NHS Resolution

Annual report and accounts 2022/23

Advise / Resolve / Learn

HC 1560

NHS Resolution Annual report and accounts 2022/23

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Any enquiries regarding this publication should be sent to **NHS Resolution 8th Floor, 10 South Colonnade, Canary Wharf, London, E14 4PU.**

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Performance overview

We are pleased to introduce the annual report and accounts of NHS Resolution for 2022/23, the successful first year of *Advise, resolve and learn: Our strategy to 2025*. We are ambitious about ensuring the services we deliver are a driver for positive change across the healthcare system, reducing harm to patients, reducing the distress caused to both patients and healthcare staff when a claim or concern arises and, ultimately, reducing the cost of delivering fair resolution.

This year's annual report highlights significant further success in early intervention and resolution, keeping a record 80% of cases out of court proceedings by reducing litigation while working with our partners across health and justice to share what we learn to help improve patient safety. It is tremendously positive that the collaborative approach seen across the legal market during the pandemic has been sustained, with a continued shift towards a less adversarial approach and an openness to different and more compassionate ways of delivering compensation. Mediation, resolution meetings and stock takes all now have their place in ensuring patients' concerns can be resolved appropriately, accepting that sometimes litigation will be unavoidable, for example in the approval of a child's damages award or where there is a need to clarify areas of law.

We have used our database of healthcare related claims, one of the biggest in the world and, arguably, unique in its capture of a single jurisdiction, to share learning nationwide and help individual providers of NHS care to understand their own claims profiles. We have expanded our upstream work on safety and accelerated liability investigations on obstetric brain injury (via our Early Notification Scheme or ENS). We have also published *Being fair 2* and well-received resources on the duty of candour which complement our work on dispute resolution and patient safety, setting out our ambition that patients and healthcare staff are supported when something goes wrong and not subject to additional distress. With 2022/23 being one of the most productive years ever, as described on page 54, we hope as a result to reduce the issues which require our services in the first place.

There is strong evidence that keeping matters out of formal processes also saves money and on pages 42 of our report we describe how our work is driving down legal costs. This has been achieved without compromising the thoroughness of our investigations with an estimated £4.6 billion[1] saved as a consequence of resolving claims without a payment of damages, coupled with a robust approach to fraud.

In a busy year with substantial change and increasing complexity in our work our organisation has grown, as planned. Our main clinical scheme, the Clinical Negligence Scheme for Trusts (CNST), has been in place for many years and has been broadly stable this year in terms of the number and type of claims received. Our remit has extended with the new and maturing indemnity schemes in general practice and new areas of risk, such as those presented by the Covid-19 pandemic. Covid-related claims remain lower than expected while Clinical Negligence Scheme for General Practice (CNSGP) claims are now increasing rapidly. This is not due to an increase in incidents but because the scheme responds to incidents which occur after the scheme started. This means that the claims take some time to come through, leading to a slow start followed by a more rapid acceleration.

Sally Cheshire CBE
Chair

Helen Vernon
CEO

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

The current pressures experienced by the NHS mean that our services and our indemnity schemes have inevitably become more complex to manage. We are successfully navigating a transformation programme to enable better insight from the claims data we hold through a fundamental change to our core IT systems. In addition, we have taken the opportunity of the extension of the indemnity schemes coupled with the changes to the wider NHS to restructure our claims service. This will, among other benefits, equip us to deliver more work in-house, making the most of the skills of our staff in keeping cases pre-action while, in time, delivering a substantial return on the investment in our organisation by reducing external legal costs.

Despite the positive changes set out above that NHS Resolution has been able to deliver, the overall cost of clinical negligence continues to rise and remains of concern. On our clinical schemes, costs are driven primarily by damages for those who are, tragically, severely harmed and who need provision for specialist care. Obstetric claims account for 13% of clinical claims reported in 2022/23 but for 64% of those claims by value, each incident leading to heartbreaking consequences for a family. This is why we have focused so much of our resource on addressing the causes and management of incidences of brain injury sustained at birth, which have a life-long and devastating impact.

Our Maternity Incentive Scheme (MIS) acts as a convener of expertise across the healthcare system, with the actions owned by providers of direct maternity care but using the financial mechanism of the CNST scheme to incentivise clear standards of care, robust governance and focused safety improvement plans. We have been acutely aware of the current pressures on the NHS and so have worked both nationally and locally with maternity trusts to refine the MIS safety actions, respond to recent inquiries and recommendations, and set realistic timescales which recognise the realities of delivering maternity care. It is a feature of the scheme that it requires trust board, and now commissioner, sign-off so that safety issues receive the scrutiny they deserve. While the overall number of trusts that are fully compliant with the MIS safety actions has dropped back this year, we have been able to increase funding to support trusts with tangible plans to improve and we expect to distribute just over £10 million back into the NHS to support safety improvement plans.

The MIS works hand in hand with our ENS. Our expert clinical staff draw learning from liability investigations in real time and work with the NHS to receive an assurance that steps are being taken to prevent the same avoidable errors happening again. The ENS has reduced the average time between an incident occurring and a family receiving an admission of liability from 80 months to less than 18 months, allowing them to access critical funding for immediate care needs without having to wait for a lengthy assessment of the full extent of the harm caused.

The largest feature in our accounts by far this year is the significant reduction in the provision from £128.6 billion to £69.6 billion. This is mainly a consequence of the changes to His Majesty's Treasury (HMT) prescribed discount rates. In short, this means that due to prevailing economic conditions, we place a lower value in today's prices on the future cost of settling all potential claims arising from incidents that occurred before 31 March 2023. The change in the discount rate does not, however, in any way reflect changes in the main drivers of claims experience, such as the number of claims that result in damages being paid or the cost of paying these claims. Although dwarfed by this adjustment, of perhaps more interest is the positive news of a continued, although small, reduction in the long-term claims inflation assumption (for high-value claims) to reflect our experience. Reported claims numbers are also slightly lower than expected, and average claims costs are growing at a slower rate than previously assumed.

Much of our activity, as described in this report, is aimed at abating the cost of claims whether that is preventing the incident happening in the first place or finding less adversarial ways of resolving those claims when they do arise. We also continue to support work across Government to address the cost of clinical negligence claims including any further developments which may result from the Health and Social Care Select Committee's inquiry report into litigation reform and the Government's response to their consultation on fixed recoverable costs in lower-value clinical negligence claims.

In other areas of our work our Practitioner Performance Advice (Advice) service has embarked on a number of ambitious programmes to support and promote a just and fair culture across the NHS, providing independent and expert advice and support to medical, dental and pharmacy practitioners and to healthcare organisations. We have started to gather more robust regional intelligence to understand performance across a whole patch and use our unique information to strengthen local capability to resolve concerns. The specific issues Advice deals with are sensitive and the investment in work to move to a more bespoke, locally focused model, building capability within organisations, has paid dividends. We published a suite of resources to help healthcare leaders make the right decisions on exclusions (one of the most complex areas of performance concerns to resolve), to ensure patients and staff are protected from harm and that practitioners are treated fairly with appropriate regard for their health, wellbeing and dignity. In line with our strategic priority on maternity care, we have also been able to contribute to the maternity safety support programme being delivered by NHS England, bringing our expertise to the difficult issues which are presented when specific interventions are needed with teams.

The work of our Primary Care Appeals (Appeals) service has both increased in complexity and extended to new areas. For example, Appeals has responded quickly and effectively to deal with disputes arising from Covid-19 arrangements for pharmacies. Our Appeals service also continues to press on with a dual approach of transparency in decisions tied to an education programme designed to improve local decision making and reduce the need for escalation.

Looking to the future, a significant amount of disruption to the usual claims process has been in evidence through and after the Covid-19 pandemic, due to issues with the availability of clinical staff, as detailed on page 21. The position in relation to new claims arising from the pandemic and all that followed continues to be uncertain as our accounts describe on page 124. However, we are confident we will continue to deliver all of our services efficiently and effectively and to do all that we can to help the entire health and care system to improve patient safety.

The hard work of our staff and our external partners is at the heart of all of our achievements during 2022/23. We were delighted this year to be awarded Investors in People (IiP) Gold, in recognition of the importance we place on developing and supporting our staff to do the very best they can in their roles with us. We also receive exceptional support from external partners such as our legal panel firms and the Government Actuary's Department as well as bodies, such as the royal colleges, charities, regulators and a range of patient groups who, together with our Maternity Voices Advisory Group, have helped us to make sure the patient's perspective is integral to our work. Our thanks go to them and to our committed staff as well as our partners in health and justice for the part they have played in the achievements described in our report. We look forward to continuing our work together to fully deliver on the strategic commitments in Advise, Resolve and Learn.

Key highlights against our four strategic priorities

Resolution

Continued to **reduce the volume** of claims entering a formal process, **thereby saving costs** and **providing resolution** for patients and healthcare staff at an earlier point

Trained over **300 delegates** through our Practitioner Performance Advice education programmes to **increase local capacity and capability**, including through the promotion of compassionate responses to performance concerns

Launched our **new legal panel framework**, procuring the services of specialist law firms at competitive rates to support the effective administration of our indemnity schemes

Resolved the first cases under new directions to handle Covid-19 Pharmacy Payment Appeals

Maternity

Published our second Early Notification Scheme report, which demonstrates evidence of process improvements, **savings in NHS legal costs** and positive feedback from families and legal representatives

Held an in-person national maternity conference attended by **215 delegates (including 77 trusts)** aimed at sharing the experiences of families, maternity units and maternity safety experts. Of those who attended, **98% said they would recommend the conference to a colleague**

Developed the approach we will take to the **evaluation of our Maternity Incentive Scheme and Early Notification Scheme** in 2023/24

Commenced development of a **maternity team review service**, with support from NHS England's (NHSE) Maternity Safety Support Programme

Data and Insights

6

Published **six thematic reviews** on claims concerning emergency medicine, complications of the lower limb in diabetes, General Practice and Early Notification Scheme; published **six Insights papers** relating to Practitioner Performance Advice

Shared learning with and **delivered training events** to NHSE and Integrated Care Board staff on primary care contracting with attendees rating the training **4.7 out of 5** on average

Published our ***Being fair 2*** **report**

Published a series of ***'Did you know?'*** leaflets and claims scorecards

Commissioned **'lived experience' research** on the experience of ethnic minority and international medical graduates of the management of concerns about their medical practice

Facilitated **eight** clinically focused virtual forums with over **2,000** delegates attending

Produced a range of digital products including a **duty of candour animation** which received **68,600** impressions on Vimeo, with our social media campaign securing **18,000** and **20,000** impressions on Twitter and LinkedIn respectively

Transformation

Achieved **Gold Investors in People accreditation**

Secured recertification of our **Cyber Essentials Plus** and **ISO 27001** standards

Launched our **People Strategy** to support the implementation of our strategy to 2025

Launched our Core Systems Programme (named **CaseHub**), delivering the first release for our Practitioner Performance Advice service

Established our **Change Management Office**

Continued to deliver our Claims Evolution Programme to move to a **new target-operating model**

Who we are and what we do

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

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

Who do we provide indemnity for?

The bulk of our work involves managing negligence claims against the NHS in England on behalf of the members and beneficiaries of our indemnity schemes, predominantly NHS trusts and foundation trusts, together with general practice and independent sector providers of NHS care. For more information about our schemes see our Appendix on page 174.

In 2022 we launched our ambitious three-year strategy, Advise, resolve and learn: Our strategy to 2025. The strategy, outlined in figure 1, builds on the work undertaken since 2017 to focus on early intervention and avoid unnecessary court action and other formal processes, which we have continued to make progress on in 2022/23. We have also continued to use our data and expertise to share insights and analysis of the causes of incidents, contributing to work in the wider healthcare system to reduce the number of incidents that could result in a claim and to improve patient safety. In parallel we have worked with our healthcare partners and stakeholders to promote higher standards of care in maternity services via our ENS and MIS.

We have also taken a pragmatic and paced approach to modernising our internal systems, structures and processes, allowing us to be responsive to changes in the NHS, the external environment and the needs of our scheme members while supporting our staff to do the best they can in their day-to-day roles.

Figure 1:
Our strategic aims for 2022–25

New strategic priorities

Priority 1.

Deliver fair resolution.

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

Priority 2.

Share data and insights as a catalyst for improvement.

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

Priority 3.

Collaborate to improve maternity outcomes.

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

Priority 4.

Invest in our people and systems to transform our business.

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

Our services

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

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

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

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

Enabled by

Finance and Corporate Planning

Digital, Data and Technology

Membership and Stakeholder Engagement

Policy, Strategy and Transformation

Our values

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

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

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

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

The year in numbers

This year 80% of clinical claims settled without entering court proceedings: the highest ever volume achieved (compared to 77% in 2021/22). This figure demonstrates our continued success in keeping claims out of formal processes, saving costs and providing resolution for patients and healthcare staff at an earlier stage.

The total number of new clinical negligence claims and reported incidents across primary and secondary care reached 13,511 – a decrease on last year (15,078 in 2021/22). In 2020/21 and 2021/22 volumes were high due to the bulk migration of responsibility for claims from the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS) as part of the establishment of our Existing Liabilities Scheme for General Practice (ELSGP)[1]. ELSGP claim numbers are expected to reduce over time as fewer new claims with incident dates before 1 April 2019 are reported.

In 2022/23 our other primary clinical schemes' reported numbers have increased. In the Clinical Negligence Scheme for General Practice (CNSGP) there has been an expected increase in reported claims of 45.1% compared with 2021/22, which is primarily due to the time-lag between incidents occurring and claims being received for this relatively new and immature scheme. Across the Clinical Negligence Scheme for Trusts (CNST), our largest clinical scheme, there was an increase in reported claims of 3.3% compared with 2021/22. Reported case numbers for CNST were impacted during the acute phases of the Covid-19 pandemic and although they have risen this year they remain 1.7% lower than the average of the five years to 2019/20 preceding the pandemic. Overall, removing the effect of ELSGP from the total of all reported clinical claims, numbers rose in 2022/23 by 8.6%, compared to an increase of 0.03% between 2020/21 and 2021/22.

What are damages?

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

While we still pursue the aims of fair and timely resolution, there has also been an increase in the number of claims settled without damages across our clinical negligence schemes, demonstrating our ability to manage claims effectively without compromising the rigour of our investigations. A total of 13,499 claims were settled across all clinical negligence schemes in 2022/23 compared to 13,070 in 2021/22. In 2022/23 49% (6,611) settled without damages, which compares to 48.2% (6,297) in 2021/22. In our non-clinical negligence schemes 57.1% (2,094) of claims settled with no damages in 2022/23 compared with 50% (1,708) in 2021/22.

[1] From 6 April 2020, indemnity for liabilities relating to incidents prior to 1 April 2019 of members of the 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 MPS in England were covered under the ELSGP.

Payments for settling claims in 2022/23 across all of our indemnity schemes increased by £232.4 million (9.5%), to £2,690.9 million, with this being driven by an increase in the number of high-value clinical claims falling due for settlement.

In 2022/23 the cost of harm for CNST was £6,278 million. This is a decrease of £7,007 million compared to last year (in 2021/22 the cost of harm for CNST was £13,285 million). The decrease is primarily due to the change in His Majesty's Treasury (HMT) discount rates which has had the effect of significantly reducing the value of claims.

If the 2021/22 discount rates were applied for the reporting year, the equivalent cost of harm figure would have been £12,631 million[1]. There has been a £654 million reduction arising from lower than expected claims numbers and average cost of periodical payment order (PPO)[2] claims, and from claims inflation assumptions.

The year-end provision has also changed compared to last year. As of 31 March 2023 provision was £69,614 million, compared to £128,550 million in 2021/22. Again the changes in HMT discount rates are the primary factor in this decrease. Without the changes in discount rates the provision would have been £144,218 million.

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

One of the key assumptions used in calculating the provisions are the discount rates which are designed to recognise the value of money over time: generally speaking £1 in the future is worth less than £1 now, because of the interest that could be earned by investing £1 today. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings in today's terms. At a high level, it tells us how much it might cost to settle those obligations today or at the balance sheet date (31 March). In accordance with International Financial Reporting Standards, HMT has applied market rates which reflect the cost of borrowing to Government.

NHS Resolution's provisions are particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities which is driven by the reporting and settlement delays as well as the fact that many high-value claims are settled as a periodical payment order (PPO) with payments provided over the remaining lifetime of the claimant. Further information about HMT's discount rates can be found in Note 7 to the Financial Statements on page 144.

What is the provision for claims?

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

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

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

Maternity claims amounted to £44,965 million (65%) of the 2022/23 clinical negligence provision, compared to £90,053 million (70%) in 2021/22, with the value and percentage share being affected by the change in HMT discount rates and how this has affected claims with a long lifespan.

While this figure alone presents a stark reminder of the impact of negligence in maternity care, we are acutely aware of the devastating consequences for the child and wider family as well as the staff involved when these incidents occur. This is why we are committed to improving maternity outcomes as part of our three-year strategy.

Table 1 on page 19 provides a summary of our key financial data.

More information on the financial performance of our organisation and its indemnity schemes is also provided in the Finance report on pages 67-74.

Table 1: The year in numbers

Financial element	2022/23 (£ million)	2021/22 (£ million)	Change (£ million)	(%)	
Funding for clinical schemes					
Income from members	2,431.1	2,458.7	(27.6)	(1.1%)	⌄
Funding from DHSC (budget)	287.9	199.8	88.1	44.1%	⌃
Total funding	**2,719.0**	**2,658.5**	**60.5**	**2.3%**	⌃
Payments in respect of clinical schemes					
Damages payments to claimants	1,992.0	1,775.1	216.9	12.2%	⌃
Claimant legal costs	490.9	470.9	20.0	4.2%	⌃
NHS legal costs	158.8	156.6	2.2	1.4%	⌃
Total payments	**2,641.7**	**2,402.6**	**239.1**	**10.0%**	⌃
Funding for non-clinical schemes					
Income from members	59.0	65.9	(6.9)	(10.5%)	⌄
Funding from DHSC (budget)	9.3	7.2	2.1	29.2%	⌃
Total funding	**68.3**	**73.1**	**(4.8)**	**(6.6%)**	⌄
Payments in respect of non-clinical schemes					
Damages payments to claimants	26.8	32.0	(5.2)	(16.3%)	⌄
Claimant legal costs	16.3	17.3	(1.0)	(5.8%)	⌄
NHS legal costs	6.1	6.3	(0.2)	(3.2%)	⌄
Total payments	**49.2**	**55.6**	**(6.4)**	**(11.5%)**	⌄
NHS Resolution administration of schemes					
Clinical	38.0	32.5	5.5	16.9%	⌃
Non-clinical	6.2	5.0	1.2	24.0%	⌃
NHS Resolution other activities					
Income	1.0	0.9	0.1	11.1%	⌃
Expenditure[1]	7.9	6.7	1.2	17.9%	⌃
Staff numbers	578	500	78	15.6%	⌃
Claims provisions expenditure[2] of which:	**(56,246)**	**45,766**	**(102,012)**	**(222.9%)**	⌄
• Change in discount rate	(74,604)	42,623	(117,227)	(275.0%)	⌄
• Other changes	18,359	3,143	15,216	484.1%	⌃
Provisions for claims	**69,614**	**128,550**	**(58,936)**	**(45.8%)**	⌄
Capital expenditure	**5.5**	**3.0**	**2.5**	**83.3%**	⌃

[1] Difference between income and expenditure – see Finance report on page 67 for further commentary and explanation.

[2] Total charge to Statement of Comprehensive Net Expenditure – see Note 7.1 to the Financial Statements for the breakdown and the Finance report on page 67 for explanation. The key change year on year is due to the increase in HMT long-term and very long-term discount rates.

The environment we work in

Operating across two interrelated landscapes – health and justice – provides us with a unique perspective, enabling us to share our insights with stakeholders and healthcare partners. Given that claims are time-lagged[1], it will be several years before we will understand the impact of current conditions on the level and nature of claims we may receive in the future. However, the following sections describe an initial overview of the environment in which we are currently working.

