 2021 and the increasing volume of claims being received from the maturing CNSGP scheme. General practice indemnity scheme claims require more activity from our staff compared to claims against secondary care providers as the latter have legal teams to support with the administration of the claim.

We have launched a programme of change in respect of our business model for claims delivery which we anticipate will increase our administration costs further, but will deliver financial benefits from reduced NHS legal costs. We have also progressed with the implementation phase of a replacement of our core IT operating systems, as well as other IT and digital projects to enhance our infrastructure and analytical capabilities. Corporate support costs have also increased in relation to provision of actuarial advice on our expanded range of indemnity schemes, and to assist with the delivery of the objectives of a growing and increasingly complex organisation.

Figure 17:
Administration spend as a percentage of annual total claims settlement costs

Capital

£3 million was spent on capital purchases in the year, an underspend of £5.4 million against the budget of £8.4 million.

The majority of capital expenditure and budget is for the Core Systems Programme, set up to replace our main operational IT systems. The start of the implementation phase of the project was delayed by half a year due to the delay in approval from DHSC as the department prioritised the Covid-19 response.

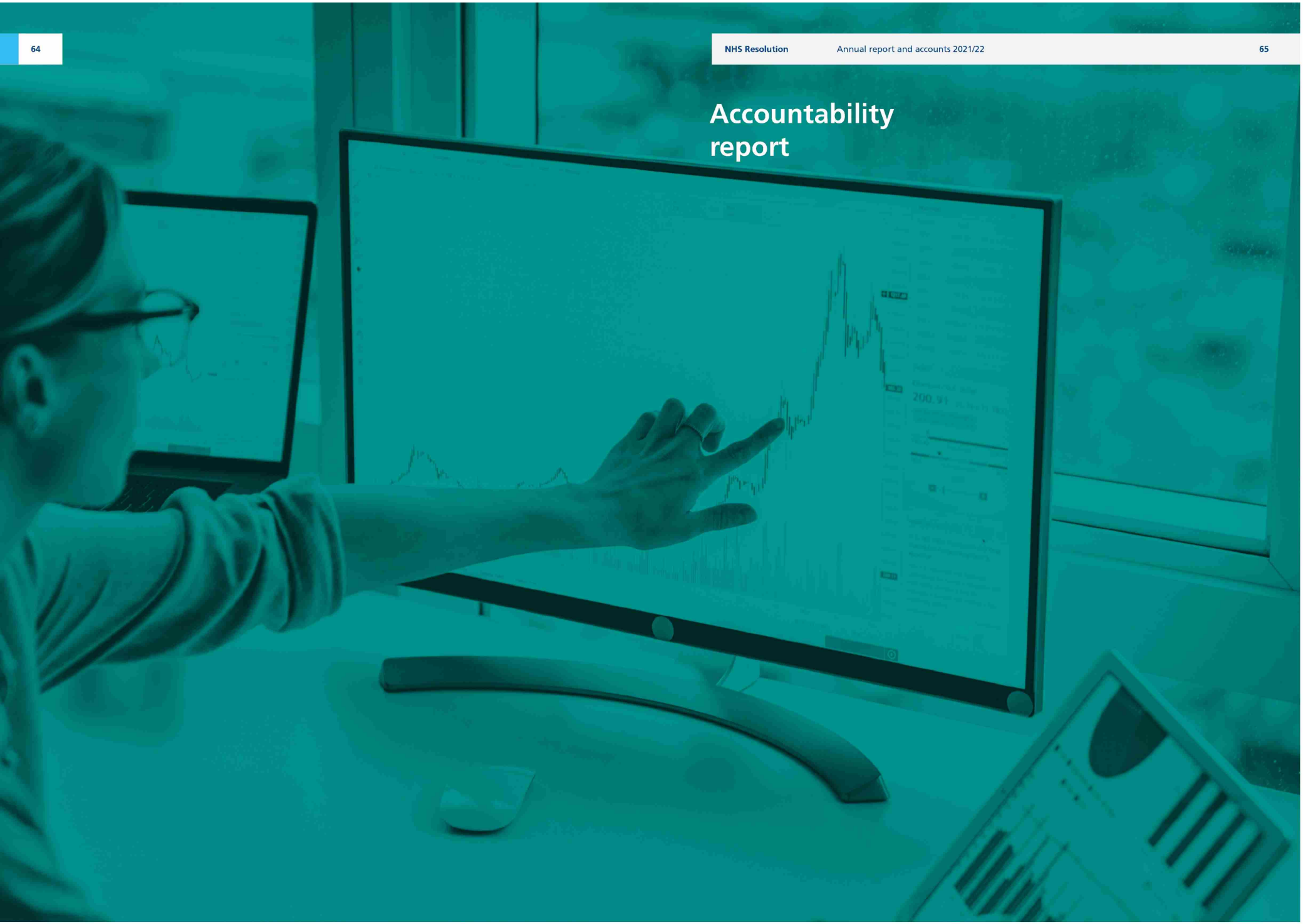
Cash

The balance has increased by £251 million to £549 million by the end of the year due to the in-year underspend on the member funded schemes. We continue to discuss 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. Funding for member-funded schemes is provided through the NHS finance regime, and any underspends incurred by NHS Resolution contribute to the management of the overall DHSC group financial position.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2021/22.

Helen Vernon
Chief Executive and Accounting Officer
Date: 14 July 2022

Accountability report

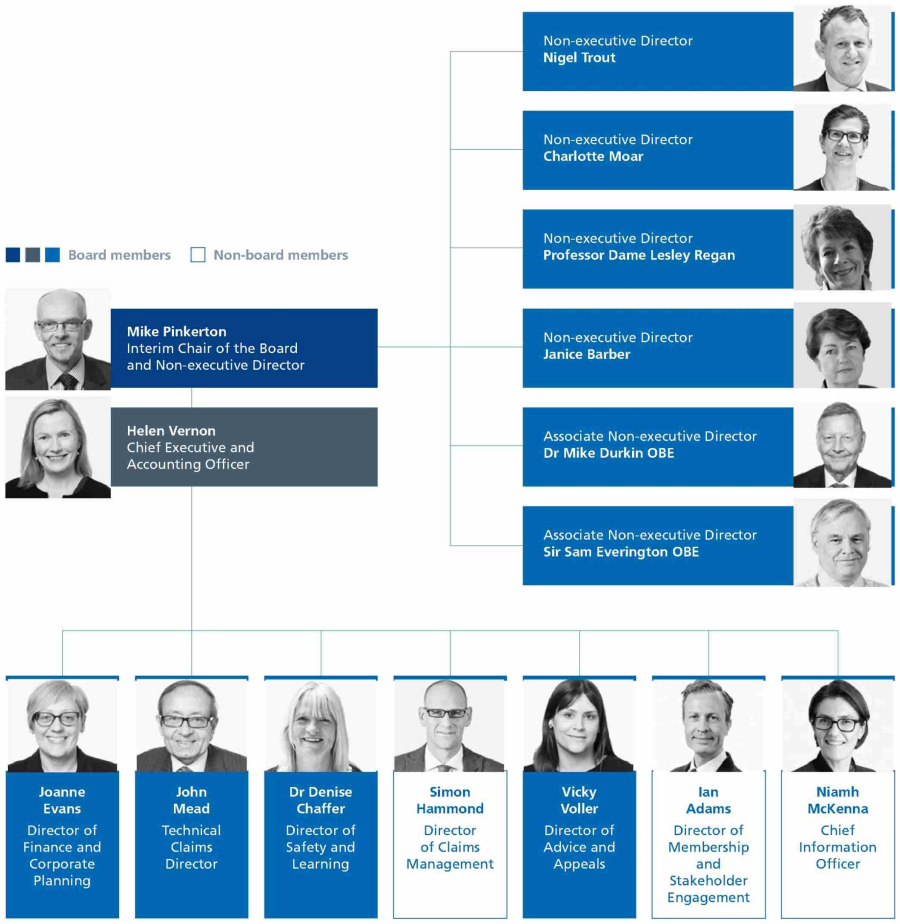


Corporate governance report

Directors' report

This report primarily provides information about the composition of the Board[1] of NHS Resolution. The Board had authority or responsibility for directing or controlling the major activities of the entity during the year.

Figure 18:
NHS Resolution's Board



[1] NHS Resolution publishes a register of interests of each of its 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 me, the Chief Executive, as Accounting Officer of NHS Resolution. The responsibilities of an accounting officer, including responsibility for the propriety and regularity of the public finances for which the accounting officer is answerable, for keeping proper records and for safeguarding NHS Resolution's assets, are set out in *Managing Public Money* published by 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 of NHS Resolution. As far as I am aware, there is no relevant audit information of which our auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that our auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable.

Helen Vernon
Chief Executive and Accounting Officer

Governance statement

Scope of responsibility

As Chief Executive and Accounting Officer of NHS Resolution I am responsible for maintaining a sound system of internal control that supports compliance with our policies and the achievement of our objectives while safeguarding public funds and our 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 our legislative and regulatory parameters, as directed by DHSC and, in conjunction with the Board through development of strategy and effective governance arrangements.

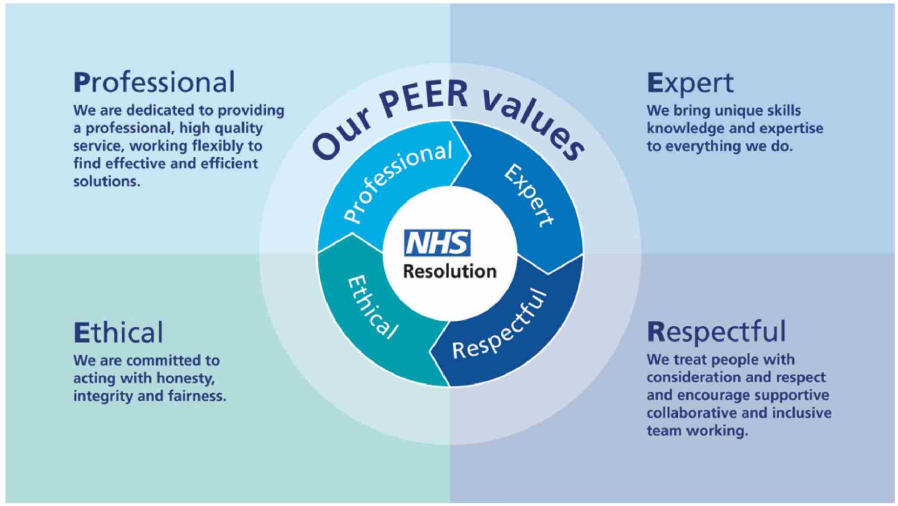
I am responsible for:

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

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

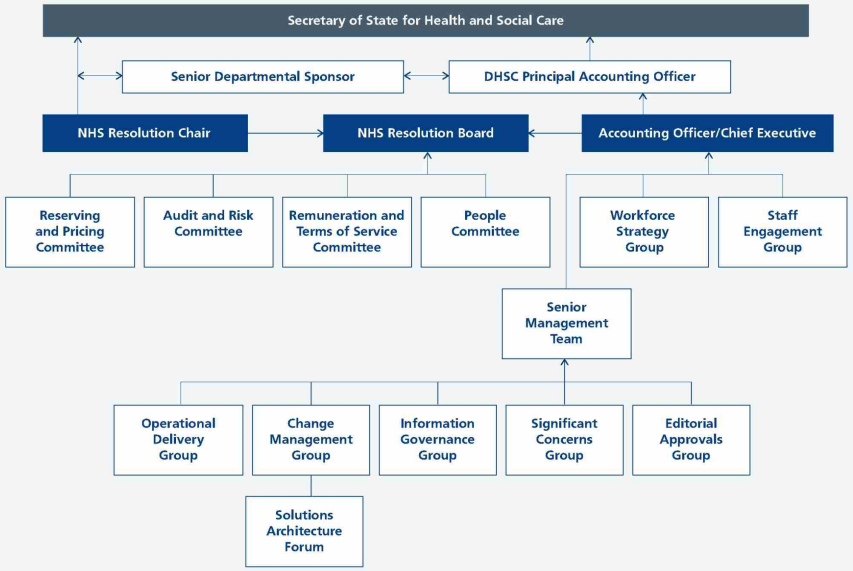
I delegate day-to-day operational responsibility for our financial systems and internal risk management arrangements to the Director of Finance and Corporate Planning, who also acts as the Senior Information Risk Owner (SIRO) for NHS Resolution.

Figure 19:
Our PEER values



The governance framework and structures

Figure 20:
NHS Resolution governance structure and subgroups reporting to the SMT



The NHS Resolution Board

As of 31 March 2022 the Board consisted of the non-executive Chair, four non-executive members and four executive members. There are also two associate non-executive and one associate executive director. The Board can consist of 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. As NHS Resolution's Accounting Officer, I am supported by the senior management team (SMT), internal audit, and Audit and Risk Committee (ARC) to provide assurance to the Board on the matters as they relate to effective governance.

The Board regularly reviews these reports to ensure it remains satisfied regarding the quality of information, and also that it is relevant and sufficient to inform the business of the Board. During the period from 1 April 2021 to 31 March 2022 the Board met on six occasions and attendance details are shown in Table 10.

Table 10: NHS Resolution Board meeting attendance

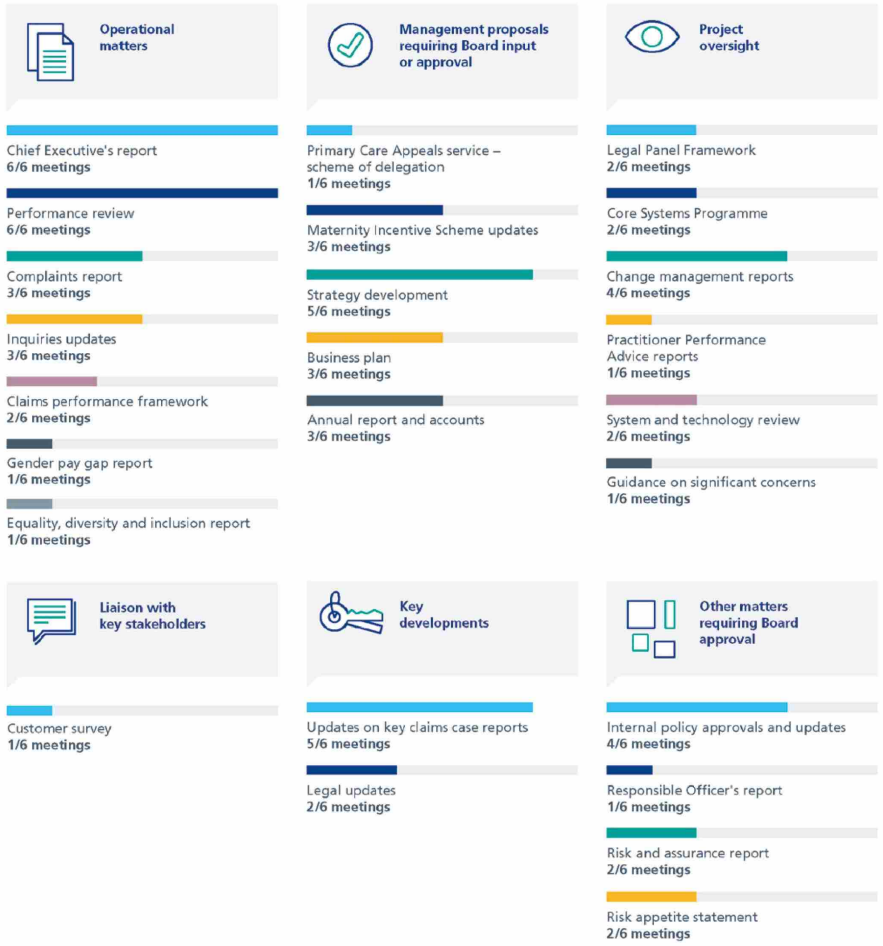
Name	Post	Meetings attended
Martin Thomas	Chair	5/5
Mike Pinkerton	Non-executive Director and Interim Chair	6/6
Charlotte Moar	Non-executive Director	6/6
Nigel Trout	Non-executive Director	6/6
Professor Dame Lesley Regan	Non-executive Director	2/2
Janice Barber	Non-executive Director	2/2
Professor Keith Edmonds	Non-executive Director and Associate Non-executive Director	4/4
Helen Vernon	Chief Executive	6/6
Joanne Evans	Director of Finance and Corporate Planning	6/6
Dr Denise Chaffer	Director of Safety and Learning	6/6
Vicky Voller	Director of Advice and Appeals	6/6
Dr Mike Durkin OBE	Associate Non-executive Director	6/6
Sir Sam Everington OBE	Associate Non-executive Director	6/6
John Mead	Associate Board Member	6/6

Key points to note:

- Martin Thomas – last meeting as Chair was January 2022
- Mike Pinkerton – first meeting as Interim Chair was March 2022
- Professor Keith Edmonds – last meeting was November 2021
- Professor Dame Lesley Regan – first meeting was January 2022
- Janice Barber – first meeting was January 2022

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

Figure 21:
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 Code of Corporate Governance the Board and its committees have due regard to the principles set out in the Code. Effectiveness reviews of the Board and ARC take the Code into account.

Board effectiveness

A Board effectiveness self-assessment was carried out in 2021. The 2021 review was also informed by a look back on the content of the Board meetings referenced against a number of sources including the following:

- HM Treasury: Corporate governance in central government departments: Code of good practice
- NAO Board Evaluation Questionnaire in line with *Corporate governance in central government departments: Code of good practice* (updated 2017).

Following the self-assessment, we have concluded that the Board is fulfilling and discharging its responsibilities effectively and there are no significant gaps.

The Board have agreed that, given the change in Chair and non-executive director membership, an independent effectiveness review will be carried out in 2022/23 which will also encompass the Board sub-committees.

Committees of the Board

The Board is supported by four committees established to enable the Board, and me as Accounting Officer, to discharge our responsibilities and to ensure that effective financial stewardship and internal controls are in place. A review of the terms of reference for the three committees was carried out in 2021/22 to assure their fitness for purpose.

Audit and Risk Committee

The ARC supports the Board and me in our responsibilities on matters related to internal and external audit, corporate governance, anti-fraud policies, internal control and risk management, and 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 Chair of the DHSC ARC attended the ARC meeting in June 2021.

ARC has two independent lay members.

During the period of 1 April 2021 to 31 March 2022 the committee met on four occasions. Attendance by members was as follows.

Table 11: Audit and Risk Committee meeting attendance

Name	Post	Meetings attended
Charlotte Moar	Non-executive Director and Chair of ARC	4/4
Mike Pinkerton*	Non-executive Director	3/3
Charles Bellringer	Independent Lay Member	4/4
Julia Wortley	Independent Lay Member	4/4

* Mike Pinkerton attended the February 2022 ARC meeting as NHS Resolution Interim Chair.

During the year ARC particularly focused on:

- Approving and having oversight of the internal audit plan. Approving and having oversight of the counter fraud plan.
- Taking assurance from the Reserving and Pricing Committee around matters related to reserving.
- Receiving regular updates on strategic and operational risks and reviewing plans to ensure those risks are being mitigated, particularly where strategic risks are outside risk appetite.
- Reports on information governance, cyber security and health, safety and wellbeing.
- Independent assurance reports on the Core Systems Programme.
- Reviewing the Annual report and accounts and updates from the NAO.
- Reviewing the statement of compliance with the mandated Government Functional Standards.
- Undertaking deep dives into Freedom to Speak Up, including details of why some staff only wish to report matters anonymously.

