NHS Resolution

Annual report and accounts
2020/21

HC **387**

Advise / Resolve / Learn

NHS Resolution
Annual report and accounts
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Chair's welcome

This has been a very strong year for NHS Resolution. We have managed our workload despite the strictures of the coronavirus pandemic, we have supported the response to the pandemic, and we have stayed faithful to our strategic plan. I extend my thanks to our staff, and those they work with across the NHS, for doing so much in such challenging circumstances.

We established two Covid-19 specific indemnity schemes that have been fundamental in allowing the health system to address the challenges posed by the pandemic. At the time of writing we have forecast Covid-19 related claims only in the broadest terms – a £0.5 billion increase to our estimate of future claims. It is too soon to expect any such claims to have been made by now.

During the year, we agreed a protocol with claimant lawyers' organisations to assist in dealing with claims more generally. We also switched to remote working without diminishing the breadth or impact of our resolution services.

The recent addition to our portfolio of primary care is the main factor behind the year on year increase in the number of clinical negligence claims that we handled.

The amount we have paid out in resolving claims is down year on year by £120 million. This is due to an improvement in underlying trends, most notably lower claims inflation (the amount by which the cost of claims is expected to go up over time), and to the fact that - understandably - the process of investigating and resolving claims slowed somewhat during the pandemic.

We have tried ever harder to settle claims without going to court. We continue to work with those who act for claimants to promote other ways of resolving disputes, such as mediation, and we have resolved a greater number of claims without going to court than ever before. We resolved a greater proportion of claims without formal proceedings (74.7%, compared to 71.5% in 2019/20). We have appointed a safety and learning expert to work in the mediation space, to make sure we capture the insights those claims reveal, for the benefit of the health system as a whole.

However, although we delivered some positive financial results in 2020/21, the evidence suggests that the total cost of resolving claims will continue to rise, largely due to factors beyond our control. We continue to contribute to the work underway across government to address the rising costs of clinical negligence.

2021/22 is the final year of our five year strategic plan. We are working now on proposing a new strategy, building on our experience and the successes achieved to date.

This report covers a year in which I joined NHS Resolution partway through. I have found the organisation to be high-performing, professional and ambitious. This is the achievement not only of our staff and the executive team that leads them but also of the board and most notably my predecessor as chair, whose drive and vision are now bearing fruit. I am grateful to them all for making a newcomer feel welcome.

Martin Thomas / Chair

Chief Executive's report

The main feature of 2020/21 for NHS Resolution, was, as for everyone (and in particular our health service partners), the Covid-19 pandemic and all that came with it. Throughout the year, the demands on our NHS colleagues have been unimaginable and we pay tribute to their incredible efforts to keep us all safe in such an extraordinary year.

NHS Resolution moved quickly to home working in advance of the first lockdown in March 2020 and we started the year with the twin aims of looking after our staff and doing all that we could to help the NHS in its response. At the same time we had a significant change programme already underway and a busy operation gearing up to respond to the transfer of several thousand general practice claims arising from new schemes. It remained important to continue in our efforts to deliver what we had set out to do before the pandemic took hold. Our annual report therefore sets out how we performed against objectives and targets we set for ourselves pre-pandemic but also describes how Covid-19 inevitably disrupted those plans and brought new challenges, which we responded to during the year.

Throughout, our staff and those we work with have responded brilliantly, doing their utmost to deliver the best possible service to the NHS and its staff and patients as well as to support each other through the various challenges that we experienced during the year.

Helen Vernon / Chief Executive

As the new healthcare arrangements for the pandemic response started to be put into place, indemnity quickly became a priority for NHS Resolution. We had already recently launched new schemes for general practice with a new scheme, the Clinical Negligence Scheme for General Practice, starting to mature and historic claims from two medical defence organisations about to come under our management. This extension of NHS Resolution's role into primary care meant that our existing indemnity schemes already covered the majority of new healthcare arrangements, such as returning staff and vaccination delivery. Where gaps existed however, we worked rapidly with the Department for Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I) and others to put in place solutions, starting with the launch of the Clinical Negligence Scheme for Coronavirus (CNSC) which we supplemented later in the year with the Coronavirus Temporary Indemnity Scheme (CTIS) as different requirements, such as designated care settings, emerged.

We established a process early on to assess the claims risks attached both to these new indemnities and to changes to healthcare arising from the pandemic. Very few claims associated with the pandemic were lodged in the year and our assumptions on the prospect of future claims are described in this report. The effect of the pandemic on our accounts is assessed as relatively limited as the vast majority of the liability continues to be driven by a small number of high value obstetric claims.

A far greater impact is seen in our expenditure for the year which is significantly lower than expected, generating an underspend on the clinical schemes of £430 million (16%) against our budget, which was set in the summer of 2019, before the pandemic. This is a reflection of the impact of the pandemic on the NHS, law firms and the court system. Clinical and other NHS staff who would normally support the investigation of a claim were understandably diverted to the frontline response, a number of lawyers acting for claimants furloughed staff, and the usual operation of the court system was constrained.

A welcome development however was greater cooperation between the parties. Our efforts to keep cases out of court gained more traction as there was an increased willingness to resolve matters without formal court proceedings and to try new approaches such as remote mediations. As a result, there has been good performance against most of our performance targets, despite the challenges.

Whilst we report an underspend overall, NHS legal costs and our own administrative costs have increased. This is as expected and planned for due to our taking on new indemnity schemes for general practice, including taking over management of several thousand additional historic claims. In addition, we have accelerated reporting of several hundred obstetric claims under our Early Notification Scheme. This new and additional work required a front loading of resource. These are costs which either would have been incurred elsewhere or incurred later in the process.

A more promising feature of the underspend, which is also reflected in a reduction in the provision from £84.1 billion to £82.8 billion is some favourable trends we have observed in our claims experience. The number of expected incoming claims is lower than expected and claims inflation has also reduced. Whilst this is good news, the cost of clinical negligence is expected to continue to rise without wider reform – we are still incurring around £8 billion annually for the cost of clinical negligence. We continue to contribute to the work underway across government to address the rising costs of clinical negligence.

Looking forward to 2021/22 we hope to be able to capitalise on some of the more positive features of new ways of delivering our services during the pandemic. Despite successive lockdowns we were able to relocate to a new office in Canary Wharf, and after consulting with our staff, we have reduced our original space requirements to reflect a hybrid of remote and office based working. At the same time, we have grown our presence in Leeds and plan to move to a more regionally focused workforce, aligned with wider changes to the way in which healthcare is delivered.

The call on our Practitioner Performance Advice service over the pandemic has highlighted the need for our expertise to support healthcare staff when performance issues arise. We have, of necessity, successfully moved to remote interventions such as virtual assessments and we have delivered educational events online. Clearly this has benefits in releasing valuable clinician time and making content more accessible which we hope to keep. Similarly, in Primary Care Appeals, we have successfully delivered virtual, on-line hearings for pharmacy market entry appeals and moved to a new technology supported operating model. This has brought some cases to resolution sooner than previously anticipated and reduced the burden on NHSE/I local teams to secure venues for hearings. Moving swiftly to digital channels for all of our services, where feasible, will continue to be a priority.

Finally, there is learning from Covid-19 itself. We paused or adapted a number of initiatives over the course of the year to minimise the burden on healthcare staff, working with partners such as the Healthcare Safety Investigation Branch (HSIB) and the royal colleges to streamline reporting. We remain committed to sharing any information we have on the causes of what goes wrong in the NHS, as well as highlighting and incentivising best practice. We introduced learning from the pandemic into our Maternity Incentive Scheme on relaunch and our analysis of general practice claims will, we anticipate, bring a unique lens to issues arising from the movement of patients between primary and secondary care. This is the first time this information has been brought into one place and with the advent of rapidly changing models for healthcare such as remote consultations, is all the more likely to yield some early lessons. The progress we are making on data analytics which we have described in this report, together with the ongoing success of our clinical fellowship programme and the appointment of an academic partner offers great potential for the year ahead.

During the year, despite working entirely remotely, we have recruited many new staff and I would like to take this opportunity to welcome them to NHS Resolution and to thank all of our staff, our external contractors and our partners in health and justice for their hard work and commitment to our shared objectives over such a difficult time. We also said goodbye to our Chair Ian Dilks in 2020 and welcomed our new Chair, Martin Thomas, who joined us on 1st January 2021.We are grateful to Ian for his leadership of NHS Resolution for the past six years and look forward to working with Martin as we start to formulate our strategy for 2022 and beyond.

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 four strategic aims outlined in our business plan for 2020/21.
For more detailed information about how we have delivered against our aims, please refer to the *Performance analysis* section (from page 31).

It has been an extraordinary year for everyone, especially those involved in the provision of healthcare. Our focus has been on supporting the system's response to the Covid-19 pandemic, for example ensuring that indemnity was not a barrier to that response, while continuing to deliver our core services. At the beginning of the pandemic we invoked our business continuity response to move swiftly to a completely remote operation. We reviewed our processes, policies and procedures to enable our staff, who were often dealing with personal challenges at the same time, to work remotely from home. We have increased collaboration with others, including claimant representatives, to deliver our core services. We have adapted our priorities to reflect changing demands and capacity, while continuing to focus on the health and wellbeing of our staff and to reduce the burden on frontline staff in the NHS.

In addition to delivering against our existing portfolio of work, we were also called upon to undertake new strands of work to help the NHS fight the pandemic.

Alongside this, throughout the year we have maintained a focus on our core aims of:

- reducing harm;
- improving the response to harm and thus reducing the conversion of harm to claim[1]; and
- dealing with claims, resolving appeals and providing advice as effectively and cost efficiently as possible.

[1] For example by improving the patient experience and reducing claims driven by a desire for greater transparency or more sensitive, empathetic handling.

Figure 1: Who we are and what we do

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

Strategic aims

Resolution

Resolve concerns and disputes fairly.

Intelligence

Provide analysis and expert knowledge to drive improvement.

Intervention

Deliver interventions that improve safety and save money.

Fit-for-purpose

Develop people, relationships and infrastructure.

Our services

Claims Management

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

Primary Care Appeals

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

Practitioner Performance Advice

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

Safety and Learning

Supports the NHS to better understand their claims risk profiles, to target their safety activity while sharing learning across the system.

Enabled by

- Finance and Corporate Planning
- Digital, Data and Technology
- Membership and Stakeholder Engagement
- Policy, Strategy and Transformation

Our values

- Professional
- Expert
- Ethical
- Respectful

Understanding our indemnity schemes

The bulk of our workload is handling negligence claims arising from NHS healthcare in England.

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-RHAS) which is a relatively small scheme, centrally funded by DHSC, covering clinical negligence claims against former Regional Health Authorities abolished in 1996.
- **DHSC clinical** which covers clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies, these are centrally funded by DHSC.
- **Clinical Negligence Scheme for General Practice** (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.
- **Existing Liabilities for General Practice** (ELGP): the interim arrangements relating to existing liabilities agreed with a medical defence organisation (MDO) under which NHS Resolution carries out the Secretary of State's oversight and governance responsibilities. This is where, the legal and operational responsibility of handling claims within scope of those interim arrangements remains with the MDO, specifically the Medical Protection Society, until 31 March 2021.
- **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 new scheme launched on 3 April 2020 to meet clinical negligence liabilities arising from NHS services provided in response to the coronavirus pandemic where no other indemnity or insurance arrangements are in place already to cover such liabilities.

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

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

In addition, we manage **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), a new, but short-term, scheme designed to manage indemnity arrangements for activities carried out in response to the pandemic, such as Designated Settings Indemnity Support for care homes.

Table 1: The year in numbers

	2019/20 (£ million	2019/20 (£ million)	Change (£ million)	%
Funding for clinical schemes				
Income from members	1,951.3	2,243.7	292.4	15.0%
Funding from DHSC (budget)	487.5	418.9	(68.6)	-14.1%
Total funding	**2,438.8**	**2,662.6**	**223.8**	**9.2%**
Payments in respect of clinical schemes				
Damages payments to claimants – excluding PIDR	1,413.4	1,367.0	(46.4)	-3.3%
Damages payments to claimants – PIDR	269.8	242.8	(27)	-10.0%
Claimant legal costs	497.5	448.1	(49.4)	-9.9%
NHS legal costs	143.5	151.4	7.9	5.5%
Total payments	**2,324.2**	**2,209.3**	**(114.9)**	**-4.9%**
Funding for non-clinical schemes				
Income from members	52.1	65.0	12.9	24.8%
Funding from DHSC (budget)	7.0	5.0	(2.0)	-28.6%
Total funding	**59.1**	**70.0**	**10.9**	**18.4%**
Payments in respect of clinical schemes				
Damages payments to claimants – excluding PIDR[1]	28.5	26.6	(1.9)	-6.7%
Damages payments to claimants – PIDR	1.5	1.9	0.4	26.7%
Claimant legal costs	18.1	16.3	(1.8)	-9.9%
NHS legal costs	7.4	5.9	(1.5)	-20.3%
Total payments	**55.5**	**50.7**	**(4.8)**	**-8.6%**
NHS Resolution administration of schemes				
Clinical	19.4	24.2	4.8	24.7%
Non-clinical	4.5	5.1	0.6	13.3%
NHS Resolution other activities				
Income	1.0	0.8	(0.2)	-20.0%
Expenditure	6.9	6.1	(0.8)	-11.6%
Staff numbers	328	400	72	22.0%
Provisions cost of claims				
Claims provisions[2]	3,057	992	(2,065.0)	-67.5%
Provisions for claims	**84,053**	**82,785**	**(1,268.0)**	**-1.5%**

[1] PIDR is the personal injury discount rate and is used by the courts to place a current value on claims settlements where there is an element of future loss.

[2] 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 the change in provision for 'incurred but not reported' (IBNR) claims due to changes in financial assumptions.

Performance overview

This section provides some of the main headlines concerning our activities during the financial year and greater detail can be found in the main *Performance analysis* section from page 31.

Financial activity

The *Finance report* on page 73 covers the year-end provisions and the in-year financial performance in more detail but the key points are as follows.

Liabilities arising from claims under all of our indemnity schemes at the end of this financial year have decreased by £1.3 billion, from £84.1 billion to £82.8 billion. This is the value of liabilities arising from incidents that occurred up to and including 31 March 2021, in relation to both claims received and claims that we are likely to receive. The decrease is due (primarily in relation to CNST, by far our largest scheme) to our assumptions that there will be a lower number of high value claims, a lower rate of claims inflation, and a lower average cost of claims, compared to 2019/20. These assumptions are based on observations of long-term trends.

In 2020/21 the effect of the Covid-19 pandemic on the value of the provision for liabilities arising is limited because:

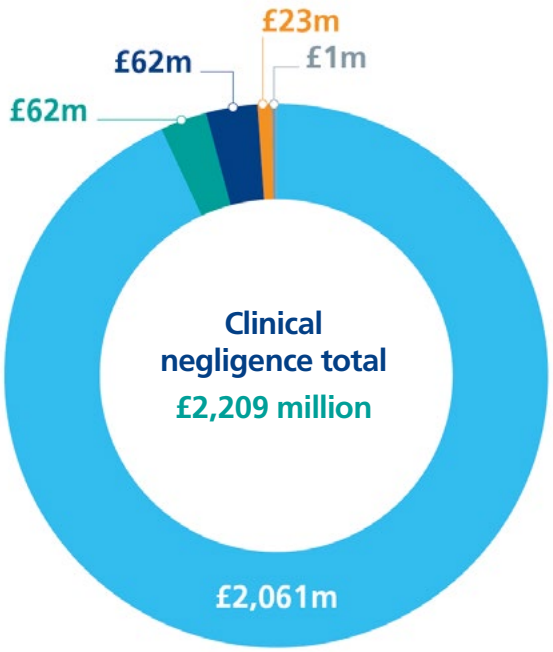
- The impact of Covid-19 is largely on the provision of healthcare in 2020/21 whereas some 90% of the provision relates to incidents which occurred before 2020/21; and
- Some 65% of the provision relates to maternity claims and the evidence available to date does not suggest that the risk of negligence from maternity activity in 2020/21 differs from previous years.

Covid-19 affects the provision in relation to the 2020/21 incident year in two counteracting ways: expected lower claim numbers from lower levels of clinical activity, particularly for non maternity activity, which we estimate at £0.4 billion, offset by new potential sources of claims, estimated at £0.9 billion. The net effect of these combined factors is a £0.5 billion increase to the IBNR[1] provision. A further allowance for general risk and uncertainty has been included in the claims inflation assumption to cover at present unquantifiable claims risk in relation to the pandemic, as well as other areas of uncertainty.

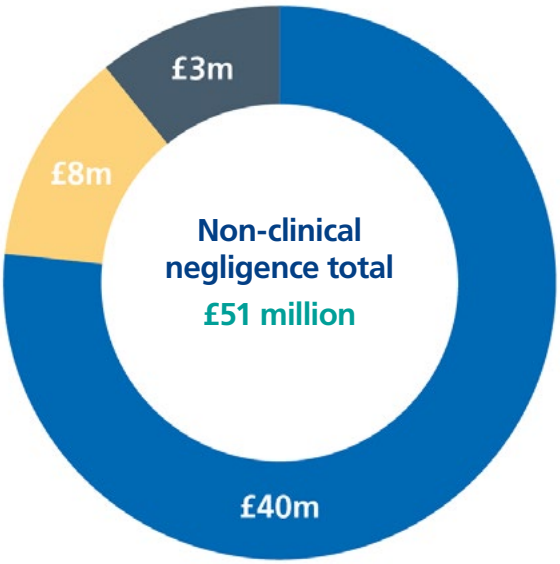
The cost of settling claims in 2020/21 reduced across all schemes by £120 million, to £2.26 billion. Expenditure on administration of all of our activities increased by £4.6 million (15%) to £35.4 million. The volume of claims taken on in respect of relatively new general practice indemnity schemes increased from 401 to 1,813, and we were preparing to take on several hundred more from the Medical Protection Society from 1 April 2021. A significant element of administration costs growth has been driven by this.

[1] 'Incurred but not reported' (IBNR) claims are an estimate of claims that we are likely to receive in the future from those incidents which have occurred but have yet to be reported to us.

Figure 2: The value of payments (damages, claimant and NHS legal costs) across all indemnity schemes for 2020/21 demonstrating the relative size of the schemes



Clinical negligence	Value
Clinical Negligence Scheme for Trusts	£2,061m
DHSC clinical	£62m
General practice indemnity	£62m
Existing Liabilities Scheme	£23m
Ex-Regional Health Authority Scheme	£1m



Non-clinical negligence	Value
Liabilities to Third Parties Scheme	£40m
DHSC non-clinical	£8m
Property Expenses Scheme	£3m

Claims, appeals and advice activity

Claims Management

Received claims

In 2020/21 we **received** 12,629 clinical negligence claims and reported incidents, compared to 11,678 in 2019/20, an increase of 951 (7.5%). The total received includes 973 new claims and incidents for the relatively new CNSGP, 840 against the ELSGP and seven against the new Clinical Negligence Scheme for Coronavirus. We saw a decrease in clinical claims overall on our other established clinical schemes.

We also recognised 192 Early Notification claims during the year, an increase of 140 from 2019/20.

Very few claims or incident reports that we received in-year can be directly attributable to healthcare provided in response to the pandemic. We expect any claims arising from the pandemic to be made in future years, given that the average time lag between incident and notification of a (non-maternity) claim is 3.6 years. The pandemic is likely to have contributed to a drop in claims reported by our members and scheme beneficiaries or asserted by claimants' solicitors due to the operational challenges faced over the year and reduced activity in some clinical areas.

The number of new non-clinical claims, typically employers' and public liability claims, reduced from 3,744 received in 2019/20 to 2,759 in 2020/21, a decrease of 985 (26.3%). This can be attributed to the effects of the pandemic. This is likely to be related to the operational challenges during the period that the legal industry faced, and continues to face. A likely additional factor was the reduced access for the public to hospital premises.

Settled claims

We continued to settle claims wherever possible. We **settled**[1] 15,674 clinical and non-clinical claims in 2020/21, 124 more than in 2019/20 when we settled 15,550 claims. Of these, 11,704 (74.7%) claims were settled without formal court proceedings[2], 3,914 (25%) with proceedings but without trial and 56 (0.3%) at trial. This compares to 2019/20 when 71.5% settled without proceedings, 27.9% with proceedings and 0.6% at trial. The increase in the number of claims settling without court proceedings is due to our efforts to avoid the need for court proceedings, which will continue beyond the pandemic. A spirit of co-operation in our work with claimant solicitors in response to the pandemic will also have contributed.

Of the 15,674 settled claims in 2020/21, 6,872 (43.8%) settled without damages being paid. This compares to 6,698 (43.1%) out of 15,500 in 2019/20, an increase of 174 (0.7%). Figure 16 on page 55 provides a full breakdown of this data.

Closed claims

In 2020/21 we **closed** 15,397 claims, compared to 16,378 in 2019/20, a decrease of 981 (6.0%). The decrease is due to the operational challenges of the pandemic. Our focus remained on settling live cases, by paying damages to harmed individuals where appropriate, rather than closing already settled claims.

The number of cases closed with damages being paid was 8,411 in 2020/21, a decrease of 1,166 (12.2%) from the 9,577 cases in 2019/20 The number of cases closed without damages being paid was 6,986 in 2020/21, an increase of 185 (2.7%) from the 6,801 in 2019/20.

The reason for the increase in closed claims without damages paid is directly related to the change in our clinical claims portfolio, following the establishment of CNSGP and ELSGP. In 2019/20 we only closed 204 general practice indemnity cases with no damages payable (1.7% of the total volume of closed cases), compared to 1,122 in 2020/21 (9.63% of the total volume of closed cases). A proportion of these cases will be where a member has notified us of an incident, we have carried out an initial investigation and provided advice, and subsequently no further involvement is required and the case is closed following our standard operating procedures.

[1] Settled claims include claims that have been agreed with ongoing periodical payment orders and claims where damages have been agreed or successfully defended, and costs have yet to be agreed. This is a different cohort to closed claims, which do not include claims settled with periodical payment orders which involve payments being made over the life of the claimant.

[2] Proceedings are formal actions taken in a court to resolve a dispute.

Practitioner Performance Advice

We continued to provide an advice service to healthcare employers on the effective local management and resolution of performance concerns about individual doctors, dentists and pharmacists. The service includes assessments and interventions where merited. Over the course of the year we received 804 new requests for advice compared to 775 in the previous financial year. These cases reflected a range of issues relating to individual performance, including: clinical capability, performance, workplace behaviour and conduct. Activity on existing cases remains high, and we continue to support the management and resolution of more complex cases.

As in previous years, doctors accounted for the majority of new cases (58%), with just over half (52%) of those cases involving clinicians at consultant grade or GP principal level. Practitioner Performance Advice has continued to include healthcare organisations based in other regions, including Wales, Northern Ireland, Jersey, Gibraltar, Guernsey and the Isle of Man, where we have provided the full scope of our specialist advice and interventions. Our operation of the Healthcare Professional Alert Notice scheme continues under the revised directions issued in December 2019.

Primary Care Appeals

Pharmacy appeals

As has been the trend over recent years, the number of appeals we received under the Pharmacy Regulations[1] was lower than those we received in the previous year, with 85 compared to 162 in the last financial year. Changes to pharmacy funding have reduced applications for new contracts. In addition, pharmacies no longer receive upfront payments for some services. This eliminates the need for clawback[2] when those services are not provided and therefore also eliminates appeals against the clawback. We resolved appeals on market entry applications from pharmacists to join the Pharmaceutical List, on applications to change the premises listing and on the issuing of breach or remedial notices. More detail about the performance of our Primary Care Appeals service is available in our Factsheet 6[3] publication. We have also made case stories available at https://resolution.nhs.uk/wp-content/uploads/2021/04/2020-21-Case-stories.pdf. There were no judicial challenges to any pharmacy-related decisions. We continued to meet key performance indicators despite increasing complexity in cases.

NHS dispute resolution procedure

In late December 2020 through to early January 2021, we were contacted by 60 dental contractors regarding action taken by NHS England and NHS Improvement (NHSE/I) for a failure to deliver the expected level of units of dental activity during the year 2019/20. It is mandatory that contractors and NHSE/I make reasonable efforts to communicate and co-operate with each other to resolve contract disputes. This should happen before referring the dispute to us or before starting court proceedings. In all these cases local resolution had not been attempted and fully exhausted. Therefore we declined jurisdiction and signposted the aggrieved contractors to the correct procedure. Disputes relating to GPs and their contracts were again the main source of resolved applications (21 compared with 46 in 2019/20). There were 8 dental adjudications compared with 23 in 2019/20.

[1] In accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 and the National Health Service Litigation Authority (Pharmaceutical Remuneration – Overpayments) (England) Directions 2018.

[2] Clawback – the act of retrieving money already paid out.

[3] https://resolution.nhs.uk/?s=factsheet+6

A summary of our activities

This section highlights key activities undertaken by NHS Resolution during 2020/21 under the five priorities identified in our business plan for 2020/21[1]. The work is described in greater detail in the *Performance analysis* section (from page 31). As mentioned, we have added a new, previously unidentified priority: 'Responding to Covid-19'.

Priority 1 Responding to Covid-19

From the beginning of February 2020 we implemented our business continuity plans, and our staff moved almost exclusively to remote working. In some circumstances our staff returned to clinical practice to help the NHS respond to the increasing demands of the pandemic.

Our aim has been to:

- deliver our services with minimal disruption;
- ensure that indemnity was not a barrier to novel arrangements needed to deliver vital care; and
- look after the wellbeing of our staff.

We ensured our existing schemes helped the NHS to rise to the challenge presented by the pandemic. Where gaps were identified, we introduced new indemnity schemes, for example for the Covid-19 vaccination programme, for NHS Test and Trace, and for independent sector healthcare workers providing NHS care. We agreed a groundbreaking Covid-19 protocol with claimant representative bodies to better manage claims during the pandemic. We continued to review our business continuity measures. This was to ensure we remained fit for our purpose and moved to deliver services virtually where possible. Wherever possible communications leaving our organisation were restricted to essential messages to avoid diverting time and resource unnecessarily. We also bolstered our internal communications capabilities to provide additional support to our staff following the abrupt move to homeworking.

[1] https://resolution.nhs.uk/wp-content/uploads/2020/07/NHS-Resolution-Business-plan-2020_21.pdf

Priority 2 Going further to deliver early resolution

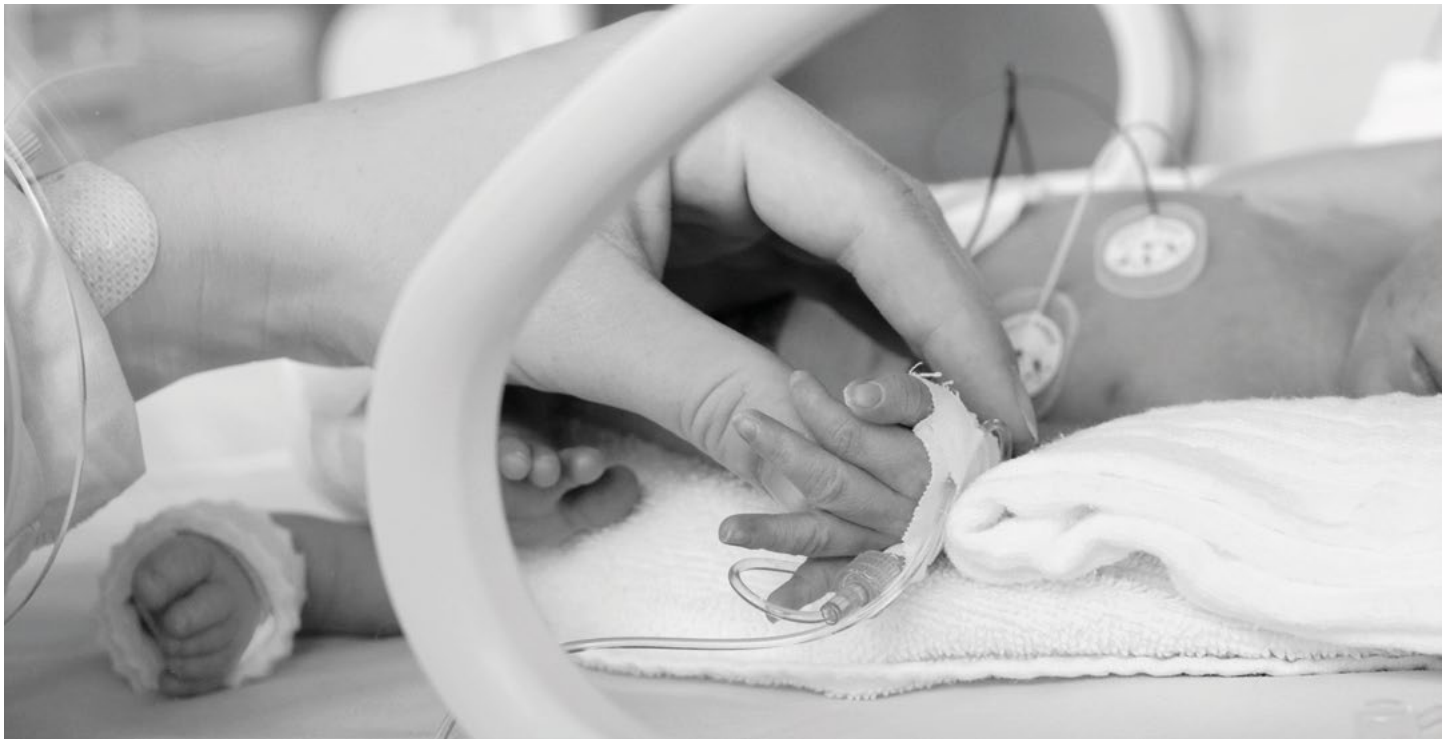
What we wanted to do and why:
"Delivering early resolution is central to our strategy and continues to be a key focus in 2020/21. We will provide cost effective resolution, concluding cases early and evaluating and broadening our range of dispute resolution services. We also want to extend the reach of our services into the organisations we indemnify and support the resolution of concerns and disputes through our Practitioner Performance Advice service. As our EN Scheme for maternity starts to mature, we will consider how to best compensate patients fairly and revisit the criteria for entry into the scheme."
NHS Resolution Business plan 2020/21.

To resolve claims fairly, reduce the time to resolution, curtail legal costs and reduce the need for formal processes, we continued to test a wide range of innovative dispute resolution techniques. We expanded the use of 'resolution meetings' and 'stock-take' processes. Both approaches seek to resolve cases fairly and efficiently without the need for formal proceedings.

We settled the majority of claims in-year without formal proceedings (74.7%, compared to 71.5% in 2019/20). These were settled via correspondence, at settlement meetings or via a form of dispute resolution, including formal mediation. Online mediation has proven to be effective. In 2020/21 of 299 mediated cases, 77% of cases settled on the day mediation took place or within 28 days of the mediation.

Our Early Notification Scheme sped up the identification of high value cases that might result in a claim. We developed processes to reduce the burden of reporting on frontline staff. For the Early Notification Scheme we updated guidance on reporting requirements and outlined key improvements to streamline the investigation process, which were implemented from 1 April 2021. Through the scheme, families with a baby affected by a severe hypoxic brain injury attributable to substandard care are better placed to receive answers and access to compensation sooner and without having to pursue court proceedings.

To develop our Practitioner Performance Advice offer we successfully introduced new assessment models in relation to clinical performance and behaviour. We also introduced a new approach to the local assessment of clinical performance. We piloted a team review service to help organisations understand and manage behavioural and relationship issues affecting the function of the team.



Priority 3 Consolidating and communicating our offer to primary care

What we wanted to do and why:
"We will continue to focus our attention on managing claims for primary care in 2020/21. We will deliver an excellent service to our primary care partners and their patients across all of our business areas whether that be Primary Care Appeals, Practitioner Performance Advice or Claims Management. We will work with others to ensure that our primary care offer supports the wider workforce objectives set out in the NHS Long Term Plan and the NHS People Plan" **NHS Resolution Business plan 2020/21**.

We took responsibility for the administration of a state indemnity scheme for general practice through the introduction of our Clinical Negligence Scheme for General Practice (CNSGP) on 1 April 2019. Our role in primary care continued to evolve in 2020/21. We increased our staff numbers in order to embed fully the Existing Liabilities Scheme for General Practice (ELSGP). This provides indemnity for the historical liabilities of current and former general practice members of two medical defence organisations who had entered into contractual arrangements with the Secretary of State in respect of their members' historical liabilities. From 6 April 2020, indemnity for liabilities relating to incidents prior to 1 April 2019 of members of the Medical and Dental Defence Union of Scotland (MDDUS) was provided under ELSGP by Government to be administered by NHS Resolution. Preparations were also undertaken during the year to ensure that from 1 April 2021, existing and former general practice members of the Medical Protection Society (MPS) in England were covered under the ELSGP.

During the course of the year we undertook a review of the first year of claims received by our CNSGP[1].

We continue to provide services to primary care via our Practitioner Performance Advice and Primary Care Appeals services, closely working with key stakeholders such as NHSE/I. Expanding our role further supports our work in secondary care. This is demonstrated by our work to explore diabetes claims, where we have been able to map the transfer of care between primary and secondary healthcare settings. This made it far easier to investigate both the specific episode of (secondary) care addressed by the claim, and the care that preceded it[2].

[1,2] Reports relating to CNSGP, ELSGP, 'never events' (incidents that should never occur), assaults on staff, claims arising from learning disabilities and thematic reviews of diabetes-related and emergency department claims will be published in 2021

Priority 4 Working with our partners to strengthen collaboration and share our insight

What we wanted to do and why:
"In order to ensure what we share for learning has the greatest impact, we must work with and through others. We will strengthen our collaboration with partner organisations to enable improvements in care, and act quickly on emerging concerns using the insights we are able to share. To make the most of the platform of membership of our indemnity schemes, we will continue our work to convene experts, providers and users of healthcare services to consider what works well in addressing the causes of harm."
NHS Resolution Business plan 2020/21.

Our work in the field of improving patient safety, in partnership with others, focuses on two key areas: prevention of harm and improving the response to harm.

We have worked with a range of organisations, such as the royal colleges, Getting It Right First Time (GIRFT) and other NHS arm's length bodies, to derive learning and make recommendations from thematic reviews of emergency department and diabetes related claims, 'never events', assaults on staff and claims arising from learning disabilities.

We have commissioned our first academic partner, a consortium of London Southbank University and Staffordshire University. They will provide a range of services to support learning from harm and to help develop our Faculty of Learning, which is a repository of themed educational resources.

We have worked closely with the Healthcare Safety Investigation Branch (HSIB) to improve the response to harm via our Early Notification Scheme. Through the support of the eight members of a Collaborative Advisory Group[1], we have used our collective insights to support providers in improving standards of care through our Maternity Incentive Scheme. Trusts that demonstrated they achieved all of the ten safety actions within the scheme recovered their contribution to the CNST maternity incentive fund plus a share of any unallocated funds. Trusts that did not meet the safety actions did not recover their contribution, but were given the opportunity to apply for a smaller payment to help them to make progress against the actions they had not achieved.

Our Practitioner Performance Advice service released a report looking at the pattern of concerns raised by healthcare organisations and another about cases raised during the pandemic.

Priority 5 Undertaking operational transformation to restructure our claims service and developing new ways of working to enable a London office move to a government hub

What we wanted to do and why:
"In order to drive further improvements in our operations we will need to restructure the way we deliver our services. In our claims management service, we will revisit our operating model in order to integrate the new general practice indemnity scheme, CNSGP, and deliver operational improvement across the board. This will benefit all of our members by targeting both the time and cost associated with managing claims and improving the experience for patients and healthcare staff. Moving to a regional approach will mean that we can work hand in hand with local health systems. In addition we will work with our staff on new ways of working given a planned London office move to a government hub in early 2021 and the expansion of our Leeds base."
NHS Resolution Business plan 2020/21.

Significant preparations have been undertaken to develop our Claims Management service under our Claims Evolution Programme.

Covid-19 had a huge impact on our ways of working. It provided an opportunity to test systems and processes with a remote workforce, in line with reduced desk space in our new London office. In March 2021 we officially moved our London office to the government hub at 10 South Colonnade, Canary Wharf – in line with the government estates strategy – at a time when the vast majority of our staff remained working from home. We anticipate that this experience, coupled with our office move, will ultimately result in more of our workforce working remotely.

Our internal Ways of Working programme sought to ensure our work environment remains inspiring, innovative and productive, and supported by reliable technology. We have used Our internal Ways of Working programme sought to ensure our work environment remains inspiring, innovative and productive, and supported by reliable technology. We have used iterative co-design to help us to develop and communicate smarter work styles with staff.

[1] Collaborative Advisory Group membership is representatives from the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, MBRRACE-UK, NHSE/I, the Care Quality Commission, NHS Digital and HSIB.

Priority 6

Setting our future course and starting work to transform our business intelligence capability and systems architecture

What we wanted to do and why:
"We are improving our business intelligence capabilities in order to: contribute to reducing harm to patients by turning the data we hold into useful information which can be shared and have impact externally; drive our operational efficiency, and enhance the level of insight into our data and operations and inform policy development"
NHS Resolution Business plan 2020/21.

We recruited our first Chief Information Officer. She leads the work to improve our technology and data analytics capabilities and infrastructure. We have completed some artificial intelligence proofs of concept research. This was to explore how advances in technology can assist us in accessing and learning from our data. This has included a document search tool, which will enable claims handlers and analysts to access information more quickly and easily.

We have also been collaborating with the NHSX Artificial Intelligence Lab and have initiated an NHSX Skunkworks project to explore the relationship between NHS datasets and claims volumes.

Challenges to delivery

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

Income generation

We were unable to generate similar levels of revenue from education activity delivered by Practitioner Performance Advice as we have in previous years due to the impact of Covid-19. The loss of revenue has been offset by savings from reduced travel costs and not undertaking planned assessment activity.

Global Medical Indemnity Forum

The joint hosts (UK and Republic of Ireland medical indemnity organisations) cancelled the Global Medical Indemnity Forum scheduled to take place in London on 24–25 June 2020 because of the pandemic. We are hoping that this important event will be rescheduled.

Technological advances

We were not able to progress some of the opportunities we had identified around technology, namely robotic process automation and our data warehouse. This was due to business capacity issues and means that the start dates for these projects have been delayed to 2021/22. It prevented us implementing improvements in processes and efficiencies rather than reducing our ability to deliver our business-as-usual activities.

Customer survey

We took the decision to cancel this annual survey, due to the pandemic. We have postponed some planned in-depth stakeholder interviews and will review our approach later in 2021/22.


The SUPREME COURT
THE SUPREME COURT
The Judicial Committee of the Privy Council
Judicial Committee of the Privy Council

The environment we work in

As with any organisation, our work is affected by the wider environment and here we identify some of the factors from 2020/21 that have influenced, and may influence our work in the future.

Reform and the legal environment

Cross-government work

Work to address the challenge of the rising cost of clinical negligence in response to the recommendations of the National Audit Office report and subsequent Public Accounts Committee findings in 2017 continues across government. We continue to support this work.

Swift v Carpenter [2020] EWCA Civ 1295

A Court of Appeal ruling changed how claims for the cost of alternative accommodation, required as a result of disability caused by negligence, should be calculated. The new basis is to take the difference in value between the claimant's previous and required properties, and deduct from that the value of the residuary interest, which is the amount someone would pay today to acquire the property when the claimant dies. This will depend upon the claimant's life expectancy and the property in question. This new ruling is likely to lead to higher payments by NHS Resolution in most affected cases.

The health landscape

NHS Long Term Plan

In 2019/20 we welcomed the NHS Long Term Plan[1], setting out clinical priority areas including cancer, cardiovascular disease, maternity and neonatal health, mental health, stroke, diabetes and respiratory care. Complementing these clinical priority areas, in 2020/21 our work continued with key partners across maternity and neonatal health to improve the delivery of safer maternity care through our Maternity Incentive Scheme. In addition, we began a detailed analysis of claims related to lower limb vascular complications associated with diabetes.

The plan describes how the NHS will increasingly be more joined up and coordinated in its care. NHSE/I have outlined their proposals, which NHS Resolution welcomed, to create a statutory basis for integrated care systems. We have been considering and advising on indemnity for emerging models of care delivery and will continue to work with system partners on this. This will include careful consideration as to how our indemnity schemes need to evolve to best serve the future NHS and to maximise the benefit of our now overarching view of harm across the primary and secondary care sectors.