Health

Although Covid-19 has become a less prevalent part of our daily lives, its impact remains across the NHS. One of the challenges that presented itself is that the impact of Covid-19 has not been linear. Members of some services have reported issues at different times to others during the pandemic, with different specialties being affected in various ways. While the delivery of NHS services is still being impacted, Integrated Care Systems (ICSs) continue to establish themselves against a challenging backdrop of pandemic recovery, elective care backlogs and workforce pressures.

In parallel, a series of inquiry reports relating to patient safety, including those focusing on maternity services, show that it is increasingly important to pay attention to what disputes we handle and what our providers and beneficiaries are telling us about the concerns of patients and the opportunities to improve. We also recognise the well-documented capacity pressures faced by emergency departments and the impact these pressures have on both staff and patients.

Justice

As we await further developments following the Health and Social Care Select Committee's inquiry report into litigation reform and the Government's response to their consultation on fixed recoverable costs in lower-value clinical negligence claims, we continue to support the Government in our national role as experts in clinical negligence compensation claims.

The Ministry of Justice has also previously consulted on a proposal to refer claims below the small claims limit to mediation in England and Wales, supporting a free and compulsory mediation service for individuals bringing claims of up to £10,000 before the case can progress to a hearing. This willingness to launch a trial of mandatory alternative dispute resolution, even if only post-issue, demonstrates that the focus on resolving disputes well before trial is gathering pace.

[1] Following an incident the focus is largely on understanding why the harm was caused and dealing with the immediate concerns of patients including ongoing care. It can also take some time for patients to decide whether they wish to pursue a claim and seek advice. These factors contribute to a time lag of approximately three years between an incident occurring and a claim being received.

The impact of Covid-19

The Covid-19 pandemic has resulted in some claims being delayed. This year we were able to undertake early analysis of a select number of claims that we received during the pandemic. Our analysis shows that 27% of the claims included in our sample were affected by the pandemic. This impact was multifactorial, including the lack of availability of clinicians (either in their capacity as an expert or in providing commentary on the circumstances and level of the care provided) who, understandably, prioritised their clinical availability in order to deliver day-to-day care. Trust capacity was also a factor in relation to provision of medical records or approving admissions. In some instances courts and coroners were affected with a knock-on impact on the time taken to progress a case. Challenges described here and in the above sections have resulted in us taking a more agile approach to claims management, deploying our expertise in operational delivery to ensure that we provide our core services within the agreed budgets and financial spending limits.

The impact of the Covid-19 pandemic has, however, contributed to improvements in how we manage claims. In part, our Covid-19 Clinical Negligence Protocol[1] has improved co-operation between all parties, supporting the resolution of more claims pre-action. The protocol outlines a best practice approach to claims handling agreed between the Society of Clinical Injury Lawyers (SCIL), the patient safety charity Action against Medical Accidents (AvMA) and ourselves, and encourages a collaborative relationship between lawyers acting for patients and defendant organisations as well as removing barriers to resolution such as limitation periods. Greater levels of collaboration have created a fertile environment for expansion of our dispute resolution offering.

In addition, following new Directions which came into force on 1 April 2022, our Primary Care Appeals (Appeals) service is responsible for managing and determining Covid-19 pharmacy payment disputes. These disputes relate to claims from NHS community pharmacies for reimbursement of the costs of delivering services during the pandemic, which include additional staffing and making premises Covid-19 secure. Our Appeals service was also able to readily flex its operating model to accept a new category of claim under the Covid-19 pharmacy payment scheme which was not envisaged when the Directions were issued. It also determined appeals from NHS community pharmacies against decisions of NHS England (NHSE) to recover monies, paid under the Home Delivery Service commissioned during the pandemic, which NHSE considered the pharmacies were not entitled to.

As described above, the challenges facing the NHS in addition to the ongoing developments in the justice sector could present both risks and opportunities for our operations. We are aware of the need to respond to any changes in the external environment that do arise, including identifying the most effective ways to collaborate with our stakeholders, described in the next section.

[1] The protocol was launched in August 2020.

How we have worked with our stakeholders

We have continued to build on our significant progress in creating strong and collaborative links in maternity, establishing NHS Resolution as a trusted partner across the whole system. Our expertise in delivering our services, such as the ENS and MIS, is increasingly underpinned by analysing and sharing learning from our work.

We use these insights to bring stakeholders and healthcare partners together to talk about the key issues at a local, regional and national level. This year we held our national maternity conference aimed at sharing the experiences of families, maternity units and maternity safety experts to explore where we can drive improvements in care. The conference was attended by 215 in-person delegates, including representatives from 77 NHS trusts. Of those who attended, 98% said they would recommend the conference to a colleague. We were also a co-signatory on the Medical Workforce Race Equality Standard (MWRES) – A commitment to collaborate; The first five to help tackle the racial disparity experienced by healthcare staff from ethnic minorities. We are committed to collaborating with our partners and others to ensure the right training, support and resources are available to employers and staff alike.

We have produced a series of Insights both with and for a range of stakeholders, as described in figure 16 on page 54. This has included collaborating with stakeholders and healthcare partners to deliver our duty of candour animation and *Being fair 2* report. Stakeholders and partners ranged from some of our member trusts, professional regulators and panel firms to several others including NHSE, the National Guardian's Office and Civility Saves Lives. We look forward to working with these stakeholders in 2023/24 as part of our *Being fair 2* implementation workshop, which will inform the future activity required to embed the behaviours required of a just and learning culture. We continue to use the clinical expertise of our healthcare partners to deliver our *Did you know?* leaflets. For example, we worked with NHSE's Clinical Improvement Lead for the Medicines Safety Improvement Programme and Regional Antimicrobial Stewardship Lead for North-East and Yorkshire. Publication of this leaflet series has resulted in us presenting these insights at national and regional Medication Safety Officer Network meetings and has increased the interest in claims data from trust pharmacy services.

In addition, our Appeals service has continued to engage with NHSE, sharing data and, where relevant, insights with NHSE's central pharmacy team. This year, the service also met with NHSE's central dental and ophthalmic contracts service, discussing dental contract reform with regard to potential disputes, future provision of data and insights from claims cases and the offer of training to NHSE dental contract managers. Our Advice service has supported the refresh of the Independent Healthcare Providers Network's Medical Practitioners Assurance Framework to improve consistency around effective clinical governance for medical practitioners across the independent sector and to raise the bar in medical leadership.

Though we are proud of our engagement with stakeholders, we recognise that the ongoing impact of Covid-19 and the pressures faced by the NHS have contributed to limitations in achieving the level of engagement we have, to date, set out to achieve. As we deliver our work across our four priorities, we will continue to take into account how the external environment impacts our stakeholders and the delivery of our work, including the identification and management of any risks and issues, as outlined in the following section.

Key risks and issues

When considering our performance, it is helpful to understand the risks and issues we face as an organisation, which are described below.

Raising concerns

As an NHS body, patient safety and public protection are of paramount concern to us. We have data from various sources which may give rise to the identification of a significant concern, and we will share information externally, for example with other NHS bodies or those with responsibility for regulation in the healthcare system. This will happen if we see activity which may have caused significant harm or which puts individuals at significant risk due to unsafe clinical practice or conduct that severely compromises the effective delivery of services. In practice, the relevant healthcare provider is likely to be our first point of contact and we may invite them to consider onward referral to other relevant parties (for example, regulators) or seek assurance that they have done so.

The challenge we have is being able to identify within our data where those concerns may exist. Indemnity scheme claims may take many years to come to NHS Resolution, and represent only a very small fraction of incidents that occur in the NHS. As a result, it may not become apparent for some time that there have been particular risks to patient safety from the data we hold.

As part of our three-year strategy, we are continuing to develop ways of deriving insight from the data we hold in relation to our operational functions. We operate a Significant Concerns Framework (described on page 52) as a guide to addressing those circumstances where a concern about serious harm has arisen, ensuring that confidential information relating to notifications is managed appropriately and in a tightly controlled governance framework, with established escalation arrangements as necessary. The framework encourages candour and openness in managing our Claims Management (Claims) and Advice services, while ensuring that we can, in very occasional circumstances, refer our concerns to other NHS bodies.

Data quality

As interest in clinical negligence and, consequently, our data continues to increase we need to ensure that the data we produce, sometimes at short notice, is accurate and adequately described, to avoid incorrect interpretation. This is challenging given the complexity of data and nuances in the definitions, and we are continually developing our control framework to ensure we capture and maintain accurate and relevant data. We are committed to transparency in our policy to publish data either directly, such as the annual report statistics derived from our Claims data, or indirectly via system partners such as Getting It Right First Time (GIRFT) or the Model Hospital while adhering to the General Data Protection Regulation (GDPR) framework. Our strategy is also to develop the use of technology to make our data more easily manageable and accessible for analysis and provision of insight, which you can read more about on page 52.

Policy environment

As the above section describes, we operate in a dynamic policy environment and through identification of emerging issues we consider their potential impact on our strategic objectives and delivery. We work closely with DHSC and other ALBs across a range of policy issues, contributing our data and expertise as appropriate. Key areas of focus for 2022/23 have included positively responding to the Department's Reform and Efficiency Programme to identify opportunities to maximise funds available for frontline NHS services and supporting the healthcare system to implement ICSs. We have undertaken initial engagement with ICSs to consider their data needs and to help them manage their local systems. We have also responded to a range of consultations focusing on guidance on medical professionals' standards, changes to NHS trusts' and foundation trusts' licence conditions, clinical standards in maternity care and the Hewitt Review of ICSs.

Protecting our assets

We continue to work on implementing proactive measures regarding cyber security for a better alignment with evolving threats. Working closely with stakeholders such as NHSE, we have also devised key performance indicators to help measure the effectiveness of our controls. We have risk assessed our information assets and their criticality to the business processes they support to ensure our technical controls are aligned to the value of our assets and are appropriately tested. We have successfully maintained Cyber Security Essentials Plus certification as well as being recertified for ISO 27001 in December 2022. Our Board, as well as our Audit and Risk Committee (ARC), are fully apprised 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 where there is evidence of a fabricated or exaggerated claim. You can find out more about our work on exaggerated and false claims on page 46.

You can find more information about how we manage risks as part of our risk management framework on page 89.

Maintaining operational delivery during transformation

Our Claims Evolution Programme (CEP) and Core Systems Programme (CSP) have moved into the design and implementation phase. We have drawn on staff to provide subject matter expertise to design more efficient business process and systems, and we have needed to recruit staff with specific technical skills to enable delivery of these change programmes. The process of change can be unsettling for staff, so investing in leadership and support to take people through the change has also been required. Through the creation of a Change Management Office, we identified that the effort to deliver transformation could divert attention away from core business delivery, which could result in additional costs to the NHS from poor handling of claims and concerns. We have addressed this by backfilling key operational roles, ongoing monitoring of core business performance, and reviewing and adjusting programme plans in light of resource availability and balancing of business priorities.

Going concern

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

Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements of 31 March 2023.

Performance report

Performance analysis

The performance analysis provides detail on our in-year activity, as outlined in our *Business plan 2022/23*, including our performance against our key performance indicators (KPIs).

Key performance indicators (KPIs)

Our KPIs provide an objective assessment of our operational performance and cover all areas of our operations. We annually review these to help us to continuously develop our services. At a high level, our KPIs provide assurance to our Board and to DHSC that we are conducting our business as intended and as we are funded for.

Our KPIs are agreed by our Board and DHSC and published annually in our *Business plan 2022/23*. 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 panel of legal firms or legal panel, which was reappointed from March 2022, 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 People Committee 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 human resources (HR) issues flowing from our business were properly managed.

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

2022/23 KPIs were updated to align with the launch of our new three-year corporate strategy and therefore, some KPIs may not have a trend comparison from 2021/22.

More detailed information about the activity we have undertaken in 2022/23 can be found on page 34.

Deliver fair resolution

No.	KPI description/measure	Area	Target	2021/22 RAG	2022/23 RAG
KPI 1	Reduction in volume of cases that enter litigation before appropriate dispute resolution.	Claims	Reduction in years two and three	N/A	N/A
KPI 2	Time to resolution (TTR) from claims decision to agreement of damages.	Claims	≤ TTR figure at close of 2021/22	R	R
KPI 3	Volume of cases repudiated initially with a subsequent payment agreed.	Claims	<10%	G	G
KPI 4	The movement in financial reserves is managed within a target range.	Claims	<20%	G	G
KPI 5	Undertake scheduled contract performance meetings with legal and costs suppliers to review performance against their KPIs.	Claims	95%–100%	N/A	G
KPI 6	Obtained relevant stakeholder input to inform at least 80% of our external products, services and/or service improvements.	Safety and Learning	80%–100%	G	G
KPI 7	90% of requests for advice responded to within two working days (or within an alternative timeframe requested by the employing/contracting organisation).	Advice	90%–100%	G	G
KPI 8	100% of Healthcare Professional Alert Notices (HPANs) issued/released or revoked (where justified) within seven working days.	Advice	=100%	G	G
KPI 9	90% of all exclusions/suspensions critically reviewed (where due).	Advice	90%–100%	A	A
KPI 10	90% of assessment and other intervention reports produced/issued within target timeframe.	Advice	90%–100%	G	G
KPI 11a	80% of pharmacy appeals where decision maker agrees with recommendation of case manager.	Appeals	80%–100%	G	G
KPI 11b	90% outcome of quality audits for Primary Care Appeals and dispute files.	Appeals	90%–100%	G	G
KPI 12	Before and after education metrics are applied to 100% of training events provided (including to primary care contracting commissioning services).	Appeals	=100%	N/A	G

Red or amber KPIs – explanatory notes

KPI 1 – focuses on reducing the number of claims that enter litigation before appropriate dispute resolution options have been considered and recommended. The emphasis on dispute resolution at the pre-litigation stage supports the strategic priority to deliver fair resolution. During 2022/23 we have worked on establishing a baseline for this KPI and implementing processes to support data capture. Full measurement of this KPI will be carried out from April 2023 onwards.

KPI 2 – due to the way in which the KPI is measured (at the point at which claims are closed) the RAG rating has continued to be out of tolerance. This is because of delays, which arose during the acute phase of the Covid-19 pandemic, have continued to have an impact in both 2021/22 and 2022/23 financial years. As a consequence of the pandemic, and as described on page 21, claims have taken longer to resolve for multiple reasons. This includes issues in the justice system and predominantly the impact of the challenges facing the NHS, such as availability of clinicians. For example, we rely to a great extent on input from clinicians, particularly for expert advice on the merits of claims and the consequences of harm.

KPI 9 – in most cases where a review was not undertaken within the required timeframe, this was due to the lack of availability of external contacts due to continued issues concerning access to frontline staff. In such cases, prompt action was taken to review these cases at the next earliest opportunity.

Share data and insights as a catalyst for improvement

No.	KPI description/measure	Area	Target	2021/22 RAG	2022/23 RAG
KPI 13a	Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative information.	Advice	=100%	N/A	G
KPI 13b	Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed).	Advice	=100%	N/A	G
KPI 13c	Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way.	NHS Resolution[1]	=100%	N/A	A
KPI 14	Actively sought and obtained feedback for 100% of the e-learning modules launched in 2022/23.	Safety and Learning	=100%	N/A	G
KPI 15	Actively sought an update on progress from all national level stakeholders tasked with delivering actions arising from national thematic review recommendations.	Safety and Learning	Actively seek update	N/A	G
KPI 16	Before and after metrics are applied to 100% of events related to compassionate conversations and non-executive director training.	Advice	=100%	N/A	N/A
KPI 17	Publication of six Practitioner Performance Advice Insights products by end of quarter 4.	Advice	=6	N/A	G
KPI 18	We will conduct at least one project with partners to explore links between incident data and our data.	Digital, Data and Technology (DDaT)	>1	N/A	G

Red or amber KPIs – explanatory notes

KPI 13c – one case missed the 'timely' measure in the first six months of the year where one action was completed outside of what was considered to be a reasonable timescale. This related to the completion of a thematic review, which took place eight months after the discussion of the initial notification.

KPI 16 – has not been met because events (to create before and after metrics) were not held in full in quarter 4 of 2022/23 and were rescheduled in response to frontline pressures. These will begin in 2023/24.

[1] Our Significant Concerns Group includes membership across all our functions, including Claims, Safety and Learning, and Advice services.

Collaborate to improve maternity outcomes

No.	KPI description/measure	Area	Target	2021/22 RAG	2022/23 RAG
KPI 19	Reduction in the time from notification to a liability decision on an ENS case compared to a similar cerebral palsy case received via the traditional claims route.	Claims	Year-on-year improvements on the baseline for future years	N/A	G
KPI 20	Percentage of contested applications for an interim payment on ENS claims where we have refused to make one.	Claims	<10%	N/A	G
KPI 21	We will share 100% of concerns derived from ENS and MIS cases with the national maternity safety group at least quarterly.	Safety and Learning	=100%	N/A	G
KPI 22	MIS evaluation approach agreed and approved by our Board and key partners by end of quarter 4.	Safety and Learning	Achieve approval	N/A	G
KPI 23	ENS evaluation approach agreed and approved by our Board and key partners by end of quarter 4.	Safety and Learning	Achieve approval	N/A	G

Invest in our people and systems to transform our business

No.	KPI description/measure	Area	Target	2021/22 RAG	2022/23 RAG
KPI 24	For CEP, aligned to the new regional ICS model by quarter 4 2022/23.	Claims	Achieve alignment	N/A	G
KPI 25	First release of CSP by quarter 4 2022/23.	DDaT	First release quarter 4 2022/23	N/A	G
KPI 26	A reduction in on-premise hardware and support costs as a result of migration to the NHS Central Tenant.	DDaT	Reduction in costs	N/A	R
KPI 27	Retention of Investors in People to at least Silver level for 2023 reaccreditation, together with evidence demonstrating progress against the standard for Gold level.	Human Resources (HR) and Operational Development (OD)	Retention of Investors in People	N/A	G
KPI 28	>90% of our staff will have accessed learning and development opportunities relevant to the individual and/or organisation's needs.	HR and OD	90%–100%	N/A	N/A
KPI 29a	We can evidence an improvement in the diversity of our workforce by reference to improvements in the gender pay gap (GPG).	HR and OD	Evidence of improvement	N/A	A
KPI 29b	We can evidence an improvement in the diversity of our workforce by reference to improvements in Workforce Race Equality Standard reports.	HR and OD	Evidence of improvement	N/A	A
KPI 30	We have actively sought and obtained formal feedback from our top strategic stakeholders (usually around 10–15 organisations) at least annually through a variety of methods.	Membership and Stakeholder Engagement	10–15 organisations	N/A	G
KPI 31	Retention of our ISO 27001 accreditation.	Corporate Governance	Retention of accreditation	N/A	G
KPI 32	Management of budgets within net Departmental Expenditure Limits (DEL) (between 95% and 100% of the in-year target for indemnity scheme spend)[1].	Finance	95%–100%	A	G
KPI 33	95% of undisputed invoices are paid within 30 days.	Finance	95%–100%	R	A

[1] Measured as income from members plus budget from DHSC, less expenditure. Further information available in the Finance report.

Red or amber KPIs – explanatory notes

KPI 26 – the migration was postponed due to the delay in availability of Microsoft Teams advanced call handling features on the NHS Central Tenant and availability of key resource. This is now available and will be re-planned for 2023/24.

KPI 28 – without a central approach for monitoring and reporting on external development opportunities accessed by staff, external learning and development opportunities cannot be reflected in the overall percentage. For this reason, we have paused the reporting of this KPI. The continued rollout of our online learning management (OLM) system will provide a central platform for the recording and monitoring of all development opportunities including those that are offered externally. This approach will still require the notification and input of non-NHS Resolution/external development opportunities, but by providing a single repository for individual learning accounts and by encouraging information to be shared as part of the existing performance and development review process, we expect to be able to provide a more accurate measure of the percentage of staff accessing non-mandatory development opportunities.

KPI 29a – we have partially achieved this KPI. Our reported GPG figures, as detailed on page 114, show an improvement in our mean rate but a decline in our median rate. The full GPG report notes the considered impacts on each of the reported figures and our intended action to continue to address the reported gaps.