ARC effectiveness

ARC carried out a self-effectiveness review in October 2021. The results indicated that the ARC has continued to perform its role effectively and as set out in its terms of reference. An action plan for further improvement was agreed in February 2022 with the key areas of focus set out in Table 12.

Table 12: ARC effectiveness review

Issue and action	Update
Maturing risk management arrangements	
Gain confidence that there is a clear deliverable resourced plan to increase maturity of risk management arrangements and embed a culture of risk identification and mitigation across the organisation.	Plan presented to ARC meeting of February 2022.
Strengthen assurances from SMT to ARC that there is an effective risk management framework in place through the reporting of risks from the governance subgroups.	Improved risk review by SMT and ODG with risk report to be presented at the May 2022 ARC meeting.
Escalation of risks to the Board.	Risk reports to the Board include an executive summary setting out the risk management and assurance ARC have agreed should be brought to the attention of the Board. ARC Chair's report redesigned to ensure that it is clear on assurances provided to the Board and any matters for escalation to the Board.
Ensuring a culture which counters fraud effectively	
Take opportunity for assessment of compliance with the new Government Functional Standard which sets out minimum and enhanced standards around countering fraud both for external (claimant) fraud and for staff/supplier fraud to gain assurance that: a) internal fraud arrangements are robust, meet legislative/Government standards and that roles and responsibilities between management and new provider GIAA are clear and working effectively. b) external (claimant) counter fraud arrangements, both pre and post claim are robust, and meet legislative/Government standards.	ARC review of compliance with GFS at meeting of February 2022. Fraud annual report and workplan on the agenda for the ARC meeting of May 2022. Deep dive into assurance around claimant fraud arrangements to be presented at the May 2022 ARC meeting.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee, the role of which 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). All meetings were quorate.

People Committee

This Committee was established in 2021/22 to support the Board and the Accounting Officer by reviewing the comprehensiveness and reliability of assurances in relation to its people strategies and activities. The first meeting of this committee was held in March 2022.

Reserving and Pricing Committee

I chair the Reserving and Pricing Committee (RPC) with membership comprised of the Director of Finance and Corporate Planning, Director of Claims, Head of Reserving and Pricing and a non-executive director. From January 2022 the committee's membership has been augmented by an independent member. The committee is attended by our actuarial advisers, the Government Actuary's Department.

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.

Key matters considered in 2021/22 included:

The results of the work undertaken by RPC on calculating the key estimates for the accounts in respect of the provision are included in the Annual report and accounts, which are presented to ARC and the Board for consideration. This supports me in the process to sign the accounts as a true and fair view of the year's activities. 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 2022 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 the working groups and the NHS Resolution's Reserving and Pricing Committee. The actuarial assumptions were selected on a best estimate basis, with no explicit adjustment for risk and uncertainty. I have calculated the IBNR provisions to be £64,288 million for all schemes combined as at 31 March 2022 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 Annual 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. The SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which the SMT oversight or approval is required, including resource management and planning, governance arrangements, complaints and stakeholder management. The SMT reviews particular areas of our activity or areas of development and considers any changes in the external environment that may have an impact on NHS Resolution and its services. The SMT reviewed its terms of reference to ensure they are fit for their purpose. 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 the SMT held a series of sessions to support the production of the business plan for 2022/23. We also held sessions to develop our 2022–25 strategy with our focus being to continue to deepen and improve the work we have been doing since 2017.

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

SMT and sub-group review

In February 2021 I commissioned an Internal Audit advisory review of the governance groups to ensure the groups have clear roles and responsibilities and that our governance structure is effective in supporting transparent and timely decision making at the appropriate level.

From the review an action plan has been developed to take forward through 2022/23. We will continue to implement the revised ways of working to ensure consistent assurance reports to the SMT where required.

Table 13: SMT sub-groups

SMT sub-group	Function	Outcome of Governance Groups Review
Change Management Group (CMG)	Provides assurance of a formal process to oversee the activity under the change portfolio of programmes and projects, and that this is aligned to our strategy.	CMG is well run with good information feed, and exception and highlights-based reporting. A key part of the success of the group is the investment in the PMO resource which assists with the functioning of the group's meetings
Operational Delivery Group (ODG)	Provides assurance on all matters related to the governance and processes of the operational delivery of the strategy and business plan.	Name change from Operational Risk Review Group to Operational Delivery Group. This more appropriately describes the broad remit of the group in terms of operational delivery. An action plan specific to ODG is being taken forward to support improvements for this group
Information Governance Group (IG)	Provides assurance on the Data Security and Protection Toolkit and that other IG requirements are being operated and delivered to required standards within NHS Resolution. Provides operational oversight of maintenance of ISO 27001 certification.	Group is well established. Recommendations included making greater use of the forward planner to document the group's work
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.	The group has an established cycle of reporting to SMT twice a year and feedback suggests that this suits the nature of the content. Any urgent or important matters for decision or awareness are directed to the CEO and/or other directors as appropriate so that there are no 'surprises'
Workforce Strategy Group (WSG)	To ensure the organisation has oversight on workforce planning and staffing decisions and to build in a process of assurance and risk management.	WSG is to be renamed Workforce Development Group to make the distinction between its role and the more strategic role of the new People Committee. Terms of reference will be reviewed to ensure clarity of responsibilities between the People Committee, WDG and operational management

The control environment

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

Capacity to handle risk

Through our risk management framework we regularly considered the risks and issues that could have an impact on the achievement of our business objectives. This included consideration of the controls we have in place to mitigate those risks and then, where required, developing plans to bring those risks within appetite.

Within the framework SMT maintain and update a strategic risk register which reflects those risks that could have an impact on the delivery of our strategy. ODG 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 14: The 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	Claims data could be incorrectly interpreted either due to the urgent nature of requests and/or the integrity and quality of our data.	Processes in place for FOI requests. Processes in place for DHSC policy requests. Annual Internal Audit reviews of claims data quality.
All strategic aims	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 reviews metrics for virus incident log. IG Group reviews incidents and takes 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	Fail to recognise and respond to changes in the environment in which NHS Resolution operates.	The Policy, Strategy and Transformation team ensure horizon scanning 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	Fail to deliver our core functions due to possible impact of planned growth and transformational change initiatives, as well as unplanned events (e.g. a pandemic).	SMT and Board overview of transformation proposals. ODG review of delivery against business plan. CMG oversight of programme and portfolio delivery.
Help the system, organisation 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.	Fail to identify information within the data we hold which either in isolation or when connected with information held by others elsewhere in the NHS indicates a current or emerging patient safety risk from a particular organisation or individual.	Early Notification Scheme launched for maternity care, with 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 look at how treatment plans have contributed to any reduction of risk impact and/or likelihood of occurrence. One such risk where we reduced the risk score was '*NHS Resolution's core systems become obsolete*' which was previously captured as a strategic risk and de-escalated to the Corporate Operational Risk Register.

Where key issues have arisen we considered whether the current controls in place could be strengthened to reduce the likelihood of a recurrence and major impact on the organisation.

Risk appetite

The Board has developed a statement of risk appetite which is reviewed and updated annually. 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 recognised there are a number of initiatives underway simultaneously, including:

- The continued challenges with the impact of the Covid-19 pandemic.
- Revising our delivery model for our services.
- Implementing a revised operating model for the claims function.
- Adopting new ways of working with a hybrid model across the organisation.
- An office move for our Leeds-based staff.
- The programme for replacing our core IT systems.

These present both challenges and opportunities. The Board expects that management will plan for and appropriately resource these initiatives, while ensuring that the health and well-being of our staff and core operations are not compromised. Confidence in our ability to deliver core business is key to maintaining our position as a trusted and effective organisation.

Business continuity

Effective business continuity arrangements continued to be paramount for us during 2021/22 due to the impacts of Covid-19 as well as an IT-related outage in April 2022. We regularly review our departmental Business Impact Assessments (BIAs), which take into account the changing external, as well as our own internal, operating environment.

Lessons learnt from any business continuity events and the BIAs have supported us in reviewing our business continuity, crisis management and pandemic plans.

Management assurance

NHS Resolution's assurance arrangements bring 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.

Data quality

We recognise the importance of having systems in place to ensure, as far as possible, the data we produce is accurate and adequately described. The controls we have in place include:

- Exception reports and management review
- Quality assurance through the Business Intelligence Team
- Internal audit of data both from the claims function and third party Internal Audit provider
- External audit review of data quality in relation to the provision.

Internal audit

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

Audit title	Assurance
Data Security Protection Toolkit	Advisory
Risk Maturity	Advisory
Data Quality	Substantial
General Practice Indemnity	Substantial
Stakeholder Management	Reasonable
Claims Evolution Programme	Advisory
Key Financial Controls – Payroll	Reasonable
Procurement of Legal Panel	Partial assurance
Follow up of outstanding internal audit recommendations	Good progress

The audit of the procurement of the legal panel resulted in a partial assurance rating arising from issues related to planning and documentation, which did not affect the outcome of the procurement. Improvement actions are being taken forward in response to the recommendations made by Internal Audit across all audits undertaken in the year.

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 2021/22.

Performance and financial controls

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

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

Timing of cashflows – known claims provisions

The known claims provision calculation uses the expected settlement date (ESD) from individual claims recorded in the Claims Management System (CMS) to apply inflation and discounting to reach a valuation. However, for the disclosure of the expected timing of cashflows, this has historically been based on an actuarial view of settlement patterns.

An adjustment to the 2021/22 known claims provision has been applied to the estimate technique as there has been a significant divergence between the two views, most likely as a result of the impact of the Covid-19 pandemic.

As part of this reassessment, we have concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time, as it results in a better estimate of the known claims provision. The prior period financial statements have therefore been restated as required by IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors. Further details of the adjustments to the financial statements are provided at Note 7.4 to the accounts.

We are identifying potential improvements to the process to estimate the expected timing of cash-flows.

Anti-fraud, bribery and corruption

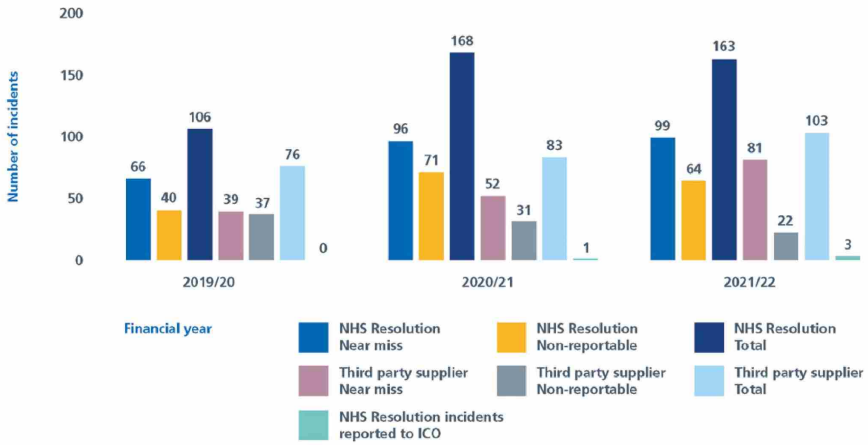
As with all NHS organisations, the risk of fraud is a significant consideration. The nature of NHS Resolution's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members, and we take a zero-tolerance stance towards fraud and bribery. We have established controls in place to mitigate the risk of fraud as far as possible, including an up-to-date *Anti-fraud, bribery & corruption policy and procedure*, as well as annual training. These provide guidance for all staff, enabling them to recognise and deal with potential instances of fraud and bribery. Counter fraud services are provided by GIAA who work in accordance with the NHS Counter Fraud Authority Standards for Providers to prevent, deter, detect and investigate fraud and bribery. During 2021/22 we have 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.

Information security and governance

NHS Resolution has maintained ISO 27001 Information Security certification which provides evidence that we have an effective information security management system. The surveillance audit carried out in December 2021 reviewed a range of governance and technical security controls. The audit identified zero major non-conformances and two minor non-conformances. As a result of this the audit recommended the certification for NHS Resolution be continued. We have also achieved Cyber Essential Plus certification which is a UK Government scheme of good practice in information security. NHS Resolution is committed to minimising the risks associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to information governance.

Figure 22:
Information governance incidents reported by severity



During this year, there were 266 incidents recorded by NHS Resolution. This includes those reported by third party suppliers. Of this total, 180 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. During this reporting period there have been three reports to the ICO, which are pending an outcome.

The trend in reporting remains high and we have noted that the reporting numbers remain similar to those of last year in the context of an increase in size and level of activity in the organisation. Further work is being planned to improve the current internal incident reporting framework so that we can better report on incidents and derive more insight and learning. We are also providing focused training and awareness of information security matters following a review of the incidents related to these matters.

Responding to members of the public

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

We received 269 requests under FOI of which 79% were responded to within the 20 working day timescale for responses. Where responses exceeded the 20 working day time period, it was due to a number of factors such as the complexity of the request. In those cases we advised the requestor of the likely timescales for a response. We are reviewing the internal processes for responding to FOI requests to consider how we can also improve our compliance rate. A significant number of FOI requests concerned maternity and obstetrics claims. There continues to be a growing interest in our claims data and we have continued to publish responses on our Disclosure Log[1].

We have also updated our Factsheets[2] and our Publication Scheme[3] to assist the public to find information about our organisation and our activities.

We seek to be open and in the majority of cases we do provide disclosure of information in full. Where we do not, it is because doing so would be to increase the risk of identifying claimants or others who trust us with their sensitive health information. Of the small number of cases where we have withheld some information, two were reported to the Information Commissioner, and our decisions to withhold information were upheld on legal grounds.

[1] https://resolution.nhs.uk/foi-disclosure-log/
[2] https://resolution.nhs.uk/resources/?fwp_resources_type=factsheet
[3] https://resolution.nhs.uk/wp-content/uploads/2020/04/Freedom-of-Information-Publication-scheme.pdf

Data Protection requests

NHS Resolution receives two types of requests under the DPA. The first type, Subject Access Requests (SARs), give individuals the right to request any information held about themselves. During this period 154 SARs were received, which is an increase of 38 (33%) on last year. Of these 140 (91%) were responded to within the statutory deadline of one calendar month. Where these were not responded to within the specified time period, we have advised the requestor of the reasons for delay, such as complexity or volume of information in scope of the request.

The second type of requests are third party requests for information for personal data relating to activities for the prevention and detection of crime. Such requests can come from the police, regulators and, in respect of our claim function, other insurance bodies who are members of the Claims and Underwriting Exchange (CUE).

Complaints and feedback

From 1 April 2021 to 31 March 2022 we received 35 complaints, which were reviewed through the processes laid down in our formal complaints policy, of which 31 were concluded and four remain active as these were received before the end of the reporting period. This compares to 26 complaints logged in 2020/21. These numbers remain small relative to the volume of activity across the organisation and there is no single explanation for an increase of complaints since last year. We are, however, always keen to learn from complaints.

There have been four complaints referred to our Chair during this reporting period. None of these were upheld. There have been no complaints to the Parliamentary and Health Service Ombudsman.

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

In March we implemented a reviewed *NHS Resolution Complaints Policy* and in doing so took into account NHS Complaints Standards which set out how organisations providing NHS services should approach complaint handling. The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution by empowered and well-trained staff.

We implemented this by changing our timelines, encouraging early resolution and giving our business areas ten working days to respond. It was believed that extending the timeframe would give more time to examine and informally resolve these complaints at the earliest opportunity.

Freedom to Speak Up

We have a Freedom to Speak Up policy and have in place four Freedom to Speak Up guardians as well as a non-executive director who is the Freedom to Speak Up officer. The guardians continue to work with a number of departments within the organisation to influence change and drive improvement arising from concerns raised, which for this year has included:

- Monthly meetings with HR/OD to talk through themes from issues raised and remedial actions that can be put in place, as well as how to mitigate against Freedom to Speak Up arrangements being used instead of appropriate line management and HR procedures.
- Identifying training or policy and procedures knowledge gaps that exist across the organisation.
- Sharing intelligence with the mental health first aiders so they can shape their offer.
- Inputting into the corporate values and behaviours framework and actions to embed these.
- Participating in corporate induction sessions to promote the commitment to speaking up and how that facilitates change in the organisation.

Health, safety and wellbeing

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures. Staff are required to participate in the training provided to ensure awareness. The health, safety and wellbeing of our staff is paramount to us. We have ensured all staff have complete display screen equipment assessments to make sure that they are working in a safe way both in the office and at home. All our staff have access to the enhanced offerings of the Employee Assistance, Health and Wellbeing Tools and Mental Health First Aiders. We have given all staff an individual risk assessment to identify those who may need extra support.

Through 2021/22 we expanded the incident reporting process to include incidents relating to staff wellbeing, in particular those related to difficult communications with service users. This ensured that we had visibility of these incidents and that we acted to put in place measures to support staff and our service users where appropriate.

Respect for human rights

We are strongly committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to 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.

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 procurement process and are completed in compliance with Public Procurement Regulations.

In May 2022 DHSC issued the ALB Schedule of Delegations, which sets out the spending authorities that apply to ALBs in line with HM Treasury and Cabinet Office, and DHSC's own requirements.

Cabinet Office had made changes to its approval levels for contingent labour from 1 November 2021; we were not made aware of this until receipt of the Schedule of Delegations. We have undertaken a review of contractual spend to identify where we may not have applied the DHSC and Cabinet Office controls. Retrospective business cases were submitted to regularise the position. These have been approved subject to meeting conditions on improving processes to ensure compliance.

We have updated our procurement and temporary staff procedures to ensure the correct approval processes are followed.

We are committed to ensuring our tenders include matters related to the Social Value Act and as such have included this as an evaluation criteria in appropriate tenders. All procurement is considered in terms of business need and is the most economically advantageous for us. We continue to develop and embed best practice in contract management to ensure we achieve good value for money on the contracts we enter into.

Statutory functions

An assurance map has been maintained, which provides high level assurance that we are operating within the relevant directions and statutory functions for NHS Resolution. This gives me as Accounting Officer the assurance that we have a clear view of those functions and regulations we should be working to. During 2021/22 we continued to administer and operate new scheme arrangements in relation to Covid-19.

Government Functional Standards

We took forward a self-assessment of our position against the mandated requirements of the Government Functional Standards which are relevant to NHS Resolution. From the assessments we concluded that:

- Overall the baseline requirements of the mandated standards have been met, in that we have governance structures in place with roles and responsibilities assigned as appropriate.
- Where some mandated standards are partially met each business area has agreed plans to take improvements forward through 2022/23.

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

Accounting Officer's conclusion

The governance arrangements detailed in the statement aim to support NHS Resolution to maximise its understanding and use all of the available information about the quality and effectiveness of our systems, to help us improve services and satisfy assurance requirements about the effectiveness of our systems of internal control. Based on my review, I am not aware of any significant control issues and I am content that appropriate arrangements are in place for the discharge of all statutory functions for which NHS Resolution is responsible, and that they are in line with the recommendations 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 2021/22.

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 (ESMs). The Committee was established by NHS Resolution's Board, which determines its terms of reference, and met three times during the 2021/22 year. All meetings were quorate.