Health and Social Care Select Committee Meeting – Safety of maternity services in England

In 2020/21 there was continued focus on the safety of maternity services inside and outside NHS Resolution. We gave evidence to the Health and Social Care Committee on the steps that we are taking to support the national ambition to halve rates of stillbirths, neonatal and maternal deaths and neonatal brain injuries occurring during or soon after birth by 2025, with an interim ambition of a 20% reduction in these rates by 2020. An additional ambition to reduce the pre-term birth rate from 8% to 6% was introduced in 2017.

The Spending Review 2020

Within the Spending Review 2020[2] the Government announced £9.4 million to improve maternity safety, including through pilot schemes aimed at reducing the incidence of birth-related brain injuries.

The NHS Patient Safety Strategy: Safer culture, safer systems, safer patients

A key part of NHSE/I's national Patient Safety Strategy is the identification by NHS Trusts of Patient Safety Specialists. We have been members of the Patient Safety Specialist forum on the Future of the NHS Collaborative Platform. In 2021 we established a Maternity Voices (Parents) Group to support NHS Resolution's work, building closer links with patients, families and carers.

Technology and NHSX

We support the use of data and new technologies to enhance the care that patients receive. The NHS has made significant progress over the past year in terms of digital transformation. We are working with NHSX and the wider health and care system to support considerations of safety as new technology is adopted. We are active participants in relevant initiatives such as Data Alliance Partnership and the Artificial Intelligence Lab. We have collaborated with NHSX to do a proof of concept using artificial intelligence to analyse our claims data and we are leveraging NHS wide products and services such as Secure Boundary. We also liaise with counterpart organisations in Australia and Canada to learn about the potential impact of new technologies on our work.

Our strategy

In April 2017 we published Our strategy to 2022: Delivering fair resolution and learning from harm[3]. At the mid-point in our implementation period we took stock of progress, publishing Our refreshed 2019–2022 strategic plan: Delivering fair resolution and learning from harm[4] in February 2020. It is our intention to prepare a new strategy in 2021/22 as we come to the end of the five years covered by our current strategy. We will of course consider the topics covered in this section, and other future environmental factors, as part of this process.

[1] https://www.longtermplan.nhs.uk/online-version/overview-and-summary/

[2] https://www.gov.uk/government/publications/spending-review-2020-documents/spending-review-2020

[3] https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Our-strategy-to-2022-1.pdf

[4] https://resolution.nhs.uk/corporate-reports/

Key risks and issues

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

Responding to changes in the environment in which we operate

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

We have sought to mitigate the risks posed by a changing environment with the establishment and continued development of a Policy, Strategy and Transformation function. The team ensures that we identify emerging issues early and consider the potential impact on our strategic direction.

We have ensured our involvement in health-system-wide policy initiatives. This includes providing information and expertise to support the Government's work on fixed recoverable costs, and more recently on the White Paper *Integration and innovation: Working together to improve health and social care for all.*

Raising concerns

As an NHS body, patient safety and public protection are our paramount concerns and, like other NHS organisations, we are obliged to act when we identify ongoing risks. On occasion, we may identify a significant concern and have a duty to share information externally, for example, with other NHS bodies or those with responsibility for regulation within the healthcare system. This would happen if we see activity which may have caused significant harm or which puts individuals at significant risk because of unsafe clinical practice or conduct that severely compromises the effective delivery of services. Any decision to do so is based on the specific circumstances presented. 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 as a guide to addressing those circumstances where a concern about serious harm has arisen through information captured in case-specific interactions by one or more functions.

We have also initiated proof of concept activity to test how technology can be deployed to more easily search and access documents and data held within our claims management system to discern themes and trends within our data.

Legal compliance

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

IT infrastructure

Since the launch of our five-year strategy in 2017, we have been reviewing our information needs to meet our strategic priorities. We established the Core Systems Programme, which will enable significant benefits to our organisation both in terms of new functionality and technical capability, improving the service we provide to our members and delivering efficiencies.

Following the approval of a full business case by DHSC we launched a tender to commission a supplier to support us in progressing the replacement of our core system with a new cloud based solution. 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. The programme has received NHSX Assurance Board approval and will follow the NHSX Digital assessment criteria and 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 some of the 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) fourteen cloud principles. The Board and the 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.

UK's future relationship with the EU

We worked with DHSC to help the health and care systems prepare for the UK's departure from the European Union. Given the work we do, there is relatively little direct impact on our organisation, but we continue to work with DHSC to strengthen the UK's relationships with the EU and the rest of the world.

Going concern

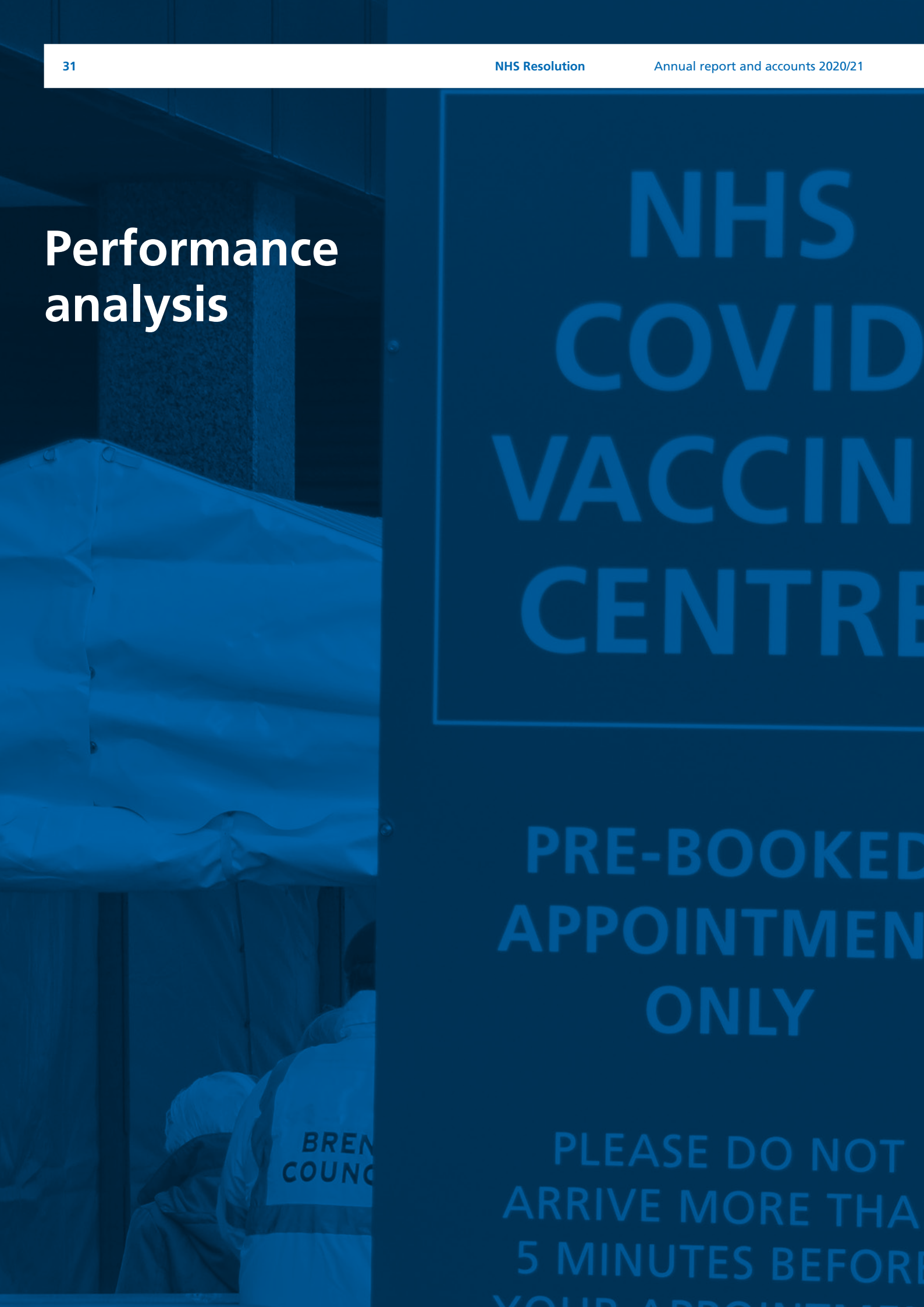
The Board has reviewed the financial position of the organisation and discussed future funding arrangements with DHSC, given that NHS Resolution reports significant net liabilities. The indemnity schemes that NHS Resolution operates are funded on a 'pay-as-you-go' basis. Members and funders of schemes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

On 27 February 2017, the Lord Chancellor announced a change to the personal injury discount rate (PIDR) from 2.5% to minus 0.75%, effective from 20 March 2017. A subsequent change in the rate to minus 0.25% was introduced on 5 August 2019 arising from the Civil Liability Act 2018.

DHSC has confirmed that it will continue to provide support and funds to NHS Resolution to meet the additional costs in settling claims arising from the current PIDR for DHSC schemes. All other costs are to be met through contributions charged to members, with equivalent funding levels provided through NHS budgets. DHSC has also confirmed that funding will be provided for the new indemnity schemes set up during 2020/21 in response to the Covid-19 pandemic.

On this basis NHS Resolution is not required to hold assets to cover liabilities arising from the indemnity schemes. Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements of 31 March 2021.

Performance analysis



Our strategic aims to 2022

This performance analysis sets out how we have delivered against our business objectives for 2020/21 and against our key performance indicators (KPIs).

Purpose

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

Our four strategic priorities	We will know we have succeeded when...
Resolution Resolve concerns and disputes fairly.	We systematically deploy the right dispute resolution approaches at the right time, resulting in fewer cases escalating into formal processes.
Intelligence Provide analysis and expert knowledge to drive improvement.	Others have taken action in response to our data, insight and recommendations to enable improvements in patient and staff experience across primary and secondary care.
Intervention Deliver interventions and solutions that improve safety and save money.	We continue to be a trusted source for learning from claims, concerns and disputes while utilising the unique levers at our disposal to make a positive difference to patient and staff safety.
Fit-for-purpose Develop people, relationships and infrastructure.	We have evolved to meet increasing demand, staff work flexibility across functions and systems and are empowered to make decisions and develop their skills, with succession plans in place for key roles.

Key performance indicators

Our KPIs provide an objective assessment of our operational performance. We annually review our KPIs covering all operations to ensure that they help us learn how to develop our services. At a high level, our KPIs provide assurance to our Board and to DHSC. And they drive continuous improvement for our operational teams.

In light of the added pressures introduced by the pandemic, including taking on additional responsibilities such as new indemnity schemes which were not anticipated when these KPIs were set, we recognised that it would not be possible to meet all our original KPIs this year and therefore undertook a wide-ranging business impact assessment to ensure that our resource was targeted most appropriately during the year. Throughout 2020/21, we continued to review the distribution of work and performance in relative, as well as absolute, terms and intervened as required.

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

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

Resolution

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

Our KPI 15: *Average number of weeks taken to resolve appeals and disputes – oral hearing* includes hearings delayed due to the pandemic. Had this not been the case, the average time would have been 23 weeks and within target.

Claims Management KPI framework

Measuring our performance this year solely on the ability to meet our KPIs would provide an incomplete and inaccurate picture when considering the extenuating circumstances of the pandemic. We have been affected by a variety of external factors, such as members diverting resources to the front line to respond to the pandemic, the operational challenges faced by law firms, and reduced access to courts leading to an ongoing backlog of some hearings. This has resulted in challenges in meeting a small number of our KPIs, specifically the time to respond to a formal claim for compensation. Despite these challenges, we have maintained a good service overall. Our performance was strong for those KPIs driven predominantly by our actions and decision-making, and our performance has been hindered only where we relied more heavily on the response of others.

Response time to a formal claim for compensation (KPIs 1, 2 and 3)

These measures record the time taken to respond to a formal claim for compensation for both the timescales specified by the pre-action protocol according to the type of claim and those agreed with other parties. The protocols require us to provide liability decisions within times ranging from thirty working days (for low-value employers' liability claims notified in our claims portal) to four months (for clinical negligence claims).

The KPI relating to compliance within protocol timescales has been influenced by the pandemic. Responses to letters of claim are heavily reliant on the input of frontline clinical staff for establishing facts and providing expert opinion, which was less readily available due to the pandemic.

We saw the greatest impact in meeting our target with a drop in performance in the lower value tranches where the vast majority of our claims occur. The target was met in the higher value tranches, where cases are more complex and take longer to investigate. Our management of these cases was strong and not only was the KPI met, but there was a 3% improvement from the previous year.

Throughout the pandemic we worked with a wide range of stakeholders, and this work included introducing a specific Covid-19 Clinical Negligence Protocol. This cross-industry collaboration contributed to the performance of the KPI measuring our response to a letter of claim within the agreed timeframe between the parties. We met this KPI, with an increase from 56% in 2019/20 to 91% in 2020/21.

Time to resolution (KPI 4)

This measures the time between a decision being made on whether to admit liability and payment of any agreed compensation. The target is intended to shorten the time taken to resolve the claim following a view being formed on the merits of the case. The target was achieved across both low and high value tranches of claim.

Repudiation failure rate (KPI 5)

The purpose of this KPI is to measure the robustness of our own decision-making in the claims process. It records the number of claims where a decision to deny liability is changed, but also recognises that there will be claims where the evidence changes and an earlier legitimate denial becomes unsustainable. The robustness of our decision-making will contribute to the volume of claims that enter formal court proceedings. By its nature this KPI is reflective of previous performance. The target was met.

Litigation rate (KPI 6)

This measure records and seeks to reduce the number of claims moving into formal litigation. It reflects our commitment to use all forms of dispute resolution to keep claims out of formal court processes. We have continued to develop our dispute resolution initiatives in collaboration with claimant representatives to achieve our aim of fair and proactive settlement. This in turn has been supported by the Covid-19 Clinical Negligence Protocol, encouraging parties to avoid litigation, extending time for the formal commencement of court proceedings wherever appropriate. This KPI has seen a significant upturn this year. The target was met for clinical and non-clinical claims and outperformed expectations.

We will continue to work with lawyers acting for claimants and hope that these lower levels of litigation can be maintained. We accept, however, that there are many cases which need judicial input to allow a resolution to be reached.

Damages estimated movement (KPI 7)

This KPI was introduced in 2019/20 and tracks movement in our damages estimate. The target was met.

Data accuracy (KPI 8)

This KPI applies to key data fields in our claims management system. Data quality is key to claims management, to our accounts and to other areas of our service which rely on accurate, reliable and high quality claims data to inform their work. The target was met.

Intelligence

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

Intervention

No.	KPI description	Area	Target	Met
19	Positive feedback from member trusts visited on recognition of products.	Safety and Learning	At least 60%	Met
	Response to members			
20	**1.** 95% response rate to members following a request for contact within three working days.	Safety and Learning	95%	Met
21	**2.** Participation in 18 regional engagement events for members which include two national sharing and learning events.		18 events	Met
22	**3.** Eight safety and learning products to be made available for members.		8 products	Not met
23	Practitioner Performance Advice education events rated by participants at least four out of five for effectiveness/impact.	Practitioner Performance Advice	90%	Met
24	Requests for advice from Practitioner Performance Advice responded to within two working days (or within an alternative timeframe requested by the employing/contracting organisation).	Practitioner Performance Advice	90%	Met
25	Assessments and other interventions delivered within target timeframe.	Practitioner Performance Advice	90%	Met
26	Assessment and other intervention reports produced/issued within target timeframe.	Practitioner Performance Advice	90%	Met
27	Percentage of exclusions/suspensions critically reviewed in line with the following timescales: **Stage 1:** after initial four weeks **Stage 2:** at three months **Stage 3:** at six months.	Practitioner Performance Advice	90%	Partially met
28	Decisions on referrals for assessments and other interventions communicated to the referrer within 13 working days of receipt of all referral information.	Practitioner Performance Advice	90%	Met

Under **KPI 22**: *Response to members – Eight safety and learning products to be made available for members,* we delivered six out of the target eight products The pandemic created challenges in obtaining necessary clinical input from frontline clinicians. The two remaining products were released in April/May 2021.

Fit for our purpose

No.	KPI description	Area	Target	Met
29	Indemnity scheme financial spend.	Finance and Corporate Planning	Between 95% and 100% of target	Not met
30	Undertake annual customer satisfaction survey to inform service development.	Membership and Stakeholder Engagement	Complete in 2020/21	N/A
31	CNST member participation in our customer satisfaction survey to ensure engaged customer base.	Membership and Stakeholder Engagement	60% of our CNST membership	N/A
32	Evidence of increasing scores covered by annual customer satisfaction surveys year on year.	Membership and Stakeholder Engagement	Increasing scores in 50% of subject areas covered	N/A
33	Overall approval rating in the 2020/21 customer satisfaction survey.	All	55%	N/A
34	Downtime (unavailability between 7am and 7pm) of any IT system.	Digital, Data and Technology	No > 5% of working month	Met
35	Downtime (unavailability between 7am and 7pm) for the extranet and claims reporting services.	Digital, Data and Technology	No > 2.5% of working month	Met
36	Critical security patches for externally facing systems to be applied promptly.	Digital, Data and Technology	Within 14 days of issue	Met
37	Helpdesk to respond to calls within two hours of receipt.	Digital, Data and Technology	90%	Met
38	Vacancy rate.	All	<10%	Met
39	Uptake of annual staff appraisals.	All	90%	Met
40	Engagement for the staff survey.	All	>75%	Met
41	Voluntary turnover of staff during six month probationary period.	All	<85%	Met
42	Prompt payment of suppliers within 30 days.	Finance and Corporate Planning	95%	Not met

We did not meet our **KPI 29**: *Indemnity scheme financial spend* given the underspend position. We go into detail on this in the *Finance report* on page 73. Factors have included difficulty in pursuing initiatives to accelerate payments, lower volumes of incoming claims and lower average payments on high value claims than were assumed in our budget.

In line with other organisations, we took the decision to suspend our annual customer satisfaction survey this year as our key stakeholders were focused on the pandemic response. This step meant that all four **KPIs 30 to 33** linked to this activity were not applicable. However, we are due to undertake a series of interviews with selected stakeholders during 2021/22 to obtain some feedback about our performance at a system level.

With regard to **KPI 41**: *Voluntary turnover of staff during six month probationary period,* the figure is calculated based on the staff who left NHS Resolution voluntarily with less than six months of service, against the total number of staff who left the organisation voluntarily in 2020/21. This does not take into account anyone who may have had their probation period extended in accordance with our probation policy.

Following the implementation of a new finance system in December 2019, we have made steady improvement in our **KPI 42**: *Prompt payment of suppliers within 30 days.* We achieved 96% in the month of March 2021 and will seek to maintain this level of performance consistently.

A closer look at our data

Claims Management

Claims patterns

In line with our strategic aims, we were pleased to see a continuing fall in the number of claims which required formal legal proceedings. We expect that the operational challenges faced by the legal system generally have been a factor.

Among our key objectives for the year was the ambition to increase the use of existing dispute resolution initiatives and to test new initiatives. However, we were unable to accelerate claims resolution to the extent we had planned for pre-pandemic. Damages and claimant legal costs payments (the most significant elements of claims settlements) reduced year-on-year, particularly on higher value claims. This contributed to the in-year financial underspend.

We experienced a small decrease in the number of new clinical claims notified to us via our established CNST and DHSC funded clinical schemes, with increases predominantly related to our general practice indemnity schemes and (within CNST) Early Notification cases. We anticipate that a contributory factor was the operational challenges faced by our members and lawyers acting for claimants. We observed an even greater fall in the number of non-clinical claims notified to us where a likely additional factor was the reduced access for the public to hospital premises.

The pandemic forced the court system to operate at a significantly reduced capacity for a period of time, hearing only urgent cases. This has contributed to a reduction in the number of cases being heard at trial from 93 in 2019/20 to 56 this year. A number of cases that were adjourned are anticipated to be heard in 2021/22 as the court system recovers from the backlog. We expect a greater number of trials to occur in 2021/22 compared to 2020/21 as a result.

Figure 3: The number of new clinical and non-clinical claims and incidents reported in each financial year from 2011/12 to 2020/21

Figure 3 shows an increase of 951 in the number of clinical claims and incidents received from 11,678 in 2019/20 to 12,629 in 2020/21.

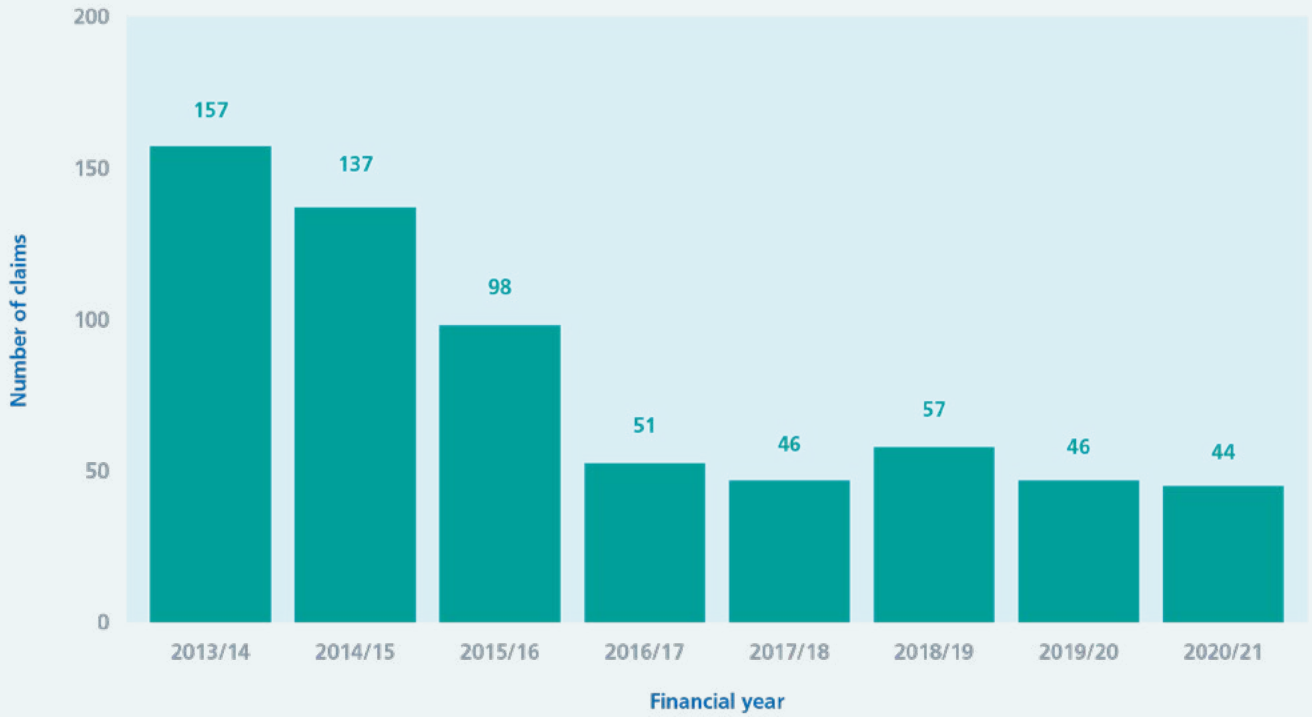
The following elements contribute to the increase in claims numbers:

- 840 relate to the take-on of historic liabilities claims of MDDUS members covered by our ELSGP from April 2020.
- An increase of 572 claims and incidents (up from 401 in 2019/20) were reported to our new and maturing CNSGP.
- 139 additional claims (192 in total) were recognised in the year for the Early Notification Scheme, as investigations accelerated.
- 7 incidents were reported to our CNSC.

Claims in respect of established clinical schemes reduced by 607. The volume of non-clinical claims reported significantly dropped to 2,759 in 2020/21 from 3,744 in 2019/20. The drop is principally in our LTPS and relates to public and employers' liability claims, where we experienced a 25.9% decrease in cases reported. Employers' liability cases experienced the largest fall in number from 2,488 to 1,753, a drop of 29.5%. Public liability cases fell from 1,148 to 943, with these 205 cases representing a 17.9% reduction.

Operational challenges in the legal industry and the wider NHS system are likely to have reduced the ability of claimants to submit claims. The time lag from the date of the incident until notification is shorter in the non-clinical schemes and therefore reduced visitors and non-Covid-19 activity in NHS premises during the pandemic may also have contributed to the drop in volumes. The full effect of the pandemic on case volumes will only become apparent in future years.

Figure 4: Legacy industrial disease claims (such as for asbestosis and mesothelioma) from 2013/14 to 2020/21 dealt with under our DHSC Liability scheme

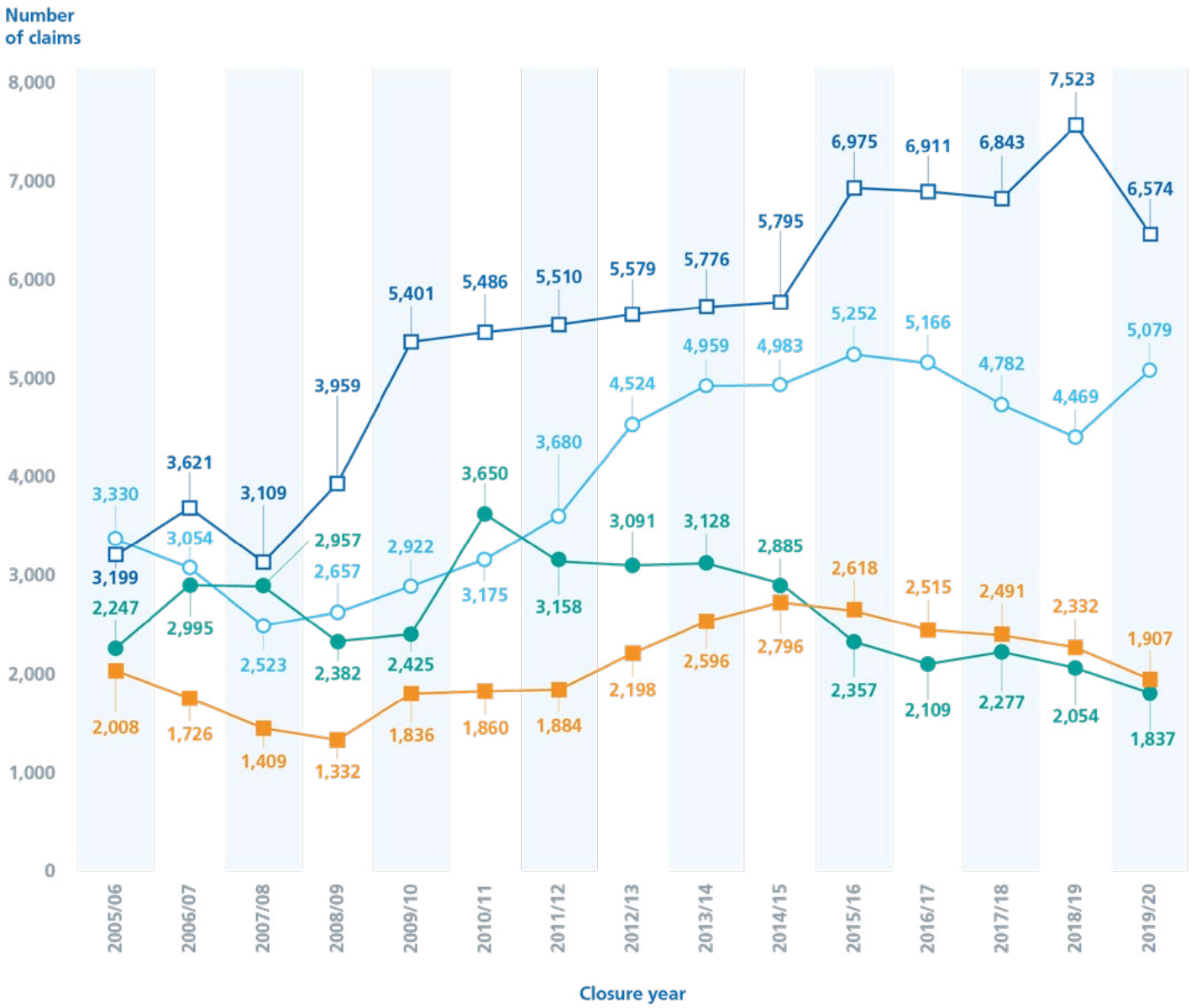


Following the abolition of strategic health authorities and primary care trusts on 1 April 2013, we were directed to handle and process claims arising from the liabilities of those organisations, which had subsequently transferred to the Secretary of State. As part of that arrangement, we inherited historical industrial disease claims brought by former NHS workers. These were claims made before we were established as an organisation in April 1995, and primarily arose from exposure to asbestos, and noise-induced hearing loss.

These claims volumes are excluded from Figure 3 because of the distorting effect they would have on our claims trends, but are shown in Figure 4. The initial spike from the take-on of claims in 2013/14 can be seen, and volumes remain stable in more recent years.

Closed claims

Figure 5: The total number of clinical and non-clinical claims closed with and without the payment of damages from 2006/07 to 2020/21



In 2020/21 we **closed**[1] 15,397 claims with and without damages, 981 fewer than in 2019/20 (16,387). Overall, 1,166 fewer claims closed with the payment of damages than in the previous financial year (8,411 compared with 9,577).

Of the 15,397 closed claims:

Clinical

In 2020/21 fewer clinical claims (↓949) received damages (6,574) than in 2019/20 (7,523). More clinical claims (↑610) received no damages (5,079) than in 2019/20 (4,469). As a proportion of the total, more clinical claims closed without damages (44%) than in the previous year (37%).

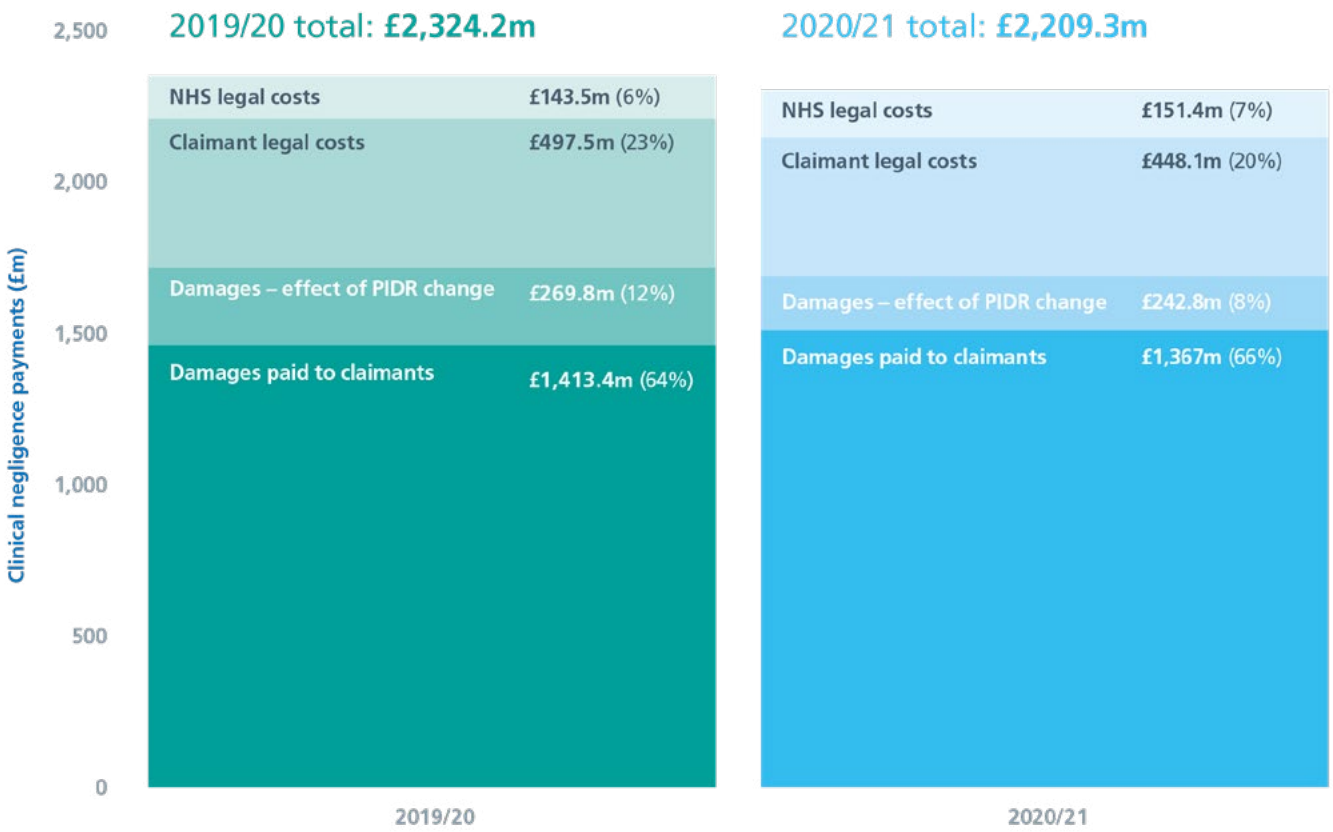
Non-clinical

In 2020/21 fewer non-clinical claims (↓217) received damages (1,837) than in 2019/20 (2,054). There were also fewer claims (↓425) that received no damages (1,907) than in 2019/20 (2,332). As a proportion of the total, 51% non-clinical claims closed without damages compared to 49% than in the previous year, although the numbers were overall smaller.

These movements in the overall numbers closing and receiving damages contributed to the reduction in the in-year expenditure shown in Figure 6.

[1] 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 6: Clinical negligence payments for 2020/21 (including PIDR and expenditure related to CNSGP and ELGP)



Total payments relating to our clinical schemes (excluding administration costs) decreased by £114.9 million to £2,209.3 million, compared to £2,324.2 million in 2019/20.

Damages paid to claimants including PIDR expenditure decreased by £73.4 million (4.4%) from £1,683.2 million in 2019/20 to £1,609.8 million in 2020/21. Alongside this, claimants' legal costs have decreased by £49.4 million (9.9%) from £497.5 million to £448.1 million. There has been a reduction in the volume of high value claims in particular that have had damages and claimant legal costs payments, and the average value of those payments has reduced during 2020/21.

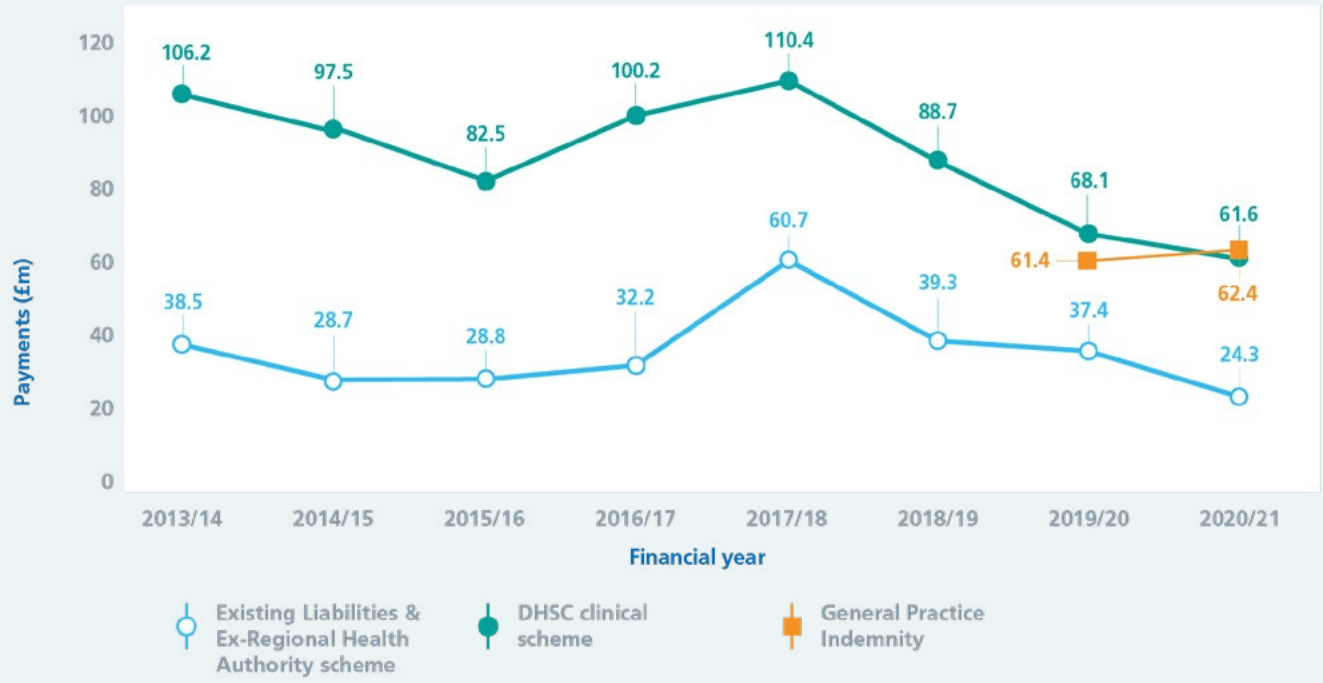
This may be in part due to the operational challenges experienced in the legal and health environments during the pandemic to progress claims. Also, costs are increased when a case enters formal court proceedings and therefore the decrease in claims entering formal proceedings may also have contributed to the decrease in spending in these areas.

NHS legal costs overall have increased by £7.9 million (5.5%). Of this, an additional £1.5 million was incurred in relation to our Early Notification Scheme, where we have recognised 192 claims in 2020/21, an increase of 139 from the previous year. We are committed to early investigations conducted in conjunction with our legal panel to establish a liability position for these claims. This proactive approach incurs upfront legal costs.

A further £4.4 million has been spent on taking on and managing 840 claims under the ELSGP scheme from April 2020. A greater proportion of NHS legal costs tend to be paid at the earlier stages of a claim, compared to claimant legal costs which are generally paid towards the conclusion.

Figure 7a: Payments on clinical claims by financial year from 2013/14 to 2020/21 for our CNST (including that attributable to the change in the PIDR)

Figure 7b: Payments on clinical claims by financial year from 2013/14 to 2020/21 for our ELS and Ex-RHA, DHSC clinical schemes (in including that attributable to the change in the PIDR) and GPI (CNSGP and ELGP)



Figures 7a and 7b show expenditure on individual schemes over time. CNST costs have been impacted by the changes in the personal injury discount rate (PIDR) in 2017 (resulting in an increase in average cost per claim) and 2019 (resulting in a decrease in costs from the 2018/19 peak). The further reduction in expenditure in 2020/21 has been explained above.

The DHSC clinical, ELS and Ex-RHA schemes are in respect of legacy organisations, and claims and costs are expected to diminish over time.

Figure 8: The number of CNST and DHSC legacy clinical negligence cases reported by estimated damages range in each financial year from 2016/17 to 2020/21

These are estimates of the damages value of claims reported in-year, as at 31 March. Some cases will have opened and been settled in-year, therefore showing a Nil estimate outstanding.