KPI 29b – we have partially achieved this KPI; some of the indicators have noted an improvement since the last report while others show a decline. Measured as at 31 March 2023, our overall workforce profile has seen a slight reduction in the number of ethnic minority staff employed. Similarly, the reported Board profile has remained unchanged with no ethnic minority representation. The organisation has only a small number of executive board members, and there were no appointments or turnover in the reference period. The chair and non-executive directors are appointed by the Secretary of State for Health and Social Care. There was only one such appointment in the reporting period. The organisation has, however, appointed several independent members to Board sub-committees[1], a number of whom have been from ethnic minority backgrounds. Our regional profiles (London and Leeds) have remained consistent when compared to the previous year[2].

KPI 33 – The number of invoices paid within 30 days is 89%, below the target of 95%, for the year to 31 March. Work is ongoing to improve business processes to work towards consistently achieving this target.

[1] This includes our ARC, the People Committee and the Reserving and Pricing Committee.

[2] For the March 2023 data, we have committed to completing our gender pay gap and ethnicity pay gap reports in quarter 1 and our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data in quarter 2 of the 2023/24 year. This will provide a timelier and more accurate picture of our progress in these areas since March 2022 and allow more time to develop an action plan to address the areas that require improvement.

Strategic priority one: Deliver fair resolution

In 2022/23, against the complex operating environment described on page 20, we are pleased to see that we have maintained a healthy level of activity across all our operational functions. Despite the challenging operating environment, and demonstrated by the volume of claims settling with no damages paid, we have managed to settle and close an increased volume of claims without impacting the robustness of our investigations. We have also managed to settle a record number of claims without formal processes being required, principally as a result of our dispute resolution initiatives and collaborative approach to claims management. The increase in damages paid has been driven in large part by the volume of high-value claims that have concluded as PPOs, a recovering volume of these following a dip in this number throughout the Covid-19 pandemic years. While we await the publication of the Government's response to the Health Select Committee's report into NHS litigation reform and the Government's response to their consultation on fixed recoverable costs on low-value clinical negligence claims we are committed, via our first strategic priority, to keeping patients and healthcare staff out of formal processes as far as possible to minimise distress and cost. The next section provides an overview of how we have worked in 2022/23 to achieve this aim.

How we manage claims

The claims process can be complex and claims can sometimes take a long time to resolve. As figure 2 illustrates, there can be a significant time-lag between an incident occurring and a claim being made – on average three years. During this period the focus is largely on understanding why the harm was caused and dealing with the immediate concerns of patients, including ongoing care. It can take some time for patients to decide whether they wish to pursue a claim and seek advice. Once a patient or family member decides to make a claim there are several procedural and investigative stages to be undertaken before a decision can be made on liability.

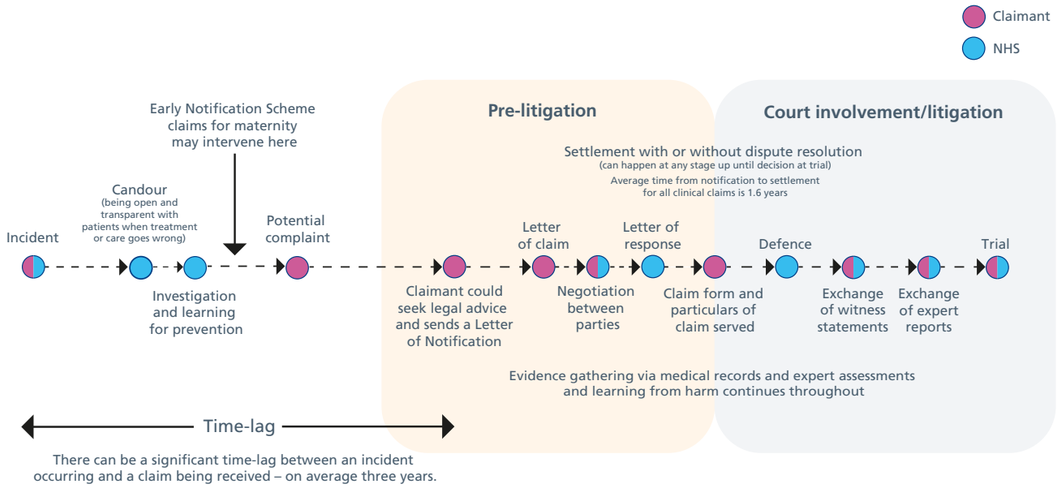
It may then also take some time to quantify and agree damages on a claim, particularly those high-value claims where brain damage has occurred at birth and where a full assessment cannot be undertaken until a child has reached developmental milestones. When describing this year's claims profile we have taken into account the realities of the life cycle of a claim, which often spans many years – highlighting where the effect of the time-lag or complexities of settling claims is important in understanding our work.

What does liability mean?

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

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

Figure 2: Claims life cycle

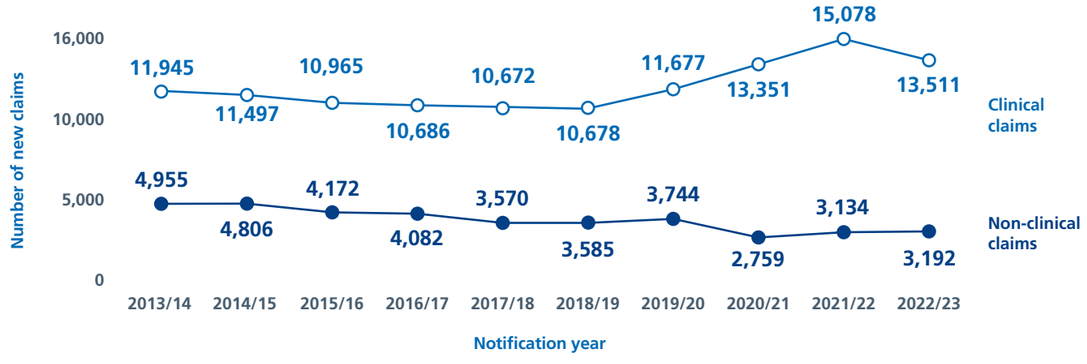


As figure 3 shows, the total number of new clinical negligence claims and reported incidents totalled 13,511, a decrease of 1,567 on last year (15,078). This figure includes:

- 341 more CNST claims (10,567 in 2022/23 compared to 10,226 in 2021/22), an increase of 3.3% compared to 2021/22;
- 2,583 fewer ELSGP claims (709 in 2022/23 compared to 3,292 in 2021/22), a decrease of 78% compared to 2021/22 due to the the bulk migration of responsibility for claims from the MPS in 2021/22; and
- 678 more CNSGP claims (2,180 in 2022/23 compared to 1,502 in 2021/22), an increase of 45% compared to 2021/22.

Putting aside the effect of the bulk migration from MPS, the underlying change in clinical claims received (CNST and CNSGP) is an increase of 1,019 claims, or 8.6%. The volume of non-clinical claims reported in 2022/23 is comparable to 2021/22 although remains lower than pre-pandemic levels.

Figure 3: The total number of new clinical and non-clinical claims and incidents reported in each financial year from 2013/14 to 2022/23

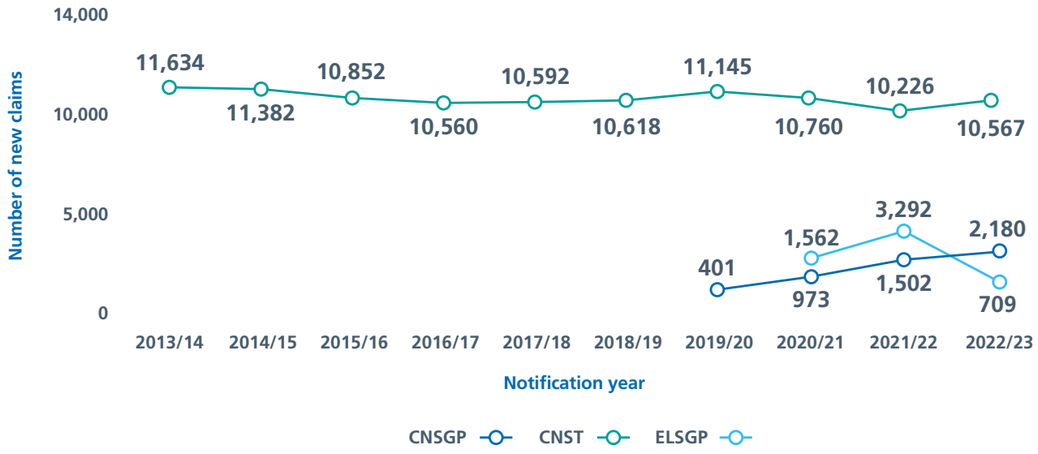


The change in reported volumes this year is due to a range of factors including:

- In 2021/22, ELSGP reported numbers were particularly high due to the bulk migration of 2,005 claims from the MPS (as shown in figure 4). As CNSGP matures ELSGP claim numbers are expected to reduce over time as fewer new claims with incident dates before 1 April 2019 are reported.
- A maturing CNSGP portfolio, illustrated in figure 4, which is as expected following inception of the scheme in 2019. CNSGP covers incidents occurring on or after 1 April 2019 and the time-lag between incident and reporting (as illustrated by figure 2 on page 35) means that we are now more steadily receiving claims relating to incidents which occurred when the scheme first began.
- Reported numbers were low during the acute phase of the pandemic, particularly in the non-clinical portfolio. Although numbers have risen since then they remain lower than pre-pandemic levels in both CNST (1.7% lower than the average over the five years to 2019/20) and Liabilities to Third Parties Scheme (LTPS) (16.4% lower than the average over the five years to 2019/20).

In relation to LTPS, which covers non-clinical claims such as public and employers' liability, we received 62 more claims (3,136 in 2022/23 compared to 3,074 in 2021/22); however, they remain lower than the average over the five years to 2019/20. This is likely to be due to the lower footfall in hospitals and healthcare settings throughout the pandemic.

Figure 4: The total number of new CNST, CNSGP and ELSGP claims and incidents reported in each financial year from 2013/14 to 2022/23[1]

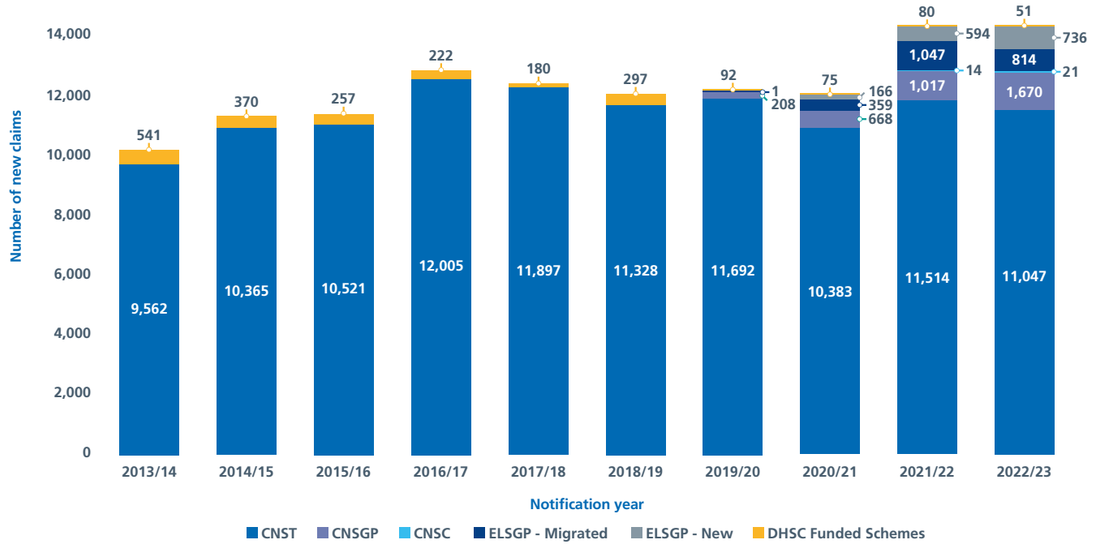


[1] Given that CNSGP and ELSGP were established on 1 April 2019 and 6 April 2020 respectively, data reporting for these schemes reflects these financial years onwards.

As shown in figure 5, we have continued to manage claims to conclusion efficiently, while maintaining high investigative standards to ensure decision making is fair. It is important that we investigate claims robustly and only make a damages payment where the merits of the case warrant it. In 2022/23 we closed 14,339 clinical claims (compared to 14,266 in 2021/22), a small increase of 0.5%. In 2022/23 6,863 claims were closed without damages, an increase of 5.4% (349 claims) on the previous year (6,514 in 2021/22). The estimated total value of claims we closed with no damages payment was £4.6 billion[1]. We also closed 7,476 clinical claims with damages in 2022/23, a decrease of 3.6% (276 claims) on the previous year (7,752 in 2021/22).

Of our non-clinical claims, 2,154 were closed without damages in 2022/23, an increase of 434 on the previous year (1,720 in 2021/22). We also closed 1,809 non-clinical claims with damages in 2022/23, an increase of 256 on the previous year (1,553 in 2021/22)[2]. This increase is primarily due to changes made to our claims operating model which have provided the opportunity to proactively review and resolve cases, resulting in an increase in settlements and closures compared with previous years.

Figure 5: The total number of clinical claims closed broken down by scheme in each financial year from 2013/14 to 2022/23[3]



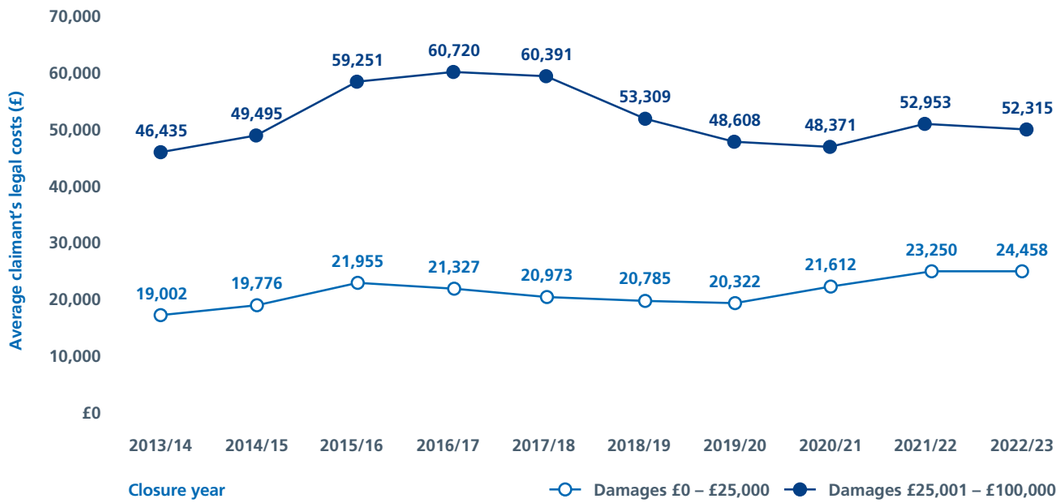
[1] The estimated value of claims closed without damages is the highest reserve estimate for damages, NHS legal and claimant legal costs, less NHS legal costs incurred on these cases.

[2] It should be noted that due to the small volume of non-clinical claims the change in averages can be more volatile than the clinical claim portfolio, which is higher in volume.

[3] CNSC refers to the Clinical Negligence Scheme for Coronavirus. Further information about the scheme can be found in the Appendix on page 174.

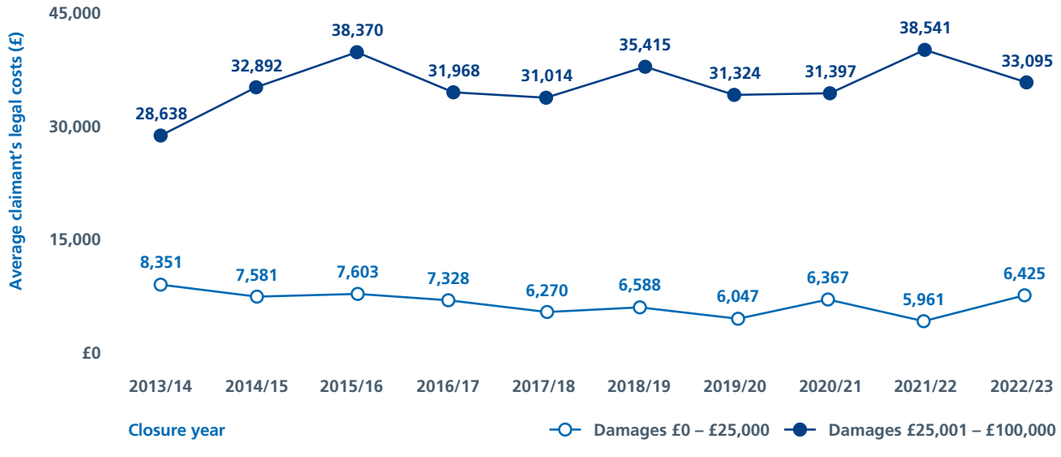
As figure 6 illustrates, of the clinical claims closed where damages were paid, in the bracket £25,000 to £100,000, the average claimant legal costs awarded per claim were £52,315, a 1.2% decrease on 2021/22. For claims valued up to £25,000 the average claimant costs award increased by 5.2%. The average legal costs on claims valued up to £25,000 has nearly exceeded the highest damages awarded in this cohort of claims.

Figure 6: Average claimant's legal costs for clinical claims closed in each financial year from 2013/14 to 2022/23



While average costs for lower-value clinical negligence claims have increased, for non-clinical negligence claims (as shown in figure 7) where costs are fixed, the average costs for lower-value claims have remained steady.

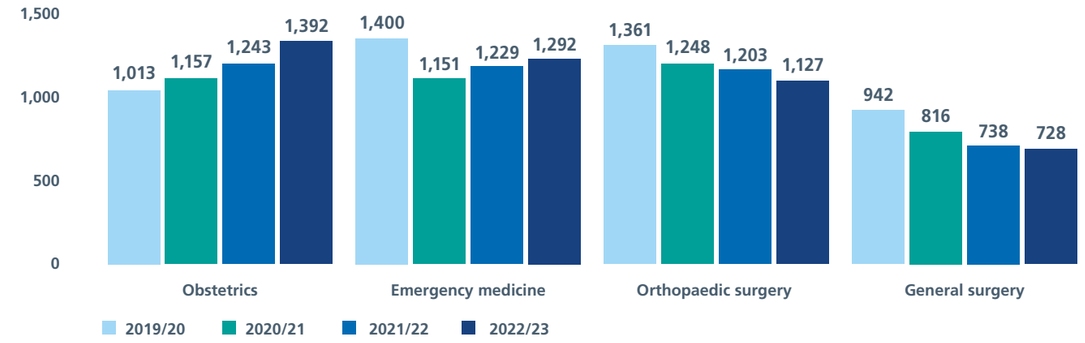
Figure 7: Average claimant's legal costs for non-clinical claims closed in each financial year from 2013/14 to 2022/23



As figure 8 highlights, the top four categories of clinical claims reported by volume this year were obstetrics, emergency medicine, orthopaedic surgery and general surgery. The top four categories remain broadly the same as last year although obstetrics is now the largest category by volume. A key factor in this change is an increase in the number of claims managed under our ENS, with 204 new obstetric ENS claims in 2022/23. This increase is because we are still receiving claims for incidents that occurred prior to April 2017 when the ENS was first launched, in addition to the identification of claims as they were notified to us in the scheme's first few years.

We expect the volume of non-ENS obstetric claims notified over the next few years to gradually decline while the ENS continues to mature. The decrease in claims volumes in orthopedic surgery and general surgery (relative to obstetrics and emergency medicine) could also reflect the reduction in elective procedures carried out in these surgical specialties during the acute phase of the pandemic, while obstetric services and services delivering emergency medical care continued to deliver care during this time.

Figure 8: The top four categories of clinical negligence claims reported in each financial year between 2019/20 and 2022/23



In 2022/23 we received 346 clinical claims reported where there was a claim related to Covid-19, compared with 364 in 2021/22. Most of these claims relate to indirect effects of the pandemic such as failures and/or delays in treatment or diagnosis.

Of the Covid-19 related clinical claims settled in 2022/23, 67% were settled without damages. Due to the fact that claims are time-lagged (as described on page 34), we only have an early picture of the claims profile for Covid-19, and we can't draw any conclusions at this stage as to future trends and patterns this may lead to. Under the non-clinical schemes, 64 claims were reported in 2022/23 compared with 80 in 2021/22. Of the non-clinical claims settled in 2022/23, 78% were settled without damages. A new scheme was launched in 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 received 15 Clinical Negligence Scheme for Coronavirus (CNSC) claims in 2022/23 compared to 22 in 2021/22 and 7 in 2020/21.