Figure 23:
Remuneration and Terms of Service Committee meeting attendance

Martin Thomas[1]
Chair

Meetings attended
2/2

Mike Pinkerton[2]
Interim Chair

Meetings attended
1/1

Professor Keith Edmonds[3]
Non-executive Director

Meetings attended
2/2

Charlotte Moar
Non-executive Director

Meetings attended
3/3

Mike Pinkerton[2]
Non-executive Director

Meetings attended
2/2

Nigel Trout
Non-executive Director

Meetings attended
3/3

Janice Barber[4]
Non-executive Director

Meetings attended
1/1

Professor Dame Lesley Regan[5]
Non-executive Director

Meetings attended
1/1

[1] Martin Thomas' term of office ended on 28 January 2022.
[2] Mike Pinkerton commenced as NHS Resolution's Interim Chair on 29 January 2022.
[3] Professor Keith Edmonds' term of office ended on 6 December 2021.
[4] Janice Barber's appointment as Non-executive Director commenced on 18 January 2022.
[5] Professor Dame Lesley Regan's appointment as Non-executive Director commenced on 6 December 2021.

In July 2021 the Committee considered and noted the annual Directors' performance reviews, presented by the Chief Executive who was in attendance. In November 2021 the 2021/22 annual pay award and performance related payments were determined by the Committee based on guidance provided by DHSC and approved. In March 2022 the Committee provided feedback to the Chief Executive on the performance of the directors and executive directors for the 2021/22 year. Other matters dealt with by the Committee during the year included the performance and objectives of the Chief Executive and the 12-month extensions for two associate non-executive directors.

The Committee considered its performance in 2021 as satisfactory and concluded that it had discharged its obligations as set out in the terms of reference. The Committee also considered that the terms of reference remain appropriate and fit for their purpose.

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. Where necessary, NHS Resolution also makes use of the national medical and dental pay, and terms and conditions of service for those positions which are deemed necessary to have a current licence to practise and/or professional membership with an appropriate body. We currently have two staff members employed under the medical and dental terms and conditions of service.

Full details on the Agenda for Change, including a copy of the current handbook, can be found on the NHS Employers website[1]. The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees 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[2]. The relevant NHS Resolution policies applied during the financial year in relation to salaries were the *Recruitment and selection policy and procedure (HR16)* and the national *NHS terms and conditions of service* noted above. Allowances to staff in payment during the year other than basic salary were high-cost area supplement, recruitment and retention 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 executive and non-executive directors who had control over the major activities of NHS Resolution during 2021/22. Tables 15, 16 and 17 are subject to audit. There was one change in Board membership during 2021/22 – the Chair Martin Thomas' term of office ended on 28 January 2022, and he was replaced by an Interim Chair, Mike Pinkerton, from 29 January 2022.

[1] http://www.nhsemployers.org/your-workforce/pay-and-reward/nhs-terms-and-conditions/nhs-terms-and-conditions-of-service-handbook
[2] https://www.nhsemployers.org/pay-pensions-and-reward/medical-staff/pay-circulars

Table 15: Executive and non-executive director salaries and allowances[1] for 2021/22

Name and title	Salary £000 bands of £5,000	Expense payments (taxable) £000 total to nearest £100	Performance pay and bonuses £000 bands of £5,000	Long term performance pay and bonuses £000 bands of £5,000	All pension-related benefits £000 bands of £2,500	Total £000 bands of £5,000
Mike Pinkerton[2] (Interim Chair)	GRO-C					
Martin Thomas[3] (Chair)	GRO-C					
Helen Vernon (Chief Executive)	GRO-C					
Joanne Evans (Director of Finance and Corporate Planning)	GRO-C					
Dr Denise Chaffer (Director of Safety and Learning)	GRO-C					
Vicky Voller (Director of Advice and Appeals)	GRO-C					
Professor Keith Edmonds[4] (Non-executive Member)	GRO-C					
Charlotte Moar[5] (Non-executive Member)	GRO-C					
Mike Pinkerton[2] (Non-executive Member)	GRO-C					
Nigel Trout (Non-executive Member)	GRO-C					
Janice Barber[6] (Non-executive Member)	GRO-C					
Professor Dame Lesley Regan[7] (Non-executive Member)	GRO-C					
Dr Mike Durkin OBE[8] (Associate Non-executive Member)	GRO-C					
Sir Sam Everington OBE[9] (Associate Non-executive Member)	GRO-C					

[1] 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 Expense payments column of this table.

[2] Mike Pinkerton commenced as NHS Resolution's Interim Chair on 29 January 2022. The interim chair full year equivalent salary is in the band £60–65k. The non-executive director full year equivalent salary is in the band £5–10k.

[3] Martin Thomas' term of office ended on 28 January 2022. Martin Thomas' full year equivalent salary was in the band £60–65k.

[4] Professor Keith Edmonds was reappointed as Non-executive Director until 30 September 2021, and then appointed as an associate non-executive member from 1 October 2021 to 6 December 2021. Professor Keith Edmonds' full year equivalent salary was in the band £5–10k.

[5] Charlotte Moar is also the Chair of the Audit and Risk Committee.

[6] Janice Barber's appointment as Non-executive Director commenced on 18 January 2022. Janice Barber's full year equivalent salary was in the band £5–10k.

[7] Professor Dame Lesley Regan's appointment as Non-executive Director commenced on 6 December 2021. Professor Dame Lesley Regan's full year equivalent salary was in the band £5–10k.

[8] Dr Mike Durkin's appointment as Associate Non-executive Director was extended for a further twelve months with effect from 1 July 2021.

[9] Sir Sam Everington's appointment as Associate Non-executive Director was extended for a further twelve months with effect from 1 July 2021.

Table 16: Executive and non-executive director salaries and allowances[1] for 2020/21

Name and title	Salary £000	Expense payments (taxable)	Performance pay and bonuses £000	Long term performance pay and bonuses £000	All pension-related benefits £000	Total £000
	bands of £5,000	total to nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Ian Dilks[2] (Chair)	GRO-C					
Martin Thomas[3] (Chair)	GRO-C					
Helen Vernon (Chief Executive)	GRO-C					
Joanne Evans[4] (Director of Finance and Corporate Planning)	GRO-C					
Dr Denise Chaffer (Director of Safety and Learning)	GRO-C					
Vicky Voller (Director of Advice and Appeals)	GRO-C					
Professor Keith Edmonds[5] (Non-executive Member)	GRO-C					
Charlotte Moar[6] (Non-executive Member)	GRO-C					
Mike Pinkerton (Non-executive Member)	GRO-C					
Nigel Trout (Non-executive Member)	GRO-C					
Dr Mike Durkin OBE[7] (Associate Non-executive Member)	GRO-C					
Sir Sam Everington OBE (Associate Non-executive Member)	GRO-C					

[1] 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 Expense payments column of this table.

[2] Ian Dilks left NHS Resolution on 31 December 2020. Ian Dilks' full year equivalent salary was in the band £60–65k.

[3] Martin Thomas' term of office ended on 28 January 2022. Martin Thomas' full year equivalent salary was in the band £60–65k.x

[4] 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.

[5] Professor Keith Edmonds was reappointed for a period of one year with effect from 1 April 2020.

[6] Charlotte Moar is also the Chair of the ARC. Charlotte Moar was reappointed for a period of three years with effect from 1 September 2020.

[7] Dr Mike Durkin's appointment as Associate Non-executive Director was extended for a further twelve months with effect from 1 July 2020.

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 Pension 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 of this report.

Table 17: Pension entitlements for executive directors

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022
	£000	£000	£000	£000
	bands of £2,500	bands of £2,500	bands of £5,000	bands of £5,000
Helen Vernon (Chief Executive)	GRO-C			
Joanne Evans (Director of Finance and Corporate Planning)	GRO-C			
Vicky Voller (Director of Advice and Appeals)	GRO-C			
Dr Denise Chaffer (Director of Safety and Learning)	GRO-C			

Name and title	Cash equivalent transfer value at 31 March 2022	Cash equivalent transfer value at 31 March 2021	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000
Helen Vernon (Chief Executive)	GRO-C			
Joanne Evans (Director of Finance and Corporate Planning)	GRO-C			
Vicky Voller (Director of Advice and Appeals)	GRO-C			
Dr Denise Chaffer (Director of Safety and Learning)	GRO-C			

Cash equivalent transfer values

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

There were no early retirements or other exit arrangements for directors during the reporting period. This is subject to audit.

Payments to past directors

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

Fair pay disclosure

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

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

The total banded remuneration of the highest-paid director in NHS Resolution in the financial year 2021/22 was £165,000–£170,000 (2020/21, £165,000–£170,000). This was 3.55 times (2020/21, 3.40) the median remuneration of the workforce, which was £47,716 (2020/21, £49,198). The 25th percentile remuneration of 4.31 (2020/21, 4.30) was £39,374 (2020/21, £39,464), which represents the lowest quartile of remuneration in the organisation, and the 75th percentile remuneration of 2.81 (2020/21, 2.82) was £60,316 (2020/21, £60,058), which represents the upper quartile of remuneration in the organisation.

The basic pay remuneration of the highest-paid director in NHS Resolution in the financial year 2021/22 was £160,000–£165,000 (2020/21, £160,000–£165,000). This was 3.55 times (2020/21, 3.87) the median remuneration of the workforce, which was £45,524 (2020/21, £41,723). The 25th percentile remuneration of 4.73 (2020/21, 5.15) was £34,172 (2020/21 £31,365), which represents the lowest quartile of remuneration in the organisation, and the 75th percentile remuneration of 3.04 (2020/21, 3.13) was £53,219 (2020/21, £51,268), which represents the upper quartile of remuneration in the organisation.

In 2021/22, no employee received remuneration in excess of the highest-paid director (2020/21, was zero). Remuneration bands ranged from £20,000–£25,000 to £165,000–£170,000 (2020/21, £20,000–£25,000 to £165,000–£170,000). There has been no year-on-year change in the remuneration banding of the highest paid director. The percentage change in salary and allowances is 3.89%. This reflects both the pay award of 3% and the increase in average workforce by 100 FTE at an average remuneration lying between the median and the upper quartile.

The fair pay disclosures are subject to audit.

Staff report

Since the start of the 2021/22 year there has been a notable increase in budgeted full time equivalent (FTE) staff. The increase in budgeted establishment continues to reflect the organisation's requirements to successfully operate the Clinical Negligence Scheme for General Practice, the Claims Evolution Programme, the Core Systems Programme and the corporate support required for the ongoing increase in remit and establishment. While increasing our budgeted establishment and headcount we have seen an increase in our annual staff turnover to 10.5%, up from 8.8% in 2020/21.

Further information on the organisational establishment, including a breakdown by directorate, is now included within our finance performance report which is presented to the Board. This additional analysis of data enables the organisation to consider where there may be risks associated with high vacancy areas.

During 2021/22 the Board approved the development of a People Committee, a sub-committee of the Board, which held its inaugural meeting in March 2022. The role of the People Committee is to support the Board and the Accounting Officer by reviewing the comprehensiveness and reliability of assurances in relation to its people strategies and activities. The committee members provide advice on the adequacy of the organisation's people plans and strategies. They provide support and recommend which issues/matters should be escalated to the Board for further discussion/agreement.

Throughout 2021/22 we have continued to support our workforce in a range of personal and professional development opportunities both internally and externally. Our ongoing commitment to people management excellence has been recognised by the interim Investors in People (IIP) report received in March 2022. We are now working towards achieving gold level accreditation when we reaccredit in early 2023.

Tables 18 and 19 set out staff costs and average staff numbers, which are subject to audit.

Table 18: Staff costs for 2020/21 and 2021/22

Staff costs	Permanently employed staff £000	Other £000	2021/22 Total £000	2020/21 Total £000
Salaries and wages	24,236	2,313	**26,549**	20,718
Social security costs	2,741	0	**2,741**	2,237
Employer contributions to NHS Pensions	4,030	0	**4,030**	3,399
NEST pension contributions	4	0	**4**	8
Apprenticeship levy	121	0	**121**	84
Total	**31,132**	**2,313**	**33,445**	**26,446**

Table 19: Average full-time equivalent staff numbers

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other*	2021/22 Total	2020/21 Total
Core department	468	24	**492**	400
Capital projects	8	0	**8**	0
Total	**476**	**24**	**500**	**400**

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

As at 31 March 2022, of the eight executive and senior managers, three were male (37.5%) and five were female (62.5%). The gender split ratio for the whole of NHS Resolution was 36% male and 64% female. The organisation regularly reports to the Board, and more recently to its established People Committee, 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 that are included under the Equality Act 2010.

The proportions of staff against each of the monitored characteristics have remained broadly comparable to the proportions for the 2020/21 year.

Figure 24:
Headcount by gender and grade[1]

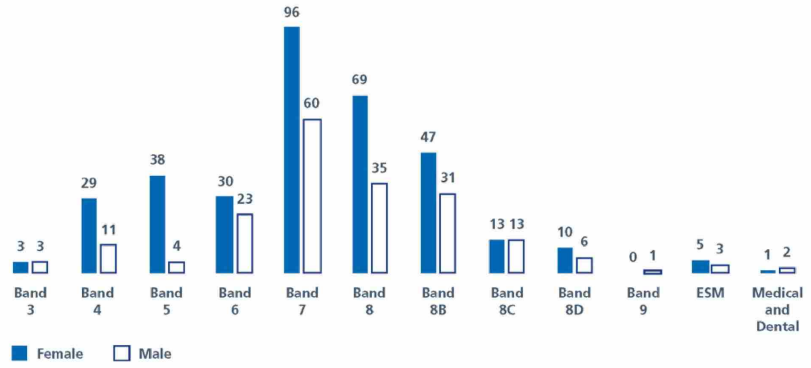


Figure 25:
Workforce – disability

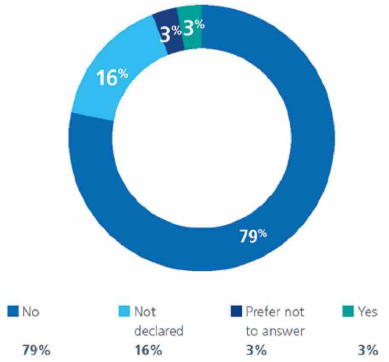
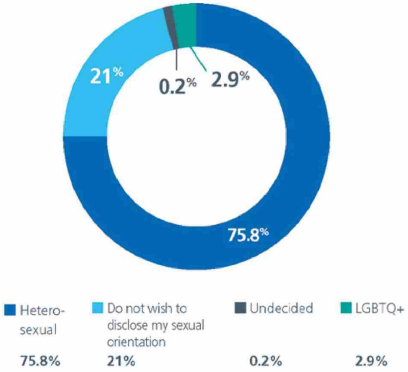


Figure 26:
Workforce – sexual orientation



[1] Under the Agenda for Change *NHS terms and conditions of service*, pay band 2 is the lowest grade and pay band 9 is the highest grade.

Figure 27:
Workforce – religion/belief[1]

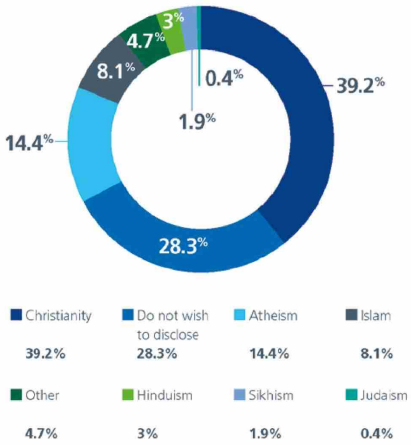
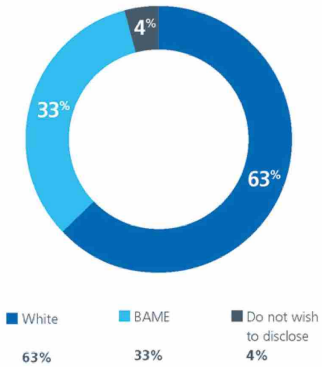


Figure 28:
Workforce – ethnicity (organisational profile)



Disability

NHS Resolution has achieved level two of the Government's Disability Confident scheme, which replaces the previous Two Ticks – Positive About Disabled People scheme.

A staff-led disability group was established in April 2021, the Disability Network. The purpose of this group is to:

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

In addition to discussing internal matters, the group invites external speakers to the meetings in order to share knowledge and best practice. The group met on a further two occasions in 2021/22 and topics covered included:

- Workforce Disability Equality Standard
- Mobility implications on returning to office-based working
- Disability leave
- Social model of disability (presentation from the Shaw Trust).

The table following shows the percentage of applications that were shortlisted and the percentage of appointments made from those who consider themselves as having a disability, those who do not consider themselves as having a disability and those who do not wish to disclose this information. It also provides a comparison to 2020/21.

[1] Note: total is 99.7% due to rounding.

Table 20: A comparison of the proportion of job candidates shortlisted and appointed to role at NHS Resolution in 2020/21 and 2021/22 with and without a disclosed disability

Application category	% Shortlisted 2021/22	% Shortlisted 2020/21	% Appointed from shortlisting 2021/22	% Appointed from shortlisting 2020/21
Disabled	24.4	8.0	**5.9**	15.0
Not disabled	26.9	5.8	**19.1**	50.0
Not disclosed	31.1	2.9	**69.7**	33.3
Total	**26.8**	**5.8**	**20.0**	**47.1**

Overall the organisation shortlisted a greater number of candidates across all categories in 2021/22. While the number of appointments made in 2021/22 increased slightly, the percentage of appointments from the number of shortlisted applicants reduced from 47.1% in 2020/21 to 20% in 2021/22.

The number of applicants who considered themselves as having a disability and who were shortlisted for interview increased to 24.4% in 2021/22 up from 8% in 2020/21. The number of appointments made within this category reduced from 15% in 2020/21 to 5.9% in 2021/22. A similar reduction was noted in the not disabled category which reduced from 50% in 2020/21 to 19.1% in 2021/22.

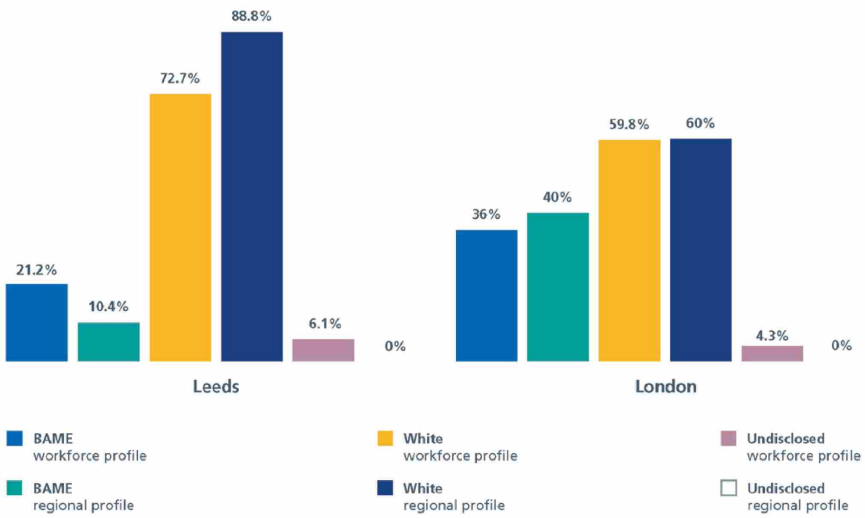
Since January 2022 we have been undertaking audits on all recruitment campaigns covering a range of monitoring characteristics. The purpose of these audits is to identify any areas which may need to be considered and addressed further by way of learning.