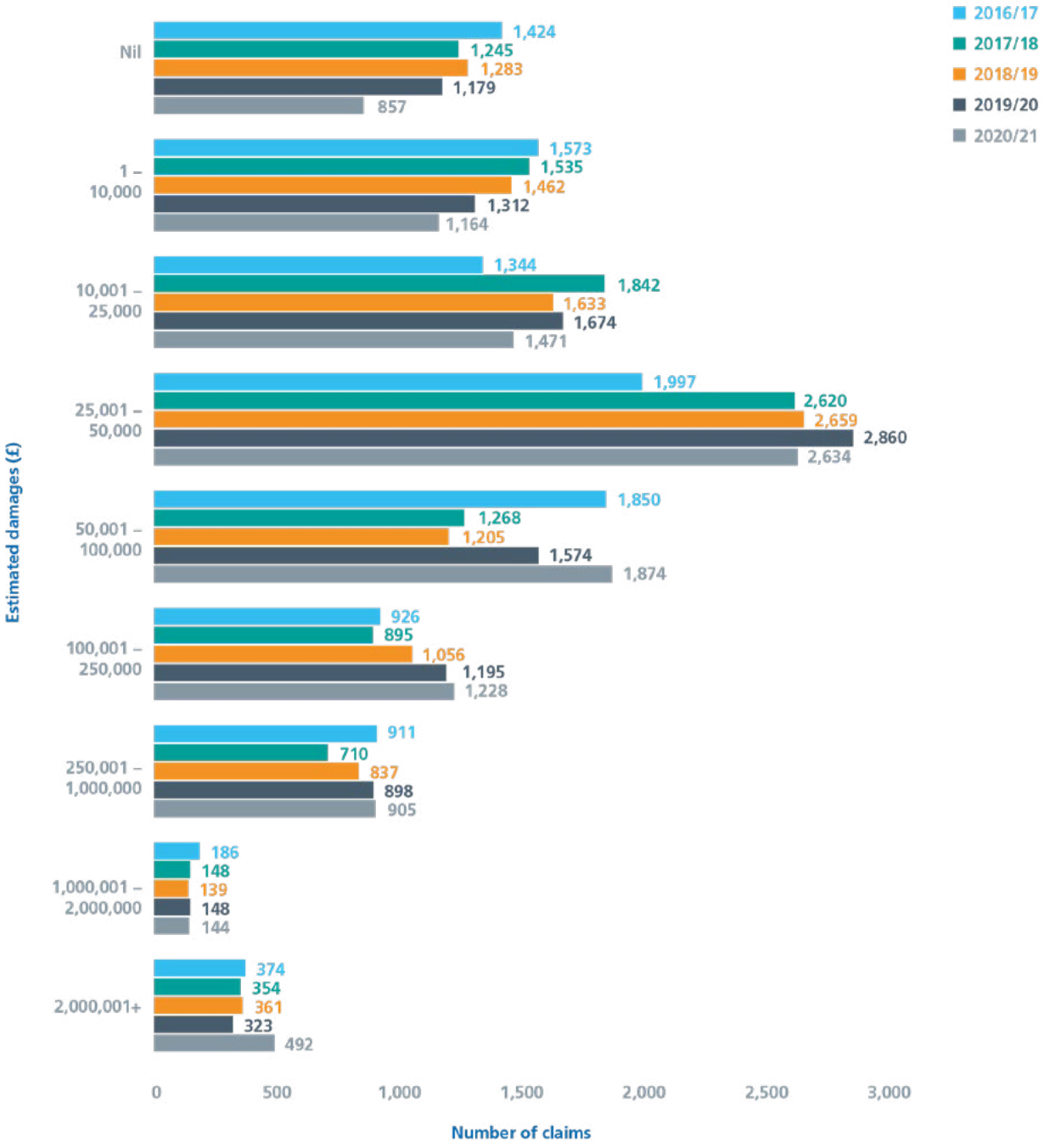
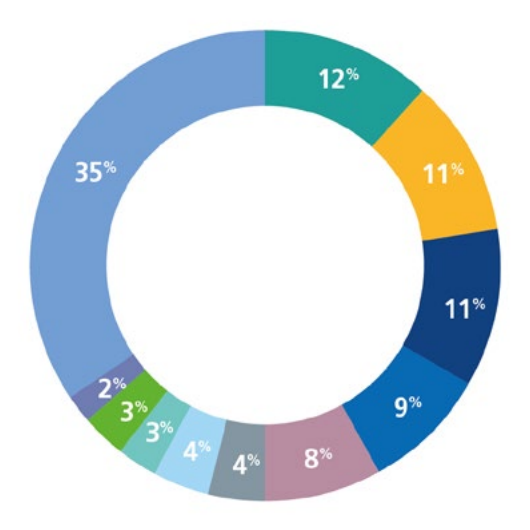
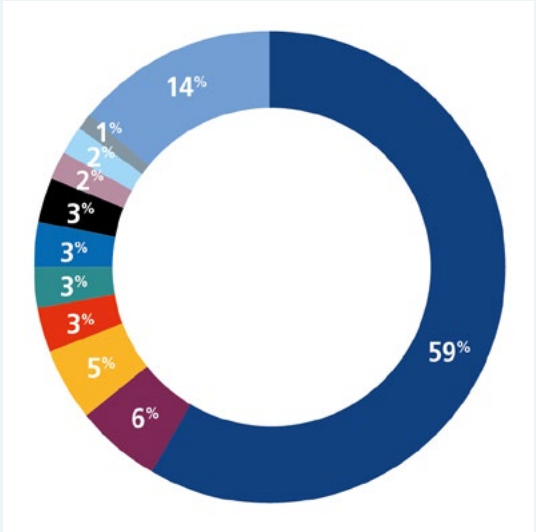


Figure 9: The number of clinical negligence claims reported in 2020/21 by specialty from a total of 10,816[1]



Orthopaedic surgery	12%	General medicine	4%
Emergency medicine	11%	Radiology	4%
Obstetrics	11%	Psychiatry/mental health	3%
• Early Notification	2%	Urology	3%
• Non-Early Notification	9%	Gastroenterology	2%
Gynaecology	9%	Other	35%
General surgery	8%		

Figure 10: Value of clinical negligence claims reported in 2020/21 by specialty across all clinical negligence schemes from a total of £7,113.8 million



Obstetrics	59%	Gynaecology	3%
• Early Notification	27%	Neurosurgery	3%
• Non-Early Notification	32%	General surgery	2%
Paediatrics	6%	Radiology	2%
Emergency medicine	5%	Neurology	1%
Neonatology	3%	Other	14%
Orthopaedic surgery	3%		

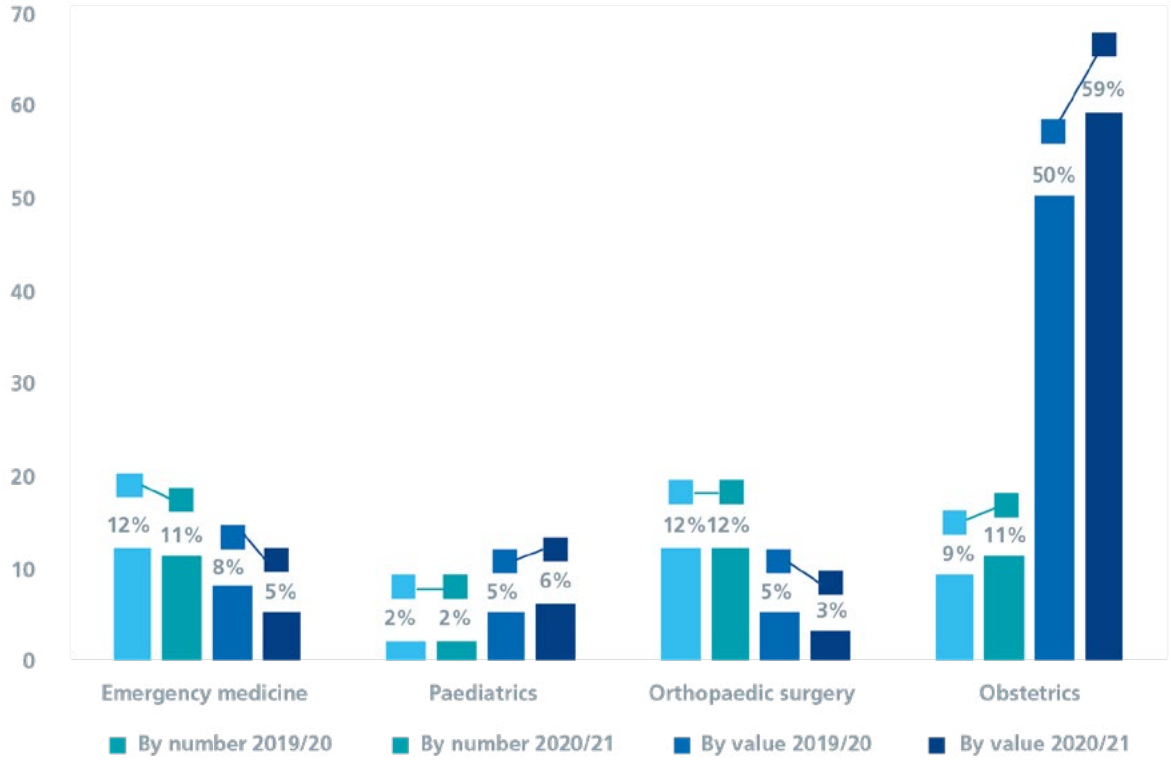
Obstetrics claims remain the largest proportion, at 59% of the total estimated value, and represents 11% of the number of 10,816 new claims received[2]. Without the addition of the new Early Notification claims, the proportion of obstetric claims would have been 44% of total reserve values of new claims received. While the volume of obstetrics claims forms a similar proportion of total claims received during the year, the value has increased from around 50% in earlier years to 59% in 2020/21. This is due to the recognition of an additional 192 (254 in total) Early Notification claims as we accelerated investigations to establish liability. The impact of the Early Notification Scheme and our accelerated activity in liability investigations on these claims has a direct impact on the value of clinical negligence claims reported. EN claims now make up 2% of claims received by volume, and 27% by value, compared to less than 1% and 10% respectively for 2019/20. Not all of these claims will go on to have damages payments made against them.

The profile of claims specialties has remained fairly similar to the previous two financial years, with emergency medicine and orthopedic surgery being the top two specialties by volume. We have continued to see an increase in cases relating to gynaecology, of which a large percentage are associated with vaginal mesh incidents.

A key focus of our strategy continues to be maternity claims because of the high value of a relatively small proportion of claims. Steps taken to help reduce the likelihood of harm and associated costs include our Early Notification Scheme and our Maternity Incentive Scheme through which we identify issues closer to the point of incident and promote best practice. In view of the lag from time of incident to notification of a claim, the effects of the pandemic on the specialty split of clinical negligence claims will not be known for a number of years.

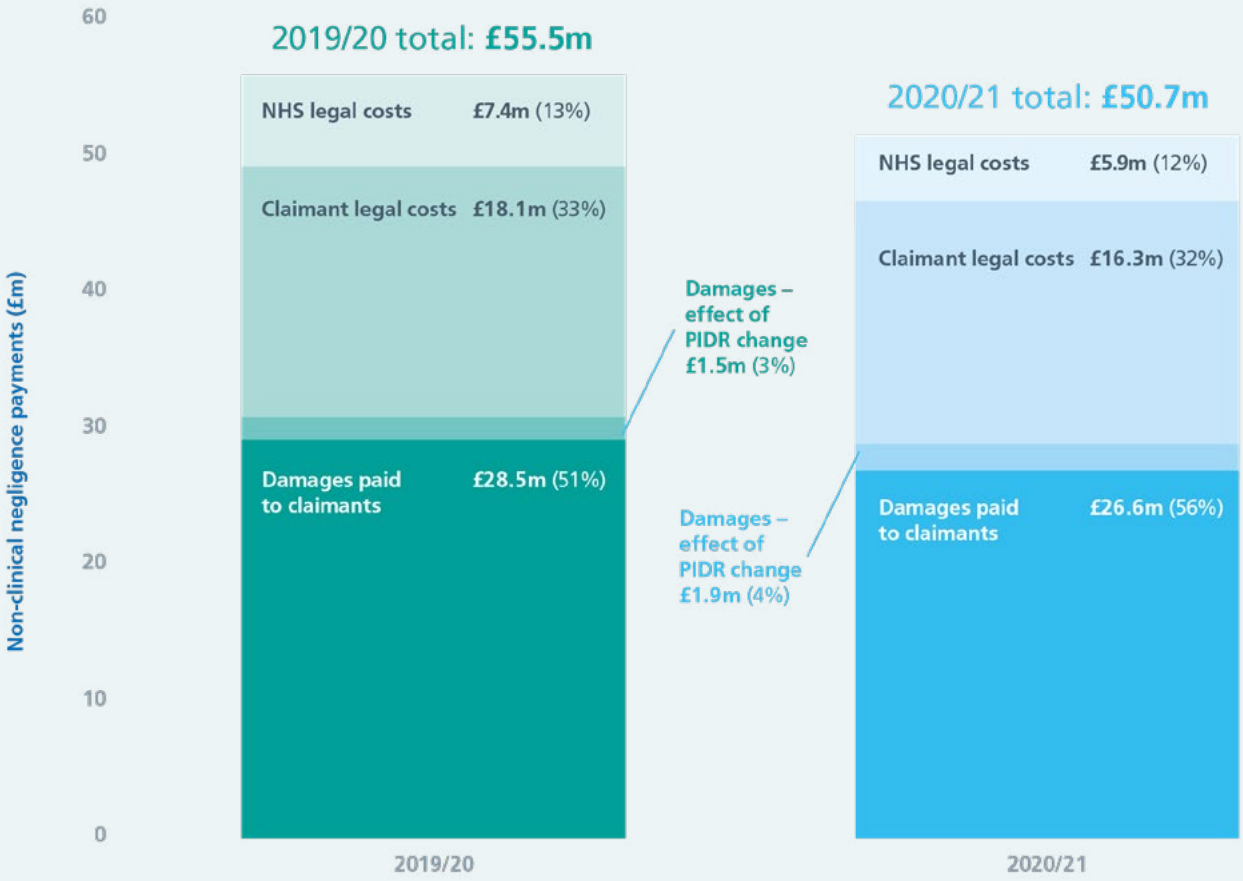
[1] This figure excludes data from our general practice indemnity schemes.
[2] Excluding claims and incidents with respect to our general practice indemnity schemes.

Figure 11: The top four categories of clinical claims received in 2020/21 and 2019/20 by % value and % number of claims



The rise in the proportion of obstetric claims from 50% to 59% from 2019/20 to 2020/21 relates to an additional 157 Early Notification claims recorded this year.

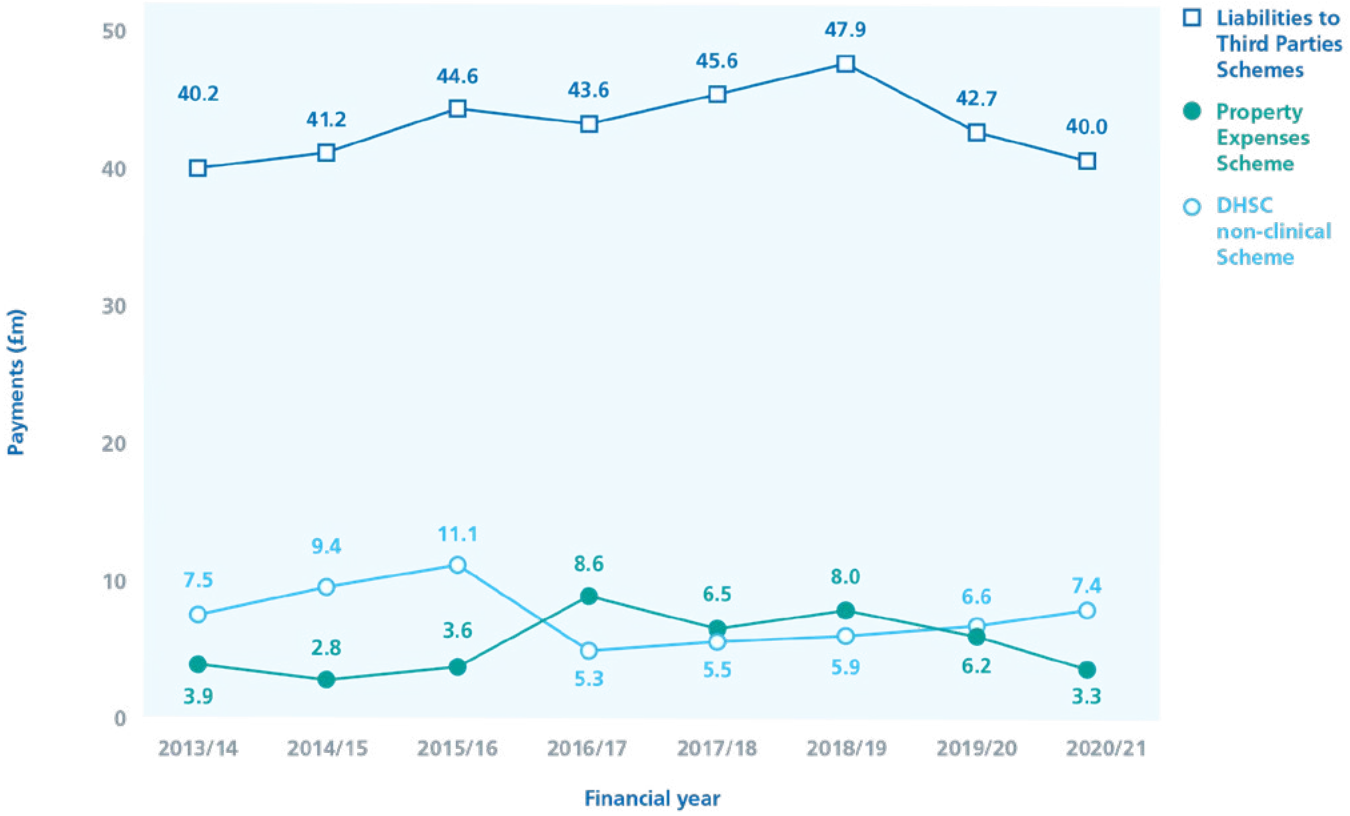
Figure 12: Non-clinical negligence payments for 2020/21 (including PIDR)



Payments on non-clinical claims decreased by £4.8 million. The distribution of spend of the total £50.7 million paid out in settling non-clinical claims was very similar to the previous year. Non-clinical claims have experienced the largest drop in reporting and settlement activity, which can be attributed to the pandemic. The time lag from incident to notification in non-clinical claims is shorter than clinical claims and therefore the impacts of the pandemic are likely to materialise earlier than clinical claims. Damages payments made to claimants have decreased by £1.5 million to £28.5 million in 2020/21.

Of the 2,711 claims, orthopaedic injuries still account for the largest percentage by number (59%) of non-clinical claims received in 2020/21, followed by psychiatric injury (17%), head injuries (7%) and facial injuries (6%) – all other injuries were recorded at less than 5% of the total number. The distribution of specialties follows a similar pattern with regard to the value of non-clinical claims. Of the £46.2m total value of claims received, orthopaedic injuries represented the largest group of claims (50%), followed by psychiatric injury (21%), head injuries (9%) and facial injuries (5%) – all other injuries were recorded at less than 5% of the total value.

Figure 13: Payments on non-clinical claims by financial year from 2013/14 to 2020/21 for LTPS, PES and DHSC non-clinical schemes (including PIDR)



Our DHSC non-clinical scheme responds to historical liabilities and liabilities inherited by the Secretary of State for Health and Social Care from abolished health service bodies. PES covers first-party losses arising from damage to NHS property assets. PES expenditure is typically volatile and unpredictable, since the trigger for most claims will be adverse incident related, principally fire or escape of water.

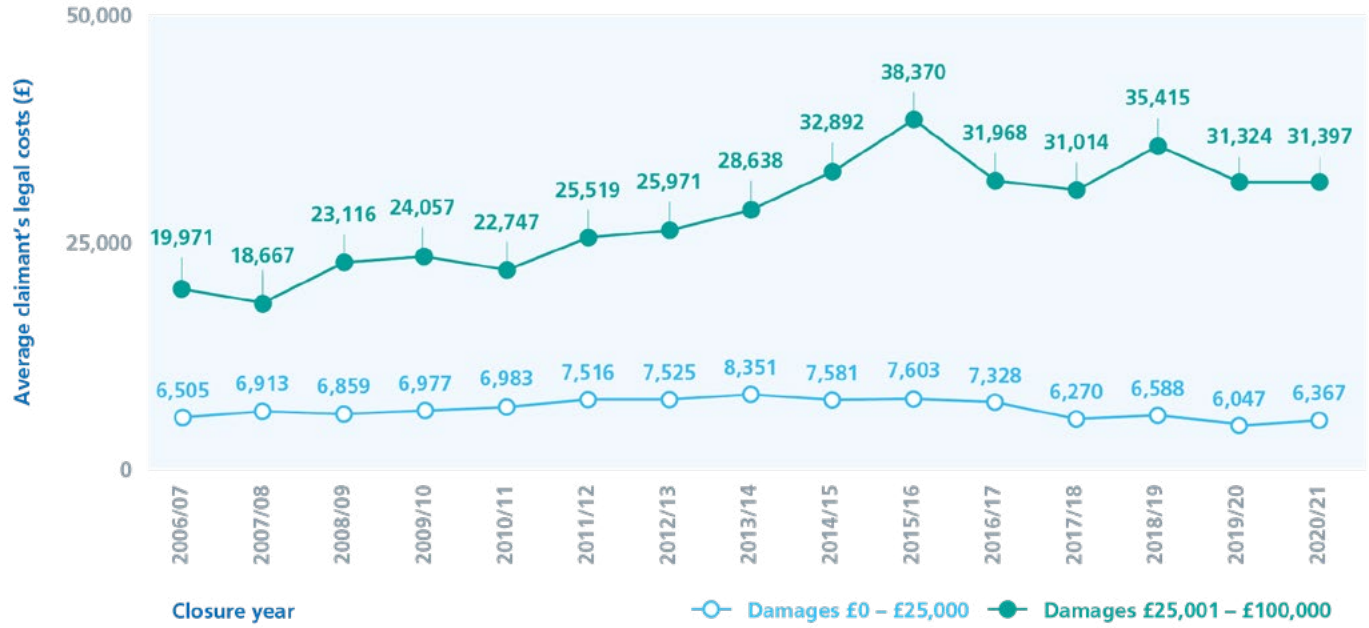
Figure 14: Average of claimant costs paid on claims where damages are between £1 and £100,000 for claims closed in the financial years from 2006/07 to 2020/21 for all clinical negligence schemes

The most frequent type of claimant legal funding for clinical negligence claims in the last five financial years continues to be a conditional fee arrangement (CFA), which is used for 82% of all closed claims up to £25,000, and 85% of all closed claims between £25,000 and £100,000.

The average value of costs paid in closed clinical claims between £25,000 and £100,000 has declined from a peak in 2016/17 and has now plateaued. This is likely to be attributable to the change in funding arrangements following the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO).

Claims funded by post-LASPO CFA agreements from 2016/17 until 2022/21 have increased from 27.4% to 85.3%, with the volume of closed cases in the same value tranche remaining fairly stable. In 2020/21 from the 1,772 closed claims, 55 (3.1%) were pre-LASPO CFA funded, a drop from 6.23% from 2019/20. This shift in funding arrangements is associated with a reducing average value of claimant costs in the £25,000 to £100,000 cohort since 2016/17. Despite a similar profile of change in funding from pre- to post-LASPO CFAs in the closed claims valued at up to £25,000, we have not seen the same decline in average costs paid and the overall amount paid out in 2020/21 was close to its highest ever average, following a very marginal decrease in recent years.

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 2006/07 to 2020/21 for all non-clinical negligence schemes



The number of non-clinical claims closed between £25,000 and £100,000 is far fewer than in the clinical schemes. The majority of claims in the last five financial years (88.9%) arise in the £1 to £25,000 tranche, which has been subject to fixed recoverable costs since 2013. This has been associated with a steady reduction in average costs for these claims, which has stabilised in recent years and contrasts with the position on clinical negligence where fixed costs do not currently apply.

How we performed against our business plan objectives for 2020/21

Priority 1: Responding to Covid-19

Our guiding principles during Covid-19 have been to protect the health and wellbeing of our staff and to help the NHS to respond to the pandemic in whatever way we can. Across the organisation we worked to a comprehensive business continuity plan for delivering our services during the pandemic.

This included identification of:

- core work to be delivered, with necessary contingency arrangements within our services to ensure business continuity; and
- business critical activity with plans and procedures in place for this work to be supported if necessary through drawing on additional trained resource elsewhere within the organisation.

Providing indemnity

During the pandemic, our existing indemnity arrangements continued to cover clinical negligence liabilities for the vast majority of NHS services. However, working closely with DHSC and NHSE/I we took steps to address any gaps arising from the new healthcare arrangements being put in place. The Coronavirus Act 2020 included additional powers to provide clinical negligence indemnity for specific Covid-19 related NHS activities where existing arrangements could not respond.

Using powers under the Coronavirus Act 2020 and launched on 3 April 2020, the Clinical Negligence Scheme for Coronavirus (CNSC) provides cover for the NHS response to Covid-19 where no other indemnity exists. It constitutes a flexible arrangement to address the fast-paced changes which had to be put in place and extends, for example, to private sector facilities which stepped in to provide overflow capacity for procedures which NHS hospitals were unable to perform owing to the need to give priority to patients with Covid-19. On the other hand, many new arrangements were picked up by one of our existing schemes, such as retired general practitioners who volunteered to return to give vaccinations being covered by either CNSGP or CNST, depending upon the contractual arrangement in question.

We also established indemnity in relation to other new arrangements to support the pandemic response, including:

- **Designated care settings** – set up for a time-limited period only, from 19 January until 30 September 2021, for certain clinical and non-clinical claims relating to the transfer of Covid-19 positive patients from hospital, so they could isolate in a designated care setting[1], such as a care home (see the CTIS below);
- **Pharmacy indemnity** – time-limited indemnity to support the Covid-19 vaccination programme for local community pharmacists commissioned to provide Covid-19 vaccinations to the general public – reassuring healthcare professionals and others working and volunteering in the NHS in England that they had appropriate indemnity arrangements; and
- **Lateral flow community testing** – assisting the NHS Test and Trace programme, indemnity cover was provided to local authorities running lateral flow testing for asymptomatic people.

Indemnity arrangements for the Covid-19 response, including the vaccination programme, were communicated directly to the NHS via a joint letter from NHS Resolution, DHSC and NHSE/I with supporting materials including FAQs published on a range of coronavirus-related issues.

We supported NHSE/I to expand the primary care workforce with retired staff coming back to the NHS to tackle the Covid-19 outbreak. We facilitated the safe return of clinicians by conducting important pre-employment checks for employers in primary care; adding practitioners to the Performers List, having ruled out past or current investigations or proceedings; and supporting the NHS frontline with 6,500 checks to help practitioners return to practice. Details of Performers Lists notifications and pre-contract checks between 1 April 2020 and 31 March 2021 are available online in our Factsheet 6 publication.

In January 2021 the non-clinical Coronavirus Temporary Indemnity Scheme (CTIS) was launched, a further indemnity arrangement covering non-clinical liabilities without cover under our existing indemnity schemes. The cover helps to manage the safe transfer of people who are being discharged from hospitals to designated care home settings.

[1] https://resolution.nhs.uk/services/claims-management/non-clinical-schemes/coronavirus-temporary-indemnity-scheme/

Improving our processes

The pandemic has also proved a catalyst for claimant and NHS legal representatives to explore new, collaborative initiatives.

In collaboration with Action against Medical Accidents (AvMA) and the Society of Clinical Injury Lawyers (SCIL) we developed the Coronavirus Clinical Negligence Protocol. Representatives for all parties had encountered challenges in managing clinical negligence claims through the pandemic due to lockdowns and social distancing restrictions impacting on solicitors meeting with clients, court closures and the disruption in access to witness and expert opinion from clinicians. The protocol provided a pragmatic framework for managing, for example, extensions of time for service of documents. It offered a limitation amnesty in certain circumstances, allowing the parties to investigate their claims without the immediate pressure to issue court proceedings. In addition, the protocol encouraged the use of remote communication. The protocol epitomised the constructive and collaborative approach many in the legal market adopted through the pandemic and allowed clinicians to focus on frontline care while protecting the legal position on active cases, reducing litigation and creating the space for parties to work together to achieve a resolution.

We have also tested new ways of working, including opportunities to take stock of claims at various points of the process. This was with a view to agreeing medical evidence and narrowing issues in dispute, aimed at reducing the time to resolution while avoiding unnecessary litigation. We also increased the number of Resolution Meetings with law firms acting for claimants. We successfully maintained our claims mediation service via online platforms, albeit with some technical challenges in the early stages.

Reducing the burden on frontline staff

From March 2020 Maternity Incentive Scheme reporting was paused. We encouraged trusts to continue to apply the principles of the scheme's safety actions and highlighted the importance, wherever possible, of maintaining external reporting such as reporting eligible cases of perinatal deaths to Mothers and Babies: Reducing Risks through Audit and Confidential Enquiries across the UK (MBRRACE-UK) and monthly Maternity Services Data Set submissions to NHS Digital. We made revisions to the scheme, extending timescales for trust submissions and revising some of the safety actions to ensure that trusts were supported to meet the scheme's safety actions, while responding to Covid-19.

From 1 April 2020 we removed the requirement for trusts to report early notification cases directly to NHS Resolution. With the support of the Royal College of Obstetricians and Gynaecologists (RCOG), MBRRACE-UK and the Healthcare Safety Investigation Branch (HSIB) all cases that meet the Early Notification criteria were reported to HSIB by the trust. HSIB then triaged cases and shared those with evidence of harm to the baby (babies with abnormal MRI or those with neurological deficit on discharge) directly with NHS Resolution. We made this reporting process the standard approach and made other key improvements to streamline the investigation process that were implemented from 1 April 2021 including an agreed clinical definition of brain injury (babies with hypoxic brain injury). More information can be found at https://resolution.nhs.uk/2021/03/18/early-notification-an-update-to-reporting-requirements/.

Given the volume of appeals and disputes dealt with by our Primary Care Appeals service, the impact of Covid-19 on the service's decision-making function was limited, but we postponed GP and pharmacy site visits, for example deferring GP premises inspections during rent disputes. We extended time limits where such power existed. These steps were taken to protect those working on our behalf and other parties. The move enabled contractors (pharmacists and GPs) to focus on delivering frontline services and helped NHSE/I to reallocate staff resource to support primary care.

Improving access to services

In addition to the changes in our reporting arrangements for maternity activity described above, we extended our Practitioner Performance Advice service operating hours, and paused activity that required the involvement of frontline clinicians. In consultation with NHS Employers we produced some general interim guidance for NHS organisations regarding the management of concerns in accordance with Maintaining High Professional Standards in the NHS (MHPS). And we developed a Local assessment of clinical performance to facilitate and support NHS organisations in undertaking local clinical performance assessments where there were concerns.

Moving services online

In July 2020, our Primary Care Appeals service explored restarting 'safe site visits' and delivering 'virtual' secure, online hearings for pharmacy market entry appeals. After consulting with Primary Care Appeals Panel Members and the NHSE/I central pharmacy team, we successfully moved to a new operating model including the use of new technology with the consent of affected parties. This approach brought some cases to resolution sooner than previously anticipated. The new model reduced the burden on NHSE/I local teams to secure venues for hearings. The January 2021 lockdown paused site visits normally undertaken prior to oral hearings, which delayed virtual hearings. In December 2020, we held a virtual staff and Panel Member event for our Pharmacy Appeals Committee[1] which determines pharmacy market entry and overpayment appeals following a review of papers or an oral hearing.

Online education for investigating and resolving concerns locally

Understandably, demand for our Practitioner Performance Advice face-to-face education services across the UK significantly reduced this year. All non-critical approaches to the NHS were paused. We have continued to support organisations where there has been a need identified and it has been risk-assessed as safe to do so, including delivering one-on-one briefing sessions. In July and August 2020 we held regional webinars on managing performance concerns during Covid-19 to share learning and provide support to managers. Time available this year has been used to revise and update our education offer to enable digital delivery. This has allowed users to access webinars and educational content remotely, which has reduced travel time and costs for delegates who would otherwise have needed to travel to attend face-to-face events.

[1] https://resolution.nhs.uk/services/primary-care-appeals/pharmacy-appeal-committee/

Priority 2: Going further to deliver early resolution

Our ambition was to:

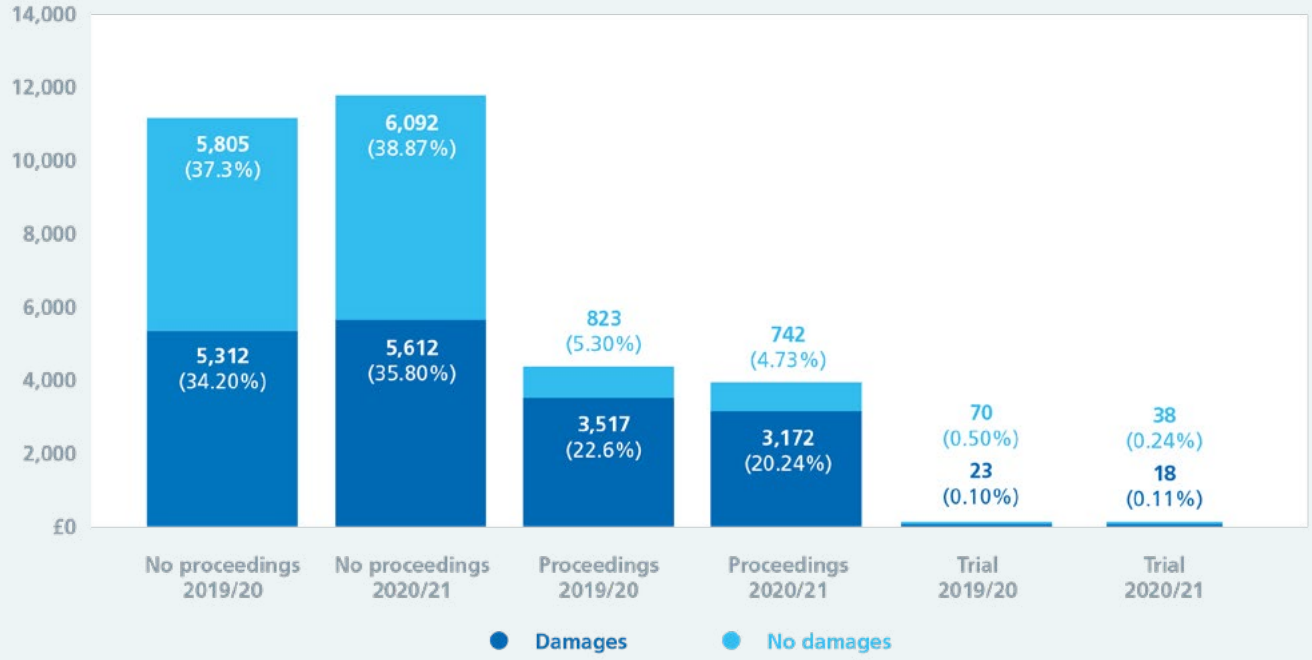
- provide cost effective resolution, concluding cases early and evaluating and broadening our range of dispute resolution services;
- extend the reach of our services into the organisations we indemnify and support the resolution of concerns and disputes through our Practitioner Performance Advice service; and
- as our Early Notification Scheme for maternity starts to mature, we wished to consider how to best compensate patients fairly and revisit the criteria for entry into the scheme.

When matters result in a claim for compensation, or a concern about a practitioner being raised with our Practitioner Performance Advice service, it is our ambition to move the parties involved into a neutral space to achieve early and cost effective resolution. We aim to prevent things escalating unnecessarily into an adversarial dispute, which drives up cost and is distressing to all concerned.

Providing cost effective resolution

The following section reports progress on the activities we undertook over the course of the year to ensure we are cost effective in how we deliver resolution and reduce the need for court proceedings.

Figure 16: 15,674 clinical and non-clinical claims were settled in 2020/21 compared with 15,550 in 2019/20 with an increasing percentage settled without proceedings



We settled 124 more claims in 2020/21 compared to 2019/20. As explained earlier in this report, the pandemic will have had some effect on our ability to settle claims, but the majority of those settled will relate to an incident from many years previously and initial investigations will have commenced pre-pandemic. We met our time to resolution KPI, which aims to reduce the amount of time taken to resolve a case, once a liability decision has been made.

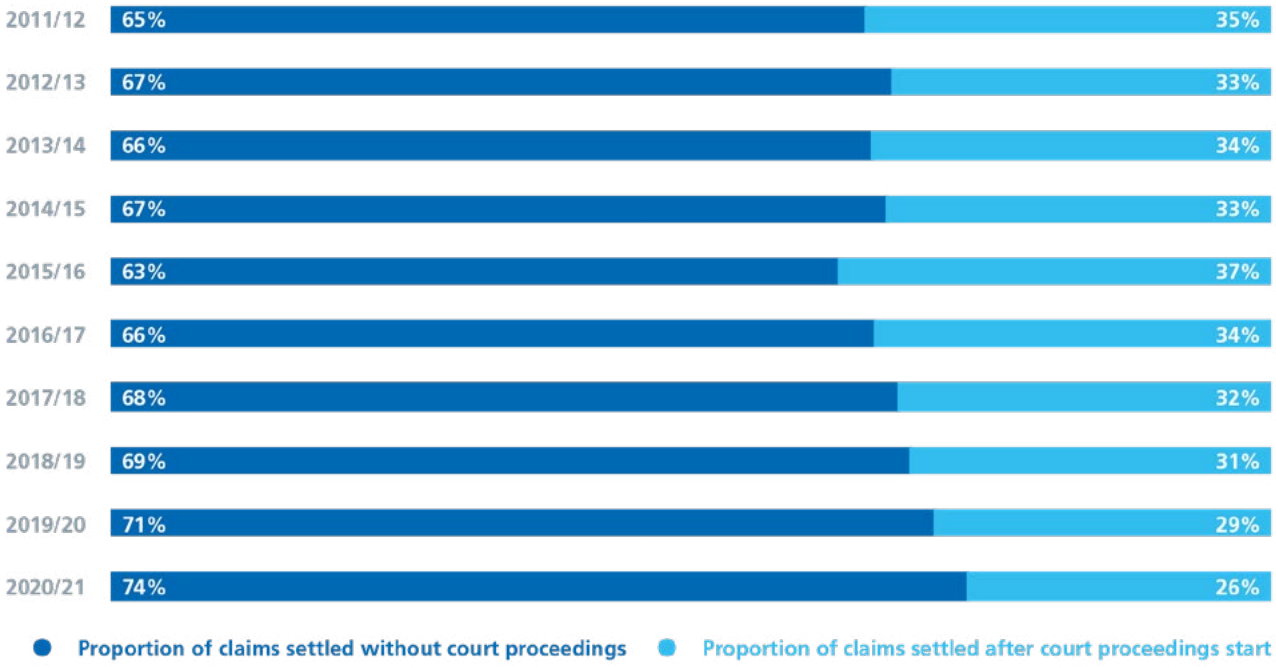
Of the 15,674 settled claims in 2020/21, 43.8% settled without damages being paid. This compares to 43.1% in 2019/20. The percentage of claims settling without damages being paid will fluctuate, depending upon the nature of cases that are settled each year. We settle cases in line with our strategic aim to resolve cases fairly.

We settled the majority of claims without formal proceedings being required (74.7%, compared to 71.5% in 2019/20 – see Figure 16). The large majority of claims settled prior to formal legal proceedings being required are managed in-house, with assistance from our legal panel. They resolve through negotiation via correspondence, at settlement meetings or another form of dispute resolution.

Just over a quarter of our claims entered formal legal proceedings in 2020/21. Of those claims that enter formal court proceedings, 75.5% resulted in the payment of damages. This includes claims that require formal court approval, such as infant approvals or where claimants lack capacity or because the claim has been brought close to the expiry of limitation, and where we wish to clarify points of legal principle. Claims may also enter court proceedings due to a dispute over the amount of compensation sought. In such cases we will still make a damages payment, even if we are successful in that dispute.

Only 56 (0.4%) of our claims proceeded to trial in 2020/21, compared to 93 claims (0.6%) in 2019/20. In 38 claims (67.9%) we were successful in achieving judgement in favour of the NHS, compared to 70 claims (75.3%) in 2019/20.

Figure 17: Litigation rate for clinical claims



The percentage of cases settling before formal court proceedings are required has continued to increase, as a result of the actions taken to keep cases out of court. For each year since our strategy 'Delivering fair resolution and learning from harm' was launched, the percentage of cases going into court has reduced to a new historic low and now stands at 26%.

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.