In April 2018, in response to concerns predominantly raised by women, the then Secretary of State for Health and Social Care, Jeremy Hunt MP, announced a review into the risks associated with: vaginal mesh for uro-gynaecological conditions; the use of sodium valproate with inadequate warnings about the risk of *in utero* exposure; and hormone pregnancy tests. The review was led by Baroness Julia Cumberlege who published her report First do no harm in July 2020. In June 2022, following a request made by DHSC, we worked with DHSC to establish separate processes to manage the procedure for reporting and investigating mesh and sodium valproate claims without the need for litigation. Both processes, often referred to as gateways, offer a simplified process for claims to be reported to us by unrepresented claimants[1]. In 2022/23 we received 13 claims via the mesh gateway and a small number of claims via the sodium valproate gateway. Although the gateways offer a simplified process for claims to be reported, it is not intended that our investigation process into the claim would be substantively different to any other mesh or negligence claim. As we progress to 2023/24 we will continue to manage these processes.

[1] We have published information about vaginal mesh and sodium valproate claims on our website.

Payments

As illustrated in figure 9, payments against our clinical schemes totalled £2,641.7 million, which included damages paid to claimants of £1,992.0 million, claimant legal costs of £490.9 million and NHS legal costs of £158.8 million.

Damages payments increased by 12.2% across our clinical schemes compared with last year. A factor contributing to an increase in damages payments in 2022/23 is the volume of PPO cases settled, which are usually of higher value. We have seen a 37.7% increase in the volume settled as PPOs this year (157 in 2022/23 compared to 114 in 2021/22). This increase can be attributed to the availability of experts and also court time to approve such awards as the effects of the pandemic eased, which has led to a similar number of claims being settled this year as in pre-pandemic years.

The rises in legal costs (4.2% for claimant costs and 1.4% for NHS legal costs) have been lower in comparison to previous years which is due, in part, to our collaboration with lawyers acting for patients and the greater use of dispute resolution to avoid formal processes. This has contributed towards our aim to ensure harmed patients are appropriately compensated but the cost of the legal process is minimised through efficient processes.

As figure 10 shows, payments against our non-clinical schemes totalled £49.1 million, which included damages paid to claimants of £26.7 million, claimant legal costs of £16.3 million and NHS legal costs of £6.1 million. An overview of the financial performance across each scheme is described on page 67.

Figure 9: Clinical negligence payments made in 2021/22 compared to 2022/23

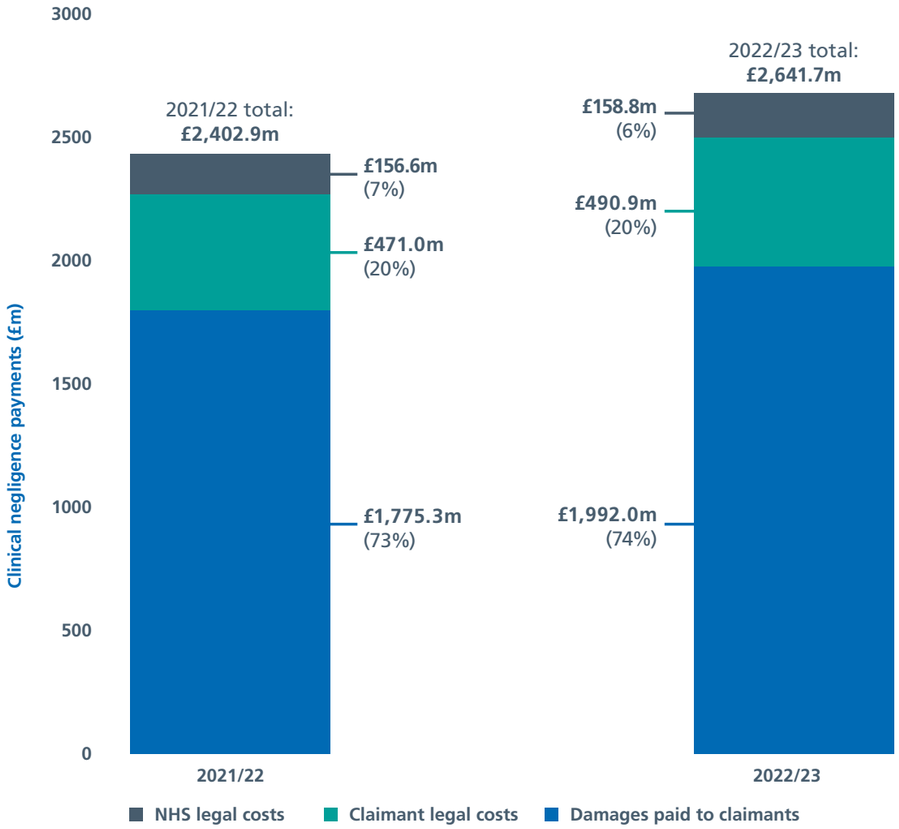
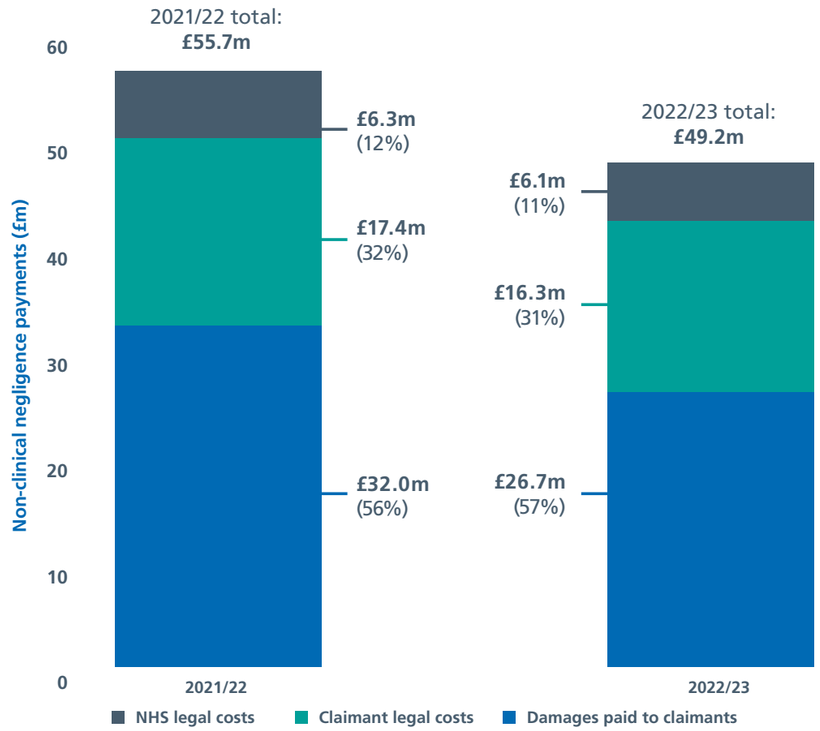


Figure 10: Non-clinical negligence payments made in 2021/22 compared to 2022/23



Our approach to dispute resolution

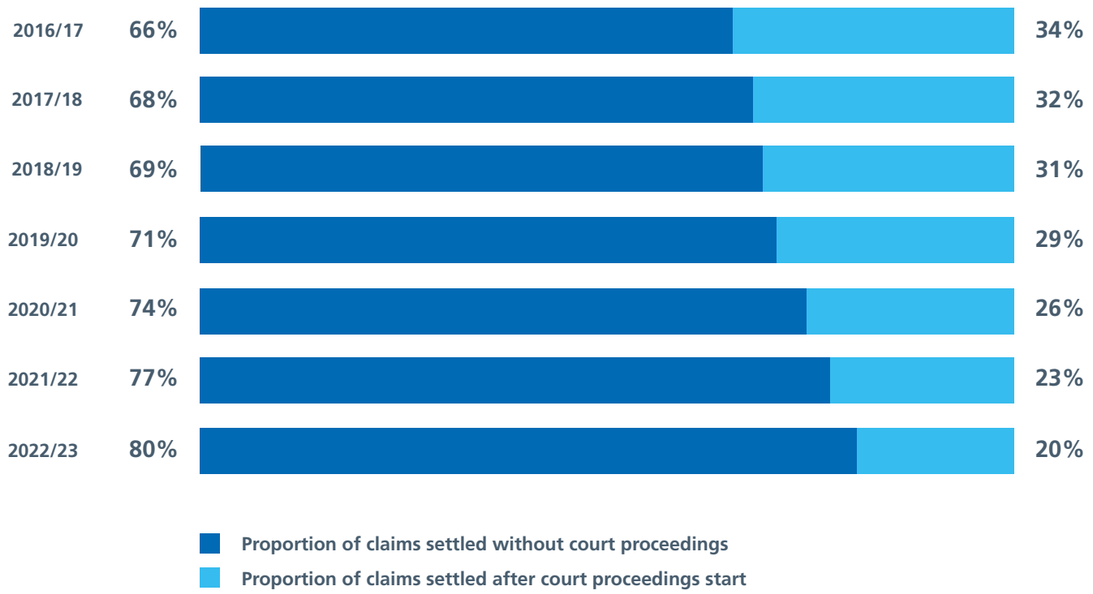
Litigation rate

Resolving matters without the need for court proceedings generally reduces costs and pressure on courts, and can provide an improved experience for claimants and healthcare staff. As figure 11 illustrates, 80% of clinical claims were settled without litigation (an increase of three percentage points on 2021/22), the highest ever volume achieved, demonstrating our continued success in keeping claims out of court processes where appropriate to do so. As mentioned in the Chair and Chief Executive's welcome and report, the Covid-19 Clinical Negligence Protocol has likely had a positive impact on the litigation rate, and as pandemic-affected claims start to settle in the coming years we will continue to monitor the impact the protocol has had.

We recognise that the longer claims take to settle or conclude, the higher the costs associated with each individual claim[1]. This is why our focus is on ensuring claims are properly investigated and settled fairly at the earliest opportunity, preferably pre-litigation. Recent analysis of a cohort of claims settled between 2019/20 and 2020/21 has shown that the average difference in costs paid to lawyers acting for patients on litigated versus non-litigated closed claims amounted to around £57,000 per claim[2].

While we continue to use a range of methods to resolve claims early and fairly, there will be some claims where litigation is the right choice, such as those where a legal point is in issue or where the court must approve a settlement in the best interests of a protected party. In 2022/23, 56 of the claims we settled were litigated to trial with 18 (32%) resulting in an award of damages. The decision to take a case to trial is often finely balanced, requiring careful assessment of all evidence. In 68% of claims the court agreed with our assessment on the merits of the claim and awarded no damages. In all claims, seeking the input of the court was appropriate to ensure there was a fair outcome delivered for all parties.

Figure 11: Litigation rate for clinical claims for each financial year from 2016/17 to 2022/23[3]



[1] See National Audit Office, Managing the costs of clinical negligence in trusts, September 2017.

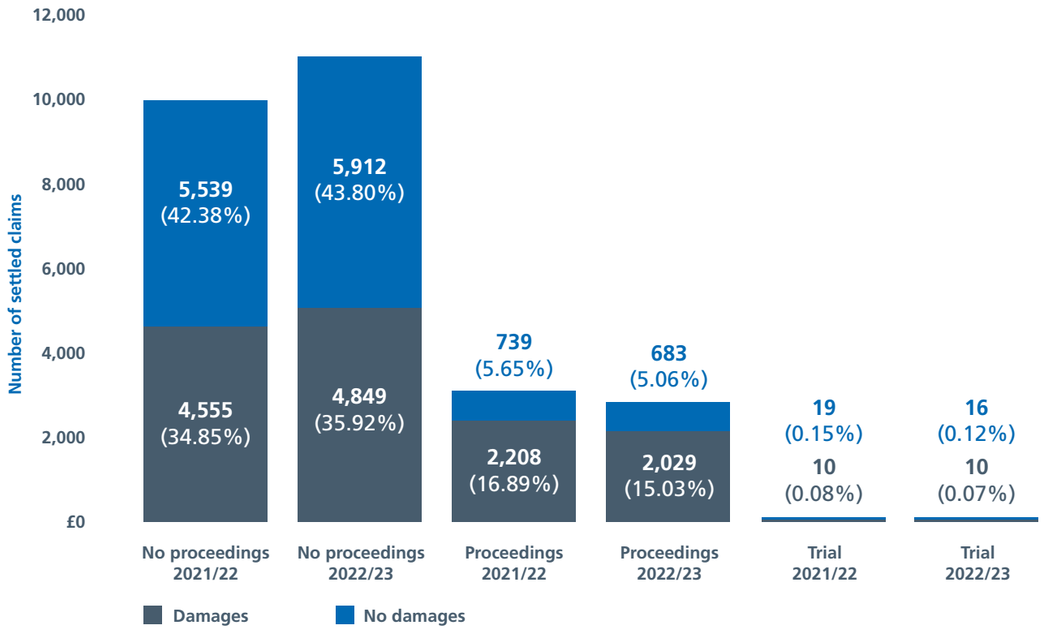
[2] This analysis derives from an in-year individual study of average difference in costs paid to lawyers acting for patients on litigated versus non-litigated closed claims.

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

Overall, as figure 12 shows, the total number of clinical claims that settled increased in 2022/23 to 13,499 from 13,070 in 2021/22 (an increase of 3.4%), with 51% of claims resulting in a payment of damages in 2022/23, compared with 51.8% in 2021/22.

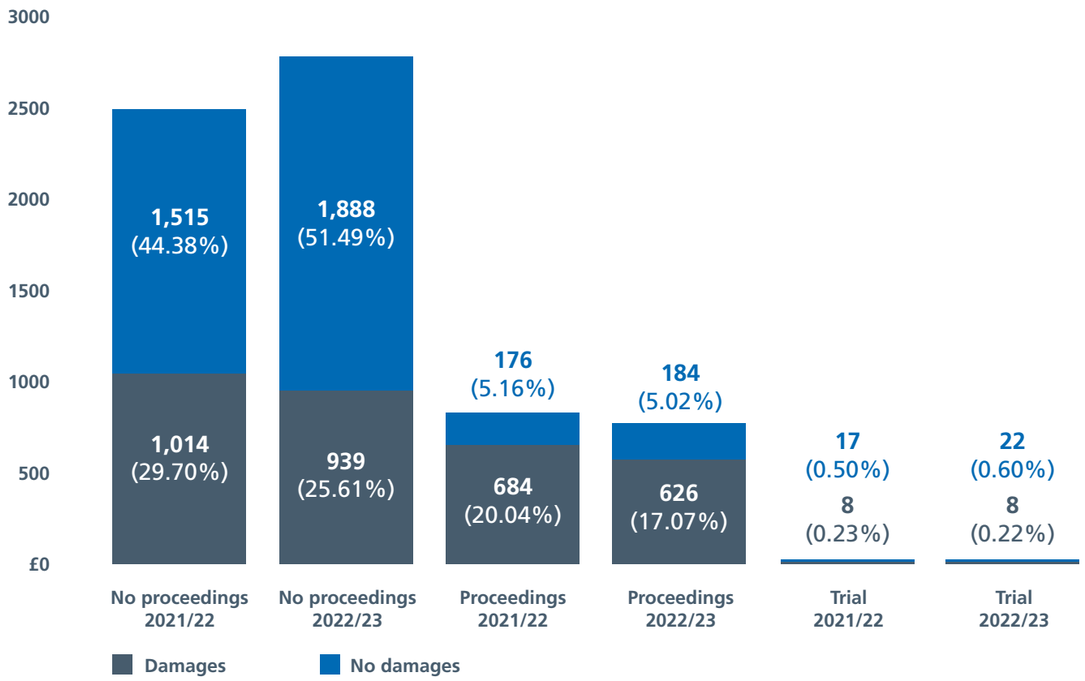
Claims settling pre-action and without payment of damages increased by 6.7% (from 5,539 in 2021/22 to 5,912 in 2022/23). For claims in proceedings, the number resolved with no damages paid has decreased by 7.8% (from 758 in 2021/22 to 699 in 2022/23).

Figure 12: The number of clinical claims settled in 2022/23 compared with 2021/22, by settlement type, and with or without damages



As figure 13 illustrates, the total number of non-clinical claims that settled in 2022/23 rose to 3,667 from 3,414 in 2021/22 (7.4%). Claims settling pre-action and without damages increased by 25% (from 1,515 in 2021/22 to 1,888 in 2022/23). Where claims had proceedings issued, the number resolved with no damages paid increased by 6.2% (from 193 in 2021/22 to 206 in 2022/23). The smaller numbers in the non-clinical portfolio mean the average damages values are more susceptible to change related to a small number of very high-value or very low-value claims settling. In this portfolio, the higher number of claims settling in the pre-action stages continues to reflect our strategic aims to keep patients and staff out of formal processes wherever possible, while also ensuring our decision making carefully considers the merits of each case.

Figure 13: The number of non-clinical claims settled in 2022/23 compared with 2021/22, by settlement type, and with or without damages



By implementing an increasing range of dispute resolution options, as described in the following section, we will continue to seek to ensure that litigation is by choice, providing the opportunity to resolve claims via a variety of means, choosing the most suitable course of action for each case.

What is litigation by choice?

While we will still thoroughly investigate claims, we will seek to avoid formal processes where appropriate (particularly where claimants might be seeking an outcome which litigation might not be able to provide) by offering the opportunity to resolve claims via a variety of means, choosing the most suitable course of action for each case. We will only look to proceed to litigation on cases where this is the most appropriate method for resolution.

Resolution meetings

Resolution meetings are an effective way to discuss the strength and prospects of a claim and can be useful to allow the parties to explain their respective positions, especially on matters which are disputed. We have increased the number of resolution meetings conducted with claimant firms over the past year, having worked with ten claimant firms to convene these meetings. This process is particularly suited to claims where the merits of the case have been investigated and the issues in question are capable of being resolved between the parties with an open and constructive dialogue, often supported by a peer review.

In 2022/23, 301 claims were discussed in resolution meetings with 191 being settled (63%). Of the claims that were discussed at a resolution meeting (and settled), only 13 (7%) were litigated, demonstrating how this process can be an effective way of avoiding formal proceedings.

Mediation

Following our innovative work in recent years[1] to implement mediation in our Claims Management (Claims) service, we continue to promote the use of mediation in appropriate claims and now consider mediation a routine part of our suite of dispute resolution options. The process provides a platform to claimants, patients and their families to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution. The forum also provides benefits to clinicians, allowing them to bring closure to historical concerns.

We contract with four providers[2] to deliver mediation, and since the start of the service in 2016 to 31 March 2023, a total number of 1,836 claims have been mediated. In 2022/23 a total of 229 claims proceeded to mediation with 72% of the claims settling on the mediation day or within 28 days of the mediation. Since the Covid-19 pandemic, the online mediation model remains popular with claimants and healthcare professionals who find that this process is less daunting, more flexible, and saves valuable travelling time.

Early neutral evaluation

In April 2023, working in partnership with two claimant law firms, we launched a pilot to test the benefits and effectiveness of early neutral evaluation. This process involves the parties appointing an independent evaluator with specialist knowledge of the subject matter to give an assessment of the merits of their respective claims. The evaluation is non-binding and without prejudice, so no reference can be made in any proceedings to what happened in the early neutral evaluation process unless otherwise agreed by the parties. We expect to publish the results from this pilot in our future annual report.

As we expand our dispute resolution options, we recognise that sometimes litigation will be unavoidable, such as for the approval of a child's damages award or where there is a need to clarify areas of law. The following section describes our approach to entering litigation and the role we play in setting legal precedent.

Stock takes

We have undertaken a pilot[3] with two claimant firms carrying out stock takes at different parts of the claim process. Through collaborative working, stock take meetings have allowed us to discuss the merits of claims with the claimant firms, allowing all parties to make better informed decisions about resolution. We have seen early successes so far with all claims that have had a stock take meeting being resolved without proceedings being issued. Of these, around a quarter resolved with no payment of damages. In the future, we will continue to work with lawyers acting for patients on stock take meetings in order to discuss case management, resolution opportunities and collaboration on medical evidence.