Ethnicity

The proportion of Black, Asian and Minority Ethnic (BAME) employees has reduced to 33% in 2021/22 (compared with 36% in 2020/21). We have continued to grow our workforce in Leeds as well as seeing a number of staff moving to 100% home working in the past 12 months.

It is important that we understand our regional figures and how these align to the local population. Figure 29 shows the current workforce profile against the regional profile information from the 2011 census data. Once the information from the 2021 census is available, we will review our regional profiles against the latest figures.

Figure 29:
Workforce – ethnicity (Leeds[1] and London against the regional figures)



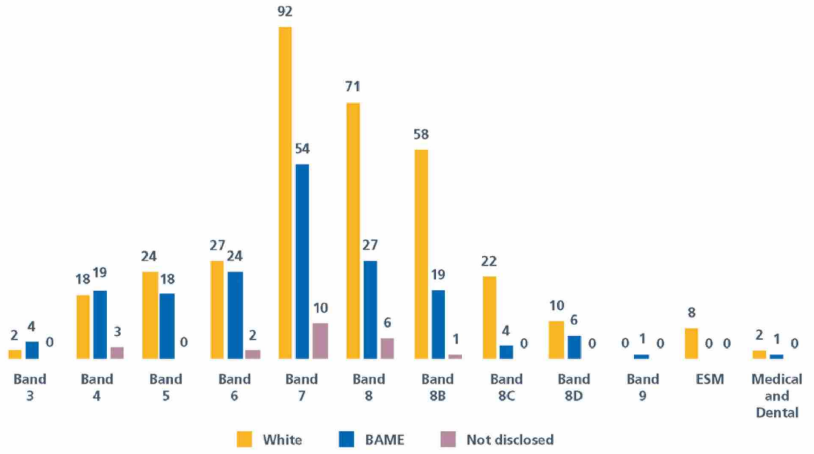
Our workforce profile is closely aligned to the regional figures for London. We continue to employ a higher proportion of BAME staff in Leeds when compared to the regional figures. The main category of BAME staff in Leeds is Asian, and we do have an underrepresentation of staff from Black African/Caribbean/British backgrounds in comparison to the regional profile.

The organisation continues to provide regular reports to the Board and its recently established People Committee, 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 30.

While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is an underrepresentation of BAME staff at the ESM level and across pay bands 8A to 8C. This is consistent with the national data around the underrepresentation of BAME staff at senior level within the NHS and in the industry in general. The information also shows that there is an overrepresentation of BAME staff within the lower pay bands. As detailed under the Equality, diversity and inclusion section of this report, the organisation continues to take a number of steps in order to address these issues.

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

Figure 30:
Headcount by ethnicity



Sickness absence

As at 31 March 2022, NHS Resolution's twelve-month cumulative sickness absence rate was 1.61%. The organisation's absence rate has remained below the NHS national average for England and for other similar national NHS organisations. During 2021/22 we maintained real-time absence reporting, and provided full oversight on the level and reasons for absence by department within weekly workforce summary reports to SMT. Through our recently established People Committee, we continue 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 2022, NHS Resolution has ten off-payroll appointments costing more than £245 per day. Four of these appointments have or are likely to last longer than six months and were new engagements within the reporting period. Four appointments have lasted between one and two years at the time of reporting. The appropriate pre-placement checks were completed for these and for all of the off-payroll engagements, with the required assurances obtained to confirm these placements were assessed to ensure that the appropriate tax and national insurance arrangements were in place as they were not covered by IR35[1].

[1] 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 21: For all off-payroll engagements as of 31 March 2022, for more than £245 per day

Off-payroll engagements as of 31 March 2022	
No. of existing engagements as of 31 March 2022	**10**
Of which:	
No. that have existed for less than one year at time of reporting	6
No. that have existed for between one and two years at time of reporting	4
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

Table 22: For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day

Off-payroll engagements between 1 April 2021 and 31 March 2022	
No. of temporary workers engaged between 1 April 2021 and 31 March 2022	**22**
Of which:	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	22
No. of engagements reassessed for compliance or assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the review	0

Table 23: For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

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

Exit packages

There were no compulsory or voluntary redundancies during the 2021/22 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 2021 to 31 March 2022.

Table 24: Relevant union officials

Number of employees who were relevant union officials during 2021/22	Full-time equivalent employee number
2	2

Table 25: Percentage of time spent on facility time

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

Table 26: Percentage of pay bill spent on facility time

Percentage of pay bill	
Total cost of facility time	£9,712
Total pay bill	£33,445,585
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.03%

Table 27: Paid trade union activities

Paid activities	
Hours spent by employees who were relevant union officials during 2021/22 on paid trade union activities, as a percentage of total paid facility time hours.	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	6.17%

People

Following the awarded Silver level Investors in People (IIP) accreditation in March 2020, our interim IIP review in March 2022 continues to recognise the progress made across a number of areas. This has been achieved despite another difficult year in navigating the organisation through the pandemic, in addition to a number of change programmes completed and underway. The support to the workforce and the continued delivery of work in line with our Workforce and Organisational Development Strategy has made a positive impact in many ways and the IIP continues to recognise our ongoing commitment to people management excellence.

As a result of the ongoing pandemic, 2021/22 continued to be a challenging period for the workforce both personally and professionally. The continued adjustments to the working from home and social distancing requirements was unsettling and required the organisation to adjust its approach to staff support on a number of occasions. In October 2021 all staff were asked to complete a further individual risk assessment in relation to a return to office-based working. In December 2021, and in response to the Government's 'plan B' announcement we had to revert to further individual risk assessments for home-based working. During the summer months of 2021 with a return to office-based working, the organisation introduced measures for monitoring, reporting and escalating when there were confirmed positive Covid-19 cases.

Our focus has continued primarily on maximising the health and wellbeing (HWB) of our entire workforce in order to support staff to work as productively as possible, while balancing home and family lives. Our health and wellbeing offer for staff was updated and launched on our Connect intranet page in September 2021. A key part of this offer is a HWB toolkit which provides information on a range of physical, mental and financial health support measures for both staff and managers and is kept under constant review, to ensure it remains relevant and fit-for-purpose.

2021/22 brought a large amount of change activity including the completion of our move from Victoria to Canary Wharf which coincided with a return to office-based working. This was in addition to the launch of our Core Systems and Claims Evolution change programmes.

In response to this significant period of change and the ongoing pandemic impacts, in January 2022, a campaign named 'Focus on you in 2022' was launched and included a number of 'Lunch & Learns' and workshops focusing on:

- 'your career'
- 'your mental health'
- 'your health and wellbeing toolkit'
- 'your financial wellbeing'.

In the spring of 2021, and as part of the ongoing support to the Ways of Working programme, our Human Resources and Organisational Development (HR&OD) team facilitated a series of co-design staff workshops to create an understanding of the support staff required in the short and longer term in relation to health and wellbeing. Feedback from these sessions have been used to inform activities and support mechanisms.

Our approach has ensured that our workforce has the required resilience to respond positively to the pandemic and associated revised ways of working.

Despite the workforce spending the vast majority of time working from home throughout 2021/22, our staff engagement activities have continued to see a positive level of input with the completion of our staff annual appraisals remaining high at 97% in 2021, and a positive response rate of 62.8% to the staff survey undertaken at the beginning of 2022.

We have progressed a significant number of the key priorities noted in our workforce and organisational development strategy. Activities delivered throughout 2021/22 include the following areas.

Equality, diversity and inclusion (EDI)

We aim to create an environment where staff respect and value each other's diversity. As an NHS arm's length body (ALB), it is imperative we are transparent and embrace the core values of the NHS, which are respect, dignity, compassion and inclusion as well as, of course, our own PEER values.

In January 2022, we updated our EDI policy (which provides details of the responsibilities of all staff for promoting EDI to ensure we consistently demonstrate our PEER values) and associated behaviours framework. Reference is also made in the policy to the Just and Learning Culture charter, the purpose of which is to ensure a consistent and fair approach is taken in relation to incidents and errors.

We continue to make progress on our EDI agenda and action plan, which was approved by the Board in July 2020. The plan is focused on three primary areas which are set out with progress to date in the following material.

Recruitment, selection and on-boarding

- There is a dedicated recruitment page on our Connect intranet which provides details of NHS Resolution vacancies. The purpose of this is to support open and transparent promotion of all our job opportunities.
- The recruitment and selection policy and staff training programme have been updated to reflect current legislation and best practice.
- A number of interventions continue to run to support individuals through the recruitment and selection process. These include preparation for the recruitment and selection process, interview and assessment centres and focused career coaching.
- Since January 2022 we have completed audits on recruitment campaigns covering a range of monitored characteristics. The purpose is to identify any areas which may need to be considered and addressed further by way of learning.
- Where appropriate, we continue to use specific job boards in order to promote roles to those groups who may be underrepresented.
- As part of our 2022/23 business plan, we have developed specific KPIs in relation to improving the diversity of our workforce.

Leadership and talent management

- We continue to promote and support access to leadership development for all levels of staff.
- Where available, we promote external leadership development opportunities aimed specifically at BAME staff, for example the Ready Now and Stepping Up programmes.
- There are dedicated Connect intranet pages for coaching (internal and external) and mentoring, including the promotion of an ALB-wide reciprocal mentoring platform.

Capacity and capability

- We have checked in regularly with our junior case managers to ensure progress is made against objectives.
- Following the development of the behaviours framework, awareness sessions have been designed to embed the framework within the organisation.
- Building on our Disability Confident Scheme we have supported the launch of a staff-led disability network which runs quarterly events.
- We have developed a dedicated Connect intranet page updated with the purpose and aims of the Disability Staff Network.
- HR&OD have facilitated an open staff discussion meeting in order to test the appetite for establishing a staff-led LBGT+ network.

Our Diversity Matters staff group continued to meet bi-monthly with a vibrant programme of topics, including:

- An update on staff survey results and next steps;
- An open discussion on how Diversity Matters has contributed to staff lived experience at NHS Resolution;
- A networking session on what we want an inclusive organisation to look like;
- An update on progress made on our Equality, diversity and inclusion strategy and action plan;
- A presentation on the Leadership Academy's wellbeing coaching offer; and
- A presentation on the leadership model at North East London NHS Foundation Trust.

As a result of a suggestion from the Diversity Matters group, we have amended our annual leave policy to introduce a 'public holiday swaps' arrangement. This gives staff the opportunity to work over public holidays and to enable them to take leave at other times, including for significant dates in religious calendars.

In accordance with the *Sickness absence and promoting attendance policy and procedure (HR09)*, NHS Resolution put together a policy statement on 'menopause at work' which aligns to our broader EDI strategy and action plan and our wellbeing work. The aim is to promote a wider understanding of menopause support and reasonable adjustments to staff experiencing menopausal symptoms.

Leadership development

The HR&OD team continue to run a range of leadership and management development interventions, working in partnership with external providers where appropriate and making best use of the apprenticeship levy. These include:

- Developing a management and leadership programme which is a foundation programme for new line managers and existing managers (apprenticeship funded).
- Developing managers to support themselves and others through change.

An SMT development programme is planned for 2022.

In response to the 2020 staff survey, in July 2021 a managing through leadership course was designed and offered to all members of staff.

The programme was delivered virtually and consisted of four two-hour sessions delivered over four weeks. The modules covered the topics outlined in Figure 31.

Eleven cohorts were delivered and there have been approximately six to eight participants in each cohort. Given the considerable change taking place, leadership development has been acutely focused on developing our leaders to respond to and manage change. This has taken place in terms of a range of OD interventions and learning and development workshops.

Figure 31:
Modules and topics covered by our leadership course

Inclusive talent management and succession planning

Talent and succession planning forms a key part of our Emerging People Strategy and will build on the work started in our existing workforce and OD strategy. We believe in investing in the development and potential of all staff, to ensure we have effective leadership at all levels. We promote equality, diversity and inclusion and are taking action to embed an inclusive approach to talent management, supporting staff to appreciate difference through our staff networks and ensuring we are focused on attracting, developing and retaining a diverse workforce.

For 2022 we have updated our performance appraisal and development review process in order to encourage a more cyclical approach to performance and talent management, and a prompt to encourage talent conversations. This will help to ensure the talent pipeline for each directorate is underpinned by individual career conversations, intentions and aspirations.

We have maintained our membership of 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.

Throughout 2021/22 the organisation has continued to promote apprenticeships as a way of learning and developing our own talent. We have used opportunities such as the National Apprenticeship Week, Lunch & Learn sessions and monthly apprenticeship drop-in sessions to educate staff on the range of options and approach to learning. We currently have 19 staff undertaking apprenticeships; this number continues to grow and it is very encouraging to see staff taking advantage of this way to improve their skills and career prospects.

Gender pay gap

In March 2022, in accordance with the requirements under the Equality Act 2010, we published our 2021 gender pay gap report. The report was published on the GOV.UK website.

What are the key highlights of the 2021 gender pay gap report?

- Our 2021 gender median pay gap has decreased to 7% compared to 9.1% in 2020. The decrease in the median pay gap could be in part due to the removal of pay points across all pay bands as part of the Agenda for Change terms and conditions contract refresh.
- Our gender mean pay gap has increased from 7.8% in 2020 to 8.4%. The report identifies a number of significant drivers behind our increased gender mean pay gap including sector and role specific considerations. During the 2021 reporting year, we employed more females than males in assistant and administrative roles at band 4 within Claims and HR&OD. In contrast, male employees predominantly occupy roles within Digital, Data and Technology (DDaT). As these roles are in high demand, they are currently attracting a recruitment and retention premium. In addition, the impact of the Covid-19 pandemic on working women has been widely reported. Having reviewed our leaver metrics for the reporting period, some of the reasons for leaving reflect the concerns that female staff have been more affected by the pandemic than male staff.
- Our pay gap remains lower than the current UK pay gap of 15.4%.
- In common with the wider NHS, our workforce is predominantly female; 64% of our workforce is female.
- Female employees received a higher amount of bonus pay compared to male employees.
- Over the 12-month reporting period, we appointed 1.5 times more females into senior roles than males.
- While bands 7 to 8b are largely reflective of the organisation's profile, as in the 2020 report there was an upwards trend in employing more female staff in band 5 during 2021.
- Although there has been an increase of 5% in female employees in the upper middle earnings quartile, there has been a decrease in 2% of female employees in the upper earnings quartile.

What are we going to do?

We are committed to closing our gender pay gap, ensuring that the right approach and actions are taken to appropriately address the areas where female staff are underrepresented. This approach can be challenging and does not always provide an immediate improvement in the reported figures. It does, however, ensure that we are closing the gap positively and to ensure longevity in terms of the diversity of our future workforce.

We want female employees to be proportionately represented across all pay grades. We have already identified and are working towards a number of actions as part of our Equality, diversity and inclusion strategy, which will support our aims to close the gender pay gap. We do recognise, however, that there is more to do to close the gap. As such, we are exploring EDI partnerships to enable the expansion of our recruitment campaigns. We will continue to promote and embed the values and behaviours framework across the organisation and into all of our policies and processes. We will also specifically address the impact that the pandemic has had and is having on female employees, by continuing to promote and champion flexible working, particularly part-time working for employees returning from parental leave or those with carer responsibilities.

Workforce Race Equality Standard and Workforce Disability Equality Standard reporting

It was confirmed by the national team responsible for Workforce Disability Equality Standard (WDES) that there will be no official 2021 WDES collation for ALBs. Similarly, the national team responsible for Workforce Race Equality Standard (WRES) have been unable to provide an update on the WRES 2020/21 data collation launch and we have been advised by the team to pause until the 2019/20 report is published. As such, we did not report on WRES or WDES for the 2020/21 reporting period.

Parliamentary accountability and audit report

The following disclosures are subject to audit.

Losses and special payments

We had losses of £129,586 in 2021/22. In 2020/21 we had losses of £3,710.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES, 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 118. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the accounts on page 126.

Expenditure on consultancy

Expenditure incurred on consultancy in 2021/22 was nil. In 2020/21 the expenditure on consultancy was nil.

Publicity and advertising

Publicity and advertising spend for the year was £95,590. This compares to £67,462 in 2020/21.

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 2021/22, 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 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 2021/22.

Helen Vernon
Chief Executive and Accounting Officer
Date: 14 July 2022

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 the NHS Litigation Authority (herein referred to as NHS Resolution) for the year ended 31 March 2022 under the National Health Service Act 2006.

The financial statements comprise NHS Resolution's:

- Statement of Financial Position as at 31 March 2022;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK adopted International Accounting Standards

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2022 and of its net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

I draw attention to the disclosures made in Note 7 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in Note 7, given the long term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events that are different from the current assumptions adopted by NHS Resolution. My opinion is not modified in respect of this matter.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing UK (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements 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 2019. I have also elected to apply the ethical standards relevant to listed entities. I am independent of NHS Resolution in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Conclusions relating to going concern

In auditing the financial statements, I have concluded that NHS Resolution's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work I have performed, I have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on NHS Resolution's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

My responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this certificate.

The going concern basis of accounting for NHS Resolution is adopted in consideration of the requirements set out in HM Treasury's Government Financial Reporting Manual, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises information included in the annual report, but does not include the financial statements nor my auditor's certificate thereon. The Accounting Officer is responsible for the other information. My opinion on the financial statements does not cover the other information and except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon. 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 I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

In my opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006, and that:

In my opinion, based on the work undertaken in the course of the audit:

- the parts of the Accountability report subject to audit have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Performance and Accountability reports for the financial year for which the financial statements are prepared is consistent with the financial statements and is in accordance with the applicable legal requirements.

Matters on which I report by exception

In the light of the knowledge and understanding of NHS Resolution and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability reports.
I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- I have not received all of the information and explanations I require for my audit; or
- adequate accounting records have not been kept by NHS Resolution or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Accountability report subject to audit are not in agreement with the accounting records and returns; or
- certain disclosures of remuneration specified by HM Treasury's Government Financial Reporting Manual have not been made or parts of the Remuneration and Staff Report to be audited is not in agreement with the accounting records and returns; or
- the Governance Statement does not reflect compliance with HM Treasury's guidance.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for:

- maintaining proper accounting records;
- the preparation of the financial statements and annual report in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- ensuring that the Annual report and accounts as a whole is fair, balanced and understandable;
- internal controls as the Accounting Officer determines is necessary to enable the preparation of financial statement to be free from material misstatement, whether due to fraud or error; and
- assessing NHS Resolution's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS Resolution will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

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

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

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations including fraud

I design procedures in line with my responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulation, including fraud. The extent to which my procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

Identifying and assessing potential risks related to non-compliance with laws and regulations, including fraud

In identifying and assessing risks of material misstatement in respect of non-compliance with laws and regulations, including fraud, we considered the following:

- the nature of the sector, control environment and operational performance including the design of NHS Resolution's accounting policies, key performance indicators and performance incentives.
- inquiring of management, NHS Resolution's Head of Internal Audit and those charged with governance, including obtaining and reviewing supporting documentation relating to NHS Resolution's policies and procedures relating to:
  - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
  - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
  - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including NHS Resolution's controls relating compliance with the National Health Service Act 2006, and *Managing Public Money*.
- discussing among the engagement team and involving relevant internal and external specialists, including actuarial and IT expertise regarding how and where fraud might occur in the financial statements and any potential indicators of fraud.