XX v. Whittington Hospital NHS Trust

(Supreme Court, 1 April 2020)

In this case the Supreme Court allowed the recovery of commercial surrogacy costs based on arrangements in California, following a failure to diagnose and treat an invasive carcinoma. https://resolution.nhs.uk/2020/07/20/case-of-note-xx-v-whittington-hospital-nhs-trust-supreme-court-1-april-2020/

Ms L Metcalf v. Calderdale and Huddersfield NHS Foundation Trust

(Committal Hearing, 11/02/2021 – The Honourable Mr Justice Griffiths)

At a committal hearing on 11 February 2021, Ms Linda Metcalf was sentenced to six months in jail for deliberately attempting to defraud the NHS of in excess of £5.7 million. In addition, Ms Metcalf was ordered to repay the costs of the committal hearing within 28 days, amounting to £23,000. We pursued committal proceedings on behalf of Calderdale and Huddersfield NHS Foundation Trust in line with its strategy to combat and deter fraud by dishonest claimants. https://resolution.nhs.uk/2021/02/16/six-month-custodial-sentence-for-multi-million-pound-attempted-fraud-on-the-nhs/

EH v. Dorset Healthcare University NHS Foundation Trust

(Supreme Court, 30 October 2020)

In this tragic case the claimant pleaded guilty to manslaughter by reason of diminished responsibility, having killed her mother while experiencing a serious psychotic episode. The court ruled that this meant that she had accepted partial responsibility for her actions and it would be wholly wrong for an individual to recover damages in her own right in such a situation. https://resolution.nhs.uk/2021/03/18/case-of-note-eh-v-dorset-healthcare-university-nhs-foundation-trust-supreme-court-30-october-2020/

Judicial challenge and review

Legal challenge also arises in connection with our management of Primary Care Appeals. During the year, there was a challenge to our decision regarding the termination of a GP contract, having found for NHSE/I on the basis of patient safety. The court rejected the challenge on all grounds and a challenge brought in 2019 was rejected this financial year. In March 2020 the contractor and NHSE/I consented for Primary Care Appeals to revisit a decision to terminate a GP contract on the basis of patient safety. When invited by Primary Care Appeals, the contractor failed to confirm they wished to proceed within the allotted timeframe: as a result, the matter was treated as withdrawn and the file closed. The contractor attempted to submit a new application relating to the same dispute, which Primary Care Appeals rejected. The judicial challenge was dismissed by the court.

As reported in 2018/19, there was a judicial review regarding a number of decisions we made under special delegation from the Secretary of State for Health and Social Care relating to Alternative Primary Medical Services Contracts and whether NHS Resolution could award interest on monies owed. We initially held that decisions relating to interest fell outside of our remit and indeed the challenge was dismissed. However, on 25 November 2020, the Court of Appeal set out its expectation that "if a party to a dispute has been kept out of their money, it is prima facie appropriate that the resolution of that dispute should include provision to reflect and compensate the party for that fact". The court found that we do have the power to award interest when we find that a contractor has been underpaid or overpaid and NHS England seeks to claw back monies. Following the judgment, we have sought the views of key stakeholders such as NHSE/I and representative bodies for GPs, dentists, community pharmacy and opticians to help inform our approach in the future.

Providing value for money through our legal panel

We are in a unique position of being able to procure high quality legal services for the NHS in bulk in order to meet with an ongoing, and often urgent, need to access law firms with specialist expertise and knowledge to provide advice and support on a wide range of health-related issues. To ensure that our legal panel is providing a competitive service we regularly go out to tender. Our current legal framework, which was procured for three years, expires in 2021 and we will be tendering for a new panel to ensure they provide maximum value for money. In preparation for the upcoming legal panel tender, we have undertaken market engagement sessions with internal stakeholders, members, general practice beneficiaries and arm's length bodies, all of which will be taken into consideration when developing the requirements of the future framework. We have delayed the launch of this tender due to the pandemic and to avoid placing unnecessary demands on our members.

Dispute resolution

We are testing a wide range of innovative dispute resolution techniques. For example, the 'resolution meeting' process allows the parties to identify and discuss claims where there is limited progress or the claim is about to enter formal court proceedings. The commitment to these meetings has facilitated good working relationships between the parties and an effective process for claims resolution. Another initiative, known as the 'stock-take' procedure, involves scheduling formal meetings with lawyers acting for claimants at fixed stages during a claim, such as following service of the Letter of Response and prior to the service of formal court proceedings. At these fixed stages, the parties can identify the risks with their respective claims and avoid the issue of court proceedings if possible.

Claims mediation

The claims mediation service is designed to support patients, families and NHS staff in working together towards the resolution of incidents, legal claims, costs disputes, and to avoid the potential emotional stress and expense of going to court. We contract four providers to deliver this service: the Centre for Effective Dispute Resolution (CEDR)[1] and Trust Mediation Limited[2] mediate disputes around personal injury and clinical negligence incidents and claims; and St John's Buildings Limited[3] and Costs-ADR[4] mediate disputes relating to the recovery of legal costs.

Due to social distancing and lockdowns we developed an online mediation model, which has proven to be a very effective tool for resolution. In 2020/21 a total of 299 cases proceeded to mediation; of these, 77% of cases settled on the day mediation took place or within 28 days of the mediation. In many cases claimants have provided feedback that they find the remote mediation process less daunting because they are in their home environment. For claimants and clinicians the online format provides flexibility and reduces the time commitment needed to attend such meetings. Participants also agree that the online format does not diminish the opportunities for engagement between the parties and the delivery of direct apologies/explanations. Online mediations will therefore continue to be a feature for dispute resolution.

Since April 2020, our Safety and Learning team have participated in 29 mediations (an increase of 11 on the previous year) with 22 settling on the day of mediation or within 28 days, representing an 83% success rate. The team identified learning that could be extracted from 27 of the claims (93% of those attended) and signposted or provided direct support for our members in 20 of these cases. The presence of a clinical representative has been shown to improve outcomes (please refer to our report, Mediation in healthcare claims – an evaluation published in February 2020).

[1] www.cedr.com/solve/services/?p=33
[2] https://www.trustmediation.org.uk/nhs-resolution/
[3] https://stjohnsbuildings.com/nhs-resolution-mediation-service
[4] http://www.costs-adr.com/nhs-resolution-mediation-service

Supporting maternity services

Obstetrics claims continue to dominate the cost of clinical negligence, amounting to 59% of the total estimated value of incoming new claims. Incidents occurring in maternity can have devastating lifelong effects on patients and their families and the NHS staff involved. A primary focus for NHS Resolution therefore continues to be maternity. Steps taken to help reduce the likelihood of harm and associated costs include our Early Notification Scheme and our Maternity Incentive Scheme and steps such as the introduction of a new neonatal coding for recording claims help to maximise learning from the data we hold.

Figure 18a: The number of maternity cerebral palsy/brain damage claims over time across all clinical negligence schemes

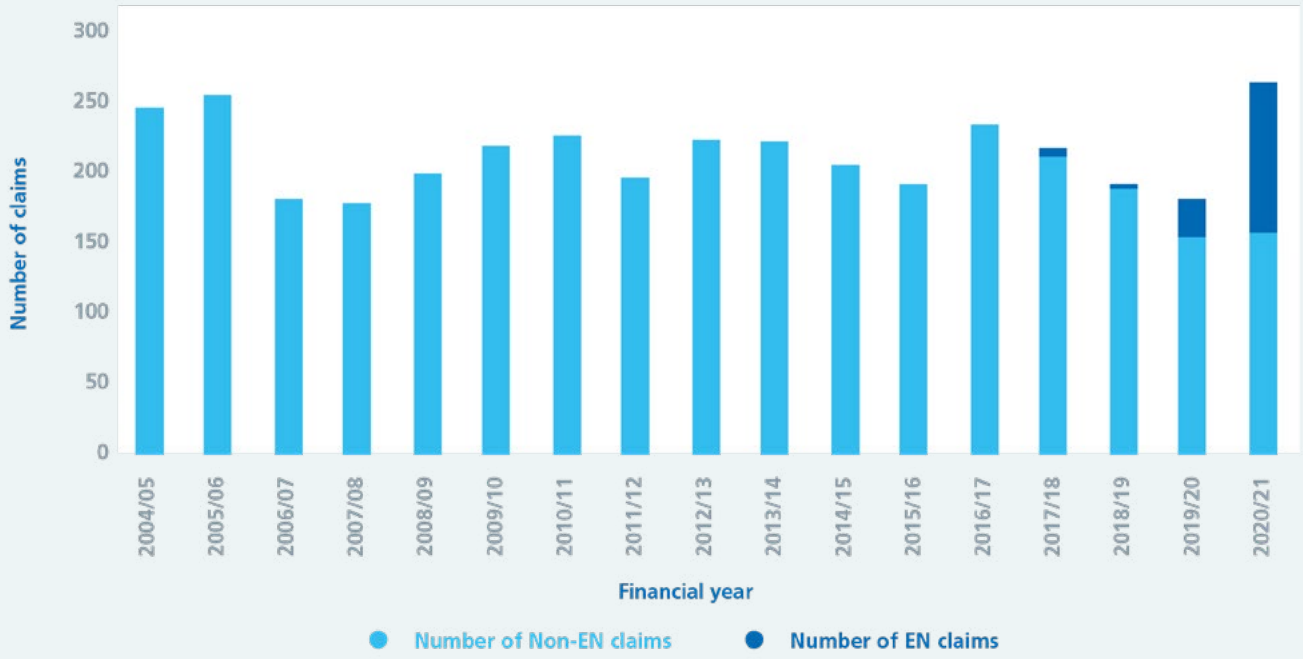


Figure 18b: The total value of maternity cerebral palsy/brain damage claims over time across all clinical negligence schemes

There has been a significant increase in the number of Early Notification matters classified as a claim during 2020/21 due to the stage of investigation reached – a total of 107 claims at a value of £1,159 million compared to 28 and £234 million respectively for 2019/20. However, it should be noted that not all of these claims will go on to have damages payments made against them.

Figure 19: Some headline maternity statistics (as of 2020/21)

40% of claim payments for all clinical schemes (£2.3 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 notifications or the incurred cost of harm described below.

59% of claims by value (£7.1 billion) notified to us in 2020/21.

60% of the £7.9 billion incurred cost of harm in CNST relates to maternity (£4.8 billion as at 31 March 2021).

68% (72% in 2019/20) of the total CNST provision (£52 billion as at 31 March 2021) – higher than incurred costs because this includes the long-term payments due under a settled periodical payment order (PPO) relates to maternity.

Early Notification Scheme

2020/21 marked the fourth year of the Early Notification Scheme and together with our partners for the scheme we evaluated the reporting requirements and its direction. Covid-19 accelerated some of this work, which was aided by clinical leads, including neonatologists and neuroradiologists. As a result we were able to issue updated guidance on reporting requirements and outline key improvements to streamline the investigation process to be implemented after 1 April 2021. Other changes in-year included establishing an Early Notification Maternity Voices (Parents) Group, to call upon the views and experiences of families who have had a baby diagnosed with a brain injury and to co-produce family-facing products and materials. We welcome their input, feedback and insight to inform future developments to the scheme.

Our next report focusing on the learning from the Early Notification Scheme is due to be published in 2021, and will build on the learning from the year one report published in September 2019. We have been supporting learning from claims with quarterly case stories (found on our dedicated Early Notification webpages under: Support for NHS trusts or member organisations). We continue to support trusts reporting cases into the scheme with progress conversations and taking action where we identify trusts of potential concern.

Maternity Incentive Scheme

Between March and October 2020, we worked with key stakeholders to monitor the effects of Covid-19 in the maternity sphere. Following approval from the Maternity Transformation Programme Board[1] the scheme was relaunched on 1 October 2020. Insights gathered during the pandemic resulted in changes to several of the safety actions[2], in particular safety action eight around multidisciplinary training and safety action six addressing the Saving Babies' Lives Care Bundle. Additional key themes that emerged, such as trust compliance to the statutory duty of candour, were included in safety action ten to improve practicein this area.

The Collaborative Advisory Group[3] approved the extension of the Maternity Incentive Scheme's deadline from 20 May 2021 to 15 July 2021, with further revisions to the safety actions and sub-requirements. To create our maternity incentive fund CNST members contribute an additional 10% of the CNST maternity premium to the scheme. In order to avoid compounding the financial impact of Covid-19, the Maternity Incentive Scheme element of contributions was not collected in April 2020. This effectively provided trusts with a years' break in Maternity Incentive Scheme fund contributions and trusts have received additional time to meet the requirements of year three of the scheme (albeit with some revisions to the requirements when relaunched on 1 October 2020). Contributions to the incentive fund and distributions from it will resume in 2021/22 as per usual.

Strengthening the conditions of the scheme

Eight trusts have been contacted regarding concerns about their Maternity Incentive Scheme declaration and have been regraded for year one and/or year two. To reduce the likelihood of mis-certifications, the conditions of the scheme in year three have been further strengthened. Full details of the revised conditions and improved external verification points are available on the NHS Resolution website[4].

Scheme impact

The scheme has had demonstrable success in driving improvements, such as improvements in trusts' safety culture, trust board engagement in maternity issues and greater influence for multi-disciplinary working, for example across anaesthetic and neonatal services. A full evaluation is expected to take place after four to five years of operation since this is the earliest we could expect to see a reduction in the number of brain injuries at birth reported to our Early Notification Scheme turning into legal claims.

Neonatal coding

Following the implementation of new coding to capture learning from neonatal claims, the Early Notification team continue to work very closely with the Group B Strep Support Charity (GBSS). Early analysis has taken place on a small number of reported claims, and the findings were shared at a national conference in June 2021. We have appointed a neonatal clinical fellow to drive forward this key area of work.

CNST pricing methodology

We are actively engaged with NHSE/I in reviewing the CNST pricing and tariff funding mechanism. The aim of this is to improve the transparency of CNST pricing and funding, and review options for incentives through the pricing mechanism. We are still in the early stages of this work and will engage with members of CNST at the appropriate time.

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[1] The Maternity Transformation Programme seeks to achieve the vision set out in Better Births by bringing together a wide range of organisations to lead and deliver across ten work streams. The programme is led by a programme Board, supported by a representative group of stakeholders that will scrutinise and challenge decisions made by the Board.

[2] https://resolution.nhs.uk/wp-content/uploads/2021/02/Maternity-Incentive-Scheme-year-three-final-01022021.pdf

[3] Collaborative Advisory Group membership includes representatives from the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, MBRRACE-UK, NHSE/I, the Care Quality Commission, NHS Digital and HSIB.

[4] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme

Extending the reach of our Practitioner Performance Advice service

This year our Practitioner Performance Advice service reached 83% of all secondary care trusts and regional primary care teams in England. Achieving this level of reach has been supported by the implementation of a new reporting system that monitors and informs engagement with healthcare organisations. We are taking steps to strengthen our profile in the primary care sector through proactively increasing our stakeholder engagement and educational reach, as well as closer partnership working with NHSE/I, particularly in the management of suspensions.

Successful introduction of new assessment models in relation to clinical performance and behaviours

In 2020/21 our focus was on making sure that assessments and interventions remained accessible to healthcare organisations during the pandemic and continued to meet their needs in managing performance concerns. At the beginning of the year, we had to pause our face-to-face assessments, but we were quickly able to move our behavioural assessments on to a virtual platform, with occupational psychologists conducting their in-depth interviews with practitioners by videoconference. We successfully completed 20 virtual behavioural assessments this year.

Another way we adapted quickly was through the development of a virtual model of assessment, initially for GPs. The aim of this model was to replace the need for independent assessors to visit the workplace, by giving them remote access to records and consultations. While this model is in development, we introduced a Local Assessment of Clinical Performance which enables healthcare organisations to undertake assessment locally. We have used our expertise to produce a bespoke framework, comprising different tools and activities, to assess different areas of a practitioner's clinical performance using local resources.

Pilot to support teams experiencing disruptive behaviours in clinical settings

We have developed a team review service which helps organisations to understand and manage behavioural and relationship issues affecting the functionality of the wider team. The training for team review facilitators was paused and it is planned this will resume early in spring 2021. By the end of the year we had been able to pilot and successfully deliver three team reviews using a remote, online format. As part of the ongoing development of the service and working in collaboration with one of our external partner organisations, Workforce Psychology Group, we have designed a bespoke team review questionnaire which is also being piloted and is expected to inform future team interventions.

Assisted mediations

We have expanded our pool of accredited mediators by training almost all of our Advisers to undertake assisted mediations. These interventions are independent, voluntary and confidential, where we work with two or more parties on an impartial basis to help resolve difficulties that are affecting professional relationships at work. In the autumn we piloted a virtual service undertaking four online mediations, which has been successful. The remote service will be rolled out more widely in 2021 and has also enabled us to provide a service which is tailored to the needs of the parties, meaning we can phase the process over two days rather than completing the mediation in a single session.

A review of our professional support and remediation service

Throughout the year, we have continued to help employers by preparing 29 action plans that supported practitioners to return to safe and effective clinical practice, sometimes after a period of absence or by addressing areas that require improvement/remediation. We developed a number of new resources to assist healthcare organisations in their management of cases locally, including a guide for clinical supervisors and templates for a behavioural agreement, and a security plan for practitioners undertaking clinical placements. These are available on our website. We maintained the efficiencies achieved through the review of the service business model we undertook last year, including improved customer service and delivery times.

Action Learning Circles

This year we piloted our new Action Learning Circles, including two cohorts of delegates (all from primary care), participating in four meetings each (with another two planned, delayed due to Covid-19 restrictions and balancing frontline commitments). Each group worked with experienced Advisers to form a trusted learning group to challenge thinking on how to manage complex case issues and to develop realistic and pragmatic solutions to problems relating to case investigation and case management. An interim evaluation was done and feedback was positive, with delegates saying that the sessions broadened their thinking and built their confidence. A final evaluation upon completion of all Action Learning Circles is planned.

Priority 3: Consolidating and communicating our offer to primary care

Our ambition was to:

- continue to focus our attention on managing claims for primary care in 2020/21;
- deliver an excellent service to our primary care partners and their patients across all of our business areas whether that be Primary Care Appeals, Practitioner Performance Advice or Claims Management; and
- work with others to ensure that our primary care offer supports the wider workforce objectives set out in the NHS Long Term Plan and the NHS People Plan.

In 2020/21 our role in primary care continued to expand as we moved into the second year of administration of the CNSGP, which launched on 1 April 2019 for all incidents occurring on or after that date, and transitioned arrangements for handling historical liabilities with two medical defence organisation, the MPS and MDDUS. In addition, with greater regionalisation and changes to provider/commissioner relationships, as we anticipate the introduction of integrated care systems we have been taking steps in-year to realign our services to support these changes at a local level.

General practice indemnity (GPI)

It is now two years since the launch of the CNSGP and one year since the launch of the ELSGP. In April 2020 we successfully migrated from the MDDUS their portfolio of historical liabilities (i.e. liability claims arising from incidents prior to 1 April 2019). We grew our expertise in general practice by expanding our teams, allowing us to fully embed ELSGP and prepare for the migration of the historical general practice liabilities of MPS members in April 2021.

We continue to support primary care clinicians and organisations by responding to indemnity queries in a timely manner and since the inception of CNSGP we have received nearly 4,500 queries, of which approximately 1,400 queries were received in 2020/21.

CNSGP is linked to contracts for the provision of NHS primary medical services rather than to individual members. This allows greater flexibility in a rapidly changing healthcare landscape. For example this meant that all general practice staff engaged in delivery of the Covid-19 vaccination programme were indemnified under CNSGP. The fully comprehensive nature of CNSGP alleviated the burden on primary care clinicians in general practice of having to ensure they had the necessary indemnity cover, as the indemnity position was communicated to primary care providers at the point of commissioning. CNSGP provides an assurance of comprehensive and unlimited cover not just to GPs themselves but also to practice nurses, receptionists and indeed anyone who plays a part in delivering care to patients working in GP practices.

We established a General Practice Sounding Board, which has been operational for the past year and provided a platform for frontline primary care workers and communication professionals to collaborate. Representatives from a number of membership organisations have used the board to shape messaging and develop products to ensure they resonate with the wider primary care workforce. The board has proven invaluable in developing materials over the past year, particularly in association with our general practice indemnity schemes.

A key benefit of having the CNSGP and ELSGP schemes under one roof along with the CNST claims is that this provides a unique overarching view of clinical claims across the NHS in England, which can support improvements to the quality and safety of healthcare services.

Learning from CNSGP claims

A comprehensive review of both open and closed cases using a high level analysis approach has been undertaken of data from the first year of CNSGP and we expect to publish a report in 2021. Reflecting such a broad clinical area, the report will focus on the scope and complexity of claims that occur in this specialty area and where there are common themes shared with secondary care. The report was developed in collaboration with subject matter experts from Royal Colleges and other arm's length bodies, and will identify some practical safety recommendations to influence improvements to general practice patient safety. We have identified early areas of focus, which include failures or delays in diagnosis and prescribing errors.
We will closely work with primary care to support their safety and quality efforts. As the CNSGP and ELSGP schemes mature we continue to work with DHSC and colleagues from NHSE/I to ensure the schemes remain fit-for-purpose and support general practice in the rapidly evolving healthcare environment in which primary medical service providers operate.

Learning from ELSGP claims

The ELSGP provides indemnity cover for NHS clinical claims made against current and former general practice members of those medical defence organisations participating in the scheme (currently the MPS and MDDUS). In April 2020 NHS Resolution inherited open claims from MDDUS, which will be managed within the scheme. Clinicians from our Safety and Learning service and legal panel have undertaken a high level review of these claims and extracted themes.

Primary Care Appeals service

In November 2020, Primary Care Appeals engaged with NHSE/I to explore joint opportunities to provide interventions and solutions to support learning from, among other things, appeals and disputes (such as sharing intelligence and developing and promoting training modules and other materials). The aim of this collaboration is to build capability and skills across NHSE/I local offices to ensure decisions are taken lawfully, fairly and consistently, with more disputes being resolved locally where possible.

In December 2020, Primary Care Appeals held a number of meetings with regular users of its services to explore users' views of the effectiveness, efficiency and robustness of the service – providing rich feedback to drive enhancements to service delivery and inform the service's educational offer for 2021/22. As part of our commitment to greater data transparency, the outcomes of pharmaceutical appeals regarding breach notices, remedial notices and overpayments and medical, dental and ophthalmic disputes for the period 1 April 2015 to 31 March 2020 are all now available in one location at https://resolution.nhs.uk/resources/primary-care-appeals-disputes-outcomes-2015-20/.

In terms of sharing knowledge to support the system, between December 2020 and March 2021 Primary Care Appeals published new or refreshed existing guidance on the following:

- general guidance for parties involved in the NHS dispute resolution procedure;
- the Local Dispute Resolution Protocol for GP premises rental disputes;
- guidance regarding termination of Primary Medical Services Contracts;
- guidance regarding termination of Primary Dental Services Contracts; and
- a range of pharmacy-related guidance.

Priority 4: Working with our partners to strengthen collaboration and share our insight

Our ambition was to:

- ensure what we share for learning had the greatest impact, working with and through others;
- strengthen our collaboration with partner organisations to enable improvements in care, and act quickly on emerging concerns using the insights we were able to share;
- make the most of the platform of membership of our indemnity schemes; and
- continue our work to convene experts, providers and users of healthcare services to consider what works well in addressing the causes of harm.

The broadened responsibility across secondary and primary care has provided opportunities to develop new relationships, build closer networks, bring system partners together and share learning to support the ambition to support improvements in safety. These relationships support collaborative working with stakeholders and raise awareness of our holistic offer to the system.

How are we contributing to the work to make the NHS as safe as we can, working through and with others?

Our work in the field of improving patient safety focuses on two key areas:

- Supporting reductions in the frequency of harm by focusing on **prevention**, for example using recommendations or safety actions, particularly at a clinical specialty level, informed by our thematic reviews.
- Improving the **response to harm** so that concerns are resolved locally including developing and sharing resources that support openness, candour, meaningful apologies, and support to families and staff. As well as ensuring that learning from claims routinely takes place, e.g. through appropriate governance meetings, action plans, etc.

Prevention

In the prevention arena we continue to collaborate with other parts of the health sector to improve safety, for example through our work with the Maternity Incentive Scheme Collaborative Advisory Group to use our financial levers for change – activity around this strand of work is described on page 61.

We work with others across the healthcare system to provide insights around organisations that may be struggling with the provision of services and that could be a cause for concern, with the aim of earlier intervention by the relevant regulatory body to provide support. During 2020, NHS Resolution convened a maternity surveillance meeting on behalf of stakeholders such as the Royal College of Midwives, RCOG, NHSE/I, CQC and HSIB, to maintain oversight and align activities where there were potential trusts of concern. This meeting evolved into the National Maternity Safety Surveillance and Concerns Group chaired by the Chief Midwifery Officer for England and the National Clinical Director for Maternity and Women's Health for NHSE/I. This group is a key element of the new approach to quality oversight and surveillance of the maternity system, in which data and intelligence flows from local and regional to national oversight boards. NHS Resolution continues to contribute to wider key stakeholder maternity meetings, and especially those where the impact of Covid-19 on maternal and neonatal outcomes are discussed.

We are the trusted source of learning from claims, concerns and disputes. Our learning resources are evidence based, co-developed with patients and families, safety experts and frontline NHS staff, and enable safety improvements locally. During 2020/21 we made significant progress on two thematic reviews exploring claims from emergency medicine (covering maximum severity claims and fatalities, missed fractures and pressure ulcers and falls) and diabetes and lower-limb complications, which we aim to publish in the next financial year.

Sharing data for learning

Emergency department thematic review

During 2020/21 we have undertaken a review of a cohort of emergency medicine claims which we plan to publish as a series of three reports later in 2021/22 covering:

- fatalities and maximum severity claims;
- missed fractures;
- hospital-acquired pressure ulcers; and
- falls.

The authors have collaborated with subject matter experts from royal colleges, GIRFT and other arm's length bodies, to produce some practical safety recommendations to influence improvements to patient safety.

Diabetes and lower limb complications thematic review

We have observed an increasing number of claims involving patients with diabetes and an associated lower limb problem. We also recognise that undergoing an amputation or losing limb function is a catastrophic event in a patient's life, with long-term repercussions. To be published this year, the aim of this thematic review will be to reduce these often devastating incidents of harm. This strand of work is also an example of the benefits we will see having expanded our Claims Management service into primary care as the addition of the general practice indemnity schemes means we now hold a data not only relating to trusts but also primary care. The project has capitalised on this knowledge by examining not only the specific episode of care addressed by the claim, but also the preceding care leading to that point. We have endeavoured to identify themes across the entire patient journey, incorporating a focus on general practice, specialist foot care teams and inpatient management, examining the pathways between these services to see where the barriers to streamlined, integrated care lie. The next stage of the project will involve working with clinicians and networks to discuss how the report's findings can be best implemented and used to improve clinical practice. The full report will be published later this year

Other topic-led work has tackled topics such as never event claims, correct site surgery, learning disabilities, assaults and cauda equina syndrome.

10 Years of exclusions report with the University of Plymouth

Our Practitioner Performance Advice service helps employers to consider the options available to them when considering excluding a practitioner, to ensure that their decision is reasonable and proportionate to the circumstances, and is in the interests of patient safety. We have made significant progress in our learning exercise to understand more about the national picture on exclusions and how we support the NHS in managing these more complex cases. Further work is underway to analyse data to better understand the likelihood of being excluded for practitioners from different ethnic and age groups. This work has already informed our new research work-plan and we aim to disseminate the learning related to exclusions in 2021/22.

During the financial year, we launched the research and evaluation work plan and took the opportunity to publish short and timely insights to support healthcare organisations to better understand, manage and resolve concerns about practitioners.

The first publication described the concerns raised by healthcare organisations. Data from 2015 to 2020 show that almost 70% of cases involved concerns associated with the behaviour of a practitioner, just under half of cases involved a concern about clinical skills and concerns around the health of the practitioner was reported in approximately 20% of cases. Our next publication summarised themes from Practitioner Performance Advice casework during the Covid-19 pandemic. Although the pattern of behavioural, clinical and health concerns has remained similar, there were numerous issues specifically related to Covid-19, including allegations of discrimination and/or racism and increased risks to BAME staff and redeployment of staff to areas outside of their specialty which may exacerbate previous performance issues.

Improving the response to harm

The Faculty of Learning

Our online Faculty of Learning provides access to a range of learning resources and materials. The aim is deliver quality education and training products to support members to improve safety, reduce harm and facilitate better patient and family experience. Current modules within the Faculty (https://resolution.nhs.uk/faculty-of-learning) include:

- consent;
- learning from inquests;
- point of incident resolution for families and carers; and
- point of incident resolution for staff.

An academic partner

In January 2021 we appointed our first academic partner, the consortium of London Southbank University and Staffordshire University, to provide a range of services to support learning from harm and to help develop our Faculty of Learning.

Other learning resources

Cauda equina syndrome

Cauda equina syndrome was an area of national focus in 2020 and our aim was to share the learning from these high value claims that are largely preventable if the right care pathways and systems are in place. The effects of inadequate management of cauda equina syndrome red flag symptoms can result in life-changing injuries, which are often associated with significant psychological effects. We reviewed all claims notified to us between 2008 and 2018 to help identify the volume, value, associated costs and themes and trends from these claims. The findings were shared via an updated *Did you know?* leaflet and two national webinars, which were attended by 350 registrants from all areas and specialities across primary and secondary care.

Never events claims

'Never events' are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. Revised January 2018, the NHS Improvement (NHSI) Never Events policy and framework explains that never events may highlight potential weaknesses in how an organisation manages fundamental safety processes. We undertook a review of all never event claims notified to us between 2014 and 2019. The research highlighted that the highest volume/value claims were for surgery: wrong site surgery, wrong implant/prosthesis; and retained foreign object post procedure. These findings will be used to produce a series of *Did you know?* leaflets to identify the volume, value and associated costs of these never event claims as well as any themes or trends to support clinicians and organisations with sharing the learning from never events.

The Safety and Learning team are also working with NHSE/I and HSIB to ensure the learning from never events is shared nationally. It is acknowledged that learning from incidents locally requires a culture of openness and honesty to ensure staff, patients, families and carers feel supported to speak up in a constructive way – and a strong reminder of the importance of our work around *Being fair*.

Being fair

We continue to promote the importance of embedding a fair and learning culture for staff, patients, families and carers. NHS organisations have been asked to promote the *Being fair* guidance and embed the associated charter. We are working with a range of NHS partners in taking this work forward, including various royal colleges, the General Medical Council, National Midwifery Council, the Care Quality Commission and other NHS arm's length bodies. Further work is planned with the British Medical Association, Royal College of Nursing, Royal College of Midwives and others during 2021.

Response to harm

Increased engagement with clinicians in member and beneficiary organisations

We support members or beneficiaries of indemnity schemes to better understand their claims risk profiles. We do this by raising awareness and supporting their analysis of claims to target their safety activity. Our Safety and Learning team are regionally based and provide both a regional and national view of patient and staff safety issues facing our members.

2020 claims scorecard

Following feedback obtained via our member survey we have created an animation to explain how members can make the best use of their claims scorecard. Using your scorecard describes what data is held in the scorecard and how it can be manipulated to help identify themes and priority safety areas, and how scorecards can be used alongside other data sets to build a broader picture of patient safety. We continue to support members at a local level to access, use and interpret their scorecards to support learning from claims. Members are encouraged to review their claims alongside their complaints and incident data to identify key contributing factors and implement actions to prevent and reduce harm. The 2021 scorecard due later this year will, as ever, provide a high level presentation of claims data for each organisation.

Duty of candour and a learning culture

From 1 April 2020 we have a Safety and Learning Lead role with a focus on mediation to:

- support our members with identifying learning, implementing quality improvements and sharing good practice;
- help foster a learning and quality improvement culture;
- drive high standards of duty of candour; and
- proactively assist in the resolution of disputes.

We have also been supporting the Parliamentary and Health Service Ombudsman with a range of work on handling concerns and the development of a Complaints Standards Framework.

Sharing data to support the system

We continue to work closely with others to share our data where this is in the public interest. For example providing information and expertise to support the Government's work on fixed recoverable costs to support decision-making across the system. Our data sharing agreements allow us to help the work of others striving to improve patient safety, such as the GIRFT team at NHSE/I. We have also taken steps to increase the transparency and accessibility of the information we hold – for example publishing an analysis of 13 years of claims data to provide the wider system with this information, available at https://resolution.nhs.uk/resources/annual-report-statistics/.

Priority 5: Undertaking operational transformation to restructure our claims service and developing new ways of working to enable a London office move to a government hub

Our ambition was to:

- drive further improvements in our operations by restructuring the way we deliver our services;
- revisit our operating model in our Claims Management service to integrate the then new general practice indemnity scheme, CNSGP, and deliver operational improvement across the board;
- move to a regional approach so that we could work hand-in-hand with local health systems; and
- work with our staff on new ways of working given a planned London office move to a government hub in early 2021 and the expansion of our Leeds base.

Our London office relocation

In March 2021 we officially relocated our London office to the government hub at 10 South Colonnade, Canary Wharf – in line with the government estates strategy.

Ways of Working

During the pandemic, along with much of the rest of the country, we moved to remote working for most of our staff. A positive outcome has been the opportunity to trial and test new ways of working at a much faster pace than we would have envisaged pre-pandemic. We worked closely with staff throughout the year, using a very engaged network of programme champions, to explore more agile ways of working in line with the government smarter working policy, and engaged with the Places for Growth Programme. This move is supported by an anticipated expansion in our regionally-based office space in Leeds as we increase our recruitment activities outside of London and extend our Claims Management service there. The expansion in Leeds also 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.

Our internal Ways of Working programme sought to ensure our work environment remains inspiring, innovative and productive – supported by reliable technology. We have used iterative co-design to help us to develop and communicate smarter work styles with staff to support our growing organisation. The adoption and embedding of MS Teams, and the move to a hybrid work pattern balanced between office and home locations as we begin to emerge from Covid-19 restrictions exemplify this. Based on the staff consultation exercise that we have undertaken, we anticipate that on average staff will work from the office two days a week.

Claims Evolution Programme

In the future more of our business (such as interacting with our claims service and our events) will be done online. To improve customer service and increase our efficiency and cost-effectiveness we started our Claims Evolution Programme aimed at getting the best out of, and developing, our workforce. You can find out more about how we are driving forward our equality, diversity and inclusion agenda in our *Remuneration and staff report* on page 101.

Investors in People (IIP)

It has been a year since we finished our IIP assessment and achieved a Silver award. We therefore undertook our 12-month review and were reassured with progress. Although our next round of accreditation is not due until 2023, we remain committed to the spirit of IIP and will continue to advance our ambitious programme of corporate investment in this area.

Priority 6: Setting our future course and starting work to transform our business intelligence capability and systems architecture

Our ambition was to improve our business intelligence capabilities in order to:

- contribute to reducing harm to patients by turning the data we hold into useful information which can be shared and have impact externally; and
- drive our operational efficiency, enhance the level of insight into our data and operations and inform policy development.

This priority explores the work we undertook to transform our business intelligence capability and systems architecture. This year we recruited our first Chief Information Officer to lead the work to improve our technology and data analytics capabilities and infrastructure.

Artificial intelligence

We completed some artificial intelligence proofs of concept to see how advances in technology will assist us in accessing and learning from our data. This included a document search tool, which will enable claims handlers and researchers to more quickly and easily access relevant information. We also collaborated with the NHSX artificial intelligence lab and initiated a project to explore the relationship between different NHS datasets and claims volumes.

Core Systems Programme

Since the launch of our five-year strategy in 2017, we have reviewed our information needs to meet our strategic priorities and how our current systems meet these. Central to this has been the creation of the core systems review which has, since 2018, examined and documented the case for a new core claims management, document management and customer relationship management system as well as a suite of new business intelligence tools to better understand and leverage our data. In 2020/21, following the completion of a review conducted by Deloitte in the previous year, we founded the Core Systems Programme and made significant progress in readying ourselves to undertake the implementation of a new system including the completion of a round of market engagement with recommended software vendors, and the approval of a full business case by NHSX and DHSC. With the approval of a full business case which supports the implementation of a new core system through to financial year 2023/24, and also the foundation of a continuous improvement team, we entered into procurement to identify a suitable vendor and implementation partner to support this Programme. We expect this procurement to complete in the summer of 2021 with implementation starting shortly thereafter.

Our finance system: one year on

Implemented in December 2019, we are now reaping the benefits of our new finance system with an improved interface with our claims management system to enable efficient processing of claims payments. The software has sufficient flexibility to evolve alongside our corporate needs. The second phase has allowed us to drive through improvements in prompt payments, with a greater proportion of invoices being paid within 30 days. The raising and approving requisitions for supplies is faster and overall accuracy of information has improved. Finally, the system is allowing us to develop dashboard reporting to provide more insightful management information.

An organisation fit for its purpose

We will need to build more infrastructure, develop our people, and make choices about our resources in order to meet the demands of the next stage of our development.

Training and talent management

Getting the right staff and retaining them is key to an efficient workforce that is fit for its purpose.

Apprenticeship and training

We are committed to staff development and the creation of career progression pathways to nurture our own talent.

Claims Management junior case manager apprenticeship programme

For the second year we have welcomed a new cohort of case handlers to the junior case manager apprenticeship programme. The apprenticeship combines practical on the job training under a supportive coaching, mentoring and training programme while studying with an external training provider to complete the Insurance Professional Level 4 Apprenticeship. The junior case managers work closely with our claims teams, handling cases with support, allowing them to put their training directly into practice and providing a pathway to the role of case manager.

Training

In 2020/21 we started the design of a training and development framework which will provide our claims handlers with the skills, competencies, and technical ability required to fulfil their roles. We also invested in our current and future leaders by implementing pathways for development in operational and technical capacities. We worked with our internal subject matter experts, panel firms and external suppliers to build technical expertise and to help staff handle claims through a more empathic approach.

Sustainability report

NHS Resolution's main activities have been run from three offices: Arena Point in Leeds, Buckingham Palace Road and 10 South Colonnade, Canary Wharf, in London during a two-month transition period as we moved from one to the other. All three offices are leased as serviced offices with the landlord 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 and lease cost savings is through our commitment to the wider government initiatives around smarter working, Places for Growth and the hub strategy.

In 2020/21 we completed the migration of our IT systems to a data centre provider under a Crown Commercial Service framework and closed our Buckingham Palace Road office, thereby substantially reducing localised energy and IT infrastructure costs. Additionally, despite the growth in our headcount we took fewer desks than originally planned at 10 South Colonnade. Our technology roadmap includes more use of existing NHS platforms and services – this aids the rationalisation of our overall cyber security risk as well as producing further costs savings in the long term. Aligned with the wider government Internet First policy, we have plans to migrate our IT systems to the NHS Digital sponsored central tenant and adopt full use of the NHS Mail system.

Much of the running costs for our premises substantially reduced in 2020/21 due to our staff working remotely. The envisaged savings in these areas would need to be offset by the costs incurred by staff working remotely and the increased localised energy and utility costs this creates. We will be exploring this topic further at the DHSC sponsored Sustainability Forum.

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

Climate change and rural proofing

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

Greenhouse gas (GHG) emissions

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

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

Table 2: GHG emissions

GHG emissions: tonnes CO^2		2020/21	2019/20	2018/19	2017/18
Gross emissions for **scopes 1 and 2**	As occupiers of serviced offices, we do not have any energy usage under scopes 1 and 2				
Gross emissions for **scope 3**	Electricity	34	48	52	107
	Gas	11	19	18	18
	Business travel	3	38	44	24

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

The values for energy consumption, waste and use of finite resources for all years (in Tables 3, 5 and 6) are calculated from the floor space occupied by NHS Resolution, as a proportion of the whole building, at Buckingham Palace Road in London and Arena Point in Leeds.

Table 3: Energy consumption

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

Table 4: Travel

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

Table 5: Waste

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

Table 6: Use of finite resources

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

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

Next year we will include data for our new office at 10 South Colonnade, Canary Wharf, London – having only occupied the space from March 2021.

Finance report

Headlines in numbers

The **provision for the liabilities** arising from claims has decreased by £1.3 billion from £84.1 billion to £82.8 billion.

The cost of CNST **clinical negligence claims** incurred as a result of incidents in 2020/21 was £7.9 billion, down from £8.3 billion the previous year.

Payments made to settle claims in 2020/21 reduced by £120 million, to £2.26 billion.

Administration costs increased by £4.6 million (15%) to £35.4 million.

Budget position

- Department Expenditure Limit (DEL) £445 million under budget.
- Annually Managed Expenditure (AME) £9.7 billion under budget.

This year has been challenging across the healthcare and legal system because of the Covid-19 pandemic. NHS Resolution's activities have continued but we have experienced a number of operational challenges, as detailed on page 35. These challenges have had some impacts on our financial position which are discussed in this report.