[1] You can find out more about our mediation service in NHS Resolution's ***Mediation in healthcare claims – an evaluation***.

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

[3] The stock take pilot has been run for cases with under £150,000 damages; however, the principles of the stock take process can benefit all types of claim.

Setting legal precedent

It may be appropriate to enter litigation when there is a requirement to take claims 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 similar claims and an outcome can either provide an opportunity for others to claim under similar circumstances or deter claims without merit. Claims can also provide our members, the legal profession and healthcare staff with valuable insights to learn from. We regularly publish cases of note on our website, and in 2022/23 this included case notes on:

- an attempt to reopen a clinical negligence claim over 15 years after it had originally been discontinued during a hearing before another High Court judge – JA v. Mid-Cheshire Hospitals NHS Foundation Trust (High Court, 26 January 2022 – Eyre J.) (case note published 19 May 2022);
- a sentencing hearing for contempt of court in a claim brought by the trust and NHS Resolution – North Bristol NHS Trust v. HBW (High Court, 26 May 2022 – Ritchie J.) (case note published 21 July 2022);
- consideration of several points of law including illegality, contributory negligence and the Human Rights Act following the claimant alleging negligent treatment of his mental illness which they argued resulted in the claimant suffering a psychotic episode and subsequently causing harm to the claimant's daughter – MT and KT v. Kent & Medway NHS Social Care Partnership Trust (High Court, 10 February 2022 – Johnson J.) (case note published 30 September 2022); and
- an attempt to bring a claim relating to a lack of informed consent nine years following the incident – Farah Saber v. University Hospitals Birmingham NHS Foundation Trust (Birmingham County Court, 2 December 2022 – Recorder Weaver KC) (case note published 27 January 2023).

Where a claim is litigated and there is evidence of fabricated or exaggerated claims, we also have a responsibility to identify and robustly manage these, and have a zero tolerance to proven fraudulent claims. Some examples of how we have challenged claims and saved public funds are detailed in the subsequent section of this report.

Exaggerated or false claims

As highlighted in our case notes, in February 2022 we brought a contempt action on behalf of North Bristol NHS Trust after we investigated a claim for £4 million. The claimant alleged that her injuries restricted her mobility, which also resulted in her not being able to drive for long periods without suffering pain and discomfort.

Our experts had concerns over the claimant's reported injuries and so we placed the claimant under video surveillance. The surveillance showed that while the claimant had mobility issues, she was able to walk without assistance and had, on one occasion, driven for 40 miles without stopping. In May 2022, a day before the hearing, the claimant admitted their dishonesty and at sentencing they were given a six-month custodial sentence.

In December 2018 a claimant alleged that they had sustained injuries following a negligent surgical repair of a left bicep tendon rupture carried out by Wye Valley NHS Trust. The claimant alleged that as a consequence of the surgery he was unable to work as a builder, could not return to playing rugby, attend the gym or fully engage with his young family. The claimant sought damages in excess of £540,000 and had received a £40,000 interim payment and £10,000 to cover his legal fees.

> In his remarks to her in court, His Honour Mr Justice Ritchie said that the claimant presented:
>
> **"A risk to the public purse and public institutions as a result of your approach to your clinical negligence claim against a tax payer funded organisation."**
>
> North Bristol NHS Trust v. HBW (High Court, 26 May 2022 – Ritchie J.), paragraph 101

Following admissions, we received an anonymous tip-off that the claimant was exaggerating his injuries. Our investigations identified that the claimant had continued to work, play rugby and attend the gym – his local rugby service website listed him as playing rugby regularly, and the claimant himself had posted weight training videos on YouTube. In light of social media and press reports of the claimant playing rugby, we raised allegations of fundamental dishonesty, seeking dismissal of the action[1]. In October 2022 the dismissal was upheld, and the claimant received no compensation and has been ordered to repay the £50,000 interim payments for damages and legal costs. The court also awarded the trust its own legal costs of the action, which are still to be assessed and are estimated to be currently in the region of £120,000.

[1] Pursuant to section 57 of the Criminal Justice and Courts Act 2015.

We do not take decisions lightly to undertake surveillance and commence committal proceedings; however, given the extent of the damages sought by the claimants in these claims, it was felt this was appropriate action. This is a stark reminder to potential claimants of the very serious consequences of submitting dishonest and exaggerated claims. Genuine claimants have nothing to fear, but these claims demonstrate that where there is evidence of a fabricated or exaggerated claim we will take steps to protect public funds and to pursue a custodial sentence.
In addition to our Claims service, our Appeals service also manages disputes, described in the following section.

Primary care contracting disputes

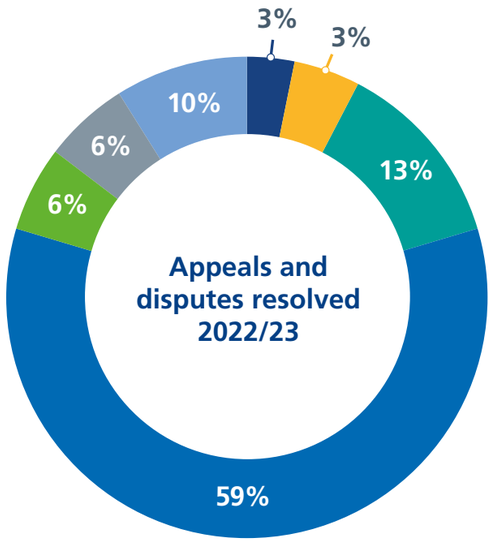
Offering an impartial resolution service for the fair handling of primary care contracting disputes, we are responsible for ensuring the prompt and fair resolution of appeals and disputes between primary care contractors or those wishing to provide primary care services and NHSE and/or ICBs.

Figure 14: Primary Care Appeals contracting disputes life cycle[1]

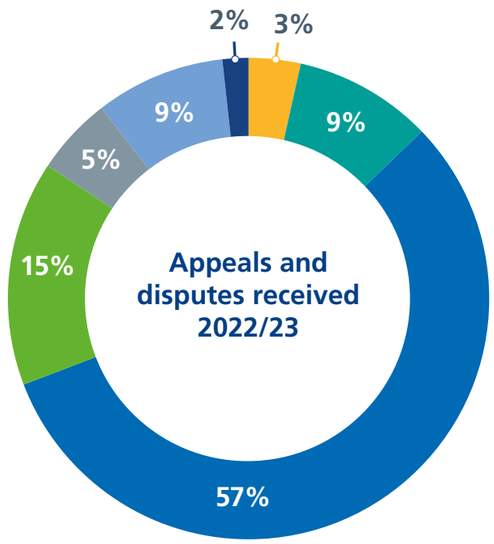
[1] Across all types of appeals and disputes, there is a common theme that parties involved are entitled to make submissions and to see and comment on what others have said before the matter is considered by the decision maker.

In 2022/23 we received 172 cases and resolved 157. Figure 15 shows a breakdown of these cases by category.

Figure 15: Appeals and disputes received and resolved in 2022/23



Dental disputes	5 (3%)
Medical disputes	20 (13%)
Pharmacy market entry and change of listing appeals	93 (59%)
Pharmacy Covid-19 payment appeals	9 (6%)
Pharmacy performance sanction appeals	9 (6%)
Pharmacy overpayment appeals	14 (10%)
Performance Lists Regulations suspension payment appeals/consent to withdraw	5 (3%)



Dental disputes	6 (3%)
Medical disputes	20 (9%)
Pharmacy market entry and change of listing appeals	97 (57%)
Pharmacy Covid-19 payment appeals	26 (15%)
Pharmacy performance sanction appeals	9 (5%)
Pharmacy overpayment appeals	15 (9%)
Performance Lists Regulations suspension payment appeals/consent to withdraw	3 (2%)

As part of our role in supporting effective decision making across primary care contracting, our Appeals service has delivered training to NHSE and ICB staff on NHS community pharmacy relocation applications. The training sessions explained the relevant regulatory tests and shared learning from our experience of handling these types of cases, using a case study to explore and develop the key skills and knowledge required. On average, those who attended the session rated the training 4.7 out 5.

In addition to managing disputes, we also play a part in supporting the healthcare system to learn from incidents – we describe how we have achieved this on the following pages.

Promoting a just and learning culture

Our first strategic priority also includes a commitment to continue to promote the principles of a just and learning culture as the optimum environment in which resolution and learning can occur, as illustrated in our claims life cycle in figure 2.

What is a just and learning culture?

A just and learning culture is an environment where there is a balance of equity, fairness and justice to ensure learning from incidents and taking responsibility for actions that need to be taken.

In late March 2022 we published our duty of candour animation to address any misunderstanding about the difference between a professional duty of candour[1] and a statutory duty of candour[2]. The animation also highlights that an apology is not an admission of liability. In meeting the needs of our healthcare partners and stakeholders the animation directly supports NHSE's NHS Patient Safety Strategy, *Safer culture, safer systems, safer patients*, which sets an expectation on all healthcare staff and providers to be open and honest with families, carers and staff when a patient safety incident occurs. We are proud that, as of 31 March 2023, the duty of candour animation has gained over 68,600 views, with our social media campaign securing 18,000 and 20,000 impressions on Twitter and LinkedIn respectively.

Building on our *Being fair* report and *Being fair charter* (published in July 2019), on 30 March 2023 we published Being fair 2: Promoting a person-centered workplace that is compassionate, safe and fair. The report highlights the importance of:

- instilling a workplace culture that is psychologically safe, compassionate and meets the basic needs of staff;
- the need for greater clarity on what constitutes incivility, bullying and harassment; and
- the need for further guidance for organisations on how to manage concerns fairly, particularly when addressing issues of incivility, bullying and harassment locally, before escalating to professional regulators.

Like our duty of candour animation, this report supports the NHS Patient Safety Strategy in addition to NHSE's multi-professional NHS Patient Safety Syllabus.

In 2022/23 we also developed an e-learning module due to be published in May 2023, specifically focused on maternity care. The module, titled *Closing the loop, learning from harm*, will share themes emerging from the ENS described on page 59 through three illustrative case stories. We hope that the e-learning module forms a key resource to support NHSE's Maternity and Neonatal Safety Improvement Programme in addition to NHSE's NHS Patient Safety Strategy and associated Patient Safety Syllabus. Working closely with the Parliamentary and Health Service Ombudsman (PHSO), our efforts to promote a just and learning culture, coupled with our insights from the ENS and MIS and implementation of dispute resolution options, have also contributed to the PHSO's new Complaint Standards Framework.

As our *Being fair 2* report highlights, we recognise the importance of fairly responding when concerns are raised, and doing so in a culture where staff feel psychologically safe. In the following pages we provide an overview of how we effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists.

[1] The professional duty of candour is a professional responsibility to be open and honest with patients and families when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This includes saying sorry and taking action to put things right where possible. It is always the right thing to do and is not an admission of liability. Regulators of specific healthcare professions oversee the professional duty of candour.

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

Resolution of concerns relating to healthcare staff

Our Advice service has embarked on a number of ambitious programmes designed to support and promote a just and fair culture across the NHS by providing an independent and expert advisory and support service for medical, dental and pharmacy practitioners and healthcare organisations. This year we have opened 787 new requests for advice from healthcare organisations with concerns about the practice of individual practitioners as well as services. Our Advice service focuses on:

- the fair and effective application of the healthcare organisation's own local performance management and associated procedures;
- promoting and enabling good practice in relation to local case management and investigation; and
- helping to identify and consider options available to the healthcare organisation to address and resolve concerns raised about an individual's practice.

We have started to build more robust intelligence gathering through a regional model where our advisers seek to understand performance concerns across a whole patch and can react more quickly to help resolve cases. This has allowed us to use more informed local knowledge and engagement to identify whether advice provided is acted upon and to challenge organisations where fairness and safety may be at risk. This also helps us to demonstrate better links between case advice and any appropriate remediation services.

We know through our casework that frontline healthcare organisations value our expertise in helping to build capability at a local level to manage and resolve concerns relating to performance.

Alongside this, most cases brought to us involve more complex behavioural concerns, which can be disruptive to services and adversely affect patient care. We have continued to strengthen our approach to managing behavioural concerns, including an evaluation of how we deliver our behavioural assessment service, which now happens entirely virtually, rather than asking practitioners to travel to undertake an assessment. We have had some very positive feedback from practitioners, which will in turn help reassure others about the process. We have also undertaken work to strengthen our interventions where concerns arise about a service that is not functioning because of interpersonal conflict.

Our HPANs continue to provide a key safety net to the NHS by informing the system about health professionals who may pose a significant risk to patient safety. We recognise that concerns must be managed according to the individual circumstances of the case. In some cases, where a healthcare practitioner's scope of practice needs to be restricted or they are excluded or suspended, our Advice service plays a role in supporting the healthcare practitioner to return to work, where safe to do so – ensuring that there is timely and fair resolution across all healthcare sectors. This year we developed resources to support good practice and help clinical leaders with decision making, documenting and managing an exclusion, as well as sharing learning from exclusion cases over a ten-year period, highlighting opportunities for learning and improvement to the health system. You can read more about the range of resources we have published this year on page 54.

Our Advice service receives consistently high levels of satisfaction from our frontline users and across the health system, which includes medical directors, HR professionals and responsible officers. The engagement between the employer and link adviser is highly valued as a way of supporting decision making and provides a strong sense of 'sense checking' and 'triangulating' an appropriate way forward.

Where it is safe to do so, we have sought to support organisations and practitioners and to get practitioners back to work in the same or a similar role, with no restrictions to practice. This year NHSE has engaged with our Advice service as it looks to strengthen the Performers Lists Regulations and arrangements around suspensions of primary care practitioners, which should help to clarify our Advice service's role in primary care cases.

Our Advice service has continued to undertake valuable engagement work with Wales and Northern Ireland as well as other territories such as Jersey, Guernsey and Isle of Man, using established frameworks to guide and support concerns that occur outside of the NHS in England.

The service has continued to share important learning for the system this year, publishing six Insights papers and building capability and capacity through our education programmes.

Our Insights publications share analysis and research which draw on our in-depth experience providing expert, impartial advice and interventions to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual healthcare practitioners. Our Advice service is uniquely placed to analyse and reflect on the range of concerns about practitioner performance in the NHS and, by sharing these insights, we aim to support the healthcare system to better understand, manage and resolve concerns.

We have developed and piloted a programme on Compassionate Conversations, which aims to develop confidence and capability to have a compassionate conversation that is honest and engages with challenging subjects, particularly in relation to practitioner performance. The programme signposts the fundamental principles in compassionate leadership and focuses on building compassion into conversations about performance, specifically when concerns are raised.

We also piloted a system of analysis and reporting that will allow providers we work with to engage in a deep-dive, five-year analysis with their adviser on the cases opened and any associated activity. This allows organisations to reflect on themes and trends over time and to consider any improvement action in relation to managing performance concerns and remediation. These pilots have been carried out during the reporting period, which have led to improved roll-out plans in 2023/24.

In addition to our data on practitioner performance concerns and the causes of contracting disputes in primary care, we hold one of the largest databases of healthcare-related compensation claims in the world. The following section provides an overview of how we have used this data to improve patient safety and of improvements across the system.

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

Reflecting our second strategic priority, we are committed to ensuring that our unique data sets help derive useable insights that benefit patients and the healthcare and justice systems.

Against the current challenges facing the NHS and in supporting the NHS to implement ICSs, it is increasingly important to use our data to improve service delivery. We have two core approaches to sharing our data and insights: using information to identify emerging patient safety risks; and supporting a greater understanding of the causes of incidents, sharing these insights with stakeholders across the system. The following pages provide an overview of how we have delivered against these two core approaches in 2022/23.

Identifying patient safety concerns

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

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

To ensure that we appropriately identify and respond to any patient safety concerns we use a framework to manage concerns, which is overseen by our Significant Concerns Group.

The key aim of the framework is to ensure that the handling of each concern is appropriate, timely and robust, in line with the framework's overarching purpose. Concerns raised by any of our functions are considered by the Significant Concerns Group on a case-by-case basis, assessing the concern against a range of factors. The following case study[1] demonstrates our rapid and coordinated action across our services to help reduce the risk of avoidable harm. The framework considers notifications from individual functions and ensures a coordinated and consistent response at a corporate level where this is required.

[1] This is a composite case study with some facts altered to protect confidentiality. It is intended to illustrate how NHS Resolution's internal framework has operated to ensure we take prompt action to safeguard patients where an emerging or significant concern is identified during the course of our work.

Managing significant concerns: a case study

Our Claims service notified the internal Significant Concerns Group about concerns they identified in three cases about a doctor in trauma and orthopaedic surgery. These included serious concerns about his standard of clinical practice and that he had been rude to junior colleagues both on the ward and in theatre, with indications that the care provided to some patients had caused harm and led to claims of clinical negligence.

The Significant Concerns Group arranged for rapid and secure information gathering across our functions, including Claims, Safety and Learning, and Advice, to build a collective picture of the scope of the concerns. This activity, which used our digital search capability, identified additional claims involving the same doctor across a number of other trusts who had employed him previously. The claims were the subject of an urgent thematic review undertaken by NHS Resolution staff who drew on relevant clinical input. This review identified the need to establish from the trust currently employing the doctor whether the behavioural and clinical performance issues were fully understood, being addressed and action being taken to safeguard patients.

Urgent and coordinated contact was made by our Claims and Advice services with the trust medical director. Our aim in these circumstances is to help ensure that concerns raised about clinicians are managed and resolved in a fair, proportionate and timely way, with appropriate support made available. We believe that organisations should foster a just and learning culture which balances fairness, justice and learning when things have not gone as planned.

Advice was provided to the trust on assuring itself that there were sufficient and robust safeguards in place to contain any patient safety risks, including strengthening supervision arrangements and formal restrictions to the doctor's practice. It was also confirmed that the doctor was not working elsewhere. We encouraged open dialogue with the doctor about the themes arising from the thematic review and ensured that he was provided with appropriate support. Our Advice service went on to work with the parties to develop an action plan to address and resolve the performance concerns – both the trust and the doctor fully engaged with the support provided. In these circumstances, the trust retained responsibility for the direct management of the performance concern with support provided by our Advice service. Our Claims service continued to work with the trust to support the coordinated management of the claims related to this doctor.

The Significant Concerns Framework enables the effective sharing of information and helped to establish a clear pathway to provide support in line with our remit. The framework allows us to consider sharing information externally where we see evidence of harm or potential harm (for example, unsafe clinical practice). We may share information with other NHS bodies or those with responsibility for regulation in the healthcare system (for example, the General Medical Council). Our paramount consideration in these circumstances is patient safety and public protection. Our approach in this complex and sensitive area continues to develop, recognising that the first line of defence rests with healthcare organisations, augmented by the expert and tailored support that we offer through our range of services.

Our data and expertise also mean we can proactively share insights and analysis of the causes of incidents. On the following page we outline how we have used our data to share our insights across the healthcare system.

Improving service delivery

Supported by our Insights Programme (detailed on page 63), we have used our data science capabilities to:

- identify maternity units where analysis suggests that there may be a higher risk to patient safety;
- develop a centralised reporting tool, which includes claims data related to all maternity cases; and
- undertake an audit of clinical coding for emergency department claims.

Our Core Systems Programme (CSP), as described on page 63, will enable us to better understand the causes of incidents, increasing the potential to mitigate them.

As the CSP progresses we are continuing to improve our approach to using our data and insights, including digitalising all of our documents and implementing search capabilities so we can more efficiently identify important information contained in documents we hold, as highlighted by the significant concerns case study on page 53.

We share our insights, as described below in figure 16, in a range of ways and to a wide range of stakeholders across the healthcare system.