As a result of these procedures, I considered the opportunities and incentives that may exist within NHS Resolution for fraud and identified the greatest potential for fraud in the following areas: recognition of revenue, bias in management estimates and posting of unusual journals. In common with all audits under ISAs (UK), I am also required to perform specific procedures to respond to the risk of management override of controls.

I also obtained an understanding of NHS Resolution's framework of authority as well as other legal and regulatory frameworks in which NHS Resolution operates, focusing on those laws and regulations that had a direct effect on material amounts and disclosures in the financial statements or that had a fundamental effect on the operations of NHS Resolution. The key laws and regulations I considered in this context included the National Health Service Litigation Authority (Establishment and Constitution) Order 1995, the National Health Service Litigation Authority Regulations 1995, the National Health Service Act 2006, and *Managing Public Money*.

Audit response to identified risk

As a result of the above, the procedures I implemented to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with provision of relevant laws and regulations described above as having direct effect on the financial statements;
- enquiring of management, and the Audit and Risk Committee concerning actual and potential litigation and claims;
- reading and reviewing minutes of meetings of those charged with governance and the Board and internal audit reports; and
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit. A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain 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.

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.

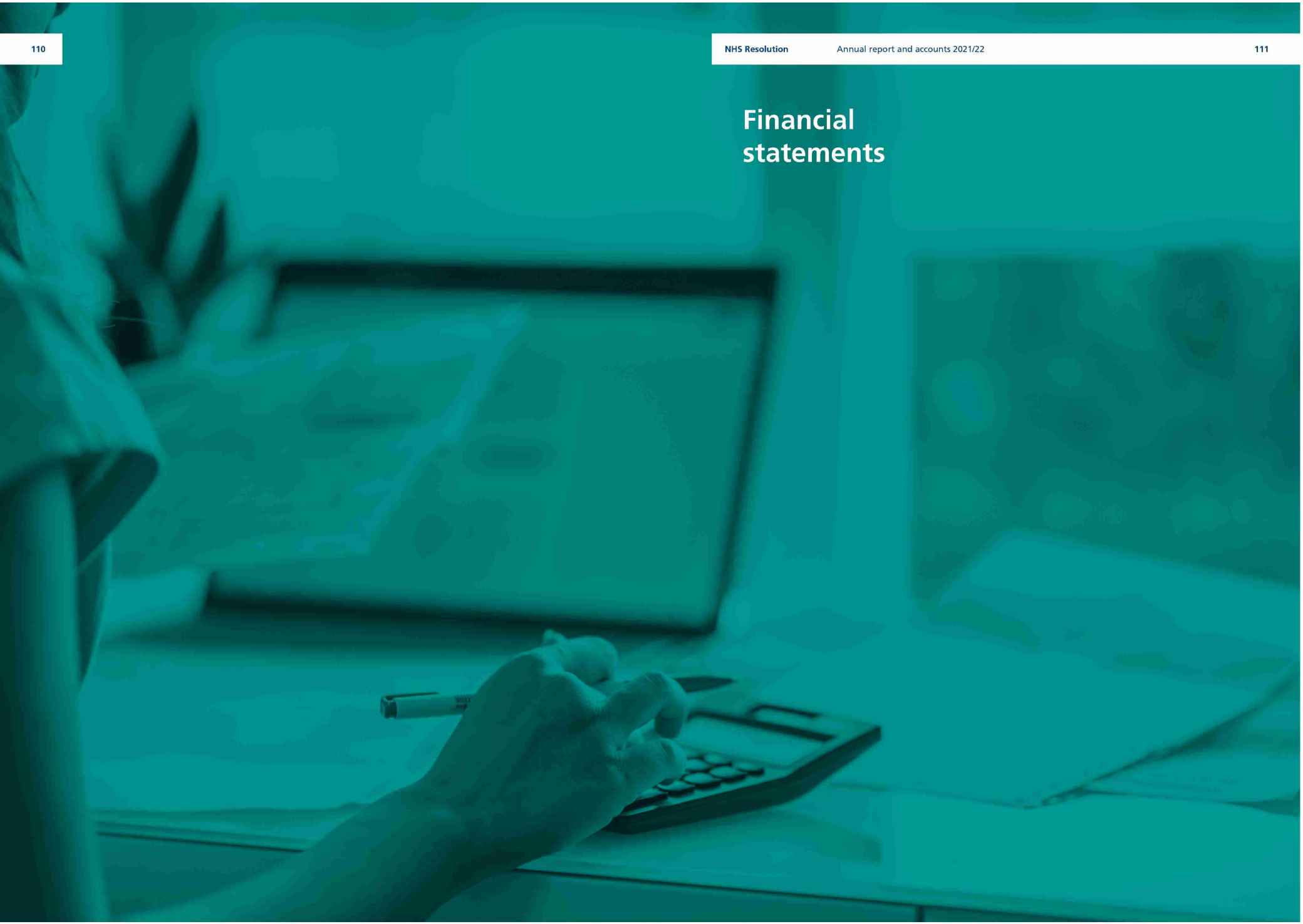
Report

I have no observations to make on these financial statements.

Gareth Davies
Comptroller and Auditor General
Date: 18 July 2022

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 2022

Comprehensive net expenditure	Notes	31 March 2022 £000	Restated[1] 31 March 2021 £000
Other operating income	3	(2,525,620)	(2,309,526)
Total operating income		**(2,525,620)**	(2,309,526)
Staff costs	2	**33,445**	26,446
Purchase of goods and services	2	**7,042**	6,247
Depreciation and impairment charges	2	**886**	934
Provision expense	7	**45,418,628**	155,363
Other operating expenditure	2	**2,830**	1,813
Total operating expenditure		**45,462,831**	**190,803**
Net operating expenditure		**42,937,211**	**(2,118,723)**
Finance expenditure	7	**347,620**	503,375
Net expenditure for the year		**43,284,831**	**(1,615,348)**
Comprehensive net expenditure for the year		**43,284,831**	(1,615,348)

The Notes on pages 118 to 156 form part of these financial statements.

[1] The 2020/21 restatement is a decrease in the provision expense of £333 million to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

Statement of financial position as at 31 March 2022

Statement of financial position	Notes	31 March 2022 £000	Restated[1] 31 March 2021 £000	Restated[1] 1 April 2020 £000
Non-current assets				
Property, plant and equipment		**858**	1,289	1,407
Trade and other receivables		**3,719**	1,142	1,354
Total non-current assets		**4,577**	2,431	2,761
Current assets				
Trade and other receivables	4	**18,117**	16,328	27,560
Cash and cash equivalents	5	**548,669**	297,829	120,691
Total current assets		**566,786**	314,157	148,251
Total assets		**571,363**	**316,588**	**151,012**
Current liabilities				
Trade and other payables	6	**(60,511)**	(50,128)	(96,407)
Provisions for liabilities and charges – known claims	7	**(2,761,484)**	(2,749,702)	(2,783,788)
Total current liabilities		**(2,281,995)**	(2,799,830)	(2,880,195)
Total assets less current liabilities		**(2,250,632)**	**(2,483,242)**	**(2,729,183)**
Non-current liabilities				
Provisions for liabilities and charges – known claims	7	**(61,500,568)**	(39,667,626)	(37,523,835)
Provisions for liabilities and charges – IBNR	7	**(64,288,000)**	(42,825,000)	(46,536,000)
Total non-current liabilities		**(125,788,568)**	(82,492,626)	(84,059,835)
Total assets less liabilities		**(128,039,200)**	**(84,975,868)**	**(86,789,018)**
Taxpayers' equity				
General Fund		**16,764**	8,165	5,873
Ex-RHA reserve		**(76,013)**	(62,451)	(65,457)
ELS reserve		**(1,536,350)**	(1,135,862)	(1,305,942)
CNST reserve		**(120,007,174)**	(78,756,404)	(80,383,206)
DHSC clinical reserve		**(4,124,538)**	(3,141,362)	(3,480,036)
ELGP reserve		**0**	(457,482)	(1,000,437)
ELSGP reserve		**(1,100,864)**	(421,168)	0
CNSGP reserve		**(821,279)**	(615,083)	(306,740)
CNSC reserve		**(92,362)**	(79,098)	0
CTIS reserve		**(2,085)**	(2,006)	0
DHSC non-clinical reserve		**(132,741)**	(111,635)	(101,309)
PES reserve		**3,007**	1,757	(5,850)
LTPS reserve		**(165,565)**	(203,239)	(145,914)
Total taxpayers' equity		**(128,039,200)**	**(84,975,868)**	**(86,789,018)**

[1] The current and non-current liabilities provisions for liabilities and charges – known claims have been increased by £2,790 million and £2,457 million respectively, to reflect a prior period adjustment as at 1 April 2020 and 31 March 2021 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

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

The Board approved a recommendation on 12 July 2022 that the financial statements from page 111 should be signed by the Accounting Officer and these were signed by Helen Vernon on 14 July 2022. The Notes on pages 118-156 form part of these financial statements.

GRO-C

Helen Vernon
Chief Executive and Accounting Officer
Date: Thursday 14 July 2022

Statement of cash flows for the year ended 31 March 2022

Cash flows	Notes	31 March 2022 £000	Restated[1] 31 March 2021 £000
Cash flows from operating activities			
Net expenditure		**(43,284,831)**	1,615,348
Other cash flow adjustments	2	**886**	982
(Increase)/decrease in receivables	4	**(1,789)**	11,232
Increase/(decrease) in payables	6	**10,383**	(46,279)
Increase/(decrease) in provisions	7	**43,307,723**	(1,601,295)
Net cash inflow/(outflow) from operating activities		**32,372**	(20,012)
Cash flows from investing activities			
Purchase of property, plant and equipment		**(43)**	(488)
Purchase of intangible assets		**(2,989)**	(164)
Net cash inflow/(outflow) from investing activities		**(3,032)**	(652)
Cash flows from financing activities			
Net Parliamentary funding		**221,500**	197,802
Net financing		**221,500**	197,802
Net increase in cash and cash equivalents		**250,840**	177,138
Cash and cash equivalents at the beginning of the period		**297,829**	120,691
Cash and cash equivalents at the end of the period	5	**548,669**	297,829

The Notes on pages 118-156 form part of these financial statements.

[1] The 2020/21 restatement is a decrease in the provision expense of £333 million to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

Statement of changes in taxpayers equity for the year ended 31 March 2022

Changes in taxpayers equity	Notes	General Fund	Ex-RHA Reserve	ELS Reserve	CNST Reserve	DHSC clinical Reserve	ELGP Reserve	ELSGP Reserve	CNSGP Reserve	CNSC Reserve	CTIS	DHSC non-clinical Reserve	PES Reserve	LTPS Reserve	Total Reserves
		(£000s	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)
Restated[1] balance at 1 April 2020		5,873	(65,457)	(1,305,942)	(80,383,206)	(3,480,036)	(1,000,437)	0	(306,740)	0	0	(101,309)	(5,850)	(145,914)	(86,789,018)
Changes in taxpayers equity for 2020/21															
Restated net expenditure for the year		(5,381)	2,006	140,080	1,626,802	253,674	473,826	(421,168)	(308,343)	(79,098)	(2,006)	(15,326)	7,607	(57,325)	1,615,348
Restated total recognised income and expense as at 2020/21		492	(63,451)	(1,165,862)	(78,756,404)	(3,226,362)	(526,611)	(421,168)	(615,083)	(79,098)	(2,006)	(116,635)	1,757	(203,239)	(85,173,670)
Net Parliamentary funding		7,673	1,000	30,000	0	85,000	69,129	0	0	0	0	5,000	0	0	197,802
Restated[1] balance at 31 March 2021		**8,165**	**(62,451)**	**(1,135,862)**	**(78,756,404)**	**(3,141,362)**	**(457,482)**	**(421,168)**	**(615,083)**	**(79,098)**	**(2,006)**	**(111,635)**	**1,757**	**(203,239)**	**(84,975,868)**
Changes in taxpayers equity for 2020/21 Transfer between schemes															
Transfer between schemes		0	0	0	0	0	(25,153)	25,153	0	0	0	0	0	0	0
Expenditure															
Authority and claims administration	2	(6,736)	(1)	(57)	(23,304)	(264)	0	(5,536)	(3,029)	(236)	(79)	(124)	(97)	(4,740)	(44,203)
(Increase)/decrease in provision for known claims	7	0	(20,840)	(397,286)	(22,282,207)	(1,034,593)	193,635	(635,499)	(58,981)	(128)	0	(13,167)	(8,660)	(45,523)	(24,303,249)
(Increase)/decrease in the provision for IBNR	7	0	6,000	(35,000)	(21,404,000)	(29,000)	289,000	(147,000)	(147,000)	(13,000)	0	(15,000)	1,000	31,000	(21,463,000)
		(6,736)	(14,841)	(432,343)	(43,709,511)	(1,063,857)	482,635	(788,035)	(209,010)	(13,364)	(79)	(28,291)	(7,757)	(19,263)	(45,810,452)
Income															
Scheme and other income	3	935	0	0	2,458,741	0	0	0	0	0	0	0	9,007	56,937	2,525,620
Total recognised income and expense for 2021/22		(5,801)	(14,841)	(432,343)	(41,250,770)	(1,063,857)	482,635	(788,035)	(209,010)	(13,364)	(79)	(28,291)	1,250	37,674	(43,284,832)
Net Parliamentary funding[2]		14,400	1,279	31,855	0	80,681	0	83,186	2,814	100	0	7,185	0	0	221,500
Balance at 31 March 2022		**16,764**	**(76,013)**	**(1,536,350)**	**(120,007,174)**	**(4,124,538)**	**0**	**(1,100,864)**	**(821,279)**	**(92,362)**	**(2,085)**	**(132,741)**	**3,007**	**(165,565)**	**(128,039,200)**

[1] The balance of reserves at 1 April 2020 and 31 March 2021 have been increased by £2,790 million and £2,457 million respectively to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.2 for further details of the revaluation.

[2] The net Parliamentary funding represents the cash drawdown of £221.5 million in 2021/22 for DHSC-funded indemnity schemes and administration costs. The Notes on pages 118-156 form part of these financial statements.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2021/22 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged most appropriate to the particular circumstances of NHS Resolution for giving a true and fair view has been selected. The particular policies adopted by NHS Resolution are described in the following text. They have been applied consistently in dealing with items that are considered material to the accounts.

The accounts are presented in pounds sterling and all values are rounded to the nearest thousand pounds. The functional currency of NHS Resolution is pounds sterling.

1.1. Accounting conventions

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

1.2. Early adoption of standards, amendments and interpretations

NHS Resolution has not adopted any IFRS, 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 IFRS, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRS, amendments and interpretations issued by the International Accounting Standards Board. These are effective for financial statements after this accounting period.

The following have not been adopted early in these accounts:

- **IFRS 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 April 2022.

From 1 April 2022, leases currently classified as operating leases will be added into the statement of financial position, recognising right-to-use lease assets and lease liabilities, and as a consequence recognising depreciation of the right-of-use assets and interest on the lease liabilities.

This standard is not anticipated to have future material impact on the financial statements of NHS Resolution.

- **IFRS 17 Insurance Contracts**

The effective date is for accounting periods beginning on or after 1 January 2021, but not adopted by the FReM with an expected adoption date from 1 April 2023. NHS Resolution's assessment is that IFRS 17 will not be applicable to the schemes it operates and so is not anticipated to have an impact on the accounts.

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

1.3. Income

A source of funding for NHS Resolution as a Special Health Authority is a Parliamentary grant from DHSC within an approved cash limit, which is reported within the Statement of Changes in Taxpayers' Equity. This funds the ELS, Ex-RHA, DHSC clinical and non-clinical liabilities schemes, CNSC and CTIS (the Covid-19 schemes created in 2020/21), 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 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 IFRS 15 Revenue Recognition:

- Revenue from contracts with customers in relation to indemnity schemes: NHS Resolution receives contributions for the provision of indemnity cover for the CNST, LTPS and PES schemes. The authorising legislation for these schemes gives the right to collect these contributions. This is deemed, per the FReM adaptation of IFRS 15, to constitute a contractual arrangement between NHS Resolution and its scheme members. The period of cover is annual, commencing on 1 April each year (contracts do not span financial years). Invoices are raised yearly, quarterly, over ten months and monthly. Revenue is recognised in our accounts in equal monthly instalments over the term of the yearly contract, as and when NHS Resolution's performance obligations are fulfilled.
- Revenue from contracts in relation to professional services: Invoices are raised either yearly or quarterly as per the contract. Regardless of the timing on raising invoices for payment, we recognise revenue in equal instalments over the accounting year, as and when performance obligations are fulfilled.
- Revenue from contracts in relation to training courses: We recognise revenue in this category only once the training has taken place, that being the point at which NHS Resolution's performance obligations are fulfilled.

NHS Resolution introduced the Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the Clinical Negligence Scheme for Trusts (CNST).

Where a trust has successfully demonstrated achievement against the ten 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 ten actions may be able to recover a lesser sum from the fund to help them achieve the actions.

As NHS Resolution is not deemed a 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.

The scheme was paused for the financial year 2020/21 due to the pandemic as we did not wish to add an additional burden to trusts responding to Covid-19 via recording requirements at the same time. Year three of the scheme was later launched in October 2020 with collection of funds from April 2021 with redistribution later in the 2021/22 financial year alongside the final evaluation of the performance of NHS trusts in delivering the actions.

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 2022/23 is £5.9 million.

NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enroll 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 Automatic Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2021/22 were £6,240 up to £50,270. Total contributions are 9%, with employee contributions at 5%, employer contributions at 3% and Government contributions (basic tax relief) at 1%. More details on NEST can be found on the NEST website www.nestpensions.org.uk/schemeweb/nest/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 HM Treasury's nominal discount rate.

Nominal discount rates are applied to general provisions, in accordance with the Financial Reporting Advisory Board (FRAB) recommendation in 2017.

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

The transfer of the claims previously managed by MDDUS (an MDO) happened on 6 April 2020; these liabilities have been accounted for under the Existing Liabilities Scheme for General Practice (ELSGP) in the 2020/21 and subsequent accounts. Claims previously managed by MPS (an MDO) were accounted for under Existing Liabilities for General Practice (ELGP) in 2020/21. The claims previously managed by MPS transferred to NHS Resolution on 1 April 2021 and are accounted for under ELSGP in 2021/22. CNSGP and ELSGP are accounted for under IAS 37, in line with the treatment of other NHS Resolution indemnity schemes. ELGP, ELSGP and CNSGP are funded out of the budget for the NHS managed by NHS England, which comes to NHS Resolution via DHSC financing.

In relation to the transfer of assets and liabilities to the DHSC Group from the MDOs, 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 and/or resolution process; and emerging evidence can alter valuation. Accordingly NHS Resolution makes a best estimate regarding the likely year of settlement and expected value 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 (nil in 2020/21).

1.9. Financial liabilities

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

1.10. Critical judgements and key sources of estimation uncertainty

In the application of NHS Resolution's accounting policies, which are described elsewhere in Note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities 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 separated into different scheme types in the Statement of Changes in Taxpayers' Equity.