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

Year-end provisions

The provision is the value of liabilities arising from incidents that occurred before 31 March 2021, 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 financial picture this year shows that the outlook for claims activity has improved. This is a continuation of the trend seen last year, with inflationary expectations reducing and favourable trends on high value claim numbers. These improvements are reflected in the fact that the total provision has reduced year-on-year from £84.1 billion to £82.8 billion.

Overall, the average cost of claims has not kept pace with the inflation expectations in recent years. This has an impact on the provision in a number of ways. First, the average cost per claim assumptions for this year are not as high as might have been expected based on the assumptions selected last year. The second impact is on the assumption for future claims inflation related to damages payments on PPO claims, which has reduced by 0.25%. The claims inflation assumptions are set by considering the inflated cost of PPO settlements over the last ten years using a range of different claims inflation rates. Based on the analysis, a reduction in claims inflation between 0% and 1% appears reasonable. The claims inflation assumption is applied to cashflows that can emerge over ten years into the future, due to the long settlement delays of PPO claims. The Reserving and Pricing committee therefore decided that it was important to reflect the improvement observed and reduce the rate by a relatively small percentage at this stage. The assumption is reviewed annually.

We have reviewed historical differences between ASHE and CPI and considered developments that might influence ASHE in the future. Based on this, a reasonable range for the ASHE assumption is CPI+1.5% to CPI+2%: a central assumption of CPI+1.75% was agreed. This represents a reduction from last year when the assumption was set at CPI+2.0% and reflects weaker forecasts of earnings. In proposing this assumption we have considered the historical difference between ASHE and CPI and considered developments that could influence ASHE in the future, such as Covid-19 and Brexit and any potential differences between health sector and general economy earnings.

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 2020/21 covered by CNST was £7.9 billion, compared to £8.3 billion in 2019/20 (see Note 2.1 to the accounts). This is lower due to changes to financial assumptions described above.

Although the Covid-19 pandemic has had a big impact on activity across the healthcare system in 2020/21 the estimated impact on the provision is limited (see Figure 20 following) because:

- The impact of Covid-19 is largely on incidents which have occurred in the last financial year only and the majority of the provision (£74.4 billion for all schemes) relates to incidents before this.
- The majority (65%) of the provision relates to maternity claims, and the evidence available to date suggests the risk of negligence from maternity activity in 2020/21 is similar to previous years.

Where Covid-19 does affect the provision, there are two partly offsetting factors. We expect lower claim numbers from lower clinical activity, particularly for non maternity activity, and estimate that this will reduce the provision by £0.4 billion. This is offset by new risks and potential sources of claims, which we have estimated will increase the provision by £0.9billion, resulting in a net increase of £0.5 billion. A further allowance for general risk and uncertainty has been included in the claims inflation assumption to cover at present unquantifiable claims risk in relation to the pandemic, as well as other areas of uncertainty.

Due to 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 is discussed in detail in Note 7 to the accounts, but in summary we have considered the impact in the following parts:

- 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 indirect 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.

Due to the inherent uncertainties in estimating the provision, we include a risk and uncertainty margin to the claims inflation assumption to allow for liabilities that may exist but where it is not possible to place a value. NHS Resolution's Reserving and Pricing Committee decided to retain the risk and uncertainty margin at the same level as 2019/20. This is due to the presence of trends which may affect high value maternity claims in a favourable direction in particular, offset by the possibility that new risks may emerge as a result of Covid-19 which are difficult to quantify at this stage.

Figure 20: Change in NHS Resolution provisions for all schemes

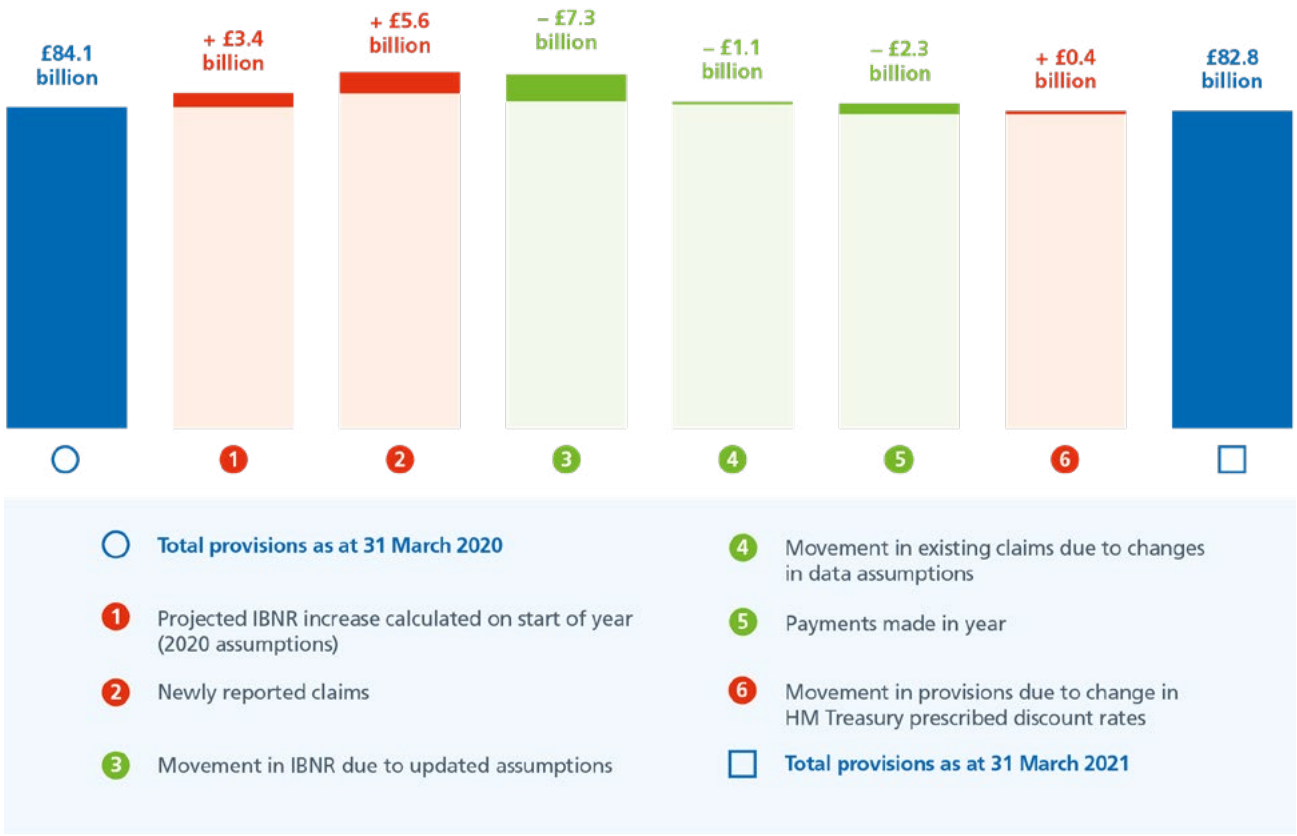


Figure 20 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

Items 1 and 2: Liabilities from another year's worth of activity for all schemes for all incident years are £9 billion.

The value of the known claims provision for new claims received during 2020/21 was £5.6 billion, £0.6 billion more than in 2019/20. Of the new claims recognised in 2020/21, £1.4 billion relates to Early Notification (EN) incidents now recognised as EN claims, an increase of £1 billion from 2019/20.

Item 3: shows a decrease of £7.3 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease in the CNST IBNR, which is the most material component, are:

- A decrease of £2.8 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 – particularly for PPO damage payments which make up the majority of the IBNR provision.
- A decrease of £1.9 billion for the future ASHE inflation assumption, which is used in the valuation of PPOs. This reflects consideration of the historical ASHE inflation rates and future earnings growth potential.
- A decrease of £3.5 billion for the change in assumption for the projected number of claims. Reported claims development continues to show improvements noted in previous years. This therefore reduces the estimated number of IBNR claims and hence reduces the provision.
- An increase of £0.7 billion for new risks arising from Covid-19 on CNST, offset by a £0.4 billion reduction due to lower clinical activity during the financial year, a net increase of £0.3 billion. This is the net of the direct and indirect impacts as discussed earlier.

The remaining increase of £0.6 billion relates to the effects of assumption changes on IBNR for the other indemnity schemes. This includes a net increase of £0.2 billion for the effect of Covid-19 on the generation of new risks and reducing business as usual activity.

Item 4: The liability has decreased by £1.1 billion in respect of changes in assumptions affecting known claims.

- A net increase of £400 million relates to claims that were open at 31 March 2020 and remain open at 31 March 2021. This is due to reserve values, estimated settlement year and probability of success of individual claims being revised as more information becomes available, as well as changes in inflation and ASHE assumptions.
- A decrease of £1.5 billion in the liability relates to claims closed during the year, either at a lower value than expected, or where the claim was repudiated.

Item 5: £2.3 billion was paid out during the financial year to settle claims. This is lower than the amount we receive in claims from another year's worth of activity (Items 1 and 2) partly because we generally settle high value cases where ongoing care is a feature, with a periodical payment order (PPO). This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2015/16 financial year), the number of PPOs in payment was 1,712 with £158 million paid out that year, and a whole life value of £10.7 billion. At the end of this financial year, the equivalent figures were 2,445, £311 million and £19.1 billion respectively. Many of those types of cases involve long life expectancy, so the liability will continue to grow for some time, as each year we add another year's worth of activity to the existing claims book.

Item 6: There is a small increase in the provision due to the reductions in the short- and medium-term discount rates specified for use by HM Treasury under the Public Expenditure System (PES).

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. The resulting small changes in assumptions, as well as changes to discount rates reflecting the financial/market environment, as described above can have significant impacts on the provision valuation from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail in *Note 7.2* to the accounts on page 146.

In-year financial performance

The settlement and administration of indemnity schemes is funded by a combination of contributions from members (NHS and independent sector providers of health care, clinical commissioning groups and other DHSC ALBs), and financing from DHSC. General practice indemnity costs are funded out of the budget held by NHSE/I for the NHS, via DHSC financing. DHSC sets a budget in respect of this financing on a DEL basis. The DEL is a HM Treasury budgetary 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

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

				2020/21	2019/20
	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	Percentage under / (over)spend	Expenditure (£ million)
Member funded – CNST	2,244	1,914	330	15%	1,913
PIDR funding – CNST	220	166	54	25%	260
DHSC funded schemes	116	85	31	27%	95
PIDR funding – DHSC schemes	15	1	14	93%	10
General Practice Indemnity	68	67	1	1%	65
CNSC	0	0	0	0%	0
Total clinical schemes	**2,663**	**2,233**	**430**	**16%**	**2,343**

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

The Personal Injury Discount Rate (PIDR), which is used by the courts to place a current value on claims settlements where there is an element of future loss, changed in August 2019 resulting in a reduction in the cost of in-year settlements compared to the previous financial year. However this has still added £245 million to the cost of settlements compared to when the rate was set at 2.5% prior to March 2017 (Figure 6 on page 43). PIDR costs were part funded by members in 2020/21. The member funded CNST line in Table 7 includes PIDR funding of £100 million in the £2,244 million budget and £76 million expenditure within the £1,914 million expenditure. In 2019/20 DHSC provided additional funding for all PIDR costs for CNST.

Clinical schemes underspent by £430 million/16% against budget, with the majority of this being against our largest scheme, CNST. The main components of the underspend were as follows:

- Cashflow forecasts, which form the basis for the budgets for the indemnity schemes, are developed in the summer prior to the budgetary year in question, in this case, summer 2019 for the 2020/21 budgetary year. However, during the second half of 2019/20, expenditure on our schemes started to slow down, and we incurred a £95 million underspend against the budget, contrary to expectations.
- We had planned for an increase in expenditure in settling claims of £225 million in 2020/21 from the prior year. This was in anticipation of a level of inflation in claims settlement costs as well as an increase in activity arising from various claims initiatives by NHS Resolution. However, as described elsewhere in the annual report, claims activity has been impacted by the pandemic, something that was not anticipated when budgets were set during the summer of 2019 when we updated our forecasts.
- Actual expenditure reduced by £110 million year-on-year, the elements of which were:
- Transaction activity:
  - Although more claims had payments made against them during 2020/21 compared to the previous year, the average cost of claims payments reduced.
  - However, much of the growth in payment activity occurred in NHS legal costs (which accounts for only 7% of total scheme payments – see Figure 6 on page 43). NHS legal costs grew by £7.9 million in 2020/21, of which £4.4 million was in relation to the take-on of over 800 claims from MDDUS in April 2020. A further £1.5 million was spent on accelerating investigations on Early Notification claims to establish liability – these costs would have been spent in future years were it not for the early recognition and investigation of birth incidents.
  - Reductions in the number of damages and claimant legal cost payments and their average size (the most significant elements of claims payments) were most pronounced in claims with a reserve value of more than £3.25 million. This accounted for £82 million of the year-on-year reduction in expenditure.
- Further reductions in expenditure were incurred in ELGP (not included in the analysis above) as MDDUS claims transferred over to NHS Resolution in April 2020, and in expenditure incurred on claims settled or expected to settle without damages.
- This was partially offset by a £4.8 million increase in NHS Resolution's administration costs for clinical schemes, which is explained later in this report.

Table 8: Non-clinical schemes financial performance

				2020/21	2019/20
	Income / budget (£ million)	Expenditure (£ million)	Under / (over)spend (£ million)	Percentage under / (over)spend	Expenditure (£ million)
Member funded – LTPS	57	45	12	21%	47
Member funded – PES	8	3	5	63%	6
DHSC funded scheme	5	8	(3)	-60%	6
CTIS	0	0	0	0%	0
Total non-clinical schemes	**70**	**56**	**14**	**20%**	**59**

Non-clinical claims expenditure continues to be relatively stable over recent years.

We have settled slightly fewer LTPS claims in 2020/21 compared to 2019/20 which has impacted in-year spending. Some claimant lawyer firms that deal with non-clinical claims and our members have been operationally impacted by events during 2020/21, and this has most likely contributed to reduced volumes of new cases reported and the pace at which existing claims have been settled. The fact the time lag from incident to case notification is shorter in non-clinical claims means that any effect the pandemic has on volumes will be noted earlier than in clinical claim volumes.

Expenditure on PES continues to be volatile and it is difficult to predict due to the nature of claims, which are predominantly due to fire or escape of water.

Annually Managed Expenditure

NHS Resolution also has a budget for Annually Managed Expenditure (AME). This is to cover expenditure on volatile or difficult-to-manage budget items, and is set on an annual basis. Our AME expenditure is in respect of the net movement in provisions for all of the indemnity schemes, i.e. the change in the provision less any provisions settled in the year. Performance against budget is forecast in line with the Parliamentary timetable, but this is before the work on setting the key assumptions from observed experience has commenced. Prudent estimates in relation to key potential variables are therefore used to inform the budget, in discussion with DHSC and HM Treasury.

As noted above (see item 3 under the waterfall Figure 20), some favourable movements in key assumptions, most significantly financial assumptions in relation to future inflation rates, have had a positive impact on AME expenditure this year, contributing to a £9.7 billion underspend. The key contributing factors to the budget variance are:

- Reduction in inflation and average costs assumptions (£2.8 billion lower than budget)
- Reduction in reported PPO claim number assumptions (£3.5 billion lower than budget)
- A prudent estimate for Covid-19 was applied to the budget resulting in a variance of £1.9 billion lower than budget.

Table 9: Annually managed expenditure

	(£m)	(£m)
Budget		8,400
Expenditure		
Net cost of new claims provisions	646	
Change in discount rate	346	
Settlement of provisions	(2,260)	
Total Expenditure		**(1,268)**
Under/(overspend)		**9,668**

Administration costs

Administration costs for all of our activities (including the costs of administering member-funded schemes and general practice indemnity arrangements which have been allocated to the scheme DEL budgets above) have increased by £4.6 million (14.9%) to £35.4 million. This primarily relates to staffing costs, as average full-time equivalent staff numbers have increased by 72 (22%) to 400.

In addition, this year we have generated £759k (£1.0 million in 2019/20) of income from commercial activity, primarily in respect of activities and services to other national governments delivered by our Practitioner Performance Advice service. These activities made a loss of £168k (22%) during the year, which was due to the impact of Covid-19 on our ability to deliver our educational events.

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 (such as new indemnity schemes for general practice) 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 0.98% to 1.28%. This reflects the increase in administration costs, but also the reduction in claims settlement costs experienced this year. Claims arising from the new general practice scheme, CNSGP, will not fall for settlement in the early years of the scheme and there is an element of front-loading of the administrative costs of establishing the scheme and handling claims before they fall for settlement, thus the above does not show a direct like-for-like comparison with activity. We have expanded our operations this year to include setting up the Clinical Negligence Scheme for Coronavirus and Coronavirus Temporary Indemnity Scheme. In addition, we have expanded our claims administration of general practice indemnity to include the claims previously managed by MDDUS and in the later part of the year we have been preparing for the take-on of claims from MPS which took effect in April 2021. This year we have also progressed on the preparatory stages of our IT infrastructure change through our Core Systems project.

Figure 21: Administration spend as a percentage of annual total claims settlement costs

Capital

£604k was spent on capital purchases in the year, an underspend of £796k against the budget of £1,400k. The key areas of capital spend were the Ways of Working project (WoW) and machine reading work. The Ways of Working project supported the move of our London office from Buckingham Palace Road to Canary Wharf. The aim of the project was not just a physical move, but also an opportunity to introduce new technology and processes to improve efficiency in the way we interact with each other. The machine reading work is looking at automating the way we extract data from our operational databases to enable us to use it more effectively in claims management and further learning. The underspend in-year was due to delays in the WoW project, and smaller IT projects.

Cash

The cash balance at the start of the year was £121 million. The balance has increased to £298 million by the end of the year due to the in-year underspend on the member funded schemes. We have discussed with DHSC the options for using cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. In the current year, we have used cash surpluses on PIDR costs for the relevant schemes and £5.9 million in relation to GPI scheme spend rather than drawing additional cash from DHSC.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2020/21.

Helen Vernon
Chief Executive and Accounting Officer
Date: 7 July 2021

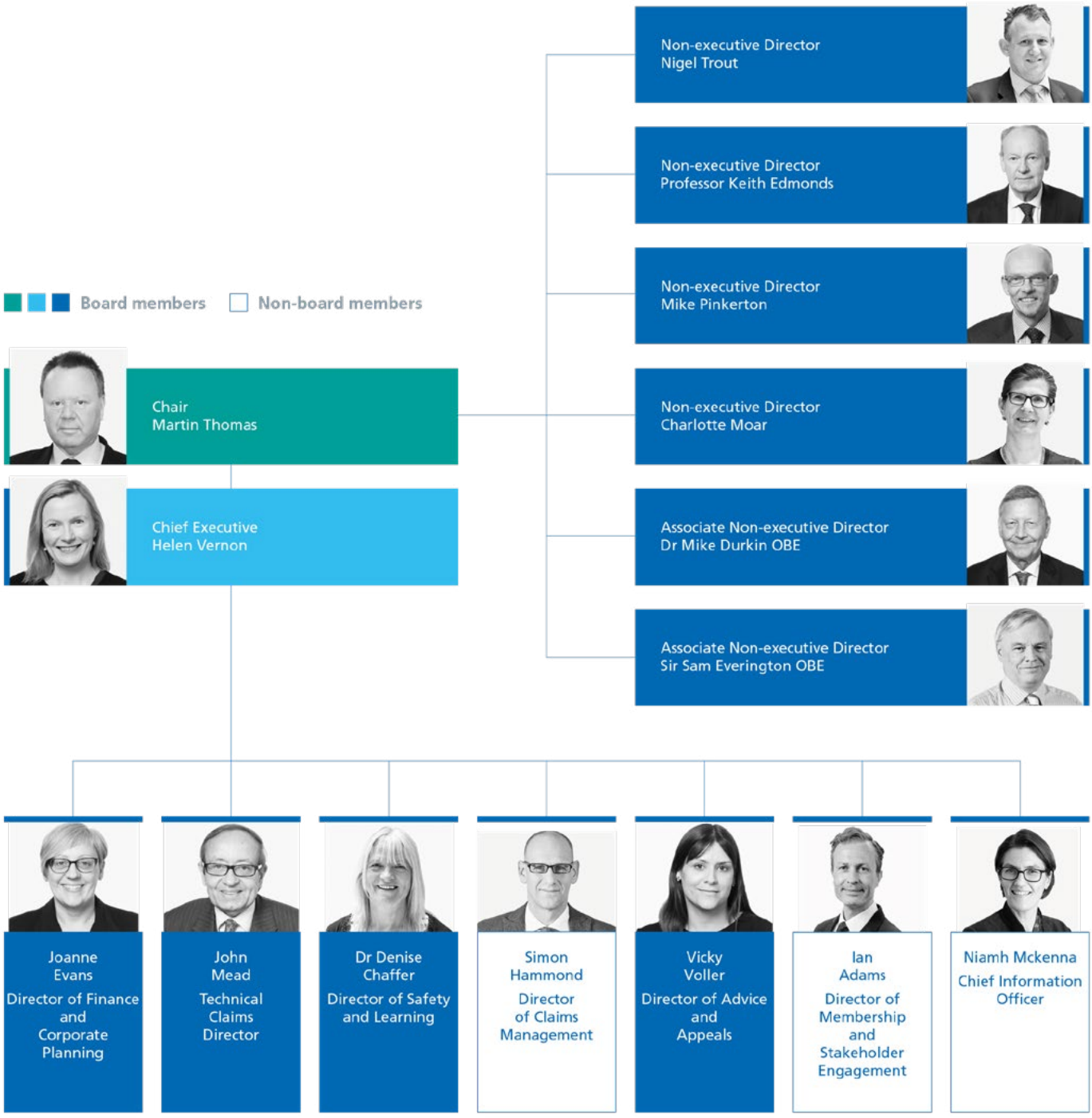
Accountability report

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 22: NHS Resolution's Board



NB Ian Dilks was Chair until 31 December 2020.

[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 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. As far as I am aware, there is no relevant audit information of which our auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that our auditors are aware of that information. I confirm that the annual report and accounts as a whole is fair, balanced and understandable.

Governance statement

Scope of responsibility

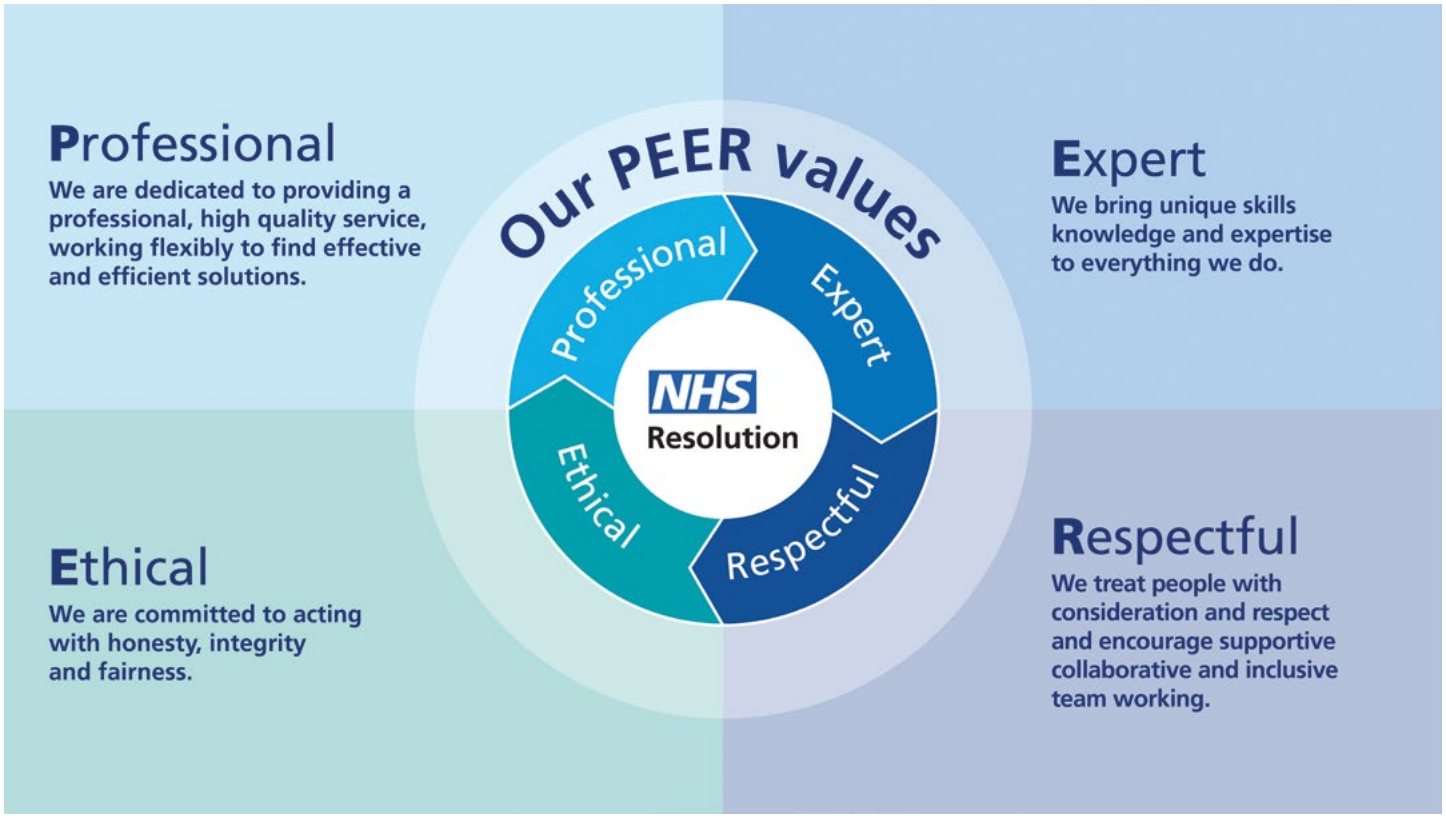
As Chief Executive and Accounting Officer of NHS Resolution I am responsible for maintaining a sound system of internal control that supports compliance with our policies and the achievement of our objectives while safeguarding public funds and our assets in accordance with the HM Treasury document *Managing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

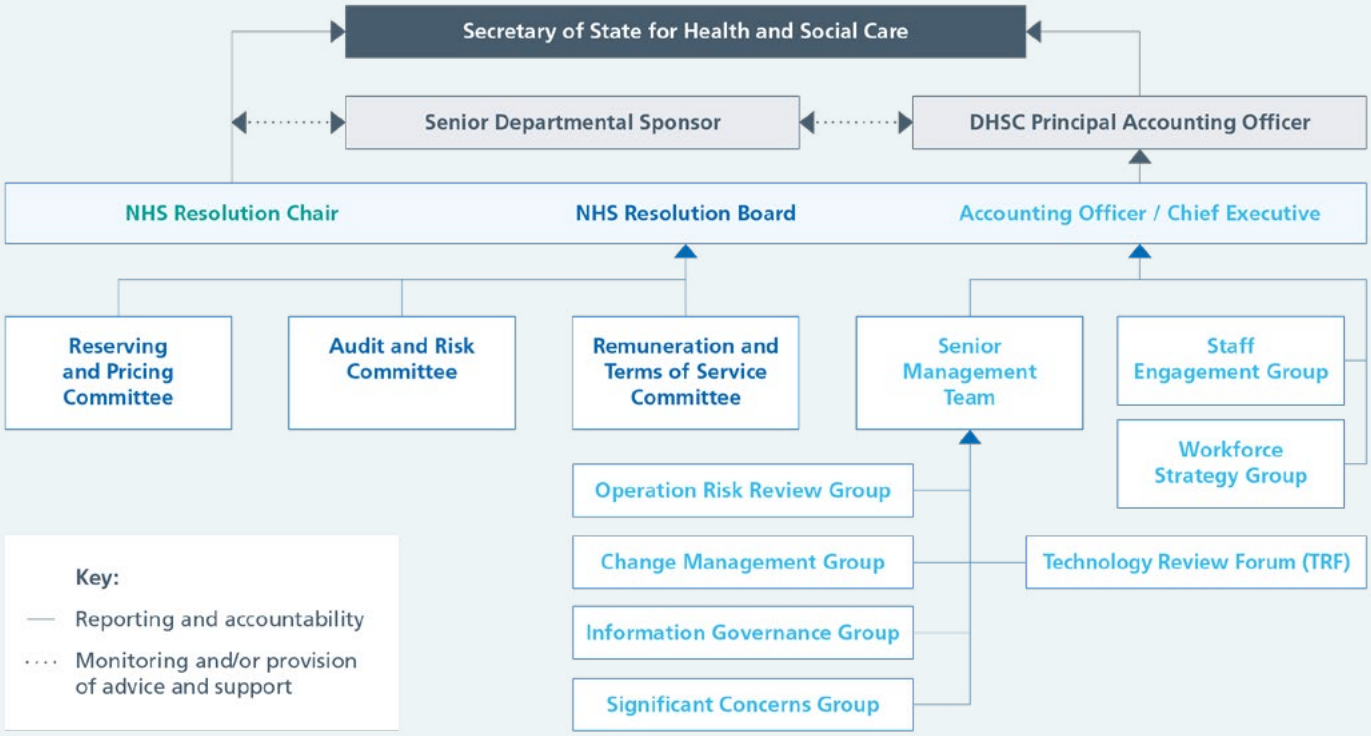
As Accounting Officer, I am supported by NHS Resolution's Senior Management Team (SMT), internal audit, and Audit and Risk Committee (ARC) and make recommendations to the Board on the matters outlined in this statement as they relate to effective governance. I am supported by the Board and SMT in ensuring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

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



The governance framework and structures

Figure 23: NHS Resolution governance structure and subgroups reporting to the SMT



The NHS Resolution Board

As of 31 March 2021 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. Ian Dilks' tenure was extended until a successor was in position. Martin Thomas commenced his three-year tenure as NHS Resolution Chair on 1 January 2021.

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. Variations from anticipated performance are, where appropriate, accompanied by reports from the ARC and/or SMT, to give me, the Board, and, where appropriate, DHSC, assurance on progress and the action being taken. The Board regularly reviews these reports to ensure it remains satisfied regarding the quality of information, and also that it is relevant and sufficient to inform the business of the Board. For example, the Board requested a report on the principles governing the re-tender of the contract for legal services.

During the period from 1 April 2020 to 31 March 2021 the NHS Resolution Board met on six occasions and attendance details are as follows.

Table 10: NHS Resolution Board meeting attendance

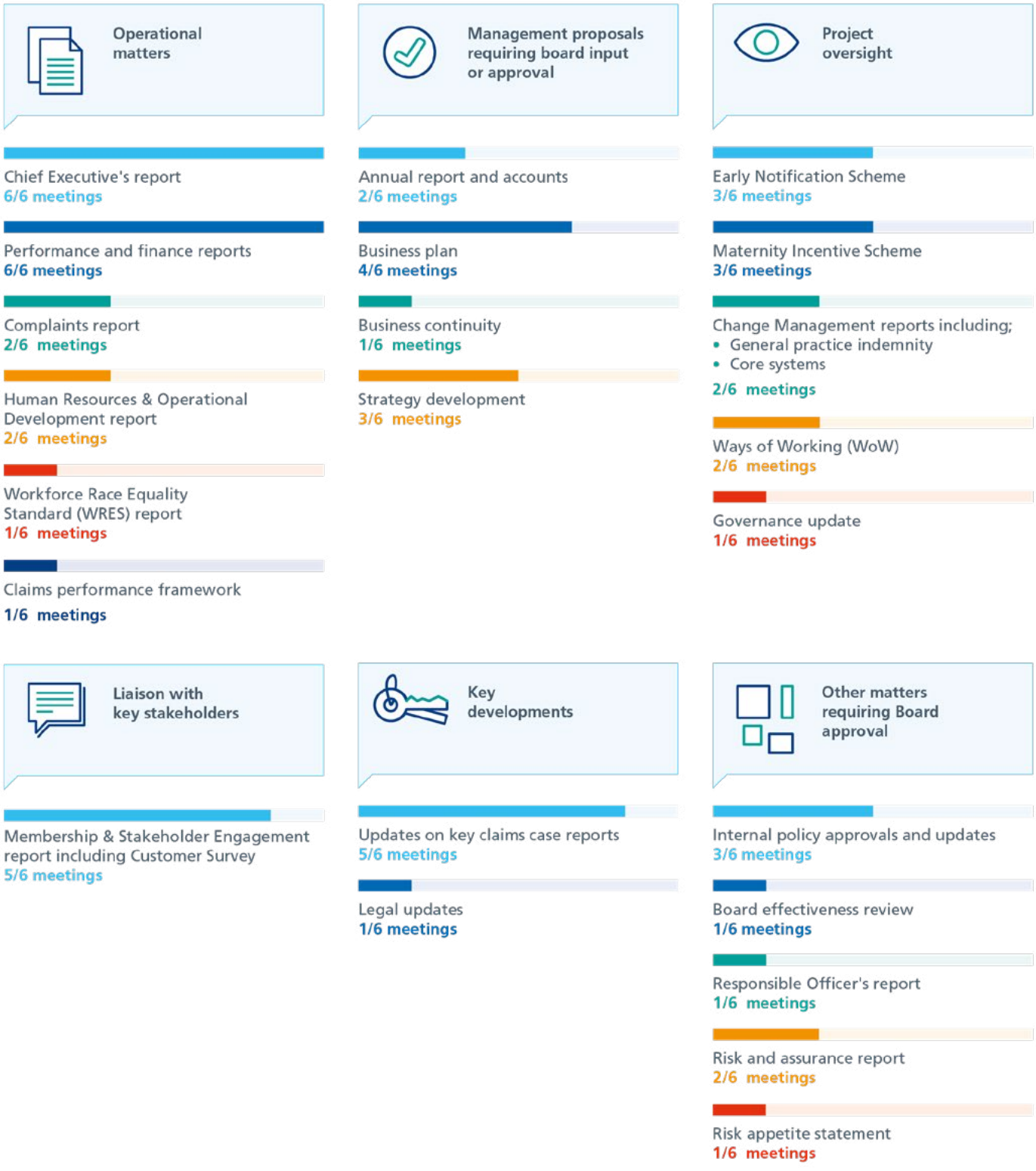
Name	Post	Meetings attended
Ian Dilks*	Chair	4 / 4
Martin Thomas**	Chair	2 / 2
Professor Keith Edmonds	Non-executive Director	6 / 6
Charlotte Moar	Non-executive Director	6 / 6
Mike Pinkerton	Non-executive Director	6 / 6
Nigel Trout	Non-executive Director	6 / 6
Helen Vernon	Chief Executive	6 / 6
Joanne Evans	Director of Finance and Corporate Planning	6 / 6
Dr Denise Chaffer	Director of Safety and Learning	6 / 6
Vicky Voller	Director of Practitioner Performance Advice	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

* Ian Dilks' last meeting was 10 November 2020.

** Martin Thomas' first meeting was 19 January 2021.

Over the year some of the topics considered at the Board meetings included the key matters outlined in Figure 24.

Figure 24: 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 2020 by the Head of Corporate and Information Governance seeking input from Board members on the progress of actions following the external review carried out in 2019. The 2020 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 key areas where there remain ongoing work are:

General	Governance	Board development
The importance to the Board of the development of our approach to operationalising our strategic approach to stakeholder engagement/ partnership working.	The Board has sought a more consistent approach across performance reports and this remains ongoing.	Board consideration on the capabilities it would like to see represented in order to enhance depth and diversity.
Ensuring that there remains sufficient time for the Board to consider long-term strategy and the risk that this is taken over by oversight of operational activity. The Board recognises that this is a continuing challenge and the progress that has been made which the majority of the Board concurred with. The challenge will be increased by the impact of Covid-19 and the need to strike a balance between achieving long-term strategic aims and dealing with short-term operational considerations in support of the NHS.		Consideration on continuous improvement and team development and how that is best achieved.

Committees of the Board

The Board is supported by three 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 2020/21 to assure their fitness for purpose.

Audit and Risk Committee

The ARC supports me and the Board in our responsibilities on matters related to internal and external audit, corporate governance, anti-fraud policies, internal control and risk management, and 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 2020.

ARC has two independent lay members. Both these appointments were extended and have provided continuity for the committee.

During the period of 1 April 2020 to 31 March 2021 the committee met on five occasions. This included an extraordinary meeting to support the sign-off of the annual report and accounts for 2019/2020. 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	5/5
Mike Pinkerton	Non-executive Director	5/5
Charles Bellringer	Independent Lay Member	5/5
Julia Wortley	Independent Lay Member	5/5

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

- Scrutinising risks which are outside the Board's risk appetite and reviewing plans to ensure the risks are being managed effectively.
- Receiving updates on the impact of Covid-19 on the accounts.
- Deep dives into particular areas where risk is important including an overview of the proposed Claims Evolution Programme, the process for ensuring accurate data is held for Periodical Payments Orders, the role of ORG in risk management and the IT strategy.
- Receiving updates on incidents and remedial actions taken including a significant incident of IT downtime which resulted in temporary loss of access to parts of NHS Resolution core systems.
- Reports on the implementation of an online expenses module and benefits realisation for the finance system implemented in 2019.
- Receiving updates on progress towards achieving and sustaining ISO 27001 and other information governance requirements as well as reports on health and safety.
- Receiving an update on Freedom to Speak Up matters including details of why some staff only wish to report concerns anonymously.
- Receiving assurance that NHS Resolution has arrangements in place to ensure compliance with all DHSC regulations and directions, as to which an assurance map was presented at the October 2020 ARC meeting.

ARC effectiveness

Following a self-effectiveness assessment in December 2019, a facilitated discussion of the findings was taken forward at the February 2020 meeting. Since then ARC members have met as a group, and subsequently with the CEO and Director of Finance and Corporate Planning to agree an action plan, which has been taken forward through 2020/21.

The table following sets out some of the key areas of focus.

Action	Update
Consider how the following are built into the ARC work programme: • **ALB/health sector reconfiguration of responsibility and funding flows** • **staff engagement/safety** • **major changes programmes** • **spending review/efficiency/value and evaluation** • **review of schemes generally.**	Deep dives and internal audit reviews have taken place. Programme of internal audits agreed for 2021/22 to include major change programmes.
Strengthen ARC work programme around reserving given uncertainty for 2020/21.	ARC received papers from the Reserving and Pricing Committee (RPC) setting out the process undertaken to deal with the impact of Covid-19 on the 2020/21 year end provisioning exercise including specific updates on the work of the Covid-19 reserving group.
Use assurance maps more widely to ensure focus on the right risks and support deep dives into key areas.	Included as part of a plan to support improvements to the risk management framework.
Consider the focus of ARC in relation to the risk, mitigation actions and treatment plans in line with the risk appetite.	Risk management and assurance discussed at each 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
Culture – consider balance between challenge and support during meetings. This includes setting out clearly the matters on which ARC is not assured and what more is required to resolve this.	Post meetings have taken place after the October and February ARCs to ensure the appropriate balance is maintained.
Ensuring time is spent well in meetings.	Director of Finance and Corporate Planning and ARC chair have a pre-ARC meeting to discuss key points for authors of papers to bring to the attention of ARC. ARC Chair has pre-meet with ARC members.
Strengthening quality of papers.	Director of Finance and Corporate Planning has worked with authors of papers to ensure executive summary is focused on the key issues for discussion, and papers are as short and concise as feasible without losing quality.

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.

Reserving and Pricing Committee

I chair an internal Reserving and Pricing Committee (RPC) with membership comprised of the Director of Finance and Corporate Planning, Director of Claims, Head of Reserving and Pricing and a non-executive director, currently our Chair[1]. 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 2020/21 included:

- impact of the coronavirus pandemic on the provisions – a working group was set up to discuss and inform the approach to estimating the impact of Covid-19. The role of the working group was also to provide RPC with the assurance that papers presented to RPC have had robust internal input and scrutiny;
- assessment of the impact of the Early Notification (EN) Scheme on the provisions and the development observed following another year of experience. The EN Scheme has been observed to be bringing forward the opening of potential PPO claims which reduces the IBNR provision and increases the known claims provision;
- sensitivities of the provisions to key assumptions; and
- provision for risk and uncertainty.