Figure 16: A selection of the products developed in 2022/23 in order to share our insights

Management

Learning from claims and cases

- An animation to explain how NHS Clinical Negligence Scheme for Trusts (CNST) contributions are calculated
- Updated guidance on inquest funding
- Insights papers on:
  - Who are the practitioners we advise on and are there any patterns of concerns?
  - Behavioural Assessments: findings from an in-depth qualitative and quantitative analysis
  - Professional Support & Remediation (PSR): key features of recent action plans
  - Insights from 10 years of supporting the management of exclusions in England
  - Insights from Primary Care
- Videos on:
  - An overview of our behavioural assessments
  - Drafting and reviewing Terms of Reference for a formal investigation
  - How to have Compassionate Conversations
  - Healthcare Professional Alert Notices

Events and webinars

- A range of forums for Member trusts and scheme beneficiaries
- A webinar on our analysis of our claims and cases data

Clinicians

Learning from claims and cases

- Clinical Negligence Scheme for General Practice (CNSGP): An overview of the first year (report)
- The second report: The evolution of the Early Notification Scheme report, webinar and animation
- Claims Scorecards 2022 – a learning from claims resource
- Early Notification Scheme case stories and guidance
- Diabetes and lower-limb complications: A thematic review of clinical negligence claims (report)
- Did you know? Guides to extravasation, anti-infectives and medication errors
- A podcast about preventing spinal infections

Events and webinars

- In-person maternity conference: Collaborate to improve maternity care: respond to, learn from and prevent harm
- Maternity clinical negligence indemnifiers roundtable: sharing best practice in learning and preventing maternity harm meeting
- Safety and Learning virtual forums focusing on:
  - Duty of candour
  - Emergency medicine
  - Anaesthetics

Our publications and training and learning modules are also complemented by the insights we share with our stakeholders through ongoing engagement and collaboration as outlined on page 22.

We have continued to support the GIRFT programme in producing standard consent forms to trial in the London area and in developing expert witness guidance.

This year we were also due to publish research into the readability of complaints correspondence, undertaken jointly with VoiceAbility and Browne Jacobson. We made the decision not to publish this work because we did not feel the conclusions from the research would add value to staff managing complaints on behalf of the NHS. We will instead continue to focus on our support to the PHSO's work on the Complaint Standards Framework, as described on page 49.

Some of our Insights work reflects the focus of our third strategic priority: collaborate to improve maternity outcomes. The following section provides an overview of what we have achieved in 2022/23 to improve maternity outcomes in England.

"The Case Investigator programme was an excellent course with the right balance of medics and non-medical staff present. It was aimed at the right level of seniority in the organisation. The course offers an excellent set of skills for anyone who is keen to keep patients safe, standards of clinical care high and professional integrity intact."

Head of Clinical Psychology, St Helens and Knowsley Teaching Hospitals NHS Trust

Strategic priority three: Collaborate to improve maternity outcomes

Both Donna Ockenden's final report into the maternity failings at Shrewsbury and Telford NHS Trust (May 2022) and the report of the independent investigation led by Dr Bill Kirkup on maternity and neonatal services in East Kent (October 2022) demonstrate that avoidable errors in maternity services still occur and that incidents have devastating consequences for the child, mother and wider family, as well as the NHS staff involved. We can never reverse the damage that has been caused but what we can do is play our part to support those affected by these incidents and to improve maternity care in the future. This is why we have included collaborating to improve maternity outcomes as a standalone priority; aiming to bring together key parties to determine what further improvements can be made in our areas of expertise to support the Government's maternity safety ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2025.

The following section provides an overview of the volume and cost of harm in maternity care, before focusing on our work to improve the experience of patients and their families impacted by avoidable errors in maternity care.

As figures 17 and 18 highlight, in 2022/23 obstetric claims accounted for 13.1% of clinical claims reported (excluding General Practice Indemnity, GPI) by volume but accounted for 64% of all clinical claims by value received in the year (compared to 62% in 2021/22). These include claims reported under our ENS described on page 59. A breakdown of the financial value of obstetric claims is shown in figure 19.

Figure 17: Total number of clinical claims received in 2022/23 by speciality[1]

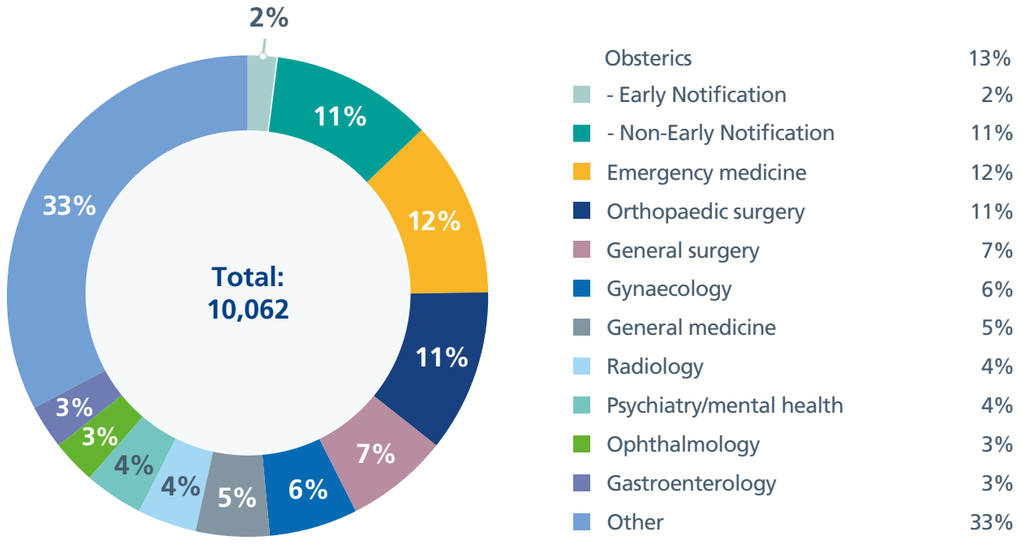
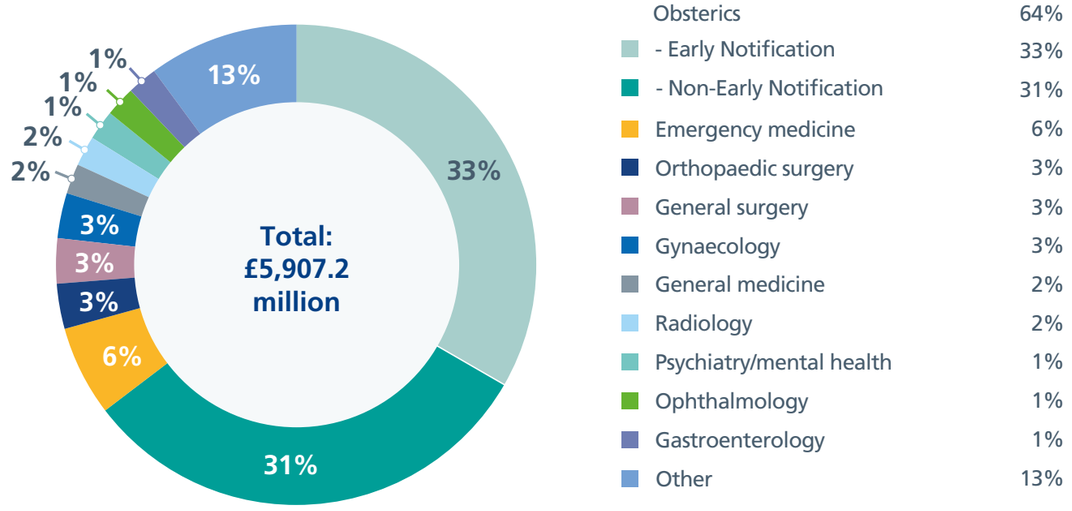


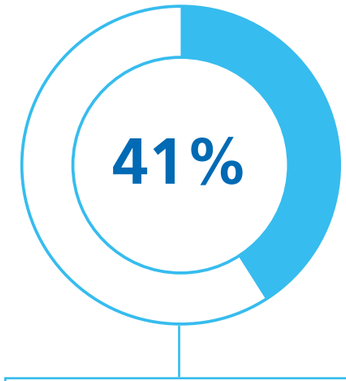
Figure 18: Total value of clinical claims received in 2022/23 by speciality[2]



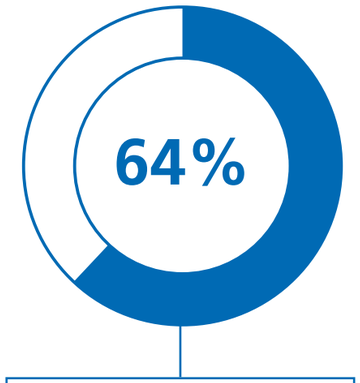
[1] Figure 17 includes all claims received against our CNSC, CNST, DH Clinical and ELS schemes. It does not include claims received against our GPI scheme. Obstetric care is defined as the care of women during pregnancy, childbirth and the period following delivery (typically 3–6 weeks).

[2] Figure 18 includes all claims received against our CNSC, CNST, DH Clinical and ELS schemes. It does not include claims received against our GPI scheme.

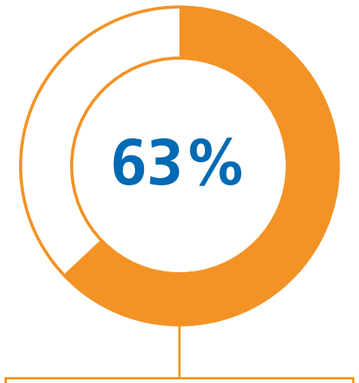
Figure 19: The financial value of obstetric claims as of 31 March 2023[1]



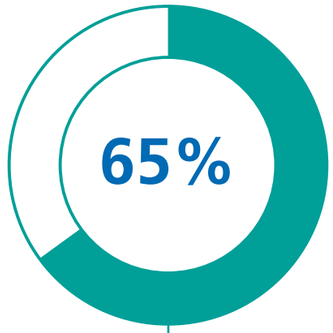
41% of the total clinical negligence **payments** (£2.6 billion) for 2022/23 relate to maternity. This is an increase from 38% in the previous year



64% of **notified claims by value** (£5.9 billion) relate to maternity. This is an increase from 62% in the previous year



63% of the total clinical negligence **cost of harm** (£6.6 billion) for 2022/23 relates to maternity. This is an increase from 60% in the previous year



65% of the total clinical negligence **provision** (£69.3 billion) as of 31 March 2023 relates to maternity. This is a decrease from 70% in the previous year

[1] This figure uses data from across all our clinical schemes.

Improving the experiences of patients and their families

With an awareness of the maternity claims profile described above, in May 2022, following the publication of the final report into the maternity failings at Shrewsbury and Telford NHS Trust, we critically reviewed our contributions to improving maternity services over the period on which the review focused (between the years 2000 and 2019). We published the outcome of the review on our website. Our review found that we have made good headway in developing our services to support stakeholders involved in improving and delivering maternity services since 2009. This includes establishing our Safety and Learning service in 2013 and then in 2017 establishing our ENS and MIS. The following sections describe how we have continued to develop these schemes in 2022/23.

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

This is why, in 2017, we established our Early Notification Scheme (ENS), allowing us to investigate potential eligibility for compensation earlier than a standard obstetric claim and to take action to reduce legal costs while improving the experience for the patient's family and affected staff. You can see where our ENS intervenes before notification in our claims life cycle in figure 2. Seeking early notification of maternity incidents also encourages trusts to embed a fair and just learning culture, being open and transparent with families and seeking opportunities to learn. The scheme has already achieved reductions in the time between an incident occurring and an admission of liability being made, monitored as one of our KPIs on page 29.

Figures 20 and 21 provide an overview of the year-on-year movement in the volume and value of cerebral palsy and brain damage claims over the last 10 years. Since the introduction of the ENS, the number of non-ENS cerebral palsy/brain damage claims being notified is steadily reducing over time, as expected. As the volume of admissions of liability under the ENS increases[1] so does our ability to provide financial support to families when they need it the most. As such, the number of interim payments made on these claims has increased and we are beginning to see claims where final settlements can also be agreed. This, coupled with inflationary pressures on claim values, has led to an increase in the value of the payments made.

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

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

What is the Early Notification Scheme?

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

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

Figure 20: The total number of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2013/14 and 2022/23[1]

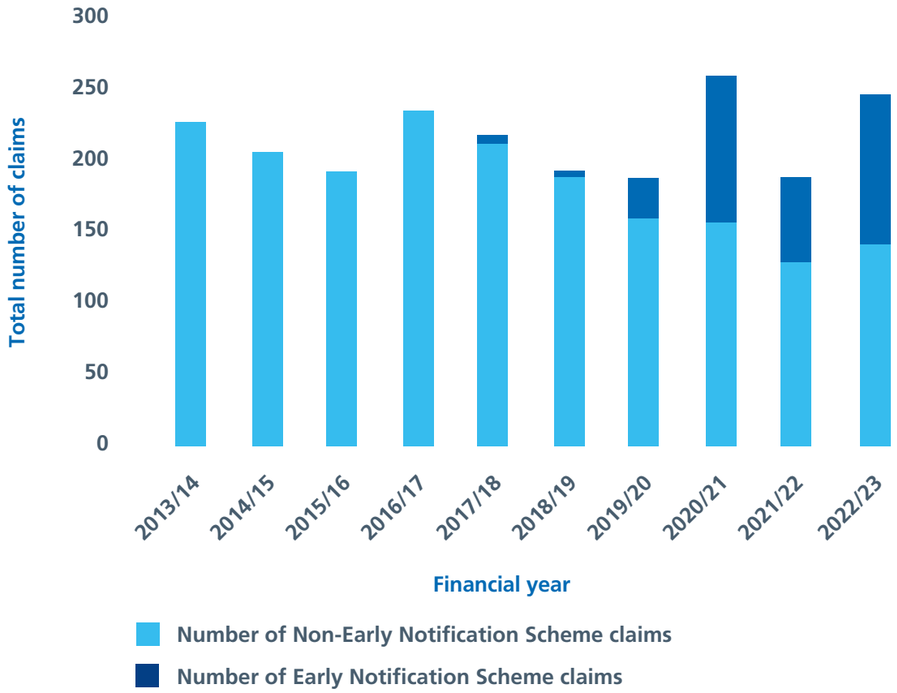
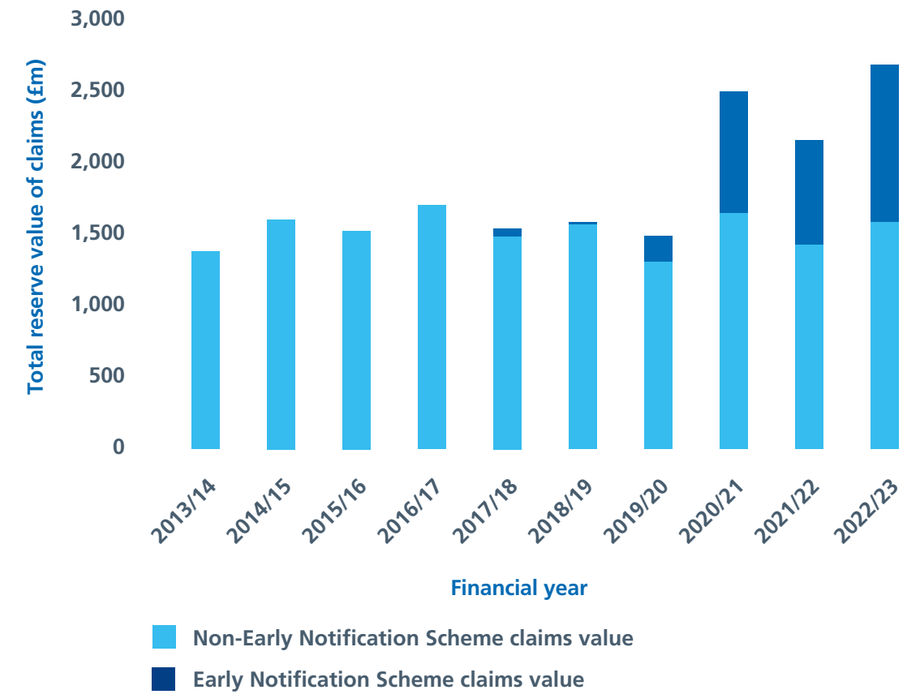


Figure 21: Total reserve value for obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2013/14 and 2022/23



[1] Given the ENS started in 2017, data reporting reflects 2017/18 onwards. Note that for ENS claims the reported year reflects the year in which the incident was identified as a claim and not the year the incident was reported.

In September 2022, building on our first report detailing the development of the first year of the ENS, we published our second report, *The evolution of the Early Notification Scheme*, which detailed some of the scheme's achievements including:

- providing families with an opportunity to support future service developments in the ENS via our Maternity Voices Advisory Group.
- based on a sample[1] of claims, a reduction in the time from an incident occurring and investigations into eligibility for compensation to an admission of liability from 80 months to less than 18 months[2];
- a reduction in average defence legal costs compared to non-ENS claims with the average defence legal cost for the ENS cohort being approximately one third of the cost for the non-ENS cohort (£11,738 compared to £34,219); and
- The ENS has also received positive feedback from families.

> "The Early Notification Scheme worked very well for our son and for us as a family. It accelerated the investigation process and resulted in an early admission of liability, which meant we received interim payments as our son's claim continued. This was so helpful as it meant we could access support and rehabilitation for him when it was needed. It was really beneficial to be able to put in place care, therapy, aids and equipment, and accommodation at an early stage."
>
> **Quote from a family member involved in our ENS**

While the scheme has enabled us to improve the experience of patients and their families, it also helps ensure steps are taken to learn from things that have gone wrong in order to improve maternity care. In addition, it promotes sharing good clinical practice including:

- recommending six key areas for national maternity care improvement;
- working with a range of stakeholders to develop the DHSC funded Avoiding Brain Injury in Childbirth (ABC) Programme[3] to take a standardised approach for intrapartum fetal monitoring and escalation, with associated training;
- highlighting problems with neonatal resuscitation which have been subsequently integrated into the Safety Action 8 of the MIS; and
- identifying a new issue with impacted fetal head at caesarean section and working with the system to create national guidance and algorithms for stepwise management, with an associated training programme.

Later this year we will commence an evaluation of the ENS. The planned evaluation will focus on the impact of earlier investigation on clinical outcomes, legal admissions and on the experiences of families and clinicians involved in claims. In addition to the ENS we also deliver the MIS to encourage trusts to improve the safety of their services. The following section outlines how the scheme has progressed in its fourth year of operation.

[1] Sample based on 10 ENS cases with 10 claims that followed a more traditional claims route (i.e. where a claimant would serve a Letter of Claim on the defendant and investigations would follow in accordance with the Pre-Action Protocol and Civil Procedure Rules) where liability was admitted following a Letter of Claim, measuring the average time taken from birth to notification and subsequent admission of liability (we have called these 'non-ENS' claims).

[2] This measurement differs from KPI 19 which tracks time from notification (not incident) to liability decision and covers the period from April 2022 onwards only.

[3] The ABC programme is funded by DHSC and is a collaboration between the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG) and The Healthcare Improvement Studies (THIS) Institute.

Improving the safety of maternity services

Following a decision in 2021 to pause the MIS due to the impact of Covid-19 on frontline services, in May 2022 we relaunched the scheme, with revisions of the safety actions in consideration to the findings of the Ockenden Report, and extended the submission period until February 2023.

In year four of the MIS 122 trusts participated, with 51.6% (63) of trusts declaring compliance with all 10 safety actions compared to 74% in 2021/22. Where trusts had lower rates of compliance compared to the previous year, it is likely that this is due to the impact of the challenges faced by the NHS as outlined on page 21. For those trusts that were unable to achieve all 10 safety actions this year, more safety improvement funding has been made available under the terms of the MIS to support these trusts on their improvement journey.

Like the ENS, the MIS provides opportunity to identify and share early intelligence regarding potential maternity safety concerns with maternity stakeholders. We share early intelligence in relation to maternity and neonatal services via our Collaborative Advisory Group (CAG)[1] of which membership includes other ALBs and royal colleges. Throughout 2023/24 we will undertake a detailed evaluation of MIS, including learning from international indemnifiers. In addition, and as outlined on page 10, our Advice service has identified further opportunities to tailor our service review intervention specifically for the context of maternity services and we are beginning to explore how this might best be taken forward.

As we continue to deliver against our third strategic priority we will continue to rely on improvements across our systems and services, as detailed under our fourth strategic priority in the next section.

What is the Maternity Incentive Scheme?

The Maternity Incentive Scheme (MIS) works by creating an incentive fund by charging trusts an additional 10% of trusts' maternity contribution to the CNST indemnity scheme. Trusts that demonstrate they have achieved all ten safety actions recover their 10% contribution and will also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions do not recover their contribution but may be eligible for a smaller discretionary payment to help them make progress against any actions they have not achieved. Trust submissions are checked against Care Quality Commission (CQC) findings in addition to a range of other external verification points.