2. Expenditure

Expenditure	Notes	2021/22 (£000s)	Restated[1] 2020/21 (£000s)
Non-executive members' remuneration[2]		**129**	135
Other salaries and wages[3]			
Salaries and wages		**26,549**	20,718
Social security costs		**2,741**	2,237
Pension costs		**4,034**	3,407
Apprenticeship levy		**121**	84
Education, training and conferences		**118**	46
Establishment expenses		**1,061**	456
Hire and operating lease rental[4]			
Land and buildings		**730**	1,516
Lease cars		**4**	7
Photocopiers		**0**	0
Franking machine		**0**	0
Vending machine		**0**	(13)
Insurance		**211**	222
Transport (business travel)		**22**	11
Premises and fixed plant		**4,395**	3,545
External contractors			
Actuary's advice		**1,322**	993
Primary Care Appeals advisory expenditure		**29**	21
Consultancy		**0**	0
External corporate legal fees[5]		**188**	165
Practitioner Performance Advice assessment expenditure		**182**	97
Practitioner Performance Advice professional services		**0**	0
Other		**1,156**	508
Auditor's remuneration: audit fees[6]		**250**	225
Internal audit fees		**63**	68
Bank charges and interest		**13**	10
		43,317	34,458
Depreciation		**454**	558
Amortisation		**376**	376
Loss on disposal		**20**	48
Impairment		**36**	0
		886	982
		44,203	35,440
Other finance costs – unwinding of discount	7	**347,620**	503,375
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	7	**6,174,216**	3,828,662
Change in the discount rate[7]	7	**42,623,207**	228,701
Increase/(decrease) in the provision for IBNR	7	**(3,378,795)**	(3,902,000)
		45,766,248	658,738
Total expenditure[8]		**45,810,452**	694,178

[4] Building lease costs reduced due to release of historical accruals upon reconciliation of costs with Government Property Agency.

[1] The 2020/21 restatement reflects a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. The impact is a reduction in the increase in provision for known claims for 2020/21 of £333 million. See Note 7.4 for further details of the revaluation.

[2] Additional explanations can be found in Remuneration and staff report in the Accountability report section.

[3] Additional explanations can be found in Remuneration and staff report in the Accountability report section.

[4] Building lease costs reduced due to release of historical accruals upon reconciliation of costs with Government Property Agency.

[5] 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.

[6] NHS Resolution did not make any payments to its auditors for non-audit work.

[7] The discount rates used are mandated by HM Treasury and are set out at Note 7.3 to the accounts.

[8] Of the £44.2 million total expenditure for 2021/21, £5.5 million is shown as administration expenditure in DHSC consolidated group accounts.

2.1 Analysis of the provision expense

2021/22	Ex-RHA	ELS	CNST	DHSC clinical	ELGP	ELSGP	CNSGP
	£000	£000	£000	£000	£000	£000	£000
2021/22 incidents							
Known claims	0	0	67,880	0	0	0	1,136
IBNR	0	0	13,216,979	0	0	0	339,523
Total 2021/22	**0**	**0**	**13,284,859**	**0**	**0**	**0**	**340,659**
Prior years incidents							
Known claims	20,840	397,286	22,214,328	1,034,592	0	441,864	57,845
IBNR	(6,000)	35,000	8,187,021	29,000	0	(142,000)	(192,523)
Total prior years	**14,840**	**432,286**	**30,401,349**	**1,063,592**	**0**	**299,864**	**(134,678)**
Total	**14,840**	**432,286**	**43,686,208**	**1,063,592**	**0**	**299,864**	**205,981**

2021/22	CNSC	CTIS	DHSC non-clinical	LTPS	PES	Total
	£000	£000	£000	£000	£000	£000
2021/22 incidents						
Known claims	72	0	39	6,344	6,053	81,524
IBNR	15,000	0	0	49,913	2,631	13,624,046
Total 2021/22	**15,072**	**0**	**39**	**56,257**	**8,684**	**13,705,570**
Prior years incidents						
Known claims	55	0	13,128	39,179	2,607	24,221,724
IBNR	(2,000)	0	15,000	(80,913)	(3,631)	7,838,954
Total prior years	**(1,945)**	**0**	**28,128**	**(41,734)**	**(1,024)**	**32,060,678**
Total	**13,127**	**0**	**28,167**	**14,523**	**7,660**	**45,766,248**

2020/21	Ex-RHA	ELS	Restated CNST	DHSC clinical	ELGP	ELSGP	CNSGP
	£000	£000	£000	£000	£000	£000	£000
2020/21 incidents							
Known claims	0	0	42,339	0	0	0	1,722
IBNR	0	0	7,896,441	0	0	0	322,920
Total 2020/21	**0**	**0**	**7,938,780**	**0**	**0**	**0**	**324,642**
Prior years incidents							
Known claims	(19)	(86,299)	4,308,866	(27,418)	(150,826)	226,081	13,323
IBNR	(2,000)	(54,000)	(11,648,441)	(227,000)	(323,000)	191,000	(30,920)
Total prior years	**(2,019)**	**(140,299)**	**(7,339,575)**	**(254,418)**	**(473,826)**	**417,081**	**(17,597)**
Total	**(2,019)**	**(140,299)**	**599,205**	**(254,418)**	**(473,826)**	**417,081**	**307,045**

2020/21	CNSC	CTIS	DHSC non-clinical	LTPS	PES	Restatement[1] Total
	£000	£000	£000	£000	£000	£000
2020/21 incidents						
Known claims	0	0	21	5,264	2,213	51,559
IBNR	79,000	1,500	0	94,649	2,930	8,397,440
Total 2020/21	**79,000**	**1,500**	**21**	**99,913**	**5,143**	**8,448,999**
Prior years incidents						
Known claims	0	0	7,150	29,125	(1,805)	4,318,178
IBNR	0	500	8,000	(19,648)	(2,930)	(12,108,439)
Total prior years	**0**	**500**	**15,150**	**9,477**	**(4,735)**	**(7,790,261)**
Total	**79,000**	**2,000**	**15,171**	**109,390**	**408**	**658,738**

[1] The provision expense has been increased by £2,457 million to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

Explanatory note

Note 2.1 provides an analysis of the provision expense charged to the Statement of Net Comprehensive Expenditure in the reporting year. The cost of claims arising from incidents occurring in 2021/22 totals £13.706 billion across all schemes. This compares to £8.449 billion in 2020/21.

The estimated cost of incidents arising from the clinical activity in 2021/22 covered by the largest scheme, CNST, was £13.3 billion. This figure is materially higher than the £7.9 billion reported in 2020/21 reflecting:

- the change in the HM Treasury long term discount rates, which places a much higher value on projected claims costs; and
- the assumption that clinical activity would have increased in 2021/22 compared with 2020/21 where activity would have been impacted by the pandemic. We estimate that the annual cost of incidents would have been £8.7 billion without the impact of the change in discount rates.

The prior year's incidents figures show the changes in provisions that have been recognised in previous reporting years. In 2021/22 this was an increase of £32.061 billion across all schemes, which has been affected by the change in the HM Treasury long term discount rates as described in the Finance report at pages 55 to 63.

The approach taken to valuing the provision is shown in Note 7.2.

3. Operating income

Operating income	2021/22 £000	2020/21 £000
CNST contributions	2,458,741	2,243,740
LTPS contributions	56,937	56,956
PES contributions	9,007	8,071
Practitioner Performance Advice	935	759
Total	**2,525,620**	**2,309,526**

4. Receivables

Receivables	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000
NHS receivables – revenue	0	0	41	0	0	0	0	0
Accrued income	0	0	0	0	0	0	0	0
Prepayments	40	948	876	2,067	0	0	0	0
VAT	0	9	5,781	56	0	494	77	12
Other receivables	0	350	2,902	4	226	0	0	0
Total	**40**	**1,307**	**9,600**	**2,127**	**226**	**494**	**77**	**12**

Receivables	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Admin £000	Total 31 March 2022 £000	Total 31 March 2021 £000
NHS receivables – revenue	0	0	49	2,003	43	2,136	3,767
Accrued income	0	0	0	0	23	23	0
Prepayments	0	0	0	0	1,188	5,119	4,486
VAT	0	23	9	302	355	7,118	3,851
Other receivables	0	0	2	74	163	3,721	4,224
Total	**0**	**23**	**60**	**2,379**	**1,772**	**18,117**	**16,328**

5. Cash and cash equivalents

Cash and cash equivalents	Ex-RHA	ELS	CNST	ELSGP	CNSGP
	£000	£000	£000	£000	£000
At 1 April 2021	100	35,208	192,279	100	100
Change during the year	13	2,558	228,159	0	0
At 31 March 2022[1]	**113**	**37,766**	**420,438**	**100**	**100**

Cash and cash equivalents	PES	LTPS	Admin	Total 31 March 2022	Total 31 March 2021
	£000	£000	£000	£000	£000
At 1 April 2021	10,978	53,400	5,664	297,829	120,691
Change during the year	4,761	8,921	6,428	250,840	177,138
At 31 March 2022[1]	**15,739**	**62,321**	**12,092**	**548,669**	**297,829**

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

6. Trade payables and other current liabilities

Trade payables	Ex-RHA	ELS	CNST	DHSC clinical	ELSGP	CNSGP	CNSC
	£000	£000	£000	£000	£000	£000	£000
NHS payables revenue	0	0	543	0	0	0	0
Prepaid income	0	0	14,362	1,320	0	0	0
Accruals	0	6	23,358	533	653	108	1
Other payables	0	351	12,765	668	273	11	0
	0	**357**	**51,028**	**2,521**	**926**	**119**	**1**

Trade payables	CTIS	DHSC non-clinical	PES	LTPS	Admin	Total 31 March 2022	Total 31 March 2021
	£000	£000	£000	£000	£000	£000	£000
NHS payables revenue	0	0	170	80	34	827	152
Prepaid income	0	0	0	0	40	15,722	16,484
Accruals	0	34	11	697	2,813	28,214	24,904
Other payables	0	24	0	242	1,414	15,748	8,588
	0	**58**	**181**	**1,019**	**4,301**	**60,511**	**50,128**

7. Provisions for liabilities and charges

Provisions	Ex-RHA	ELS	CNST	DHSC clinical	ELGP	ELSGP	CNSGP	CNSC	CTIS	DHSC non-clinical	PES	LTPS	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Opening provision for known claims	55,751	1,002,628	38,247,332	2,592,424	193,635	207,462	15,403	0	0	10,681	6,694	85,318	**42,417,328**
Opening provisions for IBNR	6,000	145,000	40,639,000	618,000	289,000	191,000	598,000	79,000	2,000	105,000	5,000	148,000	**42,825,000**
Restated[1] total provision as at 1 April 2021	**61,751**	**1,147,628**	**78,886,332**	**3,210,424**	**482,635**	**398,462**	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**85,242,328**
Movement in known claims													
Transfer between schemes	0	0	0	0	(193,635)	193,635	0	0	0	0	0	0	**0**
Provided in the year	1,198	38,279	8,408,657	221,273	0	481,934	58,235	125	0	15,341	10,016	69,701	**9,304,759**
Provision not required written back	(546)	(18,744)	(2,827,151)	(91,359)	0	(159,697)	(5,822)	0	0	(2,099)	(1,317)	(23,809)	**(3,130,544)**
Unwinding of discount	953	16,590	290,785	36,571	0	2,259	427	0	0	9	0	26	**347,620**
Change in discount rate	19,234	361,160	16,409,916	868,107	0	117,368	6,141	3	0	(84)	(39)	(394)	**17,781,412**
Provisions utilised in the year	(1,265)	(19,906)	(2,213,856)	(82,773)	0	(80,574)	(4,461)	(28)	0	(6,918)	(4,321)	(44,422)	**(2,458,524)**
Movement in known claims	**19,574**	**377,379**	**20,068,351**	**951,819**	**(193,635)**	**554,925**	**54,520**	**100**	**0**	**6,249**	**4,339**	**1,102**	**21,844,723**
Movement in IBNR													
Transfer between schemes	0	0	0	0	(289,000)	289,000	0	0	0	0	0	0	**0**
Change in discount rate	0	68,768	24,463,000	285,027	0	5,000	11,000	0	0	15,000	0	(6,000)	**24,841,795**
Provided in the year	(6,000)	(33,768)	(3,059,000)	(256,027)	0	(147,000)	136,000	13,000	0	0	(1,000)	(25,000)	**(3,378,795)**
Movement in IBNR	(6,000)	35,000	21,404,000	29,000	(289,000)	147,000	147,000	13,000	0	15,000	(1,000)	(31,000)	**21,463,000**
Closing provision for known claims	75,325	1,380,007	58,315,683	3,544,243	0	762,387	69,923	100	0	16,930	11,033	86,420	**64,262,051**
Closing provisions for IBNR	0	180,000	62,043,000	647,000	0	338,000	745,000	92,000	2,000	120,000	4,000	117,000	**64,288,000**
Total provision as at 31 March 2022	**75,325**	**1,560,007**	**120,358,683**	**4,191,243**	**0**	**1,100,387**	**814,923**	**92,100**	**2,000**	**136,930**	**15,033**	**203,420**	**128,550,051**
Analysis of expected timing of discounted cash flows[2]													
Not later than one year	1,297	36,975	2,393,405	162,955	0	109,373	11,345	0	0	6,884	6,766	32,484	**2,761,484**
Later than one year and not later than five years	5,422	125,467	10,005,727	611,766	0	327,042	249,604	5,006	1,000	130,046	8,267	170,936	**11,640,283**
Later than five years	68,606	1,397,565	107,959,551	3,416,522	0	663,972	553,974	87,094	1,000	0	0	0	**114,148,284**
Total provision as at 31 March 2022	**75,325**	**1,560,007**	**120,358,683**	**4,191,243**	**0**	**1,100,387**	**814,923**	**92,100**	**2,000**	**136,930**	**15,033**	**203,420**	**128,550,051**

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

[1] The opening balance at 1 April 2021 has been increased by £2,457 million to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

[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)

Provisions	Ex-RHA	ELS	Restated CNST	DHSC clinical	ELGP	ELSGP	CNSGP	CNSC	CTIS	DHSC non-clinical	PES	LTPS	Restated Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Restated opening provision for known claims	57,011	1,111,961	35,957,145	2,681,471	387,475	0	1,149	0	0	10,919	9,612	90,880	**40,307,623**
Opening provisions for IBNR	8,000	199,000	44,391,000	845,000	612,000	0	306,000	0	0	97,000	5,000	73,000	**46,536,000**
Restated[1] total provisions as at 1 April 2020	**65,011**	**1,310,961**	**80,348,145**	**3,526,471**	**999,475**	**0**	**307,149**	**0**	**0**	**107,919**	**14,612**	**163,880**	**86,843,623**
Movement in known claims													
Transfer between schemes	0	0	0	0	(146,616)	146,616	0	0	0	0	0	0	**0**
Provided in the year	2,413	13,190	8,027,172	190,890	60,803	134,190	15,754	0	0	10,031	4,245	56,789	**8,515,477**
Provision not required written back	(3,752)	(122,909)	(4,131,228)	(273,466)	(69,731)	(55,790)	(744)	0	0	(2,880)	(3,838)	(22,477)	**(4,686,815)**
Unwinding of discount	1,023	18,848	439,075	42,305	1,278	778	0	0	0	13	3	52	**503,375**
Change in discount rate	297	4,572	16,186	12,853	3,440	287	35	0	0	7	(2)	26	**37,701**
Provisions utilised in the year	(1,241)	(23,034)	(2,061,018)	(61,629)	(43,014)	(18,619)	(791)	0	0	(7,409)	(3,326)	(39,952)	**(2,260,033)**
Movement in known claims	**(1,260)**	**(109,333)**	**2,290,187**	**(89,047)**	**(193,840)**	**207,462**	**14,254**	**0**	**0**	**(238)**	**(2,918)**	**(5,562)**	**2,109,705**
Movement in IBNR													
Transfer between schemes	0	0	0	0	(201,000)	201,000	0	0	0	0	0	0	**0**
Change in discount rate	0	1,000	165,000	1,000	6,000	3,000	13,000	0	0	1,000	0	1,000	**191,000**
Provided in the year	(2,000)	(55,000)	(3,917,000)	(228,000)	(128,000)	(13,000)	279,000	79,000	2,000	7,000	0	74,000	**(3,902,000)**
Movement in IBNR	(2,000)	(54,000)	(3,752,000)	(227,000)	(323,000)	191,000	292,000	79,000	2,000	8,000	0	75,000	**(3,711,000)**
Closing provision for known claims	55,751	1,002,628	38,247,332	2,592,424	193,635	207,462	15,403	0	0	10,681	6,694	85,318	**42,417,328**
Closing provisions for IBNR	6,000	145,000	40,639,000	618,000	289,000	191,000	598,000	79,000	2,000	105,000	5,000	148,000	**42,825,000**
Restated[1] total provision as at 31 March 2021	**61,751**	**1,147,628**	**78,886,332**	**3,210,424**	**482,635**	**398,462**	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**85,242,328**
Analysis of expected timing of discounted cash flows[2]													
Not later than one year	1,000	35,003	2,430,244	77,006	66,790	70,372	2,280	0	0	8,001	9,000	50,006	**2,749,702**
Later than one year and not later than five years	7,005	143,086	11,767,324	315,188	173,922	157,870	144,800	6,000	1,000	21,013	2,694	183,312	**12,923,214**
Later than five years	53,746	969,539	64,688,764	2,818,230	241,923	170,220	466,323	73,000	1,000	86,667	0	0	**69,569,412**
Restated[1] total provision as at 31 March 2021	**61,751**	**1,147,628**	**78,886,332**	**3,210,424**	**482,635**	**398,462**	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**85,242,328**

[1] The opening balance at 1 April 2020 and the closing balance at 31 March 2021 have been increased by £2,790 million and £2,457 million retrospectively to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the CNST known claims provision. See Note 7.4 for further details of the revaluation.

[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.

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

Reconciliation of Note 7 to comprehensive net expenditure	Ex-RHA	ELS	CNST	DHSC clinical	ELGP	ELSGP	CNSGP	CNSC	CTIS	DHSC non-clinical	PES	LTPS	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Unwinding of discount/ finance charge	953	16,590	290,785	36,571	0	2,259	427	0	0	9	0	26	**347,620**
Increase in known claims provision	1,198	38,279	8,408,657	221,273	0	481,934	58,235	125	0	15,341	10,016	69,701	**9,304,759**
Provision not required written back	(546)	(18,744)	(2,827,151)	(91,359)	0	(159,697)	(5,821)	0	0	(2,099)	(1,317)	(23,809)	**(3,130,544)**
Change in discount rate (known claims and IBNR)	19,234	429,928	40,872,916	1,153,134	0	122,368	17,141	3	0	14,916	(39)	(6,394)	**42,623,207**
Increase/(decrease) in provision for IBNR	(6,000)	(33,768)	(3,059,000)	(256,027)	0	(147,000)	136,000	13,000	0	0	(1,000)	(25,000)	**(3,378,795)**
Provision expense charged to Statement of comprehensive net expenditure	**13,886**	**415,695**	**43,395,422**	**1,027,021**	**0**	**297,605**	**205,555**	**13,128**	**0**	**28,158**	**7,660**	**14,498**	**45,418,628**
Total charge to Statement of comprehensive net expenditure	**14,839**	**432,285**	**43,686,207**	**1,063,592**	**0**	**299,864**	**205,982**	**13,128**	**0**	**28,167**	**7,660**	**14,524**	**45,766,248**

7.2. Explanatory notes

Nature and scope of the obligation

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

- 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.