The results of the work undertaken by RPC on calculating the key estimates for the accounts in respect of the provision are presented to ARC and the Board to support 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 2021 to be included in NHS Resolution's report and accounts have been calculated using an appropriate actuarial methodology and assumptions, which are within a reasonable range, given the purpose of the calculation and taking into account discussions held with NHS Resolution's Reserving and Pricing Committee. The actuarial assumptions were selected on a best estimate basis, with explicit adjustment for risk and uncertainty included within the claims inflation assumption. There are no such margins included elsewhere in the assumptions. I have calculated the IBNR provisions to be £42,825 million for all schemes combined as at 31 March 2021 using the method and assumptions selected by NHS Resolution. This opinion statement should be considered in the context of my advice to the Reserving and Pricing Committee.

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

Senior Management Team

The Senior Management Team (SMT) includes directors and heads of the operating areas in the organisation. SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which SMT oversight or approval is required, including resource management and planning, governance arrangements, complaints and stakeholder management. The SMT reviews particular areas of 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. We reviewed our 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 SMT held additional frequent meetings to ensure strategic business continuity decisions were taken in response to Covid-19. SMT held a series of sessions to support the production of the business plan for 2021/22.

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.

[1] The role was covered by Ian Dilks until 31 December 2020 and then Martin Thomas from 1 January 2021.

Table 12: SMT sub-groups

SMT sub-group	Function
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 the organisation's strategy.
Information Governance Group (IG)	Provides assurance on the NHS Information Governance (IG) 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.
Significant Concerns Group (SCG)	Supports the prompt and effective management of significant concerns identified by individual NHS services functions where these give rise to a need for a coordinated organisational response.
Operations Risk Review Group (ORG)	Provides assurance on all matters related to the governance and processes of the operational delivery of the strategy and business plan.
Editorial Approvals Group (EAG)	Ensures all externally-facing materials have undergone a review, as part of governance processes, prior to wider public dissemination and circulation to improve consistency of messaging and branding and to provide quality assurance.

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, develop 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. ORG are charged with the review of corporate operational risks that may impact the delivery of our business plan as well as business as usual matters. Risk reporting and escalation is set out in our risk management policy and procedure, which is published on our website: https://resolution.nhs.uk/governance-policies/risk-management/.

Table 13: 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	**IT infrastructure**	
	NHS Resolution's core systems become obsolete.	• Core Systems Review Programme Board which includes key individuals from across the organisation who consider the risks and issues that may arise, as well as benefits realised, of the transfer required from our current core systems to new solutions. • Launch of tender to source a supplier for new core systems.
All strategic aims	**Cyber security**	
	Data security and integrity is compromised, for example: through cyber-attack or unauthorised/ inappropriate disclosure of data.	• IT policies and procedures in place. • System controls including firewalls. • IG group review metrics for virus incident log. • IG group review incidents and take forward learning. • IG reports to SMT, ARC and the Board. • External company carry out regular penetration tests and report findings and improvements. • Internal audit reviews and deep dives. • ISO 27001 certification. • *Cyber Essentials Plus* audit and certification.
All strategic aims	**Responding to changes in the environment in which we operate**	
	Fail to recognise and respond to changes in the environment in which NHS Resolution operates.	• Set up of Policy, Strategy and Transformation team to horizon scan and provide resource to support policy development. • SMT strategy session discussions of emerging topics. • Membership of Cross Government Strategy steering committee and working group. • Monitoring and evaluation of developments in models of care. • Monitoring and evaluation of the Maternity Incentive Scheme.
All strategic aims	**Responding to changes in the environment in which we operate**	
	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 • ORG review of delivery against business plan • CMG oversight of programme and portfolio delivery.
Help the system, organisations and individuals identify and address issues. **Work in partnership with other ALBs, NHS trusts, patients and healthcare staff to improve the way in which the NHS responds to incidents.**	**Raising concerns**	
	Fail to identify through our work and/ or appropriately act on significant concern that patient/staff safety/public protection are or have the potential to be compromised.	• Early Notification Scheme launched for maternity incentivisation of members to identify concerns early. • Significant Concerns Group and frameworks in place.

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

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

Business continuity

Effective business continuity arrangements have been paramount for us during 2020/21 because of Covid-19. We were able to continue to deliver our business operations while working remotely from the office environment without compromising our control framework. Some benefits have resulted, such as increased flexible working arrangements and greater collaborative working in the legal market.

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 recognises that there are areas that can present both a challenge and opportunity and as such the risk appetite may be high. This has been apparent through the year given the risk that there are a number of initiatives underway simultaneously, such as responding to the Covid-19 pandemic including implementing a new indemnity scheme and revising our delivery model for our services, developing our new indemnity schemes for general practice, implementing a revised operating model for the claims function, a London accommodation move, and replacing our core IT systems.

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

Management assurance

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

Internal audit

An internal audit plan is developed in conjunction with management and the 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
Primary Care Appeals Management	Substantial
GP Indemnity (part 2)	Substantial
Data Quality (parts 1 and 2)	Moderate
Key Financial Controls	Substantial
IT Service Contract	Moderate
Executive Governance Review	Advisory
Ways of Working (WoW) Programme	Advisory
Data Quality (part 3)	Advisory

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 2020/21.

The arrangement for the supply of internal audit services by RSM UK through Government Internal Agency came to an end in March 2021. A procurement process was conducted to appoint a supplier from 1 April 2021. RSM UK were appointed for a three year period.

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 assurance to management and the Board. Governance arrangements through the Reserving and Pricing Committee for the setting of reserves for claims are set out earlier in this statement.

Anti-fraud, bribery and corruption

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of 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 in place an up-to-date Anti-fraud, bribery & corruption policy and procedure advising staff how to recognise and deal with potential instances of fraud and bribery. We have in place a counter fraud team who work in accordance with the NHS Counter Fraud Authority Standards for Providers to prevent, deter, detect and investigate fraud and bribery.

During 2020/21 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.

The arrangement for Local Counter Fraud Services with RSM UK came to an end on 31 March 2021. New arrangements for 2021/22 are now in place with the Government Internal Audit Agency (GIAA). We continue our membership of the Claims and Underwriting Exchange (CUE), a database of non-clinical claims reported to insurers. This enables us to share information with other indemnifiers so as to identify potentially fraudulent claims. We are fully alive to the information governance risks entailed in such an initiative and ensure that due legal process is adhered to.

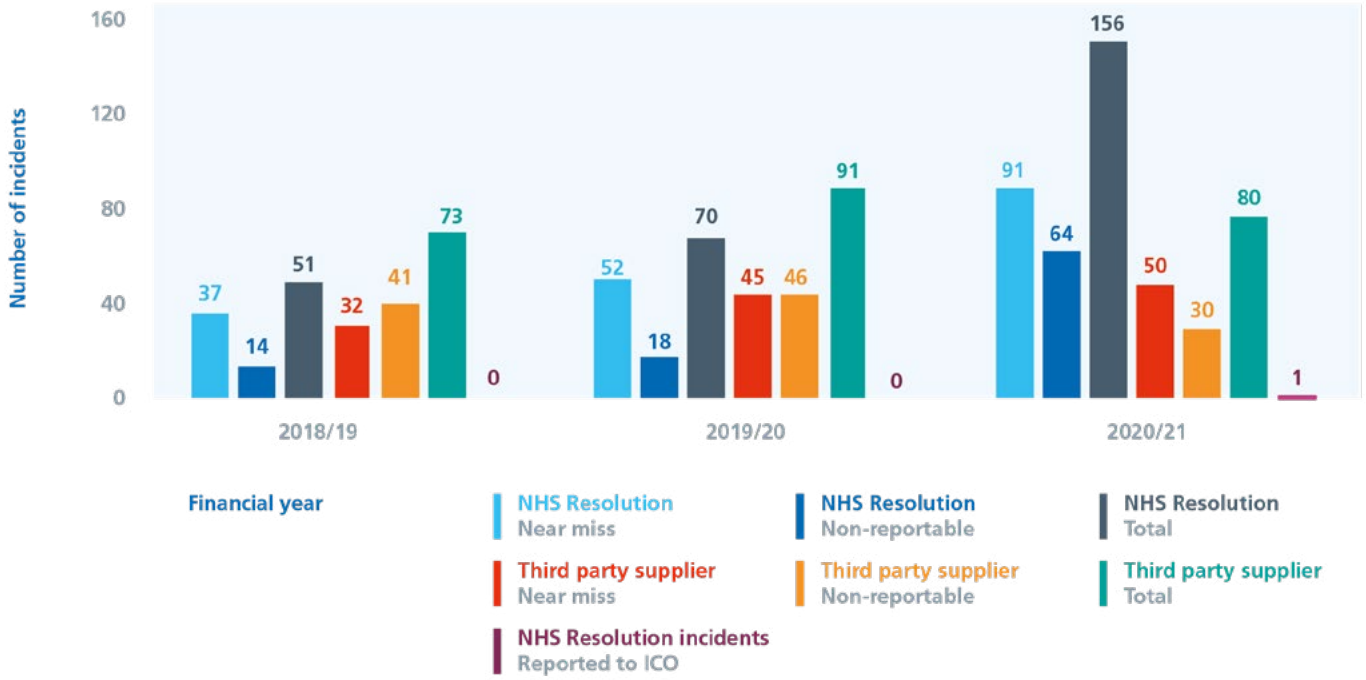
Information security and governance

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 2020 reviewed a range of governance and technical security controls in the context of the arrangements in place, which included the extensive remote working throughout the pandemic. It was noted that our security controls had not changed and information governance guidance remains in place.

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 25: Information governance incidents reported between 2018/19 and 2020/21 by severity



During this year, there were 236 information governance incidents recorded by NHS Resolution. This includes those reported by third party suppliers; of this total 141 were 'near misses'. A 'near miss' is defined as an incident that did not lead to harm, loss or damage, but could have done, and is reported in order that we can learn from the near miss occurrence. We have not identified any differences in the volume or type of incident reported due to the remote working arrangements as a result of the pandemic.

There was one incident relating to an email being sent to an incorrect recipient. A decision was taken by NHS Resolution to inform the ICO of an incident. The ICO acknowledged the incident reported to them and confirmed that no further action was necessary.

The figures show an increase in reported near misses, which is perhaps a reflection of the continuing awareness of information security being embedded within business operations. It is also a reflection on the profile of information governance that in the context of our remote working, the volume and profile of reported IG incidents remains high. We do not, however, wish to be complacent and we continue to learn from and encourage reporting and use examples from our incidents to shape future information governance learning, which is a mandatory requirement for all staff and Board members.

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

Responding to members of the public

Effective processes were in place throughout the year which ensured a swift response to all public enquiries, correspondence, parliamentary questions, issues raised under Freedom of Information and Data Protection (DPA) legislation, and complaints. NHS Resolution received 248 requests for information, ranging from journalists to clinicians and other members of the public. The majority (75%) of these requests relate to claims under our indemnity schemes and we have published responses on our Disclosure Log. This year 80% were completed within the 20 working day statutory deadline compared to 70% the previous year.

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

We seek to be open and in the majority of 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.

We will publish more regular reporting of data that are being commonly requested.

Data Protection requests

NHS Resolution receives two types of requests under the DPA (Data Protection Act): Subject Access Requests (SARs) give individuals the right to request any information held about themselves. During this period 114 SARs were received, which is an increase of 25 from last year. Of these 90% were responded to within the statutory deadline of one calendar month.

The second type are third party requests for information for personal data in relation 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 2020 to 31 March 2021 we received 26 complaints, which were reviewed through the processes laid down in our formal complaints policy, of which three were partially or fully upheld. This compares to 33 complaints logged in 2019/20. These numbers remain small relative to the volume of activity across the organisation. There have been two complaints escalated from our reviews to the Parliamentary and Health Service Ombudsman (PHSO) which were not pursued by the PHSO on the basis that these were not matters within their remit. In one of these cases we were asked to respond to issues relating to complaints handling and we acknowledged that there had been a delay to our initial response, and we did not sufficiently clarify the scope of the policy. We addressed these points in further correspondence.

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

During this period we took forward the following actions to improve our complaints handling to support the experience of complainants.

Previous action reported	Action taken
Ongoing recruitment to support the management of complaints within corporate governance and claims management	Complaints and incident manager recruited to the corporate governance team
Development of a local dispute resolution process for claims management	Framework for complaints handling within claims management has been implemented
Where learning has been identified, a system of ensuring that there are reviews being undertaken in each business area and that follow up is undertaken	There is now regular logging of complaints and learning within business functions
Consultation on new standards for complaints handling by the PHSO has been published	NHS Resolution is working with the PHSO to support the development of the new standards The cross-government complaints forum has also responded (NHS Resolution is a member)

Freedom to Speak Up

We have a Freedom to Speak Up policy and have in place three Freedom to Speak Up Guardians as well as a Non-Executive Director who is the Freedom to Speak Up Officer. There were 35 formal conversations in 2020/21, which indicates staff awareness of the Freedom to Speak Up Policy and Procedure. In terms of responding to concerns raised, it is often the case that simply listening is enough. Where it is not, the guardians direct staff to line management, policies or HR, as appropriate. The guardians have ensured a process of follow-up on the status of concerns raised and the feedback provided.

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:

- Working with OD/HR on training or policy and procedures knowledge gaps that exist across the organisation.
- At the beginning of lockdown, providing feedback to senior managers on the working from home messaging and staff experience of how doing their jobs away from the office was working for them. This was particularly relevant to the conversation around KPIs and performance management during the pandemic.
- Information from the guardians helped shape the 'Supporting staff during Covid' and the 'Coach to Lead' sessions that some of the staff participated in.
- Understanding why some staff want to report their concerns anonymously fed into a detailed discussion with SMT to agree actions for addressing this situation.
- Participating in the development of the corporate values and behaviours framework and the leadership programmes.

Health and safety

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures. Staff are required to participate in the training provided to ensure awareness. As with many other organisations, all staff at NHS Resolution have been working from home since March 2020. The health, safety and wellbeing of our staff is paramount to us: we have ensured all staff have complete display screen equipment assessments to ensure they are working in a safe way while at home. All our staff have access to the enhanced offerings of the Employee Assistance tools, which offers them and their families support through the challenges posed by Covid-19 lockdowns and working from home. We have ensured all staff have an individual risk assessment to identify those that may need extra support, and at the time when we could, we opened our London office, in a Covid-19 secure way to enable those whose risk assessment identified that they would benefit from attending the office to do so.

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 robust procurement process and are completed in compliance with Public Procurement Regulations. 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 mapping exercise has been completed, which provides high level assurance that we are operating within the relevant directions and statutory functions for NHS Resolution. This gives me as AO the assurance that we have a clear view of those functions and regulations we should be working to. During 2020/21 we were directed by DHSC to administer and operate new scheme arrangements in relation to Covid-19.

Accounting Officer's conclusion

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

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 2020/21.

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 2020/21 year. All meetings were quorate.

Figure 26: Remuneration and Terms of Service Committee meeting attendance

Ian Dilks
Chair

Meetings attended
5/5

Charlotte Moar
Non-executive Director

Meetings attended
5/5

Nigel Trout
Non-executive Director

Meetings attended
5/5

Professor Keith Edmonds
Non-executive Director

Meetings attended
5/5

Mike Pinkerton
Non-executive Director

Meetings attended
5/5

In June 2020 the committee considered and noted the annual Directors' performance reviews, presented by the Chief Executive who was in attendance. The Committee also approved a twelve-month extension of an existing Associate Non-executive Director position with effect from 1 July 2020. In October 2020 the 2020/21 annual pay award and performance related payments were determined by the Committee based on guidance provided by DHSC and approved. Other matters dealt with by the Committee during the year included the performance and objectives of the Chief Executive. The Committee considered its performance in 2020 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* terms and conditions of service, including a copy of the current handbook, can be found on the NHS Employers website. The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees which supports modernised working practices. Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system which supports NHS service modernisation and meets the reasonable aspirations of staff.

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

Remuneration for directors

The following tables provide the contractual salary and pension details of those executive and non-executive directors who had control over the major activities of NHS Resolution during 2020/21. Tables 14, 15 and 16 are subject to audit. There was one change in Board membership during 2020/21 – the Chair Ian Dilks' term of office came to an end on 31 December 2020, and he was replaced by Martin Thomas from 1 January 2021.

Table 14: Executive and non-executive director salaries and allowances[1] for 2020/21

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension-related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Ian Dilks[2] (Chair)	45–50	0	0	N/A	N/A	**45–50**
Martin Thomas[3] (Chair)	15–20	0	0	N/A	N/A	**15–20**
Helen Vernon (Chief Executive)	160–165	0	5–10	0	52.5–55	**220–225**
Joanne Evans[4] (Director of Finance and Corporate Planning)	120–125	5,700	0	0	25–27.5	**155–160**
Dr Denise Chaffer (Director of Safety and Learning)	115–120	0	0	0	22.5–25	**140–145**
Vicky Voller (Director of Advice and Appeals)	115–120	0	5–10	0	50–52.5	**170–175**
Professor Keith Edmonds[5] (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension-related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Mike Pinkerton (Non-executive Member)	5–10	700	N/A	N/A	N/A	**5–10**
Nigel Trout (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Dr Mike Durkin OBE[7] (Associate Non-executive Member)	5–10	700	N/A	N/A	N/A	**5–10**
Sir Sam Everington OBE (Associate Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**

[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.

[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.

Table 15: Executive and non-executive director salaries and allowances for 2019/20[1]

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension-related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Ian Dilks Chair	60-65	0	0	N/A	N/A	**60–65**
Helen Vernon[2] Chief Executive	150–155	0	5–10	0	47.5–50	**205–210**
Joanne Evans[3] Director of Finance and Corporate Planning	120–125	14,800	0–5	0	27.5–30	**170–175**
Dr Denise Chaffer Director of Safety and Learning	110–115	0	5–10	0	0	**115–120**
Vicky Voller[4] Director of Advice and Appeals	105–110	0	0	0	30–32.5	**135–140**
Professor Keith Edmonds Non-executive Member	5–10	0	N/A	N/A	N/A	**5–10**
Charlotte Moar[5] Non-executive Member	10–15	1,400	N/A	N/A	N/A	**10–15**

Name and title	Salary (£000s)	Expense payments	Performance pay and bonuses (£000s)	Long-term performance pay and bonuses (£000s)	All pension-related benefits (£000s)	Total (£000s)
	bands of £5,000	(taxable) total to the nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Mike Pinkerton[6] Non-executive Member	5–10	3,700	N/A	N/A	N/A	**10–15**
Nigel Trout Non-executive Member	5–10	0	N/A	N/A	N/A	**5–10**
Dr Mike Durkin OBE[7] Associate Non-executive Member	5–10	1,500	N/A	N/A	N/A	**5–10**
Sir Sam Everington OBE Associate Non-executive Member	5–10	0	N/A	N/A	N/A	**5–10**

[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.

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

[7] Dr Mike Durkin's appointment as Associate Non-executive Director was extended for a further twelve months with effect from 1 July 2019.

Pension entitlements for executive directors

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

Table 16: Pension entitlements for executive directors

Name and title	Real increase in pension at pension age (£000s)	Real increase in pension lump sum at pension age (£000s)	Total accrued pension at pension age at 31 March 2021 (£000s)	Lump sum at pension age related to accrued pension at 31 March 2021 (£000s)
	bands of £2,500	bands of £2,500	bands of £5,000	bands of £5,000
Helen Vernon Chief Executive	2.5–5	0–2.5	45–50	85–90
Joanne Evans Director of Finance and Corporate Planning	0–2.5	0	10–15	0
Vicky Voller Director of Advice and Appeals	2.5–5	2.5–5	25–30	45–50
Dr Denise Chaffer Director of Safety and Learning	0–2.5	5–7.5	40–45	130–135

	Cash equivalent transfer value at 31 March 2021 (£000s)	Cash equivalent transfer value at 31 March 2020 (£000s)	Real increase in cash equivalent transfer value (£000s)	Employer's contribution to stakeholder pension (£000s)
Helen Vernon Chief Executive	794	714	45	23
Joanne Evans Director of Finance and Corporate Planning	171	135	16	18
Vicky Voller Director of Advice and Appeals	379	329	30	16
Dr Denise Chaffer Director of Safety and Learning	0	0	0	17

Cash equivalent transfer values

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

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

Payments to past directors

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

Fair pay disclosure

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

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

The banded remuneration of the highest-paid director in NHS Resolution in the financial year 2020/21 was £165,000–£170,000 (2019/20, £165,000–£170,000). This was 3.40 times (2019/20, 3.31) the median remuneration of the workforce, which was £49,198 (2019/20, £50,662). The 25th percentile remuneration mean of 4.30 was £39,464, which represents the lowest quartile of remuneration in the organisation, and the 75th percentile remuneration mean of 2.82 was £60,058, which represents the upper quartile of remuneration in the organisation.

In 2020/21, no employees received remuneration in excess of the highest-paid director (2019/20, was also zero). Remuneration ranged from £20,419 to £169,600 (2019/20 £21,089 to £167,458).

The fair pay disclosures are subject to audit.

Staff report

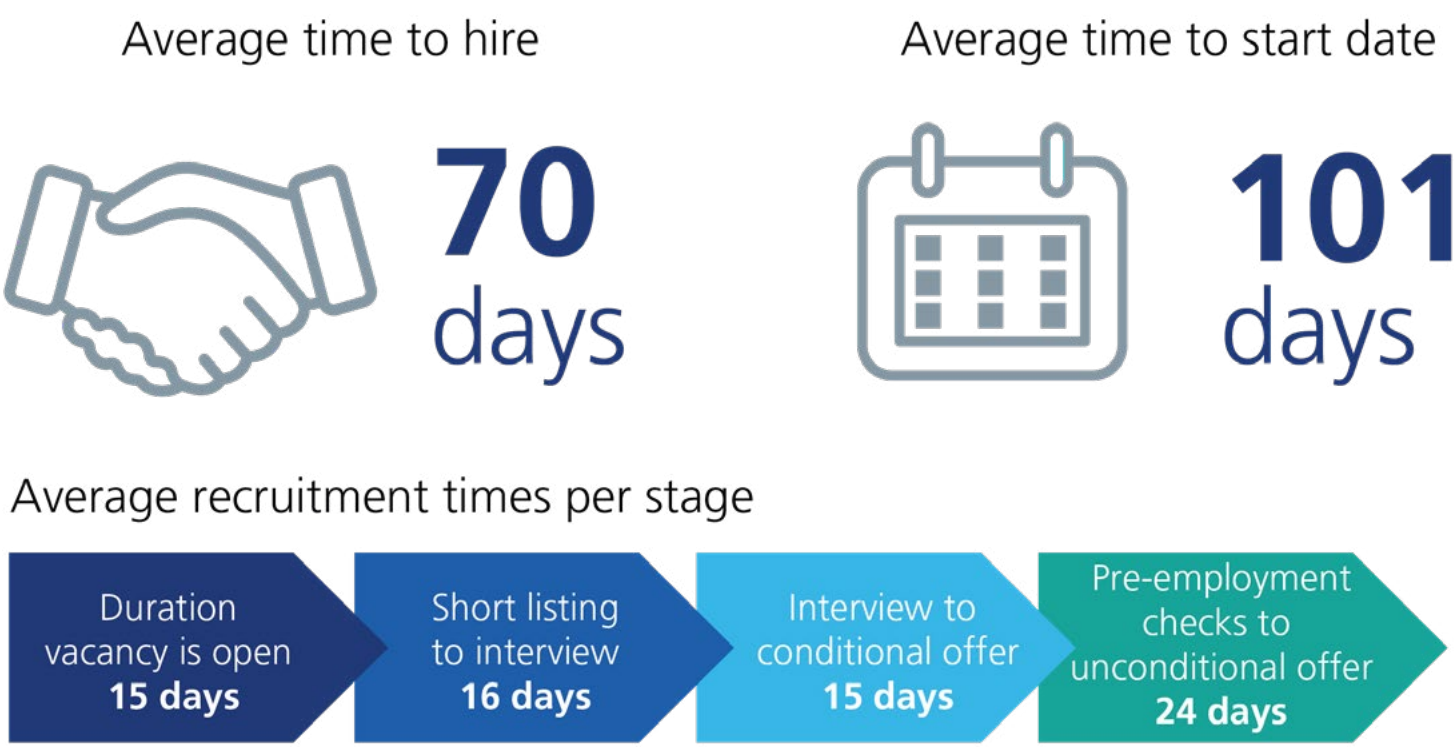
The ongoing transfer of existing liabilities from two medical defence organisations for general practice indemnities and the continued expansion of our Leeds-based activities have both contributed to the continued growth of our establishment. We have seen an increase of 22.0% of the average full-time equivalent (FTE) staff in post, up from 328 in 2019/20 to 400 in 2020/21. While increasing our budgeted establishment and headcount we have seen only a slight increase in our annual staff turnover to 8.8%, up from 8.1% in 2019/20.

In response to our continued growth throughout 2020/21, we introduced the monitoring and reporting of the organisation's average time to recruit to vacancies. The first report was presented to the Board in January 2021 and covered the period December 2019 to September 2020. In order to better understand where there are potential delays within the recruitment cycle, we included a breakdown of each stage of the recruitment process:

- Duration the vacancy was open
- Period of shortlisting to interview
- Interview outcome to conditional offer
- Pre-employment checks to unconditional offer.

We reported two overall figures; average time to hire and average time to start date. The average time to hire is measured from the date of the vacancy being opened to the date of the unconditional offer letter being issued to the successful candidate. The average time to start date is measured from the date of the vacancy being opened to the first day of employment. It is helpful to consider the two measures separately as we have no control over the length of an individual's notice period with their existing employer which can often be as long as three months.

Figure 27: Overall average recruitment times



Time to recruit information will continue to be reported twice yearly to the board. The next steps to be taken throughout 2021/22 include:

- A review of performance indicators and communication with recruitment managers
- Implementing a performance measure for the period of vacancy approval to advertisement
- Finalise an options paper for implementing recruitment support software and present to ORG/SMT for approval.

Based on our continued increase in headcount, a decision was made to hold more frequent staff induction programmes on a monthly basis. During the current period of extended home working, while we were not able to facilitate a full induction programme for new starters, we realised the importance of new staff being welcomed to NHS Resolution. As a result we developed a shortened version of the induction programme which took place remotely.
The format of the day consists of four presentations from the Chief Executive, Chair, HR & OD team and Corporate Governance team.

The presentation by HR & OD includes presentations from a Freedom to Speak up Guardian and a member of staff describing their career within NHS Resolution. The feedback for new starters on their induction has been very positive, including positive feedback on the information shared in relation to our equality, diversity and inclusion work. In this interim period, the HR & OD team are following up with all new starters within their first month to offer any additional support which may be required. New staff are also being encouraged to join and participate in group calls with other new starters as a peer support network. This approach has been well received.

We have developed our existing equality and diversity reporting processes to reflect the geographical characteristics of both our London and Leeds based workforce. This was also a key feature included in our recently developed equality, diversity and inclusion strategy and action plan.

Throughout 2020/21 we have continued to support our workforce in a vast range of personal and professional development opportunities both internally and externally. Our ongoing commitment to people management excellence has been recognised by the silver level Investors in People (IIP) award, which was obtained as part of our re-accreditation process in early 2020.

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

Table 17: Staff costs for 2019/20 and 2020/21

Staff costs	Permanently employed staff (£000s)	Other (£000s)	2020/21 Total (£000s)	2019/20 Total (£000s)
Salaries and wages	19,392	1,326	**20,718**	17,819
Social security costs	2,237	0	**2,237**	1,802
Employer contributions to NHS Pensions	3,399	0	**3,399**	1,862
NEST pension contributions	8	0	**8**	3
Apprenticeship levy	84	0	**84**	66
Total	**25,120**	**1,326**	**26,446**	**21,552**

Table 18: Average full-time equivalent staff numbers

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other*	2020/21 Total	2019/20 Total
Total	381	19	**400**	328

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

As at 31 March 2021…

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 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.

Figure 28: Headcount by gender and grade

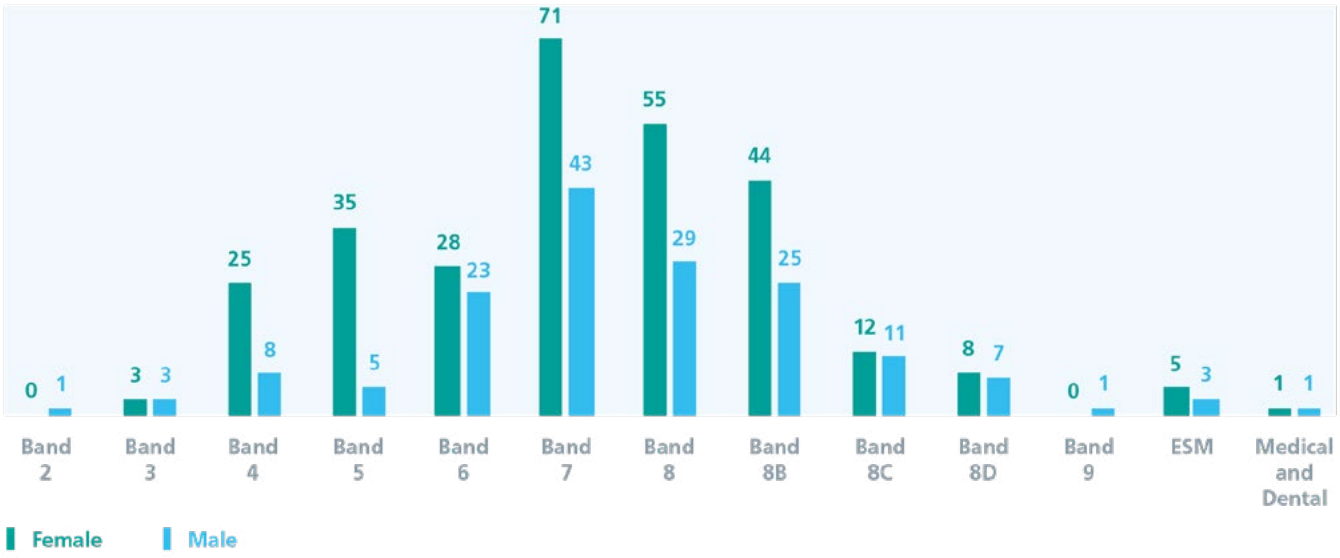


Figure 29: Workforce – disability

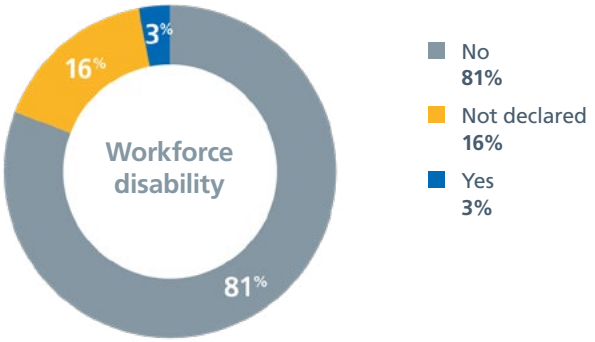


Figure 30: Workforce – sexual orientation

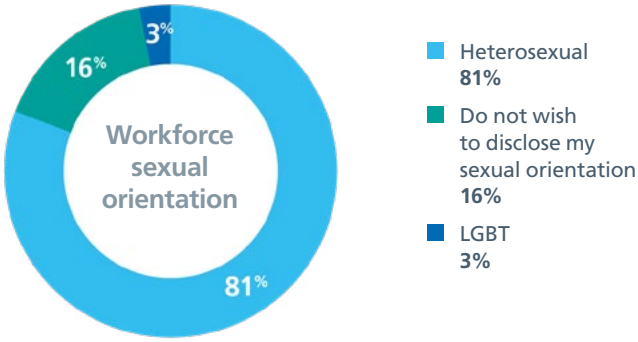


Figure 31: Workforce – religion/belief[1]

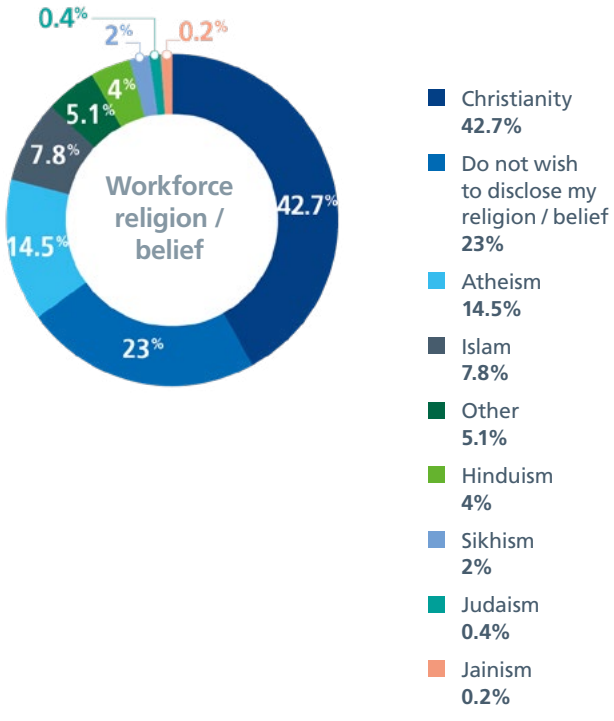
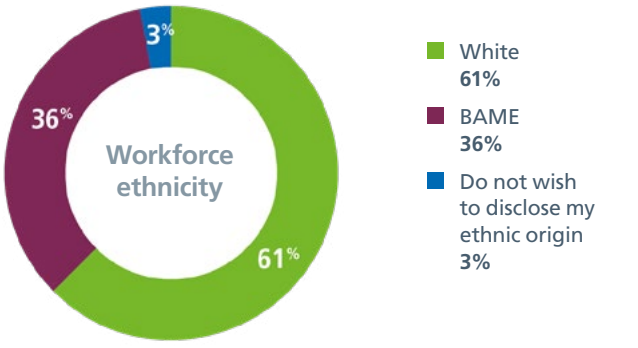


Figure 32: Workforce – ethnicity (organisational profile)



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

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'. We remain a member of the Mindful Employer Charter[1], which is intended to support the organisation in attracting a more diverse workforce. We are in the process of establishing a Disability Matters Group, which is a staff network.

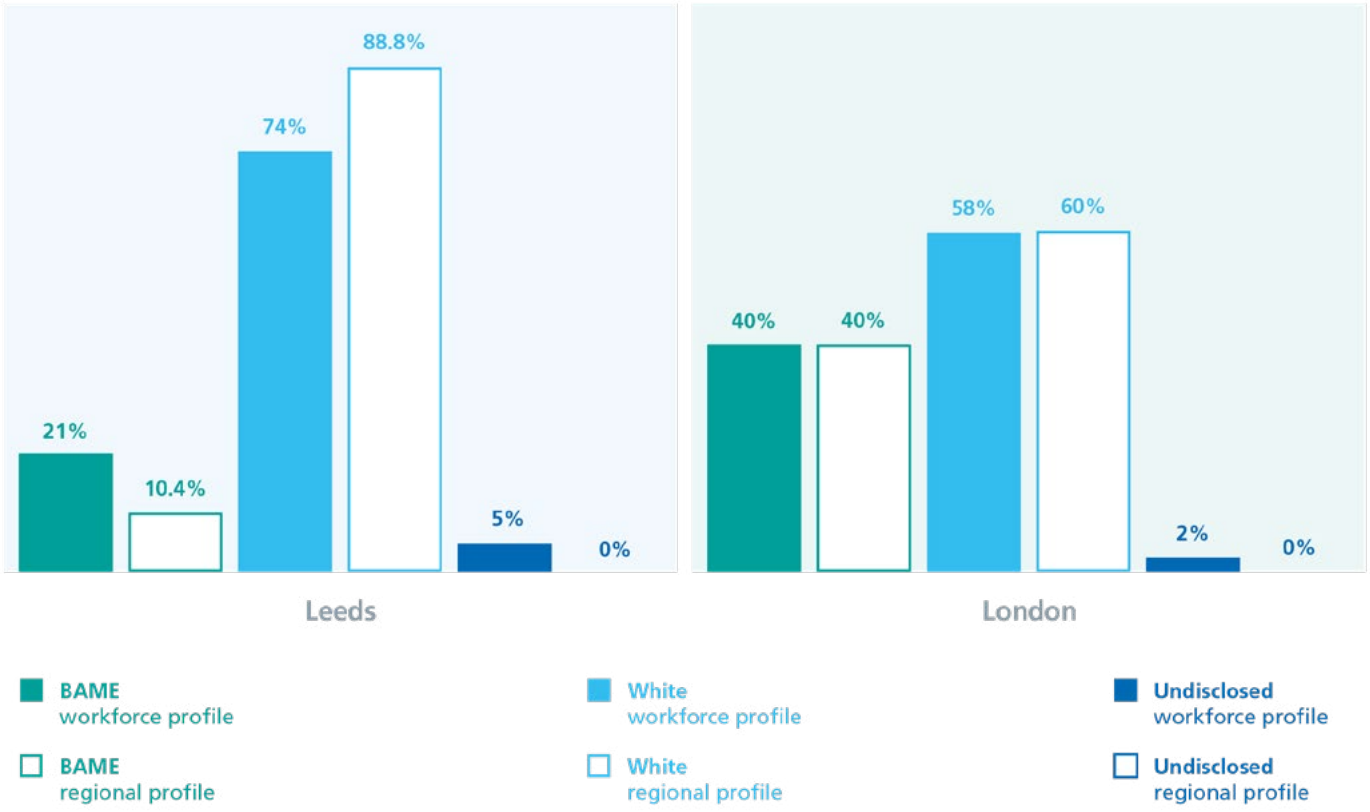
The percentage of applicants during 2020/21 who identified themselves as having a disability and who were offered an interview was 8%[2]. This was higher than the percentage of applicants who did not declare themselves as having a disability, which was 6%. When considering the percentage of appointments made from the number of applications received, this was 1.2% for those who considered themselves as having a disability and 2.9% for those who did not. The percentage of those who did not wish to disclose this information was 1%.

Ethnicity

The proportion of Black, Asian and Minority Ethnic (BAME) employees has increased to 36% in 2020/21 (compared with 35% in 2019/20). As we continue to grow our workforce in Leeds, it is important that we understand our regional figures and how these align to the local population.

Figure 33 shows the current workforce profile against the regional profile information from the 2011 census data. NHS Resolution's workforce profile is aligned to the regional figures for London, with a noted higher representation of BAME staff in Leeds. It is, however, important to note that the Leeds figures are based on a small number of staff.

Figure 33: Workforce – ethnicity (Leeds[3] and London against the regional figures)



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

[2] This data is based on the information from recruitment campaigns managed via NHS Jobs, and does not include agency appointments or those campaigns managed via expressions of interest.

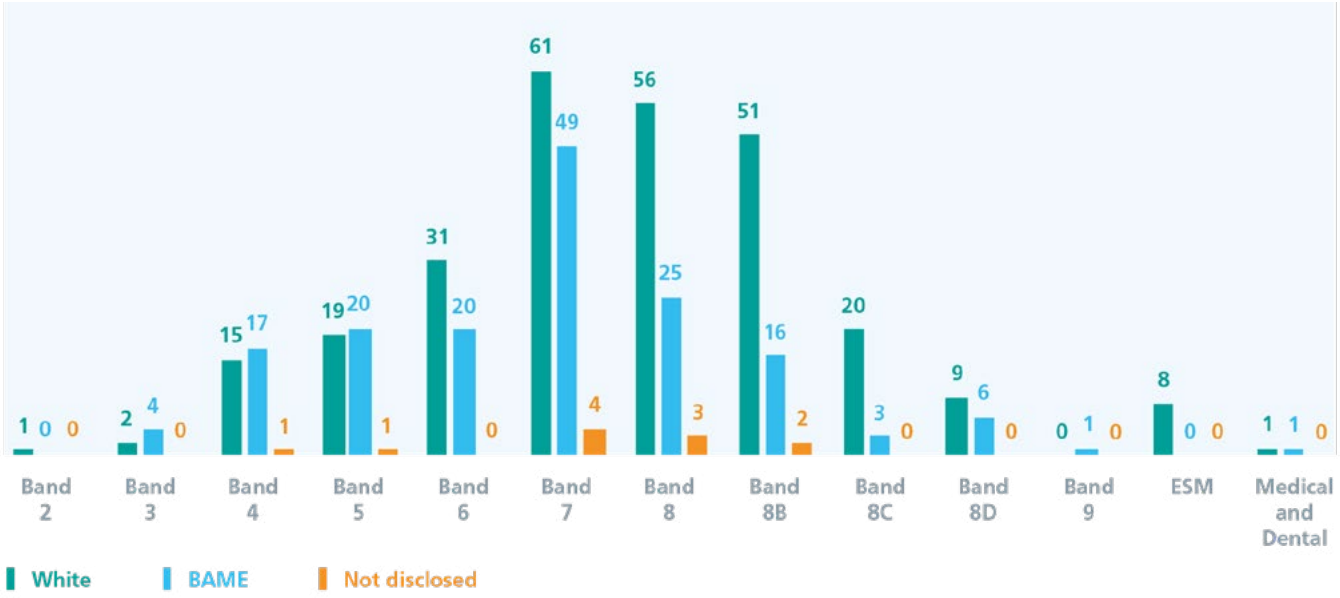
[3] For the Leeds regional census data 0.8% categorised themselves as 'other' and are not included in this figure.