[1] Members of the group include DHSC, NHSE, RCOG, RCM, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), the Royal College of Anaesthetists, the Care Quality Commission (CQC) and the Healthcare Safety Investigation Branch (HSIB).

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

Our fourth strategic priority focuses on developing our people, systems and services so that we can continue to deliver best value for public funds. We are taking a pragmatic and paced approach to our two key transformation programmes, the Core Systems Programme (CSP) and the Claims Evolution Programme (CEP), allowing us to be responsive to changes in the NHS, the external environment and the needs of our stakeholders.

Our transformation programmes

The CEP is designed to deliver optimal claims management service to the NHS, improving financial and operational efficiencies to all stakeholders we interact with. The four-year programme will deliver a new operating model which will result in a single, integrated claims function with a supportive organisational structure that avoids duplication of effort and allows teams to develop their skills.

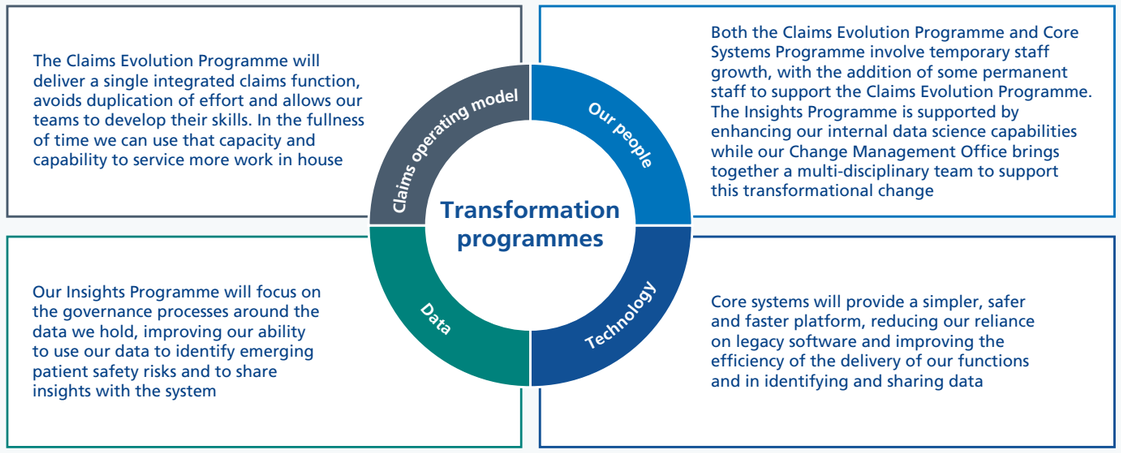
In September, as part of the CEP and reflecting the implementation of ICSs, we moved to a new regional model for provision of legal services, creating regional-facing Claims services supported by regionally aligned legal panel firms[1]. This will result in stronger relationships with members and align our work across all our services to improve the sharing of insights and identification of potential patient safety risks via our Significant Concerns Framework.

In January our Claims Support Service also went live, piloting support for case managers to undertake less administrative work and focus more on technical case work.

In March we also launched our CSP (named CaseHub), delivering the first release for our service described on page 64. The longer-term ambition is that the CSP will replace our legacy case management systems. Over time, the new system will increase our potential to use the data we hold to gain insights into the healthcare system and to support efficiency in conducting our daily operations.

As we deliver these programmes, we are committed to improving our processes. We continue to ensure that we deliver our functions to meet agreed standards and within our Departmental Expenditure Limits.

Figure 22: Transformation programmes



[1] See further: Legal firms appointed to NHS Resolution legal panel, NHS Resolution.

Our delivery models

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

Our Insights Programme draws on our data and is designed to help us realise our second strategic priority: share data and insights as a catalyst for improvement. The first phase of the programme has focused on the governance processes around the data we hold, including enhancing our internal data science capability, an example of which can be found on page 54. A central part of this work, and demonstrating our commitment to maintaining strong and collaborative relationships with our stakeholders, was gaining feedback from our scheme members in relation to our claims scorecards, in addition to engaging with GIRFT and ICSs about the data we hold. This feedback will help us identify improvements in what data we share, how we share that data and how best to co-ordinate the insights gained from that data with key system-wide stakeholders.

In 2022 we launched our People Strategy, which sets out the people-related activity required to support implementation of our strategy to 2025, described in more detail on page 113. Reflecting our fifth People Strategy pillar, Organisation Change and Transformation, we have established a Change Management Office to ensure we are supporting our staff through a concerted period of transformational change. Our achievement of Investors in People (IiP) Gold is evidence of our commitment to having an engaged and effective workforce throughout this period of change.

This year, the Change Management Office supported the Advice service to implement a pilot for advisers to trial CaseHub capability and business process requirements. The pilot will test how easily advice users (both our own staff and external stakeholders) are able to access case information, allowing us to collect feedback to refine our approach throughout the wider implementation of the CSP.

We are committed to delivering our transformation programmes and services in a sustainable way, as described in our Sustainability report in the following section.

Sustainability report

Our contribution to the Greening Government Commitment (GGC) to reduce greenhouse gas and emissions continues to support the Estates and Operations Strategy set by DHSC and the Government Property Agency's Net-Zero Estates Strategy.

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

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

We've continued to house our IT systems in data centres that are compliant with the environmental management system standard (ISO 14001) and are the UK's most efficient. They run on 100% renewable energy and emit minimal emissions, which helps to maintain a lower carbon footprint. IT asset recycling continues to be used through a reputable supplier that ensures zero waste goes to landfill, and we will repurpose and recondition some of our oldest endpoint estate equipment to remain reusable and compatible with Windows 11.

10 South Colonnade's action plan has largely been focused on improving building energy efficiency and performance, sourcing sustainable supply chains and waste streams. The building is now largely reliant on renewable electricity, with future plans in place for total de-gasification of the site. Biodiversity projects are also being discussed with the Canary Wharf Management for the surrounding area. The newly built Leeds Hub is under the management of HMRC and has not published figures for this financial year so has not been included in the following tables.

Our newly formed and staff-led Sustainability Network is aiming to achieve a net-zero carbon footprint and have a collective influence on the NHS's wider strategy. The network is currently focusing on establishing our operation CO_2 baseline and reductions strategy in addition to looking for further opportunities to make our procurement practices sustainable.

Data published for the financial years 2017/18 to 2022/23

The following data is sourced from our respective landlords and external IT supplier and indicates an overall reduction in CO_2 emissions since baseline year. Although figures are recorded against the local efficiency of two different buildings, there has been a positive decline in CO_2 levels that can be attributed to each building's efficiency initiatives.

Table 2: Greenhouse gas emissions in each financial year from 2017/18 to 2022/23

Greenhouse gas emissions (tonnes CO_2)	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Gross emissions for scope 1 Electricity	107	52	48	86	79	85
Gross emissions for scope 2 Gas	18	18	19	20	15	2
Gross emissions for scope 3 Business travel	24	44	38	2	5	20

Since last year there has been an increase in electrical consumption as staff have returned to office working since the pandemic. Although this increase is expected, the switch to a 100% renewable energy tariff has helped to maintain a lower level of CO_2 emissions. Gas demand has gradually reduced as the building moves away from gas reliant services.

Table 3: Building energy consumption in each financial year from 2017/18 to 2022/23

Building energy consumption		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Electricity	Quantity (MWh)	304	184	188	144	252	310
	Cost (£)	38,113	22,411	23,566	17,581	49,308	49,075
Natural gas	Quantity (MWh)	98	99	103	58	10	7
	Cost (£)	4,351	4,460	4,603	2,590	1,260	449

Our off-site electricity demand has increased as more IT systems are moved to our data centres. IT storage locations run on 100% renewable energy, emit minimal emissions and are deemed a far more sustainable option than on-site storage. Options to streamline and move our systems to Microsoft Cloud are being considered.

Table 4: Data centre electrical energy consumption in each financial year from 2020/21 to 2022/23

Data centre consumption		2020/21	2021/22	2022/23
Data centre 1	Quantity (MWh)	8.5	11.7	12.4
Data recovery 2	Quantity (MWh)	6.3	6.3	7.1

As with energy consumption, travel has gradually increased post-pandemic, albeit far less than baseline year due to the increase in efficient IT communication services and streamlined operational methods.

Table 5: Mileage and cost for road, air and rail travel in each financial year from 2017/18 to 2022/23

Travel		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Road	Miles	46,203	42,966	47,890	9,465	8,080	15,792
	Cost (£)	25,874	23,624	29,399	5,622	4,976	8,843
Air	Miles	42,873	43,683	49,553	0	0	54,332
	Cost (£)	12,510	11,356	14,100	0	0	5,443
Rail	Miles	333,172	290,131	371,925	6,015	39,817	142,544
	Cost (£)	112,160	115,979	162,886	1,573	15,049	57,054
Total mileage		422,248	376,780	469,368	15,480	47,897	212,668

Air miles recorded for 2022/23 relate to five members of staff who visited the team based in India which is undertaking the development work for the Core Systems Programme.

According to waste data received, we still achieve 100% diversion from landfill, therefore the figures recorded from 2020 onwards are associated with recycling waste streams only.

Table 6: Waste quantity and cost in each financial year from 2017/18 to 2022/23

Waste	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Quantity (tonnes)	12.7	14.6	12.8	5.2	6.0	6.6
Cost (£)	1,563	1,805	549	639	702	2,972

Water usage has increased since the return to office post-pandemic. Additional flushing of water systems has also been introduced throughout 10 South Colonnade to prevent stagnation in low occupancy areas. Paper consumption is still significantly lower than baseline year due to more efficient paperless IT systems.

Table 7: Use of finite resources in terms of water consumption and paper in each financial year from 2017/18 to 2022/23

Use of finite resources		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Water consumption	Quantity (m^3)	1,400	1,343	1,561	339	367.5	568
	Cost (£)	3,370	3,233	3,680	815	934	1,655
Paper	Quantity (reams)	2,655	2,500	1,805	80	20	60
	Cost (£)	6,662	5,570	4,099	178	49	208

Finance report

Headlines in numbers

- The provision for the liabilities arising from claims has decreased by £58,936 million (45.8%) from £128,550 million to £69,614 million, primarily due to the change in HMT discount rates, a technical accounting change affecting the provision.
- The total estimated cost of clinical negligence claims under CNST incurred as a result of incidents in 2022/23 was £6,278 million, down from £13,285 million the previous year. The change in the discount rates set by HMT has significantly affected this value. The expected value would have been £12,631 million if discount rates had stayed the same as in 2021/22.
- Payments for settling claims in 2022/23 increased by £232.4 million (9.5%), to £2,690.9 million.
- Administration costs increased by £7.9 million (18%) to £52.1 million.
- Budget position:
  - Departmental Expenditure Limit (DEL): expenditure was £53.6 million (1.9%) under budgeted income and funding.
  - Annually Managed Expenditure (AME): £21,655 million (58.1%) under budget.

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

Year-end provisions

The provision is the value of liabilities arising from incidents that occurred before 31 March 2023, both in relation to claims received and our estimate of claims that we are likely to receive in the future but have yet to be reported as claims (incurred but not reported, IBNR). Figure 23 on page 69 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

The provision has decreased by £58,936 million (45.8%) to £69,614 million. The most significant factor, accounting for a £74,604 million reduction, is the increase in the discount rates set by HMT. The discount rates are designed to recognise the value of money over time: generally speaking, £1 in the future is worth less than £1 now, because of the interest that could be earned by investing £1 today. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings in today's terms. At a high level, it tells us how much it might cost to settle those obligations today or at the balance sheet date (31 March). In accordance with International Financial Reporting Standards, HMT has applied market rates which reflect the cost of borrowing to Government. The increase in the discount rates is further outlined in Notes 7.2 and 7.3 to the Financial Statements.

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

This significant reduction has been partially offset by an increase in the provision arising from another year's worth of activity, and a net increase in the impact of changes in assumptions affecting the provision. However, it should be noted that reported claims numbers are slightly lower than expected, and average claims costs are growing at a slower rate than previously assumed. We have also reduced the long-term claims inflation assumption slightly againin 2022/23.

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 2022/23 covered by our CNST was £6,278 million (see Note 2.1 to the Financial Statements). This figure is materially lower than the previous year's figure of £13,285 million owing to the changes in HMT discount rates, which places a much lower value on projected claims costs.

If HMT discount rate changes for 2022/23 were not applied, the equivalent cost of harm for CNST for 2022/23 would have been £12,631 million. This figure is slightly lower than the corresponding 2021/22 cost of harm figure of £13,285 million. The decrease is mainly due to a reduction in projected claims numbers for PPO claims, as well as a lower long-term claims inflation assumption for these claims.

The estimated financial impact of Covid-19 on the provision

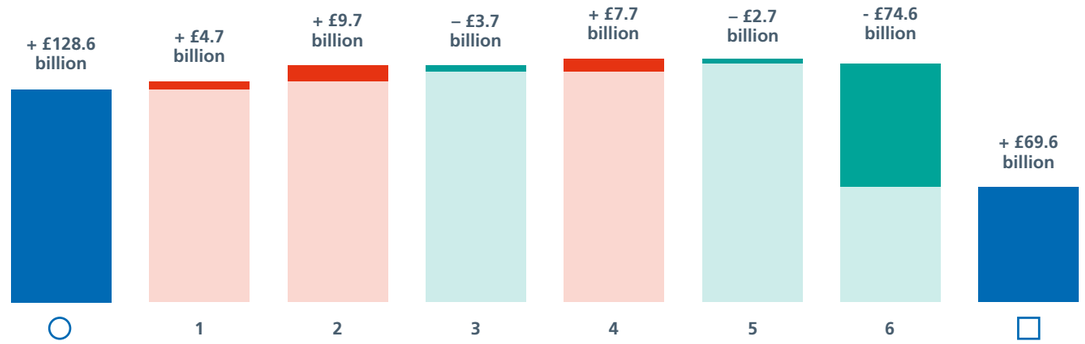
The estimated impact of Covid-19 on the provision continues to be limited because the majority of the provision relates to maternity claims (65%), and we have no evidence to suggest that the pandemic will alter the number or cost of these claims. The total IBNR provision in respect of Covid-19 of £1.5 billion is estimated across all NHS Resolution schemes, which is an overall increase of £0.2 billion from last year. The main impacts of Covid-19 on the IBNR provisions include the following:

- As described on page 16, we are seeing a reduced number of claims arise from clinical activity in 2020/21, potentially reflecting a reduced volume of elective procedures carried out during the acute period of the pandemic in addition to the wider disruption to the NHS during this time. As the NHS focuses on pandemic recovery and the elective recovery backlog, some activity has returned to pre-pandemic levels for 2021/22 and 2022/23. The impact is now assumed to be fully reflected in the claims already reported for 2020/21.
- We continue to allow for the possibility of new risks and potential claims – for example in relation to the treatment of Covid-19. Generally, the number of reported claims has been towards the lower end of the ranges previously considered, which acts to reduce the provision. This is offset by potential claims from exposure to a further year of such risks arising from clinical activity over the last year. Overall, these new risks and potential claims increase the IBNR provisions by £0.1 billion.
- We also continue to allow for additional potential claims arising from delays, cancellations and misdiagnosis. Such provisions this year have increased by £0.2 billion.
- It is partly offset by reduction on IBNR provisions of £0.1 billion due to lower than previously expected claims and exposure to incidents for other Covid-19 response activities such as vaccination.

The high-level approach adopted to quantifying the impact of Covid-19 on the provisions is discussed in Notes 7.2 and 7.3 to the Financial Statements on page 148. The following pages provide an overview of the change in provision for all schemes in 2022/23.

Provision for all schemes in 2022/23

Figure 23: The change in NHS Resolution's provisions for all schemes from 31 March 2022 to 31 March 2023



○ **Total provisions as at 31 March 2022**

1 Projected IBNR increase calculated on start of year (2022 assumptions)

2 Newly reported claims

3 Movement in IBNR due to updated assumptions

4 Movement in existing claims due to changes in data assumptions

□ **Total provisions as at 31 March 2023**

5 Payments made in year

6 Movement in provisions due to change in HMT prescribed discount rates, including change in inflation basis

Note: figures may not sum due to rounding

Items 1 and 2: Liabilities from another year's worth of activity in 2022/23 for all schemes for all incident years are £14.4 billion.

Item 3: shows a decrease of £3.7 billion due to changes in assumptions affecting the IBNR provision. The main drivers of this decrease are in the CNST IBNR, which is the most material component, where there has also been a £3.7 billion reduction, including:

- A decrease of £2.6 billion in respect of claim number projections. In general, reported claim numbers are lower than expected. This is particularly the case for claims likely to settle with PPO damage payments which make up the majority of the IBNR provision.
- A decrease of £0.7 billion following an update to the long-term inflation assumptions. This reduction is particularly driven by a lowering of the long-term inflation assumption in respect of PPO damages, supported by recent trends in settled claim costs.
- A decrease of £0.6 billion for 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.
- An increase of £0.2 billion in respect of lag and payment patterns, updated mortality assumptions in respect of potential PPO claims and updated probability assumptions in respect of paying damages.

Item 4: The liability has increased by £7.7 billion in respect of changes in data (such as reserve values and other data held for individual claims) and assumptions affecting known claims. The known claims provision is impacted by the changes in inflation and Annual Survey of Hours and Earnings (ASHE) assumptions.

Of this increase, £4.9 billion relates to the updating of probability percentages for claims that are expected to settle with damages payments.

In 2022/23, the known claims provision continues to be calculated using an actuarial view of the timing of cash flows based on historical claims settlement patterns, although the approach has been further refined for this year's calculation.

Item 5: £2.7 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 PPO. This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2017/18 financial year), the number of PPOs in payment was 1,994 with £211 million paid out that year, and a whole life value of £16 billion (21% of the total provision of £77 billion). At the end of this financial year (2022/23), the equivalent figures were 2,649, £384 million and £16.4 billion respectively (24%).

Item 6: There is a significant decrease in the provision of £74.6 billion due to increases in the discount rates specified for use by HMT, which has been discussed on page 67 of the Finance report.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the legal environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. Resulting small changes in assumptions as well as changes to discount rates reflecting the financial/market environment, as described above, can have significant impacts on the provision from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail in Note 7.2 in the Financial Statements section of this report, on page 148.

In-year financial performance

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

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

Table 8: Clinical schemes financial performance

Clinical schemes	2022/23 Income/ budget (£ million)	2022/23 Expenditure (£ million)	2022/23 Under/ (over) spend (£ million)	2022/23 Under/ (over) spend Percentage	2021/22 Expenditure (£ million)
Member funded – CNST	2,431	2,409	22	1%	2,237
DHSC funded schemes	145	130	15	10%	104
GPI	141	140	1	0%	94
CNSC	2	1	1	50%	-
Total clinical schemes	**2,719**	**2,680**	**39**	**1%**	**2,435**

Indemnity schemes in-year financial position

Expenditure on clinical schemes against income and budget set by DHSC is shown in table 8. These costs include NHS Resolution's own administration costs.

What is the Departmental Expenditure Limit (DEL)?

The DEL is a HMT budgetary control, which covers income and spending on general administration costs, e.g. salaries and goods and services, but also the settlement (utilisation) of the provisions in the financial year. HMT Consolidated Budgeting Guidance can be found at www.gov.uk/government/publications/consolidated-budgeting-guidance-2017-to-2018

CNST is our largest scheme and has the majority of the underspend against budget. In recognition of the slowing of claims inflation rates, total funding for CNST for 2022/23 was reduced by £28 million (1.1%) from the previous financial year.

Payments on CNST claims and scheme administration increased year on year by £172 million (8%), following on from a £158 million (8%) increase in 2021/22. Expenditure was within 1% of income collected from members. Income from members has been increased by £228 million (9%) to £2,659 million in 2023/24 in the expectation of a continued trend in increasing claims costs.

The year-on-year increase in CNST spending has been driven by a £146 million (17%) increase in spending on claims valued at over £3.5 million, primarily in damages payments. A further additional £42 million (16%) was incurred in relation to the structured settlement element of PPOs.