The schemes that we administer are shown in the Appendix on page 159.

Developments over the year affecting the provisions

Discount rates

One of the key assumptions used in calculating the provisions are the discount rates used to place a present value on projected future cashflows. Since the discount rates are prescribed by HM Treasury, the rates are outside the formal control of NHS Resolution.

NHS Resolution's provisions are particularly sensitive to the long term and very long term discount rates. This reflects the long term nature of the liabilities which is driven by the reporting and settlement delays as well as the fact that many high value claims are settled as a PPO with payments provided over the remaining lifetime of the claimant.

This year, there was a significant reduction in the long term and very long term discount rates prescribed by HM Treasury, which increased the provision by £42.6 billion. Although the change in discount rates prescribed by HM Treasury has a material effect on the value of the provisions, it does not alter the cost of settling claims in the short-term – which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (e.g. the personal injury discount rate).As such the £42.6 billion increase in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

Timing of cashflows – known claims provisions

The known claims provision calculation (described later in this note) uses the expected settlement date (ESD) from individual claims recorded in the Claims Management System (CMS) to apply inflation and discounting to reach a valuation. However, for the disclosure of the expected timing of cashflows, this has historically been based on an actuarial view of settlement patterns.

As at 31 March 2022, these two views had diverged considerably, most likely due to the effect of the Covid-19 pandemic on the health and legal environments, and as a result, an adjustment increasing the provision by £4.6 billion gross (£2.2 billion net after allowing for the prior period adjustment) has been made to the known claims provision calculation for the 2021/22 financial year. A prior year adjustment has also been made to the accounts, details of which are provided at Note 7.4.

This issue highlights the uncertainty in the claims environment in relation to when individual claims are likely to settle, the impact that disruptive forces may have on the individual judgements on timing of settlements, and the sensitivity of the value of the provision to payment patterns.

Indemnity arrangements for coronavirus

The coronavirus pandemic has had a significant impact on the NHS over the last two years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes that were established last year (CNSC and CTIS), there are also potential impacts on the liabilities covered under the arrangements that were already in place (i.e. through CNST, CNSGP and LTPS) owing to changes in healthcare provision.

As was the case last year, the estimated effect on the NHS Resolution provision is fairly limited (£1.3 billion) at this stage because:

- the success of the vaccination programme meant that clinical activity wasn't as severely disrupted in 2021/22.
- a large share of the total provision is in relation to incidents that occurred prior to 2020/21. While these claims might still be affected by any potential disruption in the reporting and settlement of claims, this is not expected to significantly alter the liabilities due.
- a large proportion (approximately 70% for 2021/22 compared to 68% in 2020/21) of the CNST provision is as a result of claims arising from maternity activity. Although there have been some changes to maternity activities, overall these activities have continued during the pandemic and we assume that there will be a similar level of claims as in previous years. The estimated value of IBNR PPO claims, which mainly relate to maternity, for incidents in 2020/21 is around £9 billion and for incidents in 2021/22 is around £11 billion.

While a small number of claims related to Covid-19 have been received, it will take several years for the impacts of Covid-19 to fully materialise, due to the time lags between incidents, claims and ultimately their settlement. As a result, there is limited experience from which to quantify the impacts of Covid-19 on the provisions and our estimates are subject to uncertainty. We have therefore applied a similar approach to 2020/21, where we have separately considered:

- The direct impacts that might arise from new activities related to responding to the pandemic – for example in relation to testing, diagnosis, treating and caring for Covid-19 patients and administering vaccines.
- The direct impacts on core (non-Covid-19) NHS activity and hence the claims that might normally arise – for example in relation to lower clinical activity or the risks of delayed treatment.
- The indirect impacts across all other factors that might influence claim costs – for example in relation to lags between incidents, claims and settlement or the economic impact.

Early Notification

The majority (approximately 70%) of the CNST provision is as a result of claims arising from maternity activities – such as brain damaged babies at birth following negligent care.

Under the Early Notification (EN) Scheme, trusts are required to report qualifying cases that meet the Early Notification criteria to Healthcare Safety Investigation Branch, and, from 1 April 2022, also to NHS Resolution once HSIB have confirmed they are progressing an investigation. HSIB will triage and confirm their investigation on those babies who have clinical or MRI evidence of neurological injury. Once NHS Resolution have received the final HSIB report, the EN team will triage the case further based on our internal clinical definition and then confirm to the trust which cases will proceed to a liability investigation.

- The EN Scheme has significantly altered the pace at which claims are opened. However, since the scheme was only launched in 2017 and it takes a number of years for higher value claims to settle, there is relatively little settled claims experience to fully quantify the impact of the EN Scheme.

For this year, we have separately modelled claims reported under the EN Scheme within the IBNR provision and those expected to be reported outside of the scheme. In arriving at our assumed number of claims, we have considered the rate at which EN cases have been opened to date while assuming that the overall level of risk in relation to brain damage at birth is broadly similar to the period before EN. Hence we assume that the overall number of successful high value claims after the introduction of the EN Scheme will be similar to the period before – reflecting that the EN scheme only alters the reporting and claim settlement process, rather than the exposure to risk.

Since no high value EN cases have been settled yet, other assumptions in respect of claim costs and settlement lags are set with reference to standard maternity claims.

General Practice Indemnity

From 1 April 2021 liabilities relating to incidents prior to 1 April 2019 against members of the Medical Protection Society (MPS) transferred to be administered by NHS Resolution. These are covered within the Existing Liabilities Scheme for General Practice (ELSGP), which already covered liabilities relating to incidents prior to 1 April 2019 against members of the Medical and Dental Defence Union of Scotland (MDDUS).

Short-term inflation

Short-term inflation expectations have increased significantly relative to last year owing to the post-pandemic economic recovery, higher energy prices and supply and labour constraints. The provisions are determined assuming that claims inflation will also be higher in the short term – reflecting the assumption that a higher cost of living in the general economic environment will lead through to higher claim settlement costs. The impact on the CNST provision is shown at Table 28 on page 142.

Claims inflation trends

Notwithstanding the higher short-term inflation expectations in the general economic environment, average settlement costs have not increased at the rate previously assumed. This is a continuing trend over the last few years and as such we have made reductions to our long term claims inflation assumptions. See page 142 for details of the impact of the changes to the claims inflation assumption

Risk and uncertainty

In prior years, we have included a risk and uncertainty margin in our IBNR provisions to reflect the unquantifiable risks that might affect our liabilities. This year, we have decided to remove the risk and uncertainty margin to ensure that the provisions reflect our best estimate as a result of our ongoing refinements to our reserving processes. Instead, the risk and uncertainty inherent in the provision is demonstrated via presentation of sensitivity analysis and the reasonable range covered in the following material.

Assumption of liabilities upon cessation

The NHS Act 2006 s.28A requires the Secretary of State for Health and Social Care to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This includes the liabilities assumed by NHS Resolution in respect of all schemes.

Process and methodology for setting the provision

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

NHS Resolution's Reserving and Pricing Committee is responsible for making decisions on the key judgements and estimates. This is supported by the advice of the actuaries alongside the Preparatory Reserving Group, which reports into the Reserving and Pricing Committee and brings together colleagues from across the organisation to scrutinise the analysis.

In addition to the discount rate, 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 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,
  - expected future claims inflation to settlement,
  - the likelihood that they will go on to settle under a periodical payment regime – with part of the claim paid over the life of the claimant as a regular stream of compensation income rather than purely as a lump sum, and
  - the assumed additional cost if the case were to settle as a periodic payment order (PPO).

A further adjustment has been applied to the 2021/22 known claims provision as a whole, and to the CNST provision only for 2020/21 (on grounds of materiality) to align the profile of case estimates settlement dates with an actuarial view of the expected timing of settlement of the provision.

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 provision is determined on an individual claim-by-claim basis and then aggregated across all settled PPOs. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation). A probability of survival is then applied to each projected payment, based on the individual's life expectancy and the fitted mortality tables. This provides a weighting that allows for the relative probability of each payment being made. This forms the cash flows which are then discounted using the HM Treasury-prescribed discount rates to calculate a present value of the liability.
- **IBNR** – To estimate the IBNR provision at the accounting date, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a present value (at 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 this year, we have set separate assumptions for claims reported under the EN Scheme within the IBNR provision and those expected to be reported outside of the scheme.
  - The ELSGP provisions are determined in a similar manner but the reserving assumptions are based upon the combined historical claims experience from periods where: claims were handled by MDDUS and/or MPS; and also more recently where claims have been handled by NHS Resolution.
  - The assumptions used to determine the CNSGP provisions are based mainly on ELSGP experience, scaled up to allow for the fact that CNSGP has wider exposure coverage.
  - For CNSC and other coronavirus liabilities, approximate methods have been used based on levels of activity and assumed claim frequency and severity based on similar clinical risks.

7.3 Key assumptions and areas of uncertainty

As with any actuarial projection, there are areas of uncertainty within the claims provisions estimates. This is particularly so for:

- the CNST, ELS and DHSC clinical schemes, given the long term nature of the liabilities;
- the GPI schemes, given the recent changes in these arrangements with the take-on of claims from two MDOs; and
- the CNSC and CTIS schemes and Covid-19 liabilities covered by the other schemes, given the novel nature of the liabilities and the lack of claims experience.

The IBNR provisions are subject to considerable uncertainty. At a high level, the method used to calculate the provisions assumes that future experience will be in line with past experience. In particular, the provisions are calculated on the basis of the current legal and claims environment, including the current PIDR.

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

- **The number of clinical claims reported to NHS Resolution and lag patterns:** The number of claims reported to NHS Resolution's long-established schemes has reduced over the last couple of years since the peak in 2013/14, excluding claims reported under the Early Notification Scheme. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in past claim trends. Although we have allowed for the assumed impact of Covid-19 reducing the number of claims we are likely to receive from activity in 2020/21, clinical activity appears to have recovered to pre-pandemic levels in 2021/22.

  Estimating the ultimate number of claims is complicated by the fact that clinical negligence claims can take a number of years to be reported following the incident that gives rise to the claim. The IBNR provision depends on an assumed time lag pattern for how claims are reported to NHS Resolution following the incident. If the true pattern of reporting is faster than that assumed, this may mean that the number of IBNR claims has been overestimated, and vice versa. Changing trends in this pattern over time, for example as a result of changes to the legal environment, the introduction of the Early Notification scheme (leading to earlier reporting of incidents and claims), increased awareness of the availability of compensation and potential disruptions owing to Covid 19, increase the uncertainty in this assumption.
- **Claims settling as PPOs:** PPOs remain a key area of uncertainty, given the high value of PPO settlements, 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.
- **Claims inflation:** Because of the long term nature of the liabilities, even small changes to the assumed rate of future claim value inflation can have a significant impact on the estimated provisions. Claim value inflation has historically been higher than price inflation. For clinical negligence claims, inflation is affected by a number of external factors such as the PIDR, changes in legal precedent (e.g. rules relating to accommodation costs determined by Swift v. Carpenter) 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 2021 (which specifies the financial assumptions to be used for valuing provisions at March 2022) 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 36 of Annex B of to the HM Treasury PES note PES (2021) 10.

For NHS Resolution's IBNR provisions, these conditions have been met:

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

Condition 2: the proposed alternative rates must be free from management bias. An indication of this may be an independent or professional assessment of the proposed alternative inflation rates, such as by a committee, third party or other experts. The claims inflation assumptions have been based on the actuarial adviser's assessment of historical claims inflation, which have then been reviewed and adopted by NHS Resolution's 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; and
- Then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past.

The majority of PPOs have payments linked to the retail price index (RPI) and/or ASHE 6115 (a wage inflation index) and the future rates of increase in these indices are uncertain. In particular, ASHE 6115 relates specifically to care and home workers and external factors impacting this market in recent years have increased the uncertainty in setting this assumption. Further, the reforms announced to RPI will result in a change in the way that RPI is determined in 2030.

- **Life expectancy:** The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Each claimant's life expectancy is estimated at settlement by medical experts. The actual future lifetime of 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).
- **Covid-19:** As with last year's provisions, there are additional assumptions made, and hence uncertainties in the provision, as a result of the impact of Covid-19. Broadly speaking there are two offsetting factors of the pandemic on the provisions: expected lower claim numbers from lower clinical activity in 2020/21, offset by new risks and potential sources of claims as a result of the response.
- **Legal environment:** The legal environment is a particular area of uncertainty. DHSC published a consultation in January 2022 proposing the introduction of Fixed Recoverable Costs (FRC) in lower value clinical negligence claims (generally claims with damages valued at £1,500–£25,000). The consultation proposed that an FRC scheme apply to claims notified on or after the implementation date. The consultation closed on 24 April 2022, and assumes implementation no earlier than 2023/24. Because this is a consultation there is no certainty as to whether the FRC scheme will be introduced or what it will look like. As a result, the potential impact of FRC is too remote to be included in the provision as at 31 March 2022. This will remain under review.

  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 or known claims provisions for the potential effects of such changes at this stage. However, the recently announced PIDR in Northern Ireland provides an indication that, if the PIDR in England and Wales had been reviewed and updated recently then the rate might be around 1% lower than it currently stands. Our sensitivity analysis shows the impact of changing the PIDR and shows the CNST IBNR would be around £1.3 billion higher if the PIDR was 1% lower.

- **Scheme developments:** 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.

  This year, we have set separate assumptions for claims reported under the EN Scheme and those reported outside of the scheme. Assumptions have been set based on EN experience to date and we have assumed that the overall level of risk of brain damage of babies at birth is similar to that seen in previous years but that the Early Notification Scheme brings forward the reporting of those claims. It will take several more years to ascertain fully what the impact of the EN Scheme may be.

  The provisions in respect of GP Indemnity claims rely on historical claims data provided by organisations with different claims processes and systems.

  This, together with any changes in claims development following the recent changes in these arrangements with the take-on of claims from two MDOs, contributes to the uncertainty inherent in these provisions.

Table 28 shows a summary of 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.

Key assumptions in the CNST IBNR provision

The impacts of the various assumptions can be found detailed in Figure 32: CNST IBNR sensitivities as at 31 March 2022 (page 148).

Table 28: Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes	Change in assumption between 31 March 2021 and 31 March 2022	Effect of change (CNST IBNR)
Ultimate number of claims	Derived from past claim numbers and development patterns and assumptions that the level of risk will be similar to previous years, adjusted for levels of activity	Medium	High	The EN scheme has accelerated the reporting of potential PPO claims. We have allowed for this by specifying separate assumptions for claims that are expected to be reported under the EN scheme. Generally we assume that there will be a similar number of successful PPO claims but there has been a slightly higher number of potential PPO claims reported over the year which leads to a slight increase in the assumed number of claims and IBNR provision. The expected number of future non-PPO claims is similar to last year. We continue to assume that the number of non-PPO claims arising from 2020/21 will be lower owing to disruption in clinical activities due to Covid-19.	+£1.6 billion
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 increased slightly from £3.25m to £3.5m.	Impact is minimal and included in ultimate number of claims above
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High	The average cost per claim assumptions have increased slightly but haven't kept pace with the expected level of claims inflation. The assumed average cost for PPOs also depends on the HM Treasury discount rate used to place a present value on structured settlement payments. This has been accounted below.	-£4.5 billion
Claims inflation and risk and uncertainty	Long term claims inflation: derived from past settled claims	High	High	The inflation assumption for PPO damages has decreased by 0.5 pa% from the previous year.	-£4.0 billion
	Short-term claims inflation: derived from HM Treasury prescribed CPI forecasts			We are assuming that the higher short-term inflationary environment will feed through to higher short-term claims inflation.	+£2.8 billion
	Risk and uncertainty			The risk and uncertainty margin has been removed this year. Previously it was included in the claims inflation assumption.	-£2.3 billion
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium	This has decreased by 2% for PPO damages. It is unchanged for non-PPOs.	-£1.8 billion
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)	Lag range from 2.9 to 7.5 years, increasing by 0.1 years at the lower end and decreasing by 0.2 years at the higher end of the range.	+£0.7 billion
Life expectancy for PPO payments	Based on analysis of past settled PPO claims	Medium	Low	Separate assumptions are specified for EN claims (42 years) and non EN claims (37 years).	+£1.3 billion
Nominal discount rates	HM Treasury prescribed	Prescribed	High	All discount rates have been updated. Short- and medium-term rates have increased by 0.49% and 0.52% respectively. The long term and very long term rates have decreased by 1.04% and 1.33% respectively.	+£24.5 billion
ASHE 6115 (80th percentile)	Based on earnings increases relative to CPI over the longer term	Medium	High	The ASHE assumption is unchanged at CPI+1.75%.	-

Sensitivities as at 31 March 2022

The provisions are sensitive to the assumptions used to varying degrees. The following demonstrates the sensitivity to these assumptions by showing:

- Sensitivity of the total provisions (known claims, settled PPOs and IBNR) to changes in the following key assumptions:
  - HM Treasury discount rates
  - ASHE assumption
  - Claims inflation
  - Life expectancy.
- For CNST IBNR provisions, which represent the single largest element within the total provision:
  - A reasonable range for the CNST IBNR provisions based on different plausible assumptions
  - Sensitivity of the CNST known claims provision (excluding PPOs) to changes in the payment pattern
  - Sensitivity of the CNST IBNR provisions to other assumptions.

Sensitivity of provision to key assumptions

The following tables show the effect on the valuation of the total provisions if different rates and assumptions were applied for HM Treasury discount rates, the differential between CPI and annual hourly earnings (ASHE), claims inflation and life expectancy. The tables show the separate impact on:

- The **known claims** provision. This represents 24% of total provisions.
- The **settled PPO** provision. This represents 24% of total provisions. They are typically high value cases, and their long term nature mean they are highly sensitive to changes in key assumptions.
- The **IBNR** provision. This represents 52% of total provisions.

Note that the tables that follow show the sensitivity of the total provision across all schemes. However, the provision, and sensitivity of the provision, is dominated by CNST which accounts for 94% of the total provisions.

Sensitivity to HM Treasury tiered nominal discount rates

Since 2018/19, HM Treasury specifies discount rates in nominal terms. The short- and medium-term nominal discount rates have increased this year and the long term rates have both decreased. The impacts of these changes on the provisions vary by scheme, depending on the type and duration of the expected future claim payments.

Due the long term nature of the liabilities, claims that have settled, or are expected to settle as a PPO are very sensitive to changes in the HM Treasury-prescribed discount rate, especially the long term and very long term discount rates.

Discount rates term	31/03/2021 nominal rates (%pa)	31/03/2022 nominal rates (%pa)	Change
Short term (<5 years)	-0.02%	0.47%	+0.49%
Medium term (5–10 years)	0.18%	0.70%	+0.52%
Long term (10–40 years)	1.99%	0.95%	-1.04%
Very long term (over 40 years)	1.99%	0.66%	-1.33%

As shown in the following material, the relationship between the value of the total provision and the effect of changes in the discount rate is not a symmetrical one – due to the impacts of compound discounting. A reduction of 1% in the short, medium and long term discount rates will increase the total provision by 31%, but a 1% increase will reduce the provision by 20%.