NHS Resolution's workforce profile is very closely aligned to the regional figures for London. We continue to employ a higher number of BAME staff in Leeds when compared to the regional figures, increasing from 15% in 2019/20 to 21% this year. The main category of BAME staff in Leeds is Asian. While this is largely consistent with the regional profile, we do have an underrepresentation of staff from black African/Caribbean/British backgrounds in Leeds.

The organisation continues to provide regular reports to the Board, detailing its workforce ethnicity by pay band including senior managers. There are some noted areas of under- and overrepresentation of BAME staff as detailed in Figure 34.

While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is a clear underrepresentation of BAME staff at the ESM level. This is consistent with the national data around the lack of BAME staff at senior level within the NHS (Kline, March 2014) and in the industry in general. The information also shows that there is an overrepresentation of BAME staff within the lower pay bands. However, as detailed further below under *Equality, diversity and inclusion*, the organisation continues to take a number of steps in order to address these issues.

Figure 34: Headcount by ethnicity



Sickness absence

As at 31 March 2021, NHS Resolution's twelve-month cumulative sickness absence rate was 1.55%.
The organisation's absence rate has remained below the NHS national average for England and for other similar national NHS organisations. Throughout 2020/21 we implemented real-time absence reporting, and provided full oversight on the level and reasons for absence by department within the weekly workforce summary reports to SMT. We continue to provide our Board with oversight of our absence management processes. Overall we ensure that the required level of support is provided to our workforce while supporting our managers in the management of both informal and formal cases.

Off-payroll engagements

As of 31 March 2021, NHS Resolution has eleven off-payroll appointments costing more than £245 per day. Nine of these appointments have or are likely to last longer than six months and were new engagements within the reporting period. Two 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 19: For all off-payroll engagements as of 31 March 2021, for more than £245 per day

This is subject to audit.

No. of existing engagements as of 31 March 2021	**11**
Of which:	
No. that have existed for less than one year at time of reporting	**9**
No. that have existed for between one and two years at time of reporting	**2**
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 20: For all off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day

No. of temporary workers engaged between 1 April 2020 and 31 March 2021	**16**
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	**16**
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 21: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

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 2020/21 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 2020 to 31 March 2021.

Table 22: Relevant union officials

Number of employees who were relevant union officials during 2020/21	Full-time equivalent employee number
1	1

Table 23: Percentage of time spent on facility time

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

Table 24: Percentage of pay bill spent on facility time

Total cost of facility time	£3,737.97
Total pay bill	£26,583,507
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

Table 25: Paid trade union activities

Hours spent by employees who were relevant union officials during 2020/21 on paid trade union activities, as a percentage of total paid facility time hours.	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0%

People

As a result of the ongoing pandemic, the 2020/21 year was an extremely challenging period for the workforce both personally and professionally. Our focus has been primarily on maximising the health and wellbeing (HWB) of our entire workforce in order to support staff to continue to work as productively as possible, balance home and family lives, and support the challenges that Covid-19 has created.

Throughout the year we have continued to review, and where appropriate adjust, our HR policies and procedures in order to ensure they are fit for their purpose in response to the ongoing pandemic. We have continued to develop our health and wellbeing toolkits for staff and put together a range of support measures for both staff and managers including:

- Links to relevant health and wellbeing websites
- Guidance on workplace safety and workplace adjustments
- Internal coaching and mentoring resource
- Parenting tips to support home schooling and work-life balance
- Mental health and wellbeing tips including: Emotional Freedom Technique
- Employee and manager toolkits for dealing with and managing bereavements
- Delivery of a Mental Health First Aider training programme.

A number of workshops and sessions have been developed and delivered virtually through the pandemic period including:

- Line managing effectively during Covid-19
- Intelligent resilience and wellbeing
- Managing self and others
- Managing difficult conversations
- Delegating effectively.

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 working almost entirely at home throughout 2020/21, our staff engagement activities have continued to see a positive level of input with the completion of our staff annual appraisals increasing to 99% in 2020, up from 95% in 2019, and a positive response rate of 76.5% to the staff survey undertaken in November 2020.

Following the awarded silver level Investors in People (IIP) accreditation in March 2020, our interim IIP review in February 2021 continues to recognise the progress made across a number of areas, despite the difficult year in navigating the organisation through the pandemic. 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.

We have progressed a significant number of the key priorities noted in our workforce and organisational development strategy. Activities delivered throughout 2020/21 include the following areas.

Equality, diversity and inclusion

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 NHS Resolution shows transparency and embraces the core values of the NHS, which are respect, dignity, compassion and inclusion. The last of these refers to a commitment to treat everyone with respect and significance, celebrating and valuing difference of lived experience.

In collaboration with our staff we developed an equality, diversity and inclusion (EDI) agenda and action plan, which was approved by the Board in July 2020. Since then we have been working on a number of activities covering each of the three primary areas:

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

Our vision for each of these areas is as follows.

Recruitment, selection and on-boarding

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

Leadership and talent management

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

Capacity and capability

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

Throughout 2020/21 we have:

- Published our 2018/19 and 2019/20 data in accordance with the national Workforce Race Equality Standard (WRES) framework.
- Continued to promote and support access to leadership development for all levels of staff.
- Where available, promoted external leadership development opportunities aimed specifically at BAME staff, i.e. Ready Now programme and Stepping Up programme.
- Implemented a second cohort of the junior case manager apprenticeships, which is a positive step in supporting career progression for BAME groups.
- In collaboration with staff, developed a behaviours framework which underpins our existing PEER values.
- Achieved level two of the Government's 'Disability Confident Scheme'.

During 2020, a group of staff sought support from the Senior Management Team to establish a diversity network group that was unanimously supported. The purpose of the group is to:

- Create an active forum to promote inclusion and celebrate diversity in a safe and supportive environment.
- To be central to NHS Resolution visions and values and encourage staff engagement and a feeling of belonging – ensuring that both challenges and solutions are brought to the attention of the Executive Sponsor for Equality, Diversity and Inclusion.

The group has met on three occasions and covered a range of topics including:

- Privilege and what this means in the workplace.
- How to continue to promote and celebrate diversity in the workplace as we transition into new ways of working and locate to 10SC, including the development of a Diversity calendar to recognise and celebrate different cultures.
- 'Be inspired': individual staff members sharing their stories on their career journeys.
- An introduction to coaching and mentoring.
- An update from the Freedom to Speak Up Guardians.
- An update from the Mental Health First Aiders.

The HR & OD team is currently supporting a group of staff in the development of a disability network group, which hopes to launch in early 2021.

Leadership development

Due to the ongoing pandemic, extended home working arrangements and the need to respond to other priorities such as health and wellbeing and resilience of our staff, it was decided that we would not proceed with the intended year 3 leadership development programme. While this is still very much a future intention, full consideration is being given to how the programme might best be delivered in a virtual environment at a time when our workforce are ready to receive it.

The OD team has worked in partnership with the training and recruitment manager in Claims Management to support the design of a training framework to develop and source a suitable management development programme. The programme has been designed to engage team leaders across all parts of the organisation in order to bring people together and make best and equitable use of the apprenticeship levy. We are now in the process of considering how best to deliver this programme.

Meanwhile, and as noted above, we have developed and delivered a range of workshops and sessions to support both managers and staff during these challenging times.

Succession planning

During 2020/21 the organisation has established and recruited additional deputy director positions. Following approval from DHSC, we also appointed a Chief Information Officer who joined the organisation in August 2020. These new roles, and those which have been created over the past few years, have ensured that the organisation is appropriately resourced to deliver its strategic intentions including the ongoing implementation of new indemnity schemes for general practice and now coronavirus response activities, as well as updating our IT systems and infrastructure. The introduction of these latest positions continues to support the succession plans for our senior business critical roles while offering better career pathways across all of our services.

Our talent pipeline for each directorate is underpinned by individual career conversations, intentions and aspirations, which continue to be held outside of the annual appraisal process.

We have maintained our membership 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. In September 2020 we supported the implementation of an ALB reciprocal mentoring programme. This aims to support the purpose of the HCLS network which is "to ensure we take a strategic approach to talent, management and development and work with our stakeholders to help build an increasingly confident, capable and motivated workforce across the national health and care system".

Gender pay gap

Due to the continuing impact of the coronavirus (Covid 19) pandemic, the Equality and Human Rights Commission (EHRC) have announced that employers will have an additional six months after the current deadline (5 April 2021) to report their gender pay gap (GPG) information.

All employers now have until 5 October 2021 to report their gender pay gap information. NHS Resolution will publish in line with this revised timescale.

Parliamentary accountability and audit report

The following disclosures are subject to audit..

Losses and special payments

We had losses of £3,710 in 2020/21. In 2019/20 we had losses of £348,850, which was in relation to a debt write-off.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES schemes, are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy at *Note 1.3* to the accounts on page 130. The contributions collected are set on a full cost recovery basis, and can be seen in *Note 3* to the accounts on page 138.

Expenditure on consultancy

Expenditure incurred on consultancy in 2020/21 was nil. In 2019/20 the expenditure on consultancy was £364,000.

Publicity and advertising

Publicity and advertising spend for the year was £67,462. This compares to £100,711 in 2019/20.

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 2020/21, NHS Resolution was covered under both LTPS and PES.

Remote contingent liabilities

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

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

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2020/21.

Helen Vernon
Chief Executive and Accounting Officer
Date: 7 July 2021

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 2021 under the National Health Service Act 2006. The financial statements comprise: the Statement of Comprehensive Net Expenditure, the Statement of Financial Position; the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity; and the related notes, including the significant accounting policies. These financial statements have been prepared under the accounting policies set out within them. The financial reporting framework that has been applied in their preparation is applicable law and International Accounting Standards as interpreted by HM Treasury's Government Financial Reporting Manual.

I have also audited the information in the Accountability Report that is described in that report as having been audited.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2021 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 (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 International Accounting Standards as interpreted by 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 parts of the Accountability Report described in that report as having been audited, the financial statements and 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, based on the work undertaken in the course of the audit:

- the parts of the Accountability Report to be audited have been properly prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Responsibilities of the Accounting Officer for the financial statements

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

- the preparation of the financial statements in accordance with the applicable financial reporting framework and for being satisfied that they give a true and fair view;
- 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.
- 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.

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.

My procedures included the following:

- inquiring of management, NHS Resolution's Head of Internal Audit and those charged with governance, including obtaining and reviewing supporting documentation relating to the 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 to the National Health Service Act 2006, Managing Public Money and the Coronavirus Act 2020.
- discussing among the engagement team and involving relevant internal and external specialists, including actuarial support to audit the IBNR provision, regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, I identified potential for fraud in the following areas: revenue recognition, posting of unusual journals and claims that feed into the provision;
- obtaining an understanding of NHS Resolution's framework of authority as well as other legal and regulatory frameworks that the NHS Resolution operates in, focusing on those laws and regulations that had a direct effect on 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 Act 2006, Managing Public Money, Employment Law, tax and pension Legislation and the Coronavirus Act 2020;
- inquiring of the counter-fraud team about their own identification and assessment of the risks of fraud.

In addition to the above, my procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- inquiring of management and the Audit Committee concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Board;
- 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; and
- reviewing submitted claims including supporting evidence.

I also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and significant component audit teams 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.

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

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

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

Date: 7 July 2021

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2021

	Notes	31 March 2021 (£000s)	31 March 2020 (£000s)
Other operating income	3	(2,309,526)	(2,004,401)
Total operating income		**(2,309,526)**	**(2,004,401)**
Staff costs	2	26,446	21,552
Purchase of goods and services	2	6,247	6,915
Depreciation and impairment charges	2	934	840
Provision expense	7	488,632	2,549,542
Other operating expenditure	2	1,813	1,577
Total operating expenditure		**524,072**	**2,580,426**
Net operating expenditure		**(1,785,454)**	**576,025**
Finance expenditure	7	503,375	507,878
Net expenditure for the year		**(1,282,079)**	**1,083,903**
Other comprehensive net expenditure		0	0
Comprehensive net expenditure for the year		**(1,282,079)**	**1,083,903**

The Notes on pages 130 to 167 form part of these financial statements.

Statement of financial position as at 31 March 2021

	Notes	31 March 2021 (£000s)	31 March 2020 (£000s)
Non-current assets			
Property, plant and equipment		1,289	1,407
Intangible assets		1,142	1,354
Total non-current assets		2,431	2,761
Current assets			
Trade and other receivables	4	16,328	27,560
Cash and cash equivalents	5	297,829	120,691
Total current assets		314,157	148,251
Total assets		316,588	151,012
Current liabilities			
Trade and other payables	6	(50,128)	(96,407)
Provisions for liabilities and charges – known claims	7	(2,749,702)	(2,783,788)
Total current liabilities		(2,799,830)	(2,880,195)
Total assets less current liabilities		(2,483,242)	(2,729,183)
Non-current liabilities			
Provisions for liabilities and charges – known claims	7	(37,210,538)	(34,733,478)
Provisions for liabilities and charges – IBNR	7	(42,825,000)	(46,536,000)
Total non-current liabilities		(80,035,538)	(81,269,478)
Total assets less liabilities		(82,518,780)	(83,998,661)
Taxpayers' equity			
General fund		8,165	5,873
ELS reserve		(1,135,862)	(1,305,942)
Ex-RHA reserve		(62,451)	(65,457)
DHSC clinical reserve		(3,141,362)	(3,480,036)
DHSC non-clinical reserve		(111,635)	(101,309)
ELGP reserve		(457,482)	(1,000,437)
ELSGP reserve		(421,168)	0
CNSGP reserve		(615,083)	(306,740)
CNSC reserve		(79,098)	0
CTIS reserve		(2,006)	0
CNST reserve		(76,299,316)	(77,592,849)
PES reserve		1,757	(5,850)
LTPS reserve		(203,239)	(145,914)
Total taxpayers' equity		(82,518,780)	(83,998,661)

The General Fund and individual scheme reserves are used to account for all financial resources. See the *Understanding our indemnity schemes* section on page 14 for a brief description of each scheme to which the reserves relate.

The Board approved a recommendation on 28 June 2021 that the *Financial statements* from page 123 should be signed by the Accounting Officer and these were signed by Helen Vernon on 7 July 2021. The Notes on pages 130 to 167 form part of these financial statements.

Helen Vernon
Chief Executive and Accounting Officer
Date: 7 July 2021

Statement of cash flows for the year ended 31 March 2021

	Notes	31 March 2021 (£000s)	31 March 2020 (£000s)
Cash flows from operating activities			
Net expenditure		**1,282,079**	(1,083,903)
Other cash flow adjustments	2	**982**	840
(Increase) / decrease in receivables	4	**11,232**	(11,908)
Increase / (decrease) in payables	6	**(46,279)**	17,557
Increase / (decrease) in provisions	7	**(1,268,026)**	677,699
Net cash (outflow) from operating activities		**(20,012)**	**(399,715)**
Cash flows from investing activities			
Purchase of property, plant and equipment		**(488)**	(40)
Purchase of intangible assets		**(164)**	(631)
Asset write-off		**0**	26
Net cash (outflow) from investing activities		**(652)**	**(645)**
Cash flows from financing activities			
Net Parliamentary funding		**197,802**	338,959
Net financing		**197,802**	**338,959**
Net (decrease)/increase in cash and cash equivalents		**177,138**	(61,401)
Cash and cash equivalents at the beginning of the period		**120,691**	182,092
Cash and cash equivalents at the end of the period	**5**	**297,829**	**120,691**

The Notes on pages 130 to 167 form part of these financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2021

	Notes	General Fund	ELS Reserve	Ex-RHAs Reserve	DHSC clinical Reserve	ELSGP Reserve	ELGP Reserve
		(£000s	(£000s)	(£000s)	(£000s)	(£000s)	(£000s)
Balance at 31 March 2019		**3,821**	**(1,447,553)**	**(73,492)**	**(3,903,402)**	**0**	**0**
Changes in taxpayers' equity for 2019/20							
Net expenditure for the year		**(5,907)**	**109,611**	**7,035**	**339,366**	**0**	**(1,063,937)**
Total recognised income and expense as at 2019/20		**(2,086)**	**(1,337,942)**	**(66,457)**	**(3,564,036)**	**0**	**(1,063,937)**
Net Parliamentary funding		7,959	32,000	1,000	84,000	0	63,500
Balance at 31 March 2020		**5,873**	**(1,305,942)**	**(65,457)**	**(3,480,036)**	**0**	**(1,000,437)**
Changes in taxpayers' equity for 2020/21							
Expenditure							
Authority and claims administration	2	(6,140)	(219)	(13)	(744)	(4,087)	0
(Increase)/decrease in provision for known claims	7	0	86,299	19	27,418	(226,081)	150,826
(Increase)/decrease in the provision for IBNR	7	0	54,000	2,000	227,000	(191,000)	323,000
		(6,140)	**140,080**	**2,006**	**253,674**	**(421,168)**	**473,826**
Income							
Scheme and other income	3	759	0	0	0	0	0
Total recognised income and expense for 2020/21		**(5,381)**	**140,080**	**2,006**	**253,674**	**(421,168)**	**473,826**
Net Parliamentary funding[1]		7,673	30,000	1,000	85,000	0	69,129
Balance at 31 March 2021		**8,165**	**(1,135,862)**	**(62,451)**	**(3,141,362)**	**(421,168)**	**(457,482)**

[1]The net Parliamentary funding represents the cash drawdown of £197,803 million in 2020/21 for DHSC-funded indemnity schemes and administration costs. The Notes on pages 130 to 167 form part of these financial statements.

CNSGP Reserve (£000s)	CNST Reserve (£000s)	CNSC Reserve (£000s)	DHSC non-clinical Reserve (£000s)	CTIS Reserve (£000s)	PES Reserve (£000s)	LTPS Reserve (£000s)	Total Reserves (£000s)
0	(77,565,305)	0	(111,409)	0	(4,974)	(151,403)	(83,253,717)
(307,240)	**(173,544)**	**0**	**6,100**	**0**	**(876)**	**5,489**	**(1,083,903)**
(307,240)	(77,738,849)	0	(105,309)	0	(5,850)	(145,914)	(84,337,620)
500	146,000	0	4,000	0	0	0	**338,959**
(306,740)	(77,592,849)	0	(101,309)	0	(5,850)	(145,914)	(83,998,661)
(1,298)	(17,733)	(98)	(155)	(6)	(56)	(4,891)	**(35,440)**
(15,045)	(4,684,474)	0	(7,171)	0	(408)	(34,390)	**(4,703,007)**
(292,000)	3,752,000	(79,000)	(8,000)	(2,000)	0	(75,000)	**3,711,000**
(308,343)	**(950,207)**	**(79,098)**	**(15,326)**	**(2,006)**	**(464)**	**(114,281)**	**(1,027,447)**
0	2,243,740	0	0	0	8,071	56,956	**2,309,526**
(308,343)	**1,293,533**	**(79,098)**	**(15,326)**	**(2,006)**	**7,607**	**(57,325)**	**1,282,079**
0	0	0	5,000	0	0	0	**197,802**
(615,083)	**(76,299,316)**	**(79,098)**	**(111,635)**	**(2,006)**	**1,757**	**(203,239)**	**(82,518,780)**

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2020/21 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRSs) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy 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 IFRSs, amendments or interpretations early.

Standards, amendments and interpretations in issue but not yet effective or adopted

International Accounting Standard 8, accounting policies, changes in accounting estimates and errors, requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board. These are effective for financial statements after this accounting period.

The following have not been adopted early in these accounts:

- **IFRS 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.
- **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.

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

1.3. Income

A source of funding for NHS Resolution as a Special Health Authority is a Parliamentary grant from DHSC within an approved cash limit. This funds the ELS, Ex-RHA, DHSC clinical, DHSC liabilities schemes, CNSC and CTIS (the newly created Covid- 19 schemes), the additional costs of the personal injury discount rate arising from the change in the rate announced by the Lord Chancellor in March 2017, and some administration costs. In addition, from 1 April 2019, NHS Resolution received funding from NHSE/I via DHSC for the administration of general practice indemnity arrangements, as directed by the Secretary of State. Parliamentary funding is recognised in the financial period in which it is received.

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

- Revenue from contracts with customers in relation to indemnity schemes: NHS Resolution receives contributions for the provision of indemnity cover for the CNST, LTPS and PES schemes. The authorising legislation for these schemes gives the right to collect these contributions. This is deemed, per the FReM adaptation of IFRS15, to constitute a contractual arrangement between NHS Resolution and its scheme members. The period of cover is annual, commencing on 1 April each year (contracts do not span financial years). Invoices are raised yearly, quarterly, over 10 months and monthly. 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 Schemes for Trusts (CNST). Where a trust has successfully demonstrated achievement against the 10 safety actions, it will recover its element of CNST contribution that went into the maternity incentive fund, plus a share of any unallocated funds. Trusts unable to demonstrate achievement of the 10 actions may be able to recover a lesser sum from the fund to help them achieve 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.

For the financial year 2020/21 the scheme was paused due to the pandemic as we did not want 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 but collection of funds will be from April 2021 for 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 2021/22 is £5.14 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 Auto Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2020/21 were £6,240 up to £50,000. Total contributions are 8%, with employee contributions at 4%, employer contributions at 3% and government contributions (tax relief) at 1%. More details on NEST can be found on the NEST website www.nestpensions.org.uk/schemeweb/nest/aboutnest.

1.6. Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Leave that has been earned but not taken at the year-end is not accrued on the grounds of materiality.

1.7. Provisions and contingent liabilities

NHS Resolution provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated cash flows are discounted using HM Treasury's discount rate.

In November 2017, following consultation with HM Treasury, the Financial Reporting Advisory Board (FRAB) recommended that nominal discount rates should be applied to general provisions rather than the real discount rates previously applied to an inflation rate. This change did not require a restatement of prior year balances as this was a change in accounting estimates and not a policy change.

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

NHS Resolution continues to provide management and oversight of arrangements resulting from a transfer of responsibility for claims for in-scope liabilities from medical defence organisations (MDOs) to the DHSC Group. The transfer of the claims previously managed by MDDUS (an MDO) happened on 6 April 2020; these liabilities have been accounted for under a new scheme Existing Liabilities Scheme for General Practice (ELSGP) in the accounts. Claims being managed by MPS (an MDO) transferred on 1 April 2021 therefore will be accounted for under Existing Liabilities General Practice (ELGP) in the same way as in 2019/20, these will then transfer to the 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 NHSE/I, 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 2019/20).

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 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

	Notes	2020/21 (£000s)	2019/20 (£000s)
Non-executive members' remuneration[1]		**135**	**203**
Other salaries and wages[2]			
Salaries and wages		**20,718**	17,819
Social security costs		**2,237**	1,802
Pension costs		**3,407**	1,865
Apprenticeship levy		**84**	66
Education, training and conferences		**46**	**126**
Establishment expenses		**456**	**1,393**
Hire and operating lease rental			
Land and buildings		**1,516**	528
Lease cars		**7**	4
Photocopiers		**0**	(1)
Franking machine		**0**	18
Vending machine[3]		**(13)**	11
Insurance		**222**	**200**
Transport (business travel)		**11**	**250**
Premises and fixed plant		**3,545**	**3,494**
External contractors			
Actuary's advice		**993**	847
Primary Care Appeals advisory expenditure		**21**	42

[1] Non-executive members' remuneration of £203k in 2019/20 includes a double count of £71k in relation to Chairman's pay which was offset in the salaries and wages cost.

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

[3] Release of accrued cost as lease contract was cancelled and the vendor did not charge as machine was faulty in the year.

Expenditure continued	Notes	2020/21 (£000s)	2019/20 (£000s)
Consultancy		0	364
External corporate legal fees[4]		165	284
Practitioner Performance Advice assessment expenditure		97	102
Practitioner Performance Advice professional services		0	(2)
Other		508	367
Auditor's remuneration: audit fees[5]		**225**	**175**
Internal audit fees		**68**	**69**
Bank charges and interest		**10**	**18**
		34,458	**30,044**
Depreciation		558	584
Amortisation		376	256
Disposal		48	0
		982	**840**
		35,440	**30,884**
Other finance costs – unwinding of discount	**7**	**503,375**	**507,878**
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	**7**	**4,044,297**	**7,284,312**
Change in the discount rate[6]	**7**	**346,335**	**(9,381,770)**
Increase / (decrease) in the provision for IBNR	**7**	**(3,902,000)**	**4,647,000**
		992,007	**3,057,420**
Total Expenditure[7]		**1,027,447**	**3,088,304**

[4] 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.

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

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

[7] Of the £1,027 million total expenditure for 2020/21, £5.4 million is shown as administration expenditure in DHSC consolidated group accounts.

2.1 Analysis of the provision expense

2020/21	CNST (£000s)	CNSGP (£000s)	ELSGP (£000s)	ELGP (£000s)	DHSC clinical (£000s)	ELS (£000s)
2020/21 incidents						
Known claims	42,339	1,722	0	0	0	0
IBNR	7,896,441	322,920	0	0	0	0
Total 2020/21	**7,938,780**	**324,642**	**0**	**0**	**0**	**0**
Prior years incidents						
Known claims	4,642,135	13,323	226,081	(150,826)	(27,418)	(86,299)
IBNR	(11,648,441)	(30,920)	191,000	(323,000)	(227,000)	(54,000)
Total prior years	**(7,006,306)**	**(17,597)**	**417,081**	**(473,826)**	**(254,418)**	**(140,299)**
Total	**932,474**	**307,045**	**417,081**	**(473,826)**	**(254,418)**	**(140,299)**

2019/20	CNST (£000s)	CNSGP (£000s)	ELSGP (£000s)	ELGP (£000s)	DHSC clinical (£000s)	ELS (£000s)
2019/20 incidents						
Known claims	80,715	1,208	0	0	0	0
IBNR	8,223,841	306,000	0	0	0	0
Total 2019/20	**8,304,556**	**307,208**	**0**	**0**	**0**	**0**
Prior years incidents						
Known claims	4,151,430	0	0	448,800	(177,830)	(50,748)
IBNR	(10,346,841)	0	0	612,000	(162,000)	(59,000)
Total prior years	**(6,195,411)**	**0**	**0**	**1,060,800**	**(339,830)**	**(109,748)**
Total	**2,109,145**	**307,208**	**0**	**1,060,800**	**(339,830)**	**(109,748)**

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 2020/21 totals £8.449 billion across all schemes. This compares to £8.652 billion in 2019/20, which is broadly similar.

The prior year's incidents figures show the changes in provisions that have been recognised in previous reporting years. In 2020/21 this was a reduction of £7.457 billion across all schemes. Within this total, IBNR for prior years is a reduction of £12.108 billion. The reduction is due to changes made to assumptions as more information has become available over time. In addition, 192 incidents reported under the Early Notification Scheme were recognised as claims during 2020/21, 140 more than 2019/20.

Ex-RHA (£000s)	CNSC (£000s)	CTIS (£000s)	DHSC non-clinical (£000s)	LTPS (£000s)	PES (£000s)	Total (£000s)
0	0	0	21	5,264	2,213	**51,559**
0	79,000	1,500	0	94,649	2,930	**8,397,440**
0	**79,000**	**1,500**	**21**	**99,913**	**5,143**	**8,448,999**
(19)	0	0	7,150	29,125	(1,805)	**4,651,447**
(2,000)	0	500	8,000	(19,648)	(2,930)	**(12,108,439)**
(2,019)	**0**	**500**	**15,150**	**9,477**	**(4,735)**	**(7,456,992)**
(2,019)	**79,000**	**2,000**	**15,171**	**109,390**	**408**	**992,007**

Ex-RHA (£000s)	CNSC (£000s)	CTIS (£000s)	DHSC non-clinical (£000s)	LTPS (£000s)	PES (£000s)	Total (£000s)
0	0	0	5	6,468	3,398	**91,794**
0	0	0	0	27,026	3,340	**8,560,207**
0	**0**	**0**	**5**	**33,494**	**6,738**	**8,652,001**
(4,044)	0	0	4,760	32,775	2,483	**4,407,626**
(3,000)	0	0	(11,000)	(30,026)	(2,340)	**(10,002,207)**
(7,044)	**0**	**0**	**(6,240)**	**2,749**	**143**	**(5,594,581)**
(7,044)	**0**	**0**	**(6,235)**	**36,243**	**6,881**	**3,057,420**

Without the operation of the Early Notification Scheme, these claims would have been accounted as IBNR rather than known claims.

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

3. Operating income

	2020/21 (£000s)	2019/20 (£000s)
CNST contributions	2,243,740	1,951,259
LTPS contributions	56,956	46,070
PES contributions	8,071	6,066
Practitioner Performance Advice	759	1,006
Total	**2,309,526**	**2,004,401**

4. Receivables

	Ex-RHA (£000s)	ELS (£000s)	DHSC clinical (£000s)	ELGP (£000s)	ELSGP (£000s)	CNSGP (£000s)
NHS receivables – revenue	0	0	0	0	0	0
Prepayments	40	516	2,288	0	0	0
Other receivables	0	658	51	524	72	110
Total	**40**	**1,174**	**2,339**	**524**	**72**	**110**

5. Cash and cash equivalents

	Ex-RHA (£000s)	ELS (£000s)	ELSGP (£000s)	CNSGP (£000s)
At 1 April 2020	100	27,949	6,565	409
Change during the year	0	7,259	(6,465)	(309)
At 31 March 2021[1]	**100**	**35,208**	**100**	**100**

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

CNST (£000s)	PES (£000s)	LTPS (£000s)	DHSC non-clinical (£000s)	Admin (£000s)	Total 31 March 2021 (£000s)	Total 31 March 2020 (£000s)
769	48	2,788	0	162	**3,767**	**6,958**
794	0	0	0	848	**4,486**	**4,081**
5,915	11	271	18	445	**8,075**	**16, 521**
7,478	**59**	**3,059**	**18**	**1,455**	**16,328**	**27,560**

CNST (£000s)	PES (£000s)	LTPS (£000s)	Admin (£000s)	Total 31 March 2021 (£000s)	Total 31 March 2020 (£000s)
33,432	6,289	41,292	4,655	**120,691**	**182, 092**
158,847	4,689	12,108	1,009	**177,138**	**(61,401)**
192,279	**10,978**	**53,400**	**5,664**	**297,829**	**120,691**

6. Trade payables and other current liabilities

	ELS (£000s)	DHSC clinical (£000s)	ELSGP (£000s)	CNSGP (£000s)	CNST (£000s)
NHS payables revenue	0	0	0	0	0
Prepaid income	1,442	0	0	0	14,979
Accruals	17	104	246	42	20,097
Other payables	334	941	9	0	7,251
Total	**1,793**	**1,045**	**255**	**42**	**42,327**

[1] The debit balance of £124k is due to a large credit memo received from Government Property Agency.

PES (£000s)	LTPS (£000s)	DHSC non-clinical (£000s)	Admin (£000s)	Total 31 March 2021 (£000s)	Total 31 March 2020 (£000s)
0	126	0	26	152	334
0	0	0	63	16,484	5,433
8	298	47	4,045	24,904	15,839
0	129	48	(124)[1]	8,588	74,801
8	553	95	4,010	50,128	96,407

7. Provisions for liabilities and charges

	Ex-RHA (£000s)	ELS (£000s)	CNST (£000s)	DHSC clinical (£000s)	ELGP (£000s)
Opening provision for known claims	57,011	1,111,961	33,166,788	2,681,471	387,475
Opening provisions for IBNR	8,000	199,000	44,391,000	845,000	612,000
Total provisions as at 1 April 2019	**65,011**	**1,310,961**	**77,557,788**	**3,526,471**	**999,475**
Movement in known claims					
Transfer between schemes	0	0	0	0	(146,616)
Provided in the year	2,413	13,190	8,242,807	190,890	60,803
Provision not required written back	(3,752)	(122,909)	(4,131,228)	(273,466)	(69,731)
Unwinding of discount	1,023	18,848	439,075	42,305	1,278
Change in discount rate[1]	297	4,572	133,820	12,853	3,440
Provisions utilised in the year	(1,241)	(23,034)	(2,061,018)	(61,629)	(43,014)
Movement in known claims	**(1,260)**	**(109,333)**	**2,623,456**	**(89,047)**	**(193,840)**
Movement in IBNR					
Transfer between schemes	0	0	0	0	(201,000)
Change in discount rate[1]	0	1,000	165,000	1,000	6,000
Provided in the year	(2,000)	(55,000)	(3,917,000)	(228,000)	(128,000)
Movement in IBNR	**(2,000)**	**(54,000)**	**(3,752,000)**	**(227,000)**	**(323,000)**
Closing provision for known claims	55,751	1,002,628	35,790,244	2,592,424	193,635
Closing provisions for IBNR	6,000	145,000	40,639,000	618,000	289,000
Total provision as at 31 March 2021	**61,751**	**1,147,628**	**76,429,244**	**3,210,424**	**482,635**
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
Later than one year and not later than five years	7,005	143,086	11,767,324	315,188	173,922
Later than five years	53,746	969,539	62,231,676	2,818,230	241,923
Total provision as at 31 March 2021	**61,751**	**1,147,628**	**76,429,244**	**3,210,424**	**482,635**

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

ELSGP (£000s)	CNSGP (£000s)	CNSC (£000s)	CTIS (£000s)	DHSC non-clinical (£000s)	PES (£000s)	LTPS (£000s)	Total (£000s)
0	1,149	0	0	10,919	9,612	90,880	**37,517,266**
0	306,000	0	0	97,000	5,000	73,000	**46,536,000**
0	**307,149**	**0**	**0**	**107,919**	**14,612**	**163,880**	**84,053,266**
146,616	0	0	0	0	0	0	**0**
134,190	15,754	0	0	10,031	4,245	56,789	**8,731,112**
(55,790)	(744)	0	0	(2,880)	(3,838)	(22,477)	**(4,686,815)**
778	0	0	0	13	3	52	**503,375**
287	35	0	0	7	(2)	26	**155,335**
(18,619)	(791)	0	0	(7,409)	(3,326)	(39,952)	**(2,260,033)**
207,462	**14,254**	**0**	**0**	**(238)**	**(2,918)**	**(5,562)**	**2,442,974**
201,000	0	0	0	0	0	0	**0**
3,000	13,000	0	0	1,000	0	1,000	**191,000**
(13,000)	279,000	79,000	2,000	7,000	0	74,000	**(3,902,000)**
191,000	**292,000**	**79,000**	**2,000**	**8,000**	**0**	**75,000**	**(3,711,000)**
207,462	15,403	0	0	10,681	6,694	85,318	**39,960,240**
191,000	598,000	79,000	2,000	105,000	5,000	148,000	**42,825,000**
398,462	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**82,785,240**
70,372	2,280	0	0	8,001	9,000	50,006	**2,749,702**
157,870	144,800	6,000	1,000	21,013	2,694	183,312	**12,923,214**
170,220	466,323	73,000	1,000	86,667	0	0	**67,112,324**
398,462	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**82,785,240**

[1] The methodology adopted to account for the impact of the change in the discount rates set by HM Treasury has changed for 2020/21. The change has been made due to the selection of a revised ASHE assumption in 2020/21 that was not directly related to the level of general inflation assumed (long term CPI remained unchanged this year). The change in the discount rate now does not include the impact of changes to the future inflation rates relative to past rates and ASHE assumptions i.e. it now only includes the effect of the changes in the notional discount rate mandated by HM Treasury. The impact of the change in the inflation rate relative to past rates and ASHE assumption are now included in the provided in year and provision not required written back lines. The change in provision in 2020/21 due to the change in discount rates is £346.3 million (£155.3 million for known claims and £191 million for IBNR). Further details are in Note 7.2 Explanatory notes.

[2] Discounted cash flow timings are based upon actuarial estimates for known claims and IBNR. Actual cash flows will vary due to a number of factors including claims settling on a periodical payment basis rather than lump sum, claims which take longer than anticipated to resolve, and changes in the value and timing of payments.

Provisions for liabilities and charges (prior year)

	Ex-RHA (£000s)	ELS (£000s)	DHSC clinical (£000s)
Opening provision for known claims	62,317	1,198,889	2,927,385
Opening provisions for IBNR	11,000	258,000	1,007,000
Total provisions as at 1 April 2019	**73,317**	**1,456,889**	**3,934,385**
Movement in known claims			
Provided in the year	652	70,484	160,489
Provision not required written back	(550)	(33,749)	(158,115)
Unwinding of discount	1,161	21,525	51,153
Change in discount rate[1]	(5,307)	(109,008)	(231,357)
Provisions utilised in the year	(1,262)	(36,180)	(68,084)
Movement in known claims	**(5,306)**	**(86,928)**	**(245,914)**
Movement in IBNR			
Change in discount rate[1]	(1,000)	(16,000)	(69,000)
Provided in the year	(2,000)	(43,000)	(93,000)
Movement in IBNR	**(3,000)**	**(59,000)**	**(162,000)**
Closing provision for known claims	57,011	1,111,961	2,681,471
Closing provisions for IBNR	8,000	199,000	845,000
Total provision as at 31 March 2020	**65,011**	**1,310,961**	**3,526,471**
Analysis of expected timing of discounted cash flows[2]			
Not later than one year	998	37,905	97,755
Later than one year and not later than five years	3,940	150,819	349,686
Later than five years	60,073	1,122,237	3,079,030
Total provision as at 31 March 2020	**65,011**	**1,310,961**	**3,526,471**

DHSC non-clinical (£000s)	ELGP (£000s)	CNSGP (£000s)	CNST (£000s)	PES (£000s)	LTPS (£000s)	Total (£000s)
12,714	0	0	31,091,984	9,981	94,297	**35,397,567**
108,000	0	0	46,514,000	4,000	76,000	**47,978,000**
120,714	**0**	**0**	**77,605,984**	**13,981**	**170,297**	**83,375,567**
7,298	448,800	1,208	9,279,404	8,166	118,606	**10,095,107**
(2,520)	0	0	(2,534,702)	(2,283)	(78,876)	**(2,810,795)**
21	0	0	433,972	0	46	**507,878**
(34)	0	0	(2,946,529)	(2)	(533)	**(3,292,770)**
(6,560)	(61,325)	(59)	(2,157,341)	(6,250)	(42,660)	**(2,379,721)**
(1,795)	**387,475**	**1,149**	**2,074,804**	**(369)**	**(3,417)**	**2,119,699**
(3,000)	0	0	(6,000,000)	0	0	**(6,089,000)**
(8,000)	612,000	306,000	3,877,000	1,000	(3,000)	**4,647,000**
(11,000)	**612,000**	**306,000**	**(2,123,000)**	**1,000**	**(3,000)**	**(1,442,000)**
10,919	387,475	1,149	33,166,788	9,612	90,880	**37,517,266**
97,000	612,000	306,000	44,391,000	5,000	73,000	**46,536,000**
107,919	**999,475**	**307,149**	**77,557,788**	**14,612**	**163,880**	**84,053,266**
3,990	131,961	2,466	2,443,875	7,980	56,858	**2,783,788**
15,758	384,040	70,702	11,206,499	6,632	107,022	**12,295,098**
88,171	483,474	233,981	63,907,414	0	0	**68,974,380**
107,919	**999,475**	**307,149**	**77,557,788**	**14,612**	**163,880**	**84,053,266**

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

	Ex-RHA (£000s)	ELS (£000s)	CNST (£000s)	DHSC clinical (£000s)	ELSGP (£000s)
Unwinding of discount / finance charge	**1,023**	**18,848**	**439,075**	**42,305**	**778**
Increase in known claims provision	2,413	13,190	8,242,807	190,890	134,190
Provision not required written back	(3,752)	(122,909)	(4,131,228)	(273,466)	(55,790)
Change in discount rate (known claims and IBNR)	297	5,572	298,820	13,853	3,287
Increase / (decrease) in provision for IBNR	(2,000)	(55,000)	(3,917,000)	(228,000)	(13,000)
Provision expense charged to Statement of comprehensive net expenditure	**(3,042)**	**(159,147)**	**493,399**	**(296,723)**	**68,687**
Total charge to Statement of comprehensive net expenditure	**(2,019)**	**(140,299)**	**932,474**	**(254,418)**	**69,465**

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.

Scope of the schemes and arrangements

The scope of the schemes and arrangements administered by NHS Resolution are described on page 14.

Developments over the year affecting the provisions

Indemnity arrangements for coronavirus

The coronavirus pandemic has had a significant impact on the NHS this year, which has the potential to affect the value of the liabilities covered by NHS Resolution.

Many of the liabilities arising from healthcare provision in relation to the pandemic are covered by arrangements already in place (i.e. through CNST, CNSGP and LTPS). However two new schemes have been established to provide indemnity cover for activities related to the response to the coronavirus pandemic. These are:

- The Clinical Negligence Scheme for Coronavirus (CNSC) which meets clinical negligence liabilities arising from the special healthcare arrangements that were put in place in response to the pandemic.
- The Coronavirus Temporary Indemnity Scheme (CTIS). The scheme will provide state cover for employer's liability and public liability to fill gaps where Covid-19 positive patients have been discharged from the NHS into designated care home settings which have been unable to secure sufficient private insurance cover.

ELGP (£000s)	CNSGP (£000s)	CNSC (£000s)	CTIS (£000s)	DHSC non-clinical (£000s)	PES (£000s)	LTPS (£000s)	Total (£000s)
1,278	**0**	**0**	**0**	**13**	**3**	**52**	**503,375**
60,803	15,754	0	0	10,031	4,245	56,789	**8,731,112**
(69,731)	(744)	0	0	(2,880)	(3,838)	(22,477)	**(4,686,815)**
9,440	13,035	0	0	1,007	(2)	1,026	**346,335**
(128,000)	279,000	79,000	2,000	7,000	0	74,000	**(3,902,000)**
(127,488)	**307,045**	**79,000**	**2,000**	**15,158**	**405**	**109,338**	**488,632**
(126,210)	**307,045**	**79,000**	**2,000**	**15,171**	**408**	**109,390**	**992,007**

The significant effects of the pandemic only materialised in 2020. There have not yet been many claims received related to Covid-19. It is therefore challenging to arrive at firm estimates for the impact of the pandemic. We have put in place other frameworks to attempt to ascertain the financial impact on the provision. A multidisciplinary working group was set up to review the risks and valuation of Covid-19, reviewing an extensive list of risks and multiple sources of data from across the healthcare sector to ascertain the likely impact on our provision. The membership of the group consisted of representation from our Claims, Finance and Policy teams as well as the actuarial advisors and specialist input from other areas of the organisation as required.

The high-level approach adopted to quantifying the impact of Covid-19 on the provision separately considers:

- 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.

The provision includes £0.9 billion across all schemes for claims arising from new risks generated by the pandemic. This is partially offset by the estimated £0.4 billion impact of a reduction in claims resulting from lower levels of usual activity in the NHS. A further allowance for general risk and uncertainty has been included in the claims inflation assumption to cover at present unquantifiable claims risk in relation to the pandemic, as well as other areas of uncertainty.

Although the pandemic has materially affected activity in 2020/21 and the risk of clinical and non-clinical claims that arise from that activity, the estimated impact on the NHS Resolution provision is fairly limited at this stage because:

- a large share (90%) 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, for example due to legal firms furloughing staff, this is not expected significantly to alter the liabilities reported.
- the majority (approximately 65%) of the CNST provision is as a result of claims arising from maternity activity. Although there have been some changes, maternity activities overall have continued during the pandemic and are expected to result in 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 £6 billion, which is similar to previous years.

Early Notification

The majority (approximately 65%) of the CNST provision is as a result of claims arising from maternity activities – such as brain damage to babies at birth from negligent care.

We collaborated with HSIB throughout the Covid-19 pandemic to reduce the burden of reporting on trusts and sharing learning from maternity investigations. From 1 April 2021, NHS Resolution's criteria for an investigation narrowed to those cases where there was evidence of or the potential for an intrapartum hypoxic brain injury. We apply the following clinical definition of brain injury to Early Notification cases: 'babies who have an abnormal MRI scan where there is evidence of changes in relation to intrapartum hypoxic ischaemic encephalopathy (HIE)'.

The EN Scheme therefore has the potential significantly to alter the pace at which incidents and/or claims are reported to NHS Resolution. In arriving at the number of claims, we have assumed that the overall level of risk in relation to brain damage at birth is broadly similar to the period before EN and hence will result in a similar number of claims.

General practice indemnity

Our role in primary care continued to develop in 2020/21. From 6 April 2020 indemnity for liabilities relating to incidents prior to 1 April 2019 of members of the Medical and Dental Defence Union of Scotland (MDDUS) was provided by Government and administered by NHS Resolution under the Existing Liabilities Scheme for General Practice (ELSGP).

In 2020/21 the interim arrangements continued with the Medical Protection Society (MPS). This is where the legal and operational responsibility of handling claims within scope of those interim arrangements remains with the MDO and NHS Resolution carries out the Secretary of State's oversight and governance responsibilities. This arrangement is known as Existing Liabilities for General Practice (ELGP). From 1 April 2021 indemnity for these claims was provided by Government and administered by NHS Resolution under the Existing Liabilities Scheme for General Practice (ELSGP).

Assumption of liabilities upon cessation

The NHS Act 2006 section 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 contracts actuarial advisers, the Government Actuary's Department, to assist with the preparation of financial statements through analysis and modelling of claims data. This is combined with information provided by management on the current economic and claims environment in order to provide estimates 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, drawing on advice of the Government Actuary's Department.

One of the key assumptions used in the production of the estimates reported is outside the formal control of NHS Resolution, as HM Treasury prescribes the discount rates to be used in calculating the provisions. There are other factors that influence the provision that are also outside NHS Resolution's control; for example, patients (and their legal representatives) have an element of control over the timing of the reporting of claims. The Reserving and Pricing Committee keeps all of the factors affecting the calculation of provisions under review to ensure that the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

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

- **Known claims**
  The provision is based on the case estimates of individual reported claims received by NHS Resolution. The case estimates are adjusted by reference to the case handlers' estimated probability of each claim being successful, for expected future claims inflation to settlement, for the likelihood that they will go on to settle as structured settlements – with part of the claim paid over the life of the claimant as a periodical payment order (PPO) rather than purely as a lump sum – and for the assumed additional cost if the case were to settle as a PPO.
  For ELGP, because case estimates have not been set by NHS Resolution, adjustments have been made to the valuation to reflect historical differences in ultimate settlement costs compared with earlier case estimates.
  The resulting adjusted claim values are then discounted for the time value of money (at the Treasury-prescribed rates) to give a present value at the accounting date.
- **Settled PPOs**
  The Settled PPO model carries out projections on an individual claim-by-claim basis and then aggregates the results. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation).
  A probability of the claimant's survival is then applied to each projected payment and provides a weighting that allows for the relative chance of each payment being made. This forms the cash flows. The longevity of the cash flows is consequently determined by the probabilities of survival. The probabilities of survival for each year for each settled claim are determined using medical expert assessments of each claimant's future life expectancy, and standard mortality tables.
- **IBNR**
  To estimate the IBNR provision at the accounting date, the future cash flows expected to arise from IBNR claims are discounted (using HM Treasury prescribed rates) back to the accounting date so that the amounts are valued in present day terms.

The steps to arrive at an estimate are:

- A characteristic pattern of claims reporting from claim incident year is identified to determine the 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 appropriately combining the average claim sizes with the claim numbers and the time lag from reporting to payment, a projection is made for the total value of claim payments for IBNR claims in each future year.
- For claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows, based on mortality assumptions derived from the settled PPO claims. Lump sum settlements are assumed to be paid out in full around settlement time.
- The final step in the process is to calculate the present value of the projected future cash flows (using the HM Treasury-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.
- For CNST, ELS and DHSC Clinical Liabilities, these calculations are carried out separately for damages, NHS legal costs and claimant costs, and for PPO and non-PPO type claims.
- For CNSGP, approximate methods have been used based on the estimated costs of ELGP claims in view of the fact that there is only two years of claims experience available.
- For CNSC, CTIS 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 general practice indemnity schemes, given the recent changes in these arrangements; and
- the CNSC, CTIS 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.

Table 26 shows a summary of the key assumptions used to determine the CNST IBNR provision, and is included 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.

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:** Following an increasing trend up to 2012/13, reported claim numbers have been stable in more recent years. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting uncertainty in past claim trends. As noted above, 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.

  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, increased awareness of the availability of compensation and a lack of past data preceding the formation of NHS Resolution, increases the uncertainty in this assumption.
- **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 increased at a significantly higher rate than price inflation. For clinical negligence claims, inflation is affected by a number of external factors such as the PIDR, changes in legal precedent (e.g. a recent judgement that overturned rules relating to accommodation costs determined by Roberts v. Johnstone) and changes in legal costs. The variety of potential external influences on future claims inflation means that this assumption is subject to significant uncertainty.

The HM Treasury PES discount rate note from December 2020 (which specifies the financial assumptions to be used for valuing provisions at March 2021) states that all cash flows should be assumed to increase in line with the OBR CPI forecasts unless certain conditions are met for this assumption to be rebutted. These conditions are set out in Paragraph 34 of Annex B to the HM Treasury PES note.

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

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

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

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

As a result, the claims inflation assumptions are derived by:

- first, looking at nominal increases in average claim costs over past years by reserving segment;
- then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past; and
- finally, adding an explicit adjustment for the risk and uncertainty inherent in the provisions. This is set at 0.3% a year. This is unchanged from last year, reflecting increased uncertainty likely to emerge from Covid-19 offset by improvements in other areas such as recent trends in PPO settlements and reducing birth numbers.

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 has been estimated by medical experts prior to settlement. The actual future lifetime of the claimant may differ significantly from these estimates. 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:** For this 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, offset by new risks and potential sources of claims as a result of the response. In addition, we have considered the potential effect of Covid-19 on each assumption made in the provisions. It is possible that Covid-19 might have an indirect effect on many of the assumptions – for example changes in the broader economic environment might influence future claims inflation, the propensity for claims to settle as PPOs and the likelihood of claims being made. For many of the assumptions, the potential effect of Covid-19 is uncertain and there is limited data available to inform a view and justify a change in the assumptions. Such risks and uncertainties are reflected in the risk and uncertainty margin included in the provision.
- **Legal environment:** The future legal environment is a particular area of uncertainty. There have been a number of recent consultations that might impact the schemes' provisions (such as 'Introducing Fixed Recoverable Costs in Lower Value Clinical Negligence Claims' issued by DHSC). The provisions have been valued using the current Personal Injury Discount Rate (PIDR) of minus 0.25%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR. As there is no certainty on the outcomes of future reviews, no adjustments have been made to the IBNR for the potential effects of such changes at this stage.
- **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. 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 Early Notification Scheme will 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, contributes to the uncertainty inherent in these provisions.

Table 26: Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes
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
Propensity to settle as PPO	Value threshold derived from recent years' settled claims data	Medium	Medium
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High
Claims inflation	Derived from past settled claims	High	High
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)
Cash flow pattern for PPO payments	Based on analysis of past settled PPO claims	Medium	Low
Nominal discount rates	HM Treasury prescribed	Prescribed	High
ASHE 6115 (80th percentile)	Based on earnings increases relative to CPI over the longer term	Medium	High

The impacts of the various assumptions can be found detailed in Figure 35: CNST IBNR sensitivities as at 31 March 2021 (page 155).

Change in assumption between 31 March 2020 and 31 March 2021	Effect of change (CNST)
Both the expected number of future PPO claims and non-PPO claims assumptions have reduced. For non-PPOs an adjustment for lower activity due to Covid-19 has been included.	**-£3.5bn**
A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has reduced slightly from £3.3m to £3.25m.	-£0.1bn
The average costs per claim assumptions are similar to last year's assumptions which means that they haven't kept pace with the expected level of claims inflation.	**-£2.8 billion** combined impact of updated average cost per claim and claims inflation
The inflation assumption for PPO damages has decreased by 0.25 pa% from the previous year.	
This has increased by 1% for non-PPO damages.	**+£0.1bn**
Lag range from 2.8 to 7.7 years, remaining the same at the lower end of the range and increased by 0.2 years at the higher end of the range.	**+£0.5bn**
Expected future lifetime of PPO claimants at settlement has remained the same (37 years).	+£0.2bn
Short- and medium-term rates have reduced by 0.53% and 0.37% respectively. The long-term rate remains unchanged.	**+£0.2bn**
The ASHE assumption has reduced from CPI+2.0% to CPI+1.75%.	**-£1.7bn**

CNST IBNR sensitivities as at 31 March 2021

The IBNR provisions are sensitive to the assumptions used to varying degrees. The CNST IBNR provision is the single largest element within the total provision. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision.

The following sections indicate the impacts on the CNST IBNR provision of using different assumptions in two different ways. The reasonable range results are intended to illustrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision. For this assessment, a number of assumptions are varied together but the variations are limited to those that could have reasonably been chosen based on the same analysis of past data.

The sensitivity analysis shown subsequently indicates how wider variations in individual assumptions would affect the provision. This demonstrates the extent to which plausible differences between the assumptions chosen and actual future experience could affect future years' provisions and the ultimate costs of settling claims.

Reasonable range of results

The provision in the accounts is based on a set of chosen assumptions. It is possible to have a range of different results if a different set of assumptions had been chosen.

A reasonable range of results follows, based on assumptions which, considering the historical data analysed and the approach used, could have reasonably been selected in lieu of the chosen assumptions. The reasonable range illustrates the potential outcome if different conclusions had been reached based on the same data. Although it should be noted that this in itself does not reflect the potential uncertainty in the assumptions underpinning the provision as future experience may differ to the past, changes may occur in the claims and legal environment, and the modelling approach may not be a perfect representation of real life.

CNST IBNR reasonable range

	Value	Difference to accounts estimate
Baseline CNST IBNR	**£40.6 billion**	
Reasonable upper range	£47.3 billion	16.4%
Reasonable lower range	£33.1 billion	-18.4%

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

- The estimate for numbers of PPO damages claims for the incident years 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 adjustment to non-maternity activity as a result of Covid-19.
- The range of Covid-19 related claims.

In summary, the provision in the accounts for CNST IBNR could have been reasonably set at a value between £33.1 billion and £47.3 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 £40.6 billion.

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

Sensitivity analysis

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

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

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

Figure 35: CNST IBNR sensitivities as at 31 March 2021

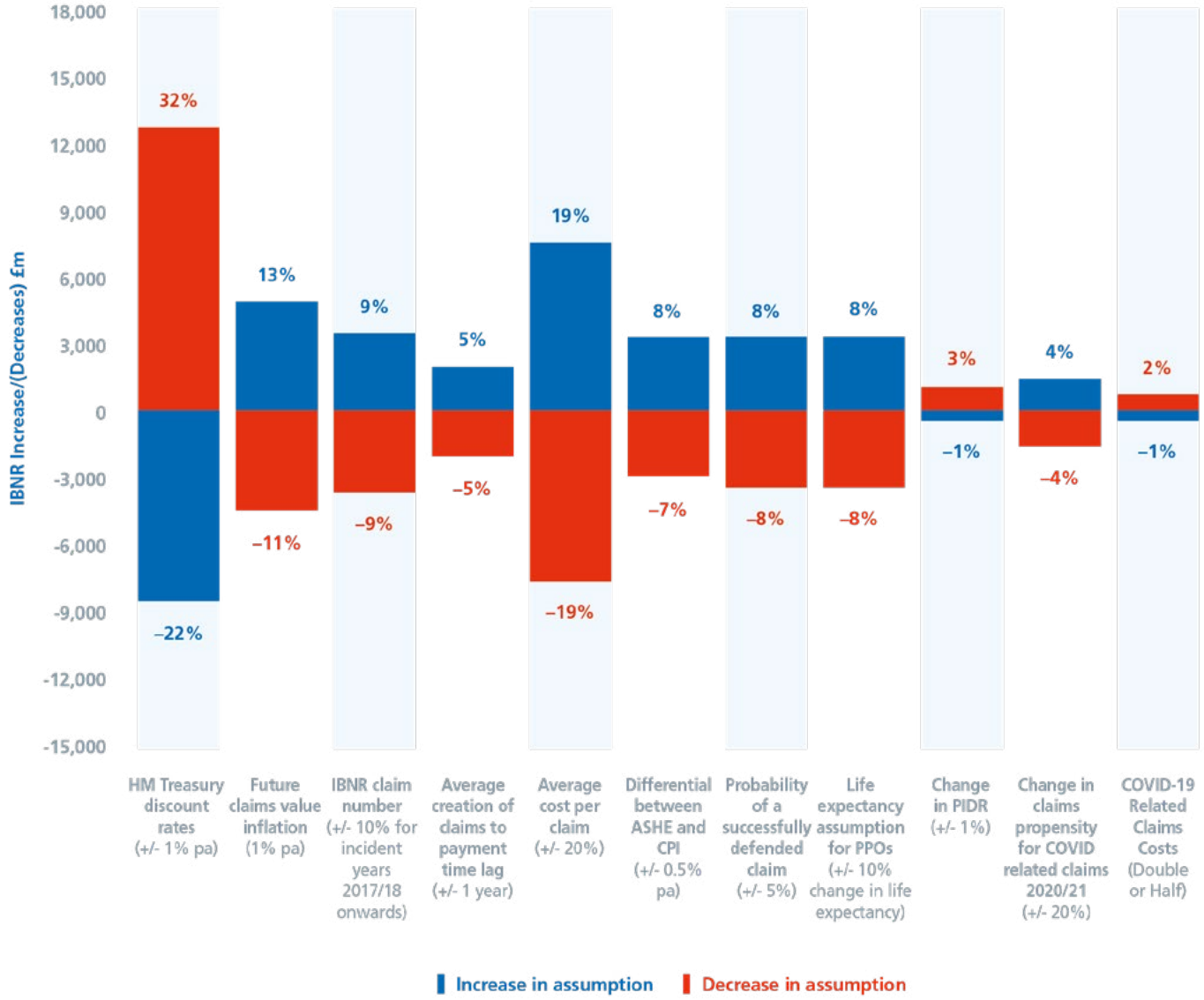


Figure 35 sets out both the value and percentage impact of variations in the key assumptions within the CNST IBNR estimate. The sensitivities around these key assumptions are explained further in the remainder of this note.

Sensitivity to Covid-19 assumptions

Figure 35 shows the sensitivity of the CNST provision to varying the two key assumptions in determining the Covid-19 claims – namely the propensity for, and cost of, successful Covid-19 claims. The propensity for successful Covid-19 claims reflects a combination of:

- the exposure to activity that might give rise to Covid-19 claims, for example the number of hospitalised patients;
- the level of negligence; and
- the likelihood of the claimant making a successful claim.

The sensitivities show that relatively large changes in the assumed propensity and/or cost of Covid-19 claims are expected to lead to relatively small change in the CNST provision. As noted above, this reflects the fact that a large share of the CNST provision either relates to incidents before 2020/21 and to maternity activity where a similar level of claims to previous years is expected.

Sensitivity to future claims value inflation

The margin for risk and uncertainty is included in the claims inflation assumption so the claims inflation sensitivity should be read as a reference for assessing either (i) a change in the raw inflation assumptions; and/or (ii) a change in the uncertainty margin.

Sensitivity to HM Treasury tiered nominal discount rates

Since 2018/19, HM Treasury specifies PES discount rates in nominal terms. The short- and medium-term nominal discount rates have decreased this year and the long-term rates have remained unchanged.

The impacts of these changes on the IBNR provisions vary by scheme, depending on the type and duration of the expected future claim payments.

		31 March 2020 nominal rates (%pa)	**31 March 2021** nominal rates (%pa)
Short term	(<5 years)	0.51%	**-0.02%**
Medium term	(5-10 years)	0.55%	**0.18%**
Long term	(10-40 years)	1.99%	**1.99%**
Very long term	(over 40 years)	1.99%	**1.99%**

Figure 36: Sensitivity of the CNST IBNR provision to changes in the nominal discount rates assumption (£ billion, by change in discount rate from base assumption)

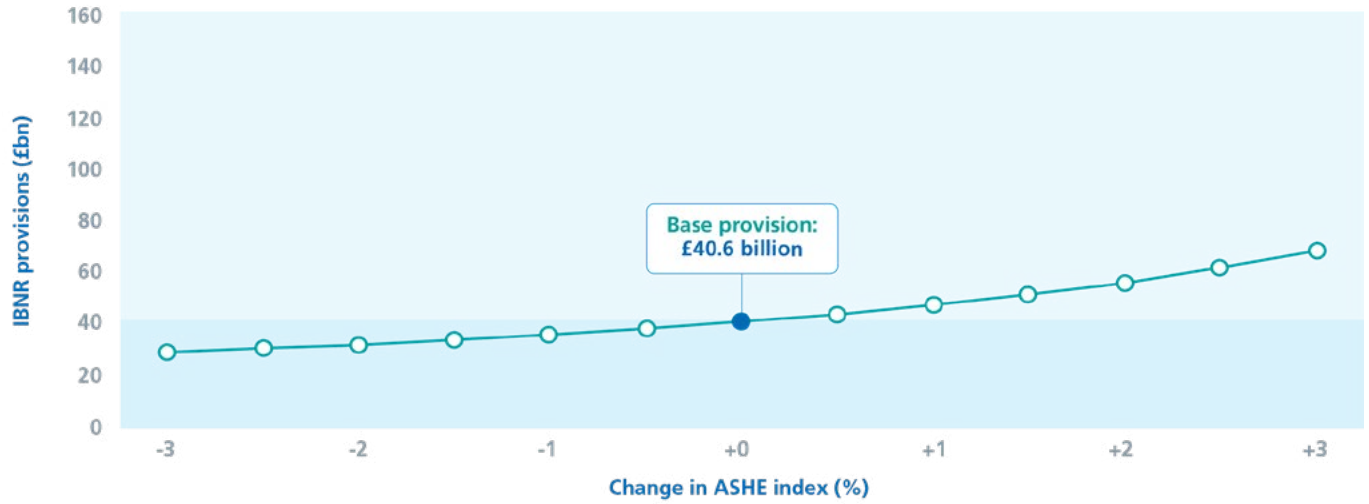
Figure 36 is based on adjusting the nominal discount rate by the increments shown. A change in the nominal interest rate of +1% would represent short-, medium- and long-term nominal interest rates of 0.98%, 1.18% and 2.99%, respectively. As a result of the range of the increments analysed (and, for example, the long-term nominal interest rate of 1.99%), results to the left of the graph imply a negative nominal discount rate.

For the clinical schemes, the changes in discount rates this year have had a relatively small impact on the IBNR provisions. This is because a large proportion (by value) of the IBNR provisions are expected to be paid in more than 10 years' time and the long-term discount rate hasn't changed since last year.

Sensitivity to 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 37: CNST IBNR (£bn) adjusted by ASHE index



Settled PPO sensitivities

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

Settled PPOs represent 50% of the value of the known claims provision and are typically high value cases, and the long-term nature of them means they are highly sensitive to changes in key assumptions. The following tables show the effect on the valuation if different rates and assumptions were applied for HM Treasury discount rates, the differential between CPI and annual hourly earnings (ASHE), and life expectancy.

HM Treasury discount rate assumptions

Due to the long-term nature of PPOs, where PPO claims can be expected to continue for 50 years or longer, the PPO element of the provision is very sensitive to changes in the HM Treasury-prescribed discount rate, especially the long-term discount rate. As shown above in the discussion of the CNST IBNR provision sensitivity, the relationship between the value of the provision and the effect of changes in the discount rate is not a proportionate one. A reduction of 1% in the discount rates will increase the PPO element of the CNST provision by 36%, but a 1% increase will reduce the provision by 24%.

Provision for settled PPOs at 31 March 2021

HM Treasury discount rate	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
All rates -1% pa	25,869	21,788	1,243	2,762	73	2	1
Base assumption	19,140	15,979	947	2,155	56	2	1
All rates +1% pa	14,709	12,189	743	1,730	44	2	1

Percentage change to provision

HM Treasury discount rate	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -1% pa	35%	36%	31%	28%	30%	0%	0%
Base assumption	0%	0%	0%	0%	0%	0%	0%
All rates +1% pa	-23%	-24%	-22%	-20%	-21%	0%	0%

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

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. It is currently assumed that the rate of inflation in carers' wages is 1.75% higher than CPI annually.

The following table shows the effect on the value of the PPO element of the schemes' provisions where this differential is varied. An additional +/- 0.5% difference between ASHE and CPI will either increase the CNST PPO provision by 16% or reduce it by 13% respectively.

Provision for outstanding claims at 31 March 2021

Differential between CPI and ASHE	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
All rates -0.5%	**16,815**	13,949	854	1,959	50	2	1
Base assumption: 1.75% pa	**19,140**	15,979	947	2,155	56	2	1
All rates +0.5%	**21,976**	18,463	1,059	2,389	62	2	1

Percentage change to provision

Differential between CPI and ASHE	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -0.5%	**-12%**	-13%	-10%	-9%	-11%	0%	0%
Base assumption: 1.75% pa	**0%**	0%	0%	0%	0%	0%	0%
All rates +0.5%	**15%**	16%	12%	11%	11%	0%	0%

Life expectancy assumptions

The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Where the assumption as to life expectancy of individual claimants at settlement is increased by 10%, the provision for CNST PPOs will increase by 17%. A 10% reduction in life expectancy will reduce the CNST provision by 15%.

Provision for settled PPOs at 31 March 2021

Life expectancy of claimants	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	Ex-RHA (£m)	LTPS (£m)	DHSC non-clinical (£m)
Life expectancy -10%	16,202	13,530	799	1,823	47	2	1
Base assumption:	19,140	15,979	947	2,155	56	2	1
Life expectancy +10%	22,367	18,678	1,105	2,516	65	2	1

Percentage change to provision

Life expectancy of claimants	Total	CNST	ELS	DHSC clinical	Ex-RHA	LTPS	DHSC non-clinical
All rates -10%	-15%	-15%	-16%	-15%	-16%	0%	0%
Base assumption:	0%	0%	0%	0%	0%	0%	0%
All rates +10%	17%	17%	17%	17%	16%	0%	0%

Outstanding claim sensitivities

Sensitivity of outstanding claims to key assumptions excluding ELGP

Outstanding claims represent 25% of the total claims provision. The following tables show the effect on the valuation if different assumptions were applied in relation to the HM Treasury discount rates, the differential between CPI and annual hourly earnings (ASHE), life expectancy and the claims inflation assumptions

HM Treasury discount rate assumptions

The following table shows the impact of adjusting the HM Treasury prescribed nominal discount rates by +1% and -1% on known claims. Payments expected to be made in the distant future are more significantly impacted by changes to the discount rates. In general, the clinical schemes are more sensitive to changes to the discount rates due to the long-term payment profile of the claims. In particular, claims that are expected to settle as PPOs can have payments that are expected to be made over 50 years into the future, so even small changes to the discount rates can significantly impact the value of these claims in current prices. A reduction of 1% in the discount rates will increase the PPO element of the CNST provision by 23%, but a 1% increase will reduce the provision by 16%.

Provision for outstanding claims at 31 March 2021

HM Treasury discount rate	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	CNSGP (£m)	ELSGP (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -1%	25,365	24,393	69	550	18	234	85	7	10
Base assumption	20,580	19,767	55	436	15	207	83	7	10
All rates +1%	17,336	16,619	46	359	15	198	82	7	10

Change to provision

HM Treasury discount rate	Total	CNST	ELS	DHSC clinical	CNSGP	ELSGP	LTPS	PES	DHSC non-clinical
All rates -1%	23%	23%	25%	26%	20%	13%	2%	0%	0%
Base assumption	100%	0%	0%	0%	0%	0%	0%	0%	0%
All rates +1%	-16%	-16%	-16%	-18%	0%	-4%	-1%	0%	0%

Differential between CPI and ASHE

The ASHE index is commonly used to determine the size of future structured settlement payments for PPOs. The value of claims contained in the known provision that is expected to settle as PPOs in the future is sensitive to the future ASHE assumption. The future ASHE assumption is set in relation to CPI (CPI+1.75%).

The following table shows the effect on the value of the outstanding claims in the known claims provision of changes to the future ASHE assumption. An additional +/- 0.5% per annum difference between CPI and ASHE will either increase the value of the CNST outstanding claims in the known claims provision by 10% or reduce it by 8%, respectively.

Provision for outstanding claims at 31 March 2021

Differential between CPI and ASHE	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	CNSGP (£m)	ELSGP (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -0.5%	18,956	18,188	50	397	16	205	83	7	10
Base assumption	20,580	19,767	55	436	15	207	83	7	10
All rates +0.5%	22,549	21,666	61	483	17	221	84	7	10

Change to provision

Differential between CPI and ASHE	Total	CNST	ELS	DHSC clinical	CNSGP	ELSGP	LTPS	PES	DHSC non-clinical
All rates -0.5%	-8%	-8%	-9%	-9%	7%	-1%	0%	0%	0%
Base assumption	100%	0%	0%	0%	0%	0%	0%	0%	0%
All rates +0.5%	10%	10%	11%	11%	13%	7%	1%	0%	0%

Life expectancy assumptions

The value of claims contained in the known provision that are expected to settle as PPOs in the future is sensitive to changes to the life expectancy of claimants.

The following table illustrates the effect on the value of the outstanding claims in the known claims provision of changes to claimant's life expectancies. Where the life expectancies of individual claimants at settlement are increased by 10%, the value of the CNST outstanding claims in the known claims provision would be expected to increase by 9%. A 10% reduction in life expectancies would be expected to reduce the provision by 8%.

Provision for outstanding claims at 31 March 2021

Life expectancy of claimants	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	CNSGP (£m)	ELSGP (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
Life expectancy -10%	18,854	18,089	50	395	15	205	83	7	10
Base assumption	20,580	19,767	55	436	15	207	83	7	10
Life expectancy +10%	22,537	21,654	61	483	17	221	84	7	10

Change to provision

Life expectancy of claimants	Total	CNST	ELS	DHSC clinical	CNSGP	ELSGP	LTPS	PES	DHSC non-clinical
Life expectancy -10%	-8%	-8%	-9%	-9%	0%	-1%	0%	0%	0%
Base assumption	-100%	0%	0%	0%	0%	0%	0%	0%	0%
Life expectancy +10%	10%	10%	11%	11%	13%	7%	1%	0%	0%

Changes to claims inflation

The following table shows the effect on the value of outstanding claims in the known claims provision of a +/- 1% change to the claims inflation assumptions. An increase of 1% to the claims inflation assumptions will increase the value of the CNST outstanding claims in the known claims provision by 1% per annum, and a 1% reduction per annum will reduce the provision by 1%.

Provision for outstanding claims at 31 March 2021

Change in claims inflation	Total (£m)	CNST (£m)	ELS (£m)	DHSC clinical (£m)	CNSGP (£m)	ELSGP (£m)	LTPS (£m)	PES (£m)	DHSC non-clinical (£m)
All rates -1%	20,340	19,527	55	431	16	211	83	7	10
Base assumption	20,580	19,767	55	436	15	207	83	7	10
All rates +1%	20,843	20,015	56	442	16	214	83	7	10

Change to provision

Change in claims inflation	Total	CNST	ELS	DHSC clinical	CNSGP	ELSGP	LTPS	PES	DHSC non-clinical
All rates -1%	-1%	-1%	0%	-1%	7%	2%	0%	0%	0%
Base assumption	100%	0%	0%	0%	0%	0%	0%	0%	0%
All rates +1%	1%	1%	2%	1%	7%	3%	0%	0%	0%

8. Contingent liabilities

Ex-RHA (£m)	ELS (£m)	CNST (£m)	DHSC clinical (£m)	ELGP (£m)	ELSGP (£m)	CNSGP (£m)
Contingent liability as at 31 March 2021						
14,000	348,643	42,910,030	735,414	602,000	392,119	721,938
Contingent liability as at 31 March 2020						
16,000	496,782	45,319,186	942,028	1,048,000	0	349,033

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 provision also includes probabilities of a claim being paid for each of the schemes. The contingent liability is then the difference between the total valuation of IBNR and known claims (including estimations on claims which are ultimately expected to settle at nil) and the main valuation of known claims and IBNR (which excludes claims expected to settle at nil).

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. Those risks that are not material and/or quantifiable are allowed for in the risk and uncertainty margin included in the provision.

	CNSC (£m)	DHSC non-clinical (£m	CTIS (£m)	PES (£m)	LTPS (£m)	Total (£m)
	43,000	95,522	1,000	5,819	210,267	**46,079,751**
	0	90,854	0	7,100	129,394	**48,398,377**

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		2020/21 (£000s)	2019/20 (£000s)
Amounts payable:	Within 1 year	1,051	1,228
	Between 1 and 5 years	3,685	0
	After 5 years	5,737	0
		10,473	1,228
Other leases:	Within 1 year	0	7
	Between 1 and 5 years	0	0
	After 5 years	0	0
		0	7

10. Related parties

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

- All clinical commissioning groups
- All commissioning support units
- All English NHS foundation trusts
- All English NHS trusts
- Care Quality Commission
- NHS Digital
- Health Education England
- Health Research Authority
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS England and NHS Improvement
- NHS Property Services
- NHS 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 below. The remuneration for executive and non-executive directors for the roles they perform for NHS Resolution is disclosed in the *Remuneration and staff report* on page 101.

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

Name and position in NHS Resolution	Party	Nature of relationship	Payments to related organisation (£000s)	Receipts from related organisation (£000s)	Amount owed to related organisation (£000s)	Amount due from related organisation (£000s)
Dr Denise Chaffer Director of Safety and Learning	Epsom and St Helier NHS Trust	Midwife	–	19,595	–	8
	Croydon University NHS Trust	Partner is a Consultant Radiologist	–	17,795	–	8
Sir Sam Everington OBE Associate Non-executive Member	Tower Hamlets CCG	Clinical lead Wife is a Board Member	–	8	–	–
Mike Pinkerton[1] Non-executive Member	Omnes Healthcare Group Limited	Non-executive Director	–	18	–	–
Helen Vernon Chief Executive	Tameside and Glossop NHS Trust	Brother is a Consultant Geriatrician	–	8,697	–	10

[1]Mike Pinkerton left Omnes Healthcare Group Limited in October 2020

11. Financial instruments

IFRS 7 Financial Instruments: Disclosures requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Special Health Authorities are financed, NHS Resolution is not exposed to the degree of financial risk faced by business entities. 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

From the 1 April 2021 claims arising from the historical liabilities within scope of the interim arrangements with the Medical Protection Society (MPS) have, been handled by NHS Resolution on behalf of the Secretary of State.

Indemnity arrangements for designated care settings were extended from the 30 June 2021 to the 30 September 2021 on the 29 June 2021.

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

Glossary

ALB
Arm's length body.

AvMA
Action against Medical Accidents (www.avma.org.uk).

CCGs
Clinical commissioning groups have taken over commissioning from primary care trusts.

CFA
Conditional fee arrangement: a type of funding agreement between claimant lawyers and their clients.

CNSGP
Clinical Negligence Scheme for General Practice.

CNSC
Clinical Negligence Scheme for Coronavirus.

CNST
The Clinical Negligence Scheme for Trusts indemnifies members for clinical negligence claims.

CPI
Consumer Price Index.

CTIS
Coronavirus Temporary Indemnity Scheme, a new scheme designed to manage indemnity arrangements for activities carried out in response to the pandemic, such as Designated Settings Indemnity Support for care homes.

DHSC
Department of Health and Social Care.

HM Treasury discount rates
These discount rates are designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today's prices. It tells us how much we would need to pay out if we settled all of those future obligations today.

Duty of candour
The statutory duty of candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. It means providers must notify the patient about incidents where 'serious harm' has occurred and provide an apology and explanation where appropriate.

ELGP
Existing Liabilities for General Practice. The Secretary of State has agreed interim arrangements with two Medical Defence Organisations, Medical Protection Society and Medical and Dental Defence Union of Scotland, in relation to NHS historical liabilities arising from general practice incidents that occurred prior to 1 April 2019.
NHS Resolution carries out the Secretary of State's oversight responsibilities under those interim arrangements in relation to the management of claims for the liabilities within scope of the arrangements. The costs are funded out of the budget for the NHS held by NHSE/I, which are transferred to NHS Resolution via financing from DHSC.

ELS
Existing Liabilities Scheme is funded by DHSC and is a clinical negligence claims scheme that indemnifies pre-April 1995 incidents.

ELSGP
The Existing Liabilities Scheme for General Practice covers NHS historical liability claims of general practice members of medical defence organisations that enter into interim arrangements in respect of such liabilities. Liabilities within scope of the interim arrangements with the Medical Protection Society (MPS) were covered under the ELSGP from 1 April 2021. Those within scope of the arrangements with the Medical and Dental Defence Union of Scotland (MDDUS) were covered under the ELSGP from 6 April 2020.

Ex-RHA
The Ex-Regional Health Authorities Scheme is funded by DHSC and is a clinical negligence claims scheme that indemnifies the liabilities of former regional health authorities.

Extranet
A secure web portal providing our members and our solicitors with real-time access to their claims data. The data help our members prevent harm to patients and staff, which might otherwise lead to future claims against the NHS.

FHSAU
Family Health Services Appeal Unit, now known as Primary Care Appeals.

GIRFT
Getting It Right First Time
(https://gettingitrightfirsttime.co.uk)

HPAN
Healthcare Professional Alert Notice is an alert system managed nationally by Practitioner Performance Advice to alert employers to the existence of serious grounds for concern about a regulated health practitioner who has departed an organisation and for whom concerns were unresolved. This differs from performers' list management (restrictions on practice), which are logged centrally by Primary Care Appeals and shared with requesting health bodies.

HSIB
Healthcare Safety Investigation Branch.

IBNR
Incurred but not reported claims; claims that may be brought in the future.

LASPO
Legal Aid, Sentencing and Punishment of Offenders Act. Legal reforms that came into force on 1 April 2013. The reforms change, among other matters, the amount that claimant solicitors can recover from the defendant under conditional fee agreements and limit after-the-event insurance.

Legal costs
Amounts paid out by NHS Resolution in legal costs for claims resolved: including NHS legal and claimant costs, this can include expert and counsel's fees as well as court costs.

LTPS
The Liabilities to Third Parties Scheme indemnifies the NHS for employers' liability, public liability and professional indemnity claims made against the NHS.

MDDUS
Medical and Dental Defence Union of Scotland is a medical defence organisation (www.mddus.com).

MDU
Medical Defence Union is a medical defence organisation (www.themdu.com).

Member
NHS Resolution is a membership organisation comprising NHS trusts, CCGs, independent healthcare providers to the NHS and other government agencies related to healthcare.

MPS
Medical Protection Society is a medical defence organisation (www.medicalprotection.org).

NCAS
The National Clinical Assessment Service, now known as Practitioner Performance Advice.

NHS LA
National Health Service Litigation Authority, the legal name of NHS Resolution.

NHSE/I
NHS England and NHS Improvement.

NRLS
The National Reporting and Learning System was established in 2003, and is a system that enables patient safety incident reports to be submitted to a national database. These data are then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

OBR
Office for Budget Responsibility.

PCTs
Primary Care Trusts. Local NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

PES
The Property Expenses Scheme indemnifies NHS members for property claims.

PIDR
Personal injury discount rate.

PNA
Pharmaceutical needs assessment.

PPO
A periodical payment order is a court order that grants the claimant a lump sum payment followed by regular payments over the life of the claimant.

RPI
Retail Price Index.

SHAs
Strategic Health Authorities. Regional NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

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