Provisions	Sensitivity of total provisions to HM Treasury discount rate (£m)				
	All rates reduced by		Base assumptions	All rates increased by	
	1% pa	%		1% pa	%
Known claims	35,630	3%	**34,691**	33,816	-3%
Settled PPOs	42,493	44%	**29,572**	21,450	-27%
IBNR	90,124	40%	**64,288**	47,730	-26%
Total provisions	**168,247**	**31%**	**128,551**	**102,996**	**-20%**

The table above is based on adjusting the nominal discount rate by +1% and -1%. A change in the nominal interest rate of +1% would represent short, medium, long and very long term nominal interest rates of 1.47%, 1.70%, 1.95% and 1.66% respectively. As a result of the range of the increments analysed (and, for example, the long term nominal interest rate of 0.66%), results to the far left of the table imply a negative nominal discount rate.

For the clinical schemes, the changes in discount rates this year have had a materially large impact on the IBNR provisions. This is because a large proportion (by value) of the provisions are expected to be paid in more than ten years' time and the long term discount rates have reduced significantly.

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 1.75% higher than CPI price inflation each year.

The table that follows shows the effect on the value of the CNST provisions where this differential is varied and, as the table shows, this is a non-linear relationship. An additional +/- 0.5% difference between ASHE and CPI will either reduce the provision by 11% or increase it by 13% respectively.

Provisions	Sensitivity of total provisions to ASHE assumptions (£m)				
	All rates reduced by		Base assumptions	All rates increased by	
	0.5% pa	%		0.5% pa	%
Known claims	30,948	-11%	**34,691**	39,188	13%
Settled PPOs	25,262	-15%	**29,572**	34,875	18%
IBNR	58,827	-8%	**64,288**	70,684	10%
Total provisions	**115,037**	**-11%**	**128,551**	**144,747**	**13%**

Claims inflation

The following table shows the effect on the value of the provisions of a +/- 1% change to the claims inflation assumptions. An addition of +/- 1% to the claims inflation assumptions will reduce the value of the claims by 6% or increase it by 7% per annum. The effect of changes in the discount rate is not a symmetrical one – due to the impacts of compound discounting.

Sensitivity of provisions to claims inflation (£m)					
Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1% pa	%		1% pa	%
Known claims	33,875	-2%	**34,691**	35,543	2%
Settled PPOs	29,572	0%	**29,572**	29,572	0%
IBNR	57,044	-11%	**64,288**	72,722	13%
Total provisions	**120,491**	**-6%**	**128,551**	**137,837**	**7%**

Life expectancy

The provisions in respect of PPOs are sensitive to the assumed life expectancy of claimants.

Sensitivity of total provisions to life expectancy (£m)					
Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1% pa	%		1% pa	%
Known claims	32,614	-6%	**34,691**	36,993	7%
Settled PPOs	23,583	-20%	**29,572**	36,559	24%
IBNR	57,092	-11%	**64,288**	73,409	14%
Total provisions	**113,289**	**-12%**	**128,551**	**146,961**	**14%**

CNST Known claims sensitivity to changes in payment pattern

Payment patterns are used to express the timing of when a claim is expected to be paid, defining the lag between the claim being reported and the claim paying out. The following table shows the effect on the value of the known claims provisions of a +/- 1 year adjustment to the claims payment pattern. Lengthening the assumed payment dates by 1 year will increase the known claims provision by 3%, whilst shortening the payment pattern by 1 year reduces the provision by 2%. The effect of changes in the payment pattern is not a symmetrical one, due to the impacts of compound discounting.

Sensitivity of CNST known claims (excluding PPOs) provisions to claims payment pattern (£m)					
IBNR range	Reduced by 1 year	%	Base assumptions	Increased by 1 year	%
Known claims	32,362	-2%	**33,016**	33,974	3%

CNST IBNR: reasonable range

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 CNST IBNR 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. To illustrate this, a reasonable range is shown in the following material to demonstrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision.

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

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.

IBNR reasonable range	Value	Difference to accounts estimate
Baseline CNST IBNR	£62.0 billion	
Reasonable upper range	£81.1 billion	30.7%
Reasonable lower range	£43.8 billion	-29.4%

In prior years, the reasonable range has been derived by varying the assumptions specified for PPO claims – as these are the most material assumptions in the CNST IBNR provisions. However as per last year, the reasonable range presented this year also varies the assumptions specified to allow for Covid-19. The impact of varying the Covid-19 assumption was c+£1.4 billion /-£0.9 billion. Given the reduced uncertainty around Covid-19 and the materiality of Covid-19 provisions, we have only varied the PPO assumptions. Hence the results above 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 2016/17 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;
- The Covid-19 related claims costs.

In summary, the provision in the accounts for CNST IBNR could have been reasonably set at a value between £43.8 billion and £81.1 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 £62.0 billion.

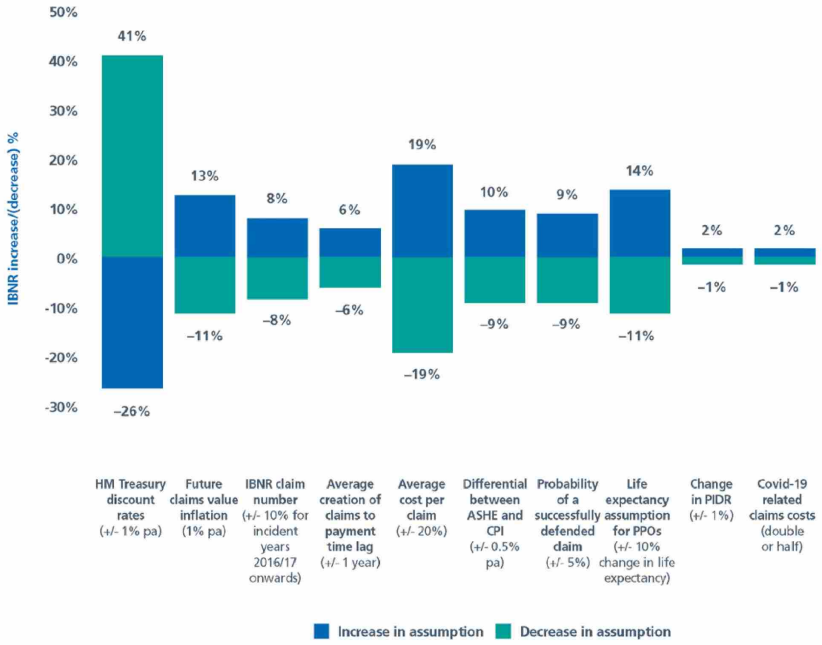
CNST IBNR: sensitivity of provision to other assumptions

The sensitivity analysis that follows 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.

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

CNST IBNR sensitivities as at 31 March 2022

Figure 32:
The value and percentage impact of variations in the key assumptions within the CNST IBNR estimate



The sensitivities around these key assumptions are explained earlier in this note.

Sensitivity to changes in the nominal discount rate

Figure 33 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, long term and very long term nominal interest rates of 1.47%, 1.70%,1.95% and 1.66% 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.

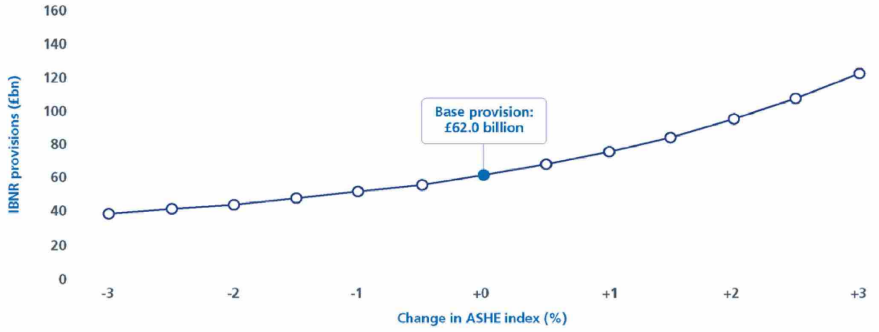
This year, there was a significant reduction in the long term and very long term discount rates prescribed by HM Treasury, which increased the provision significantly. This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than ten years' time and the long term discount rate hasn't changed since last year.

Figure 33:
Sensitivity to changes in the nominal discount rate

Sensitivity to differential between ASHE and CPI

The ASHE index, used in the calculation of damages in PPO 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 1.75% 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 34:
Sensitivity to differential between ASHE and CPI



7.4. Prior period adjustment – known claims

The known claims provision calculation (described at Note 7.2) uses the expected settlement date (ESD) from individual claims recorded in the Claims Management System (CMS) to apply inflation and discounting to reach a valuation. However, for the disclosure of the expected timing of cashflows, this has historically been based on an actuarial view of settlement patterns.

The ESD for individual known claims is based on the judgement and experience of individual claims handlers informed by advice and regular review by panel lawyers (where instructed). It is dynamic as it responds to developments on the individual claim, which will not follow a prescribed timetable. Claims handlers are required to keep this field under review and as part of their reporting requirements, panel law firms revise and recommend any changes to the ESD. This judgement is based on a range of factors pertinent to the individual claim such as whether liability issues are clear or complex, or whether the claimant's condition can be assessed easily or requires further examination and expert evidence.

While these judgements may be reasonable at individual claim level, collectively they may be optimistic compared to the number and value of claims that the legal and health systems have the capacity to settle. The appropriateness of the ESD on individual cases is audited as part of the rolling audit programme internally and also when a claims handlers' financial authority limit is considered for review or approval. The audit considers the reasonableness of the claims handlers' judgement, based on the evidence available at that point in time.

A difference between reasonable granular judgements taken together and likely cashflows is not unexpected. NHS Resolution has had in place an actuarial view of the timing of cashflows (derived from historical settlement patterns) for the provisions disclosures in the accounts.

However, the difference between these two views has diverged in 2021/22, most likely due to the impact of the Covid-19 pandemic on the legal and health operating environments. There has been an increase in the volume and value of claims with a settlement date within a shorter timeframe. An adjustment to the known claims provision (£4.6 billion across all schemes at 2021/22 HM Treasury discount rates) has been made to reflect an actuarial view of a slower settlement pattern than the claims ESDs suggest.

As a result of this review, we have concluded that this approach should have been applied to prior periods, drawing on the information that was available at the time, as it results in a better estimate of the known claims provision. The prior period financial statements have therefore been restated as required by IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors.

The closing position for the provision at 31 March 2021 has therefore been increased by £2.5 billion, and a corresponding change to the provision expense has been made. The prior year restatement has been confined to the CNST scheme on the basis the impact on the other schemes is not material (based on the work done for the 2021/22 adjustment).

The opening position for the provision at 1 April 2020 for CNST only has also been restated, resulting in an increase of £2.8 billion. Taken together with the restatement at 31 March 2021, there was a net reduction in the provision expense for the restated 2020/21 financial year of £0.3 billion.

The following table sets out the changes made to the financial statements and notes to the accounts as a result of the prior year restatement.

Statement/note	Balance in 2020-21 accounts £000	Restatement £000	Revised balance in 2020-21 accounts £000
Statement of comprehensive net expenditure			
Provision expense	488,632	(333,269)	155,363
Total operating expenditure	**524,072**	**(333,269)**	**190,803**
Net operating expenditure	(1,785,454)	(333,269)	(2,118,723)
Net expenditure for the year	(1,282,079)	(333,269)	(1,615,348)
Comprehensive net expenditure for the year	(1,282,079)	(333,269)	(1,615,348)
Statement of financial position			
Non-current liabilities: Provisions for liabilities and charges – known claims	(37,210,538)	(2,457,088)	(39,667,626)
Total non-current liabilities	(80,035,538)	(2,457,088)	(82,492,626)
Total assets less liabilities	**(82,518,780)**	**(2,457,088)**	**(84,975,868)**
Taxpayers' equity: CNST reserve	(76,299,316)	(2,457,088)	(78,756,404)
Total taxpayers' equity	**(82,518,780)**	**(2,457,088)**	**(84,975,868)**
Statement of cash flows			
Net expenditure	1,282,079	333,269	1,615,348
Increase/(decrease) in provisions	(1,268,026)	(333,269)	(1,601,295)
Statement of changes in taxpayers' equity			
Balance at 1 April 2020	(83,998,661)	(2,790,357)	(86,789,018)
Net expenditure for the year	1,282,079	333,269	1,615,348
Total recognised income and expense as at 2020/21	(82,716,582)	(2,457,088)	(85,173,670)
Balance at 31 March 2021	(82,519,780)	(2,456,088)	(84,975,868)
2. Expenditure			
Increase in provision for known claims	4,044,297	(215,635)	3,828,662
Change in the discount rate	346,335	(117,634)	228,701
Total expenditure	1,027,447	(333,269)	694,178
2.1 Analysis of the provision expense			
Prior years incidents	4,651,447	(333,269)	4,318,178
Total prior years	7,456,992	333,269	7,790,261
Total	**992,007**	**(333,269)**	**658,738**

Statement/note	Balance in 2020-21 accounts £000	Restatement £000	Revised balance in 2020-21 accounts £000
7. Provisions for liabilities and charges (prior year)			
Opening provision for known claims	84,053,266	2,790,357	86,843,623
Provided in the year	**8,731,112**	**(215,635)**	**8,515,477**
Change in discount rate	155,335	(117,634)	37,701
Movement in known claims	2,442,974	(333,269)	2,109,705
Closing provision for known claims	39,960,240	2,457,088	42,417,328
Total provision as at 31 March 2021	**82,785,240**	**2,457,088**	**85,242,328**
Analysis of expected timing of discounted cash flow: Later than five years	67,112,324	2,457,088	69,569,412
Total provision as at 31 March 2021	**82,785,240**	**2,457,088**	**85,242,328**
8. Contingent liabilities			
Contingent liability as at 31 March 2021	46,079,751	1,392,285	47,472,036

8. Contingent liabilities

Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELGP £000	ELSGP £000
Contingent liability as at 31 March 2022					
0	**446,084**	**70,798,022**	**939,759**	**0**	**670,183**
Restated[1] contingent liability as at 31 March 2021					
14,000	348,643	44,302,315	735,414	602,000	392,119

CNSGP £000	CNSC £000	DHSC non-clinical £000	CTIS £000	PES £000	LTPS £000	Total £000
Contingent liability as at 31 March 2022						
462,758	**54,077**	**108,543**	**2,000**	**9,181**	**177,015**	**73,664,622**
Restated contingent liability as at 31 March 2021						
721,938	43,000	95,522	1,000	5,819	210,267	47,472,037

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

The contingent liability represents an estimation of the additional provision NHS Resolution would recognise in its accounts if damage payments were awarded on all claims, rather than taking into account the probability of damages being paid (i.e. reflecting that typically many claims settle at nil). The known claims provision is calculated as the sum of outstanding reserve values (i.e. total claim value less payments) multiplied by the probability of damages being paid, inflated and discounted to provide a present value of the claim based on the expected settlement dates. The IBNR provisions calculation also includes probabilities of a claim being paid for each of the schemes. The contingent liability is then the difference between the total valuation of IBNR and known claims (including estimations on claims which are ultimately expected to settle at nil) and the main valuation of known claims and IBNR (which excludes claims expected to settle at nil).

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.

We have not determined a separate and additional contingent liability for Covid-19 risks because we have included explicit provisions for the material and quantifiable risks.

[1] The balance at 31 March 2021 for the CNST scheme has been increased by £1,392 million to reflect a prior period adjustment for 2020/21 in respect of the revaluation of the known claims provision. See Note 7.4 for further details of the revaluation.

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		2021/22 £000	2020/21 £000
Amounts payable			
	Within 1 year	938	1,051
	Between 1 and 5 years	4,417	3,685
	After 5 years	5,677	5,737
		11,032	**10,473**

Other leases		2021/22 £000	2020/21 £000
Amounts payable			
	Within 1 year	11	0
	Between 1 and 5 years	26	0
	After 5 years	0	0
		37	**0**

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 (NHSE) [which legally merged with NHS Improvement as a result of the Health and Care Act 2022]
- NHS Property Services
- NHS Trust Development Authority (now part of NHSE/I)
- Public Health England
- NHS Counter Fraud Authority

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out in the following material. The remuneration for executive and non-executive directors for the roles they perform for NHS Resolution is disclosed in the Remuneration and staff report on page 84.

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[1]	Party	Nature of relationship	Payments to related organisation (£000)	Receipts from related organisation (£000)	Amount owed to related organisation (£000)	Amount due from related organisation (£000)
Sir Sam Everington OBE Associate Non-Executive Member	North East London Clinical Commissioning Group	Deputy Clinical Chair	-	38	-	-
	Tower Hamlets CCG (replaced by North East London CCG)	Clinical Chair	-	1	-	1
DHSC[1]	Leeds Teaching Hospital NHS Trust	Related party to DHSC	101	42,643	-	40
DHSC[1]	Lincolnshire Partnership NHS Foundation Trust	Related party to DHSC	-	919	-	2

[1] The Department of Health and Social Care (DHSC) have provided us with a list of individuals and entities which are deemed to be related parties of theirs for this financial year. These entities are deemed to related parties of NHS Resolution for the purposes of IAS 24 Related Party Disclosures. In addition, an irrecoverable debt of £30,518, for amounts charged to The Ministry of Defence (also a related party of DHSC) in a previous financial year, was written off at 31 March 2022.

11. Financial instruments

IFRS 7 Financial Instruments: Disclosures requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Special Health Authorities are financed, NHS Resolution is not exposed to the degree of financial risk faced by business entities. In addition, financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. NHS Resolution has limited powers to borrow or invest surplus funds. Financial assets and liabilities are generated by day-to-day operational activities, rather than being held to changes within the risks facing NHS Resolution in undertaking its activities.

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

As the majority of NHS Resolution's income comes from contracts with other NHS bodies, NHS Resolution has low exposure to credit risk. The maximum exposures are in receivables from customers, as disclosed in Note 4: Receivables.

12. Events after the reporting period

These financial statements were authorised for issue on the date that the Comptroller and Auditor General certified the accounts.

Reference

Glossary

An online glossary is now available to support this document at
https://resolution.nhs.uk/glossary/?fwp_glossary_topic=annual-report-and-accounts

Appendix

Our indemnity schemes

The bulk of our workload is handling negligence claims arising from NHS healthcare in England. We manage eight clinical negligence schemes and four non-clinical schemes.

The eight 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 the Department of Health and Social Care (DHSC) and covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.
- **Ex-Regional Health Authority Scheme** (Ex-RHA) 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) which covered interim arrangements relating to existing liabilities agreed with a medical defence organisation (MDO) under which NHS Resolution carried out the Secretary of State's oversight and governance responsibilities, and having completed this work this scheme is now closed. The legal and operational responsibility of handling claims within scope of those interim arrangements remained with the MDO until 31 March 2021 and now operational responsibility of handling claims has transferred to NHS Resolution.
- **Existing Liabilities Scheme for General Practice** (ELSGP) which covers claims for historical NHS clinical negligence and other tortious incidents of GP members of participating medical defence organisations occurring at any time before 1 April 2019. This scheme covered members of Medical and Dental Defence Union of Scotland from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.
- **Clinical Negligence Scheme for Coronavirus** (CNSC), a scheme launched on 3 April 2020 to meet clinical liabilities arising from certain special healthcare arrangements that were put in place in response to the coronavirus pandemic where no other indemnity or insurance arrangements 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 two other non-clinical schemes:

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

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