NHS legal costs of CNST have increased by £2.3 million (2%) year on year. Within this, expenditure on claims with a value of over £3.5 million increased by £7 million year on year.

For both damages and NHS legal costs, these increases in spending in high-value claims were partially offset by decreases in spending on lower-value claims.

Claimant legal costs decreased year on year for claims with a value of £250,000 but increased by £13 million overall.

As described on page 59, the ENS within CNST is still in its early stages of development and, due to the nature of the incidents notified to us, it may take some time to quantify and agree damages on a claim, particularly those high-value claims where a full assessment cannot be undertaken until a child has reached developmental milestones. The value of damages payments on the ENS has increased from £10.2 million in 2021/22 to £24.4 million as the scheme aims to support families in real time. Claimant legal costs have also increased by £1.1 million from £1.9 million to £3.0 million, as claims are now progressing. NHS legal costs have seen a small increase of £0.3 million to £4.3 million by maintaining a streamlined approach to investigating cases.

Expenditure on DHSC and GPI schemes also increased year on year. A number of high-value claims settled against the DHSC clinical scheme in 2022/23 as expected. Similarly, a small number of claims with high-value damages settlements on the ELSGP are the primary driver for the year-on-year increase in GPI scheme expenditure.

Very few claims have been received for the CNSC, an indemnity scheme set up as part of the response to Covid-19. £0.2 million has been spent on dealing with claims, with a further £0.5 million spent on administration costs (including corporate overhead costs).

Table 9: Non-clinical schemes financial performance

Non-clinical schemes	2022/23				2021/22
	Income/ budget (£ million)	Expenditure (£ million)	Under/ (over) spend (£ million)	Under/ (over) spend Percentage	Expenditure (£ million)
Member funded – LTPS	51	41	10	19%	49
Member funded – PES	8	8	0	2%	4
DHSC funded scheme	9	6	3	32%	7
CTIS	-	-	-	0%	-
Total non-clinical schemes	**68**	**55**	**13**	**19%**	**60**

As table 9 shows, expenditure on LTPS has decreased by £8 million (16%) compared to 2021/22, with most of this occurring in £1 million to £3.5 million value claims (the highest-value tranche for LTPS claims).

Expenditure on the Property Expenses Scheme (PES) is volatile and it is difficult to predict due to the nature of claims received under this scheme. No claims have been received for the Coronavirus Temporary Indemnity Scheme (CTIS), and £0.2 million has been spent on administration (including corporate overhead costs).

What is Annually Managed Expenditure (AME)?

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

We also have a budget for AME in respect of the net movement in provisions for all the indemnity schemes, such as the change in the provision less any provisions settled in the year. The budget is set in line with the Parliamentary timetable, but this is before the work on setting the key assumptions from observed experience has commenced. Prudent estimates in relation to key potential variables are therefore used to inform the budget, in discussion with DHSC and HMT.

As detailed in table 10, a negative budget of £37,281 million was set as HMT discount rates were published in advance of the forecast being submitted to DHSC and it was therefore possible to provide an estimate of the significant reduction they were likely to generate. The underspend of £21,655 million consists of the following variances:

- an allowance for the risk of unfavourable movements in IBNR and known claims assumptions was made of which £11 billion was not used;
- favourable changes in IBNR assumptions in PPO claims numbers, average cost of claims and claims inflation reduced the provision by £3.9 billion; and
- the known claims provision was £6.8 billion lower than expected in the budget due to favourable changes in assumptions and methodology.

Table 10: Annually Managed Expenditure

Annually Managed Expenditure	(£million)	(£million)
Budget		(37,281)
Expenditure		
Net cost of claims provision	18,359	
Change in discount rates	(74,604)	
Settlement of provisions	(2,691)	
Total expenditure		(58,936)
Under/(over) spend		**21,655**

Administration costs in-year financial performance

Administration costs for all our activities (including the costs of administering member-funded schemes and GPI arrangements which have been allocated to the scheme DEL budgets above) have increased by £7.9 million (18%) to £52.1 million. This primarily relates to staffing costs, as average full-time equivalent staff numbers have increased by 64 (13%) to 556. The costs of a further 22 full-time equivalent staff were charged to capital projects bringing our total to 578 full-time equivalent staff members.

In addition, this year we have generated £981k (£935k in 2021/22) of income from commercial activity in respect of activities and services to NHS bodies and other national governments delivered by our Advice service. These activities made a small loss of £16k (1.6%) during the year (£142k surplus in 2021/22).

As highlighted in figure 24, the average administration cost of resolving claims has increased in recent years as a result of our investment in staffing to meet our widened remit and objectives in tackling the broader drivers of claims costs to minimise costs overall.

Figure 24: Administration spend as a percentage of annual total claims settlement costs

As a proportion of the value of total claims settlements, administration costs have increased from 1.5% to 1.6%. Administration costs have continued to increase at a faster rate than claims payments, although this has slowed compared to the 25% growth in the administration cost base in 2021/22.

We have continued to expand our operations this year to handle the increasing volume of claims being received from the maturing CNSGP. GPI scheme claims require more activity from our staff compared to claims against secondary care providers as the latter have legal services to support with the administration of the claim.

The growth in administration costs relative to claims settlements was due in part to the expansion of the claims team to prepare for the new GPI schemes and take on existing claims in bulk from previous insurers.

As described on page 63, the Claims service is also expanding in preparation for the next phase of the CEP, designed to deliver cost savings in the handling of claims. We expect that administration costs will continue to rise as a percentage of total annual claims settlement costs as a result.

We have also continued with the implementation phase of a replacement of our core IT operating systems, as well as other IT and digital projects to improve our infrastructure and analytical capabilities. Corporate support costs have increased in relation to provision of actuarial advice on our expanded range of indemnity schemes, and to assist with the delivery of the objectives of a growing and increasingly complex organisation. The transition to IFRS 16 Leases has also increased depreciation charges by £1 million.

Capital

There was £5.5 million in capital additions in the year, an underspend of £2 million against the budget of £7.5 million. The majority of the £5.5 million of capital expenditure is for the CSP, set up to replace our main operational IT systems, which is now into the second year of implementation.

IFRS 16 Leases has been adopted for 2022/23, resulting in leases for office accommodation being transitioned onto the balance sheet and creating an asset of £9.4 million (net book value) through a technical accounting change. However, the latter is not regarded as an addition, as the leases existed prior to 1 April 2022.

Cash

The balance has increased by £57.0 million to £605.7 million by the end of the year due to the in-year underspend on the member-funded schemes. We continue to discuss with DHSC the options for using cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. Funding for member-funded schemes is provided through the NHS finance regime, and any underspends incurred by NHS Resolution contribute to the management of the overall DHSC group financial position.

Expected future performance

Our business plan for the coming year aims to make our interactions with the NHS as easy as possible for hard-pressed NHS staff, ensuring that what we do as far as possible removes additional burden, helps in a tangible way with work to improve patient care and gives the best possible return for the investment in our expertise. To achieve this, we will also build on the success of our Covid-19 Clinical Negligence Protocol and continue to take a more collaborative approach to engaging with our panel and our members.

In parallel, we will also continue to build our external relationships and partnerships, in particular working with key stakeholders across the maternity system to support the Government's National Maternity Safety Ambition to halve the 2010 rates of stillbirths, neonatal and maternal deaths and brain injuries occurring during or soon after birth by 2025. Our planned evaluation of the ENS and MIS will support this aim and help us improve and build on both schemes, working with our Maternity Voices Advisory Group and others to ensure an effective and compassionate response to families affected by maternity incidents, in the current legal frameworks.

The impact of the environment in which we are working and the demand-led nature of our services means that much of our planned work for the year is targeted at delivering savings and efficiency, such as the development and launch of CaseHub. Our CEP will also move into a crucial next phase as we continue to seek, where appropriate, to reduce the number of claims that enter litigation, reducing stress to patients and staff and reducing costs through our dispute resolution.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2022/23.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 5 July 2023

Accountability report

Corporate governance report

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

Directors' report

NHS Resolution's Board

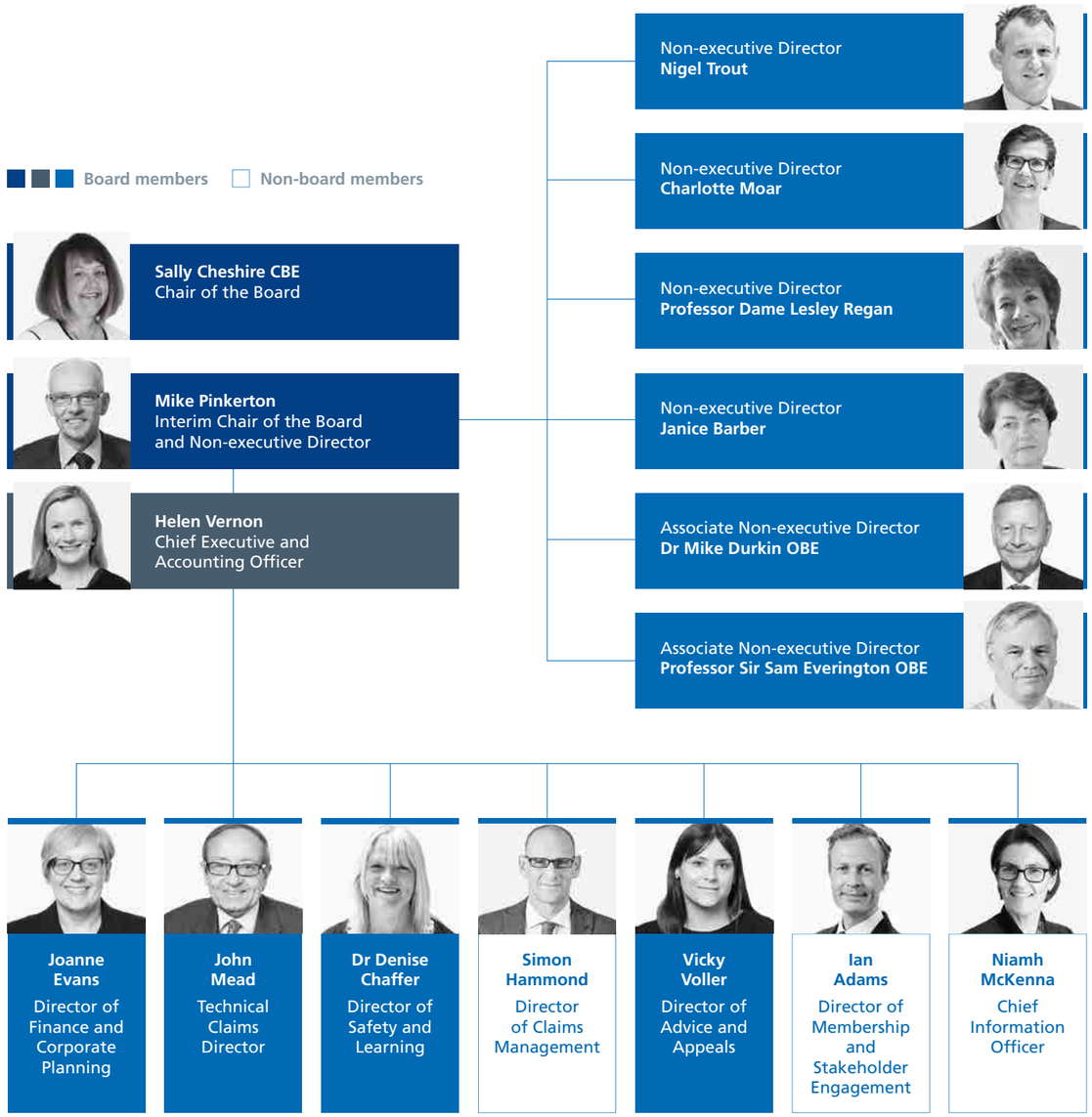
This report primarily provides information about the composition of the Board[1] of NHS Resolution. The Board had authority or responsibility for directing or controlling the major activities of the entity during the year and has responsibility for setting the strategic direction and risk appetite of the organisation. It is collectively accountable, through the Chair, to the Secretary of State for Health and Social Care for ensuring a sound system of internal control including implementing arrangements for securing assurance about the effectiveness of the organisation's governance[2]. Details of the Board's activities can be found on page 84.

Board composition

As of 31 March 2023 the Board consisted of a non-executive chair, four non-executive members and four executive members. There are also two associate non-executive directors and one associate executive director. The Board can consist of between three and five non-executive directors and executive directors.

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

Figure 25: NHS Resolution's Board in operation from 1 April 2022 to 31 March 2023[1]



[1] Sally Cheshire CBE started as Chair from 19 September 2022 and Mike Pinkerton's Interim Chair term of office ended at that time. Mike Pinkerton's term of office as Non-executive Director ended on 15 January 2023, with his last meeting as a Non-executive Director in December 2022.

Statement of Accounting Officer's responsibilities

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

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

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

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

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

Helen Vernon
Chief Executive and Accounting Officer

Governance statement

Scope of responsibility

As Chief Executive and Accounting Officer of NHS Resolution I am responsible for maintaining a sound system of internal controls that supports compliance with our policies and the achievement of our objectives while safeguarding public funds and our assets in accordance with HMT's guidance *Managing Public Money*[1].

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

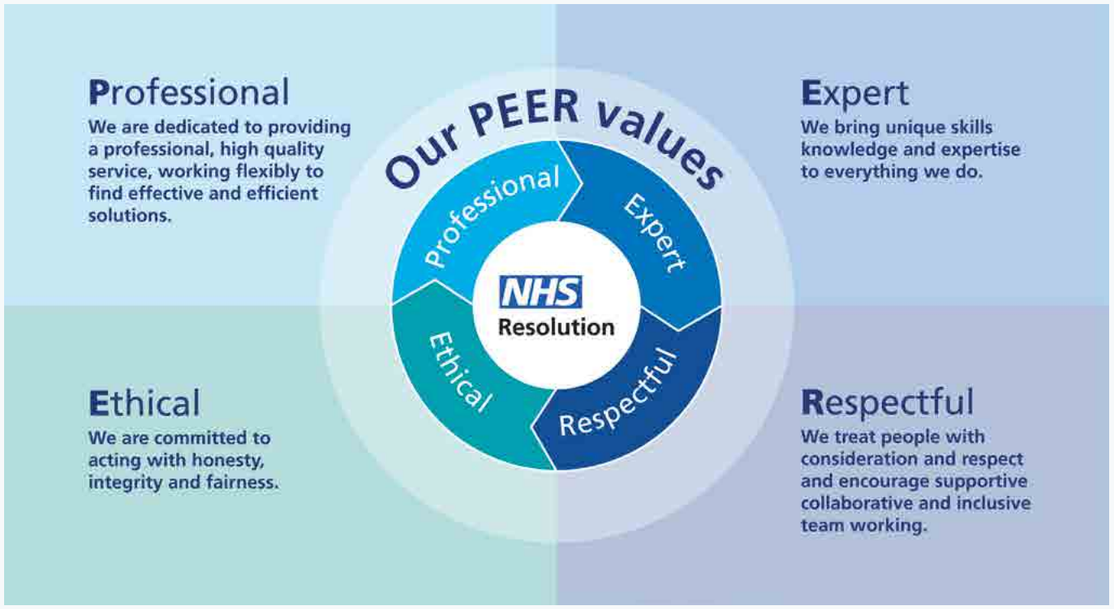
I am responsible for:

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

As Accounting Officer, I am supported by our Senior Management Team (SMT), internal audit and the ARC, and make recommendations to the Board on the matters outlined in this statement as they relate to effective governance. I am supported by the Board and SMT in ensuring we commit to and embed our aims and values, as outlined in figure 26, in everything we do.

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

Figure 26: Our PEER values

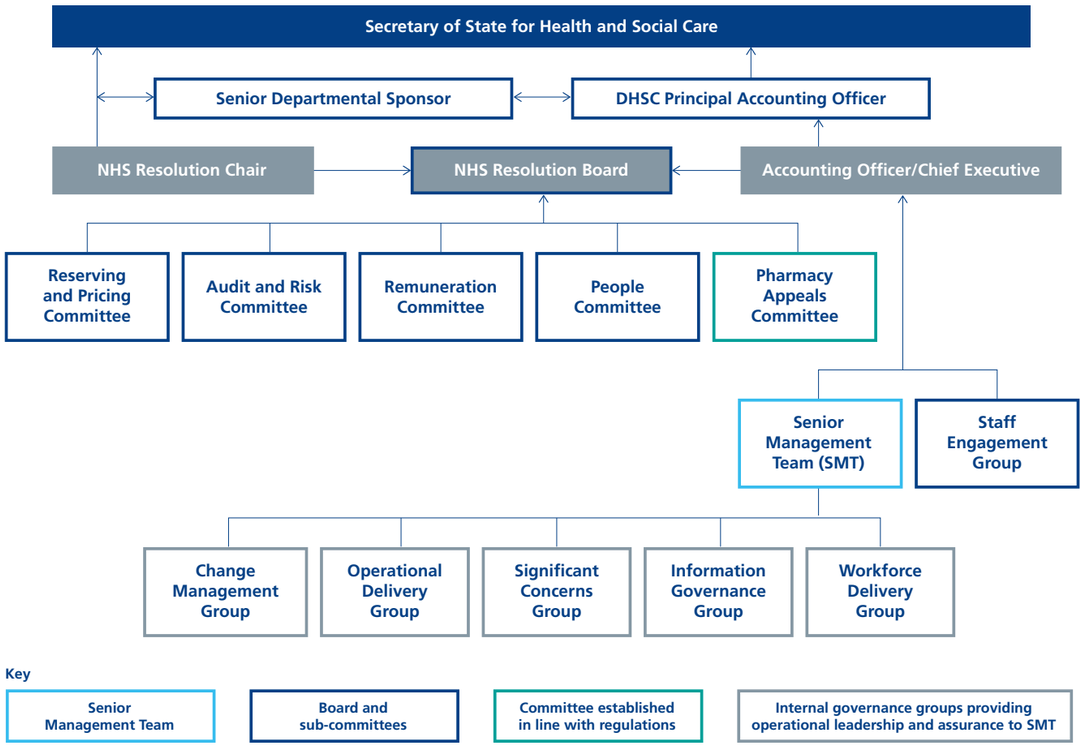


[1] *Managing Public Money*, MPM_Spring_21__without_annexes_040322__1_.pdf, publishing.service.gov.uk.

The governance framework and structures

Figure 27 outlines our governance structure and subgroups that report to the SMT, with the following sections describing the role of our Board and committees, the SMT and its sub-groups.

Figure 27: NHS Resolution governance structure in operation from 1 April 2022 to 31 March 2023



The NHS Resolution Board

Board activities

As NHS Resolution's Accounting Officer, I am supported by the SMT, internal audit and the ARC to provide assurance to the Board on the matters as they relate to effective governance. I provide reports on the organisation's performance to the Board and to DHSC on a regular basis in accordance with the Framework Agreement with DHSC. The Board regularly reviews these reports to ensure it remains satisfied regarding the quality of information, ensuring that it is relevant and sufficient to inform the business of the Board.

During the period from 1 April 2022 to 31 March 2023 the Board met on six occasions. Table 11 provides further information on the attendance of the Board at these meetings during 2022/23 and Table 12 provides an overview of the key matters considered at these meetings.

Table 11: NHS Resolution Board meeting attendance from 1 April 2022 to 31 March 2023

Name	Post	Meetings attended
Sally Cheshire CBE[1]	NHS Resolution Chair	3/3
Mike Pinkerton[2]	Non-executive Director and Interim Chair	4/4
Charlotte Moar	Non-executive Director	6/6
Nigel Trout	Non-executive Director	6/6
Professor Dame Lesley Regan	Non-executive Director	6/6
Janice Barber	Non-executive Director	6/6
Helen Vernon	Chief Executive	6/6
Joanne Evans	Director of Finance and Corporate Planning	6/6
Dr Denise Chaffer	Director of Safety and Learning	6/6
Vicky Voller	Director of Advice and Appeals	6/6
Dr Mike Durkin OBE	Associate Non-executive Director	6/6
Professor Sir Sam Everington OBE	Associate Non-executive Director	5/6
John Mead	Associate Board Member	6/6

[1] Sally Cheshire CBE started as Chair from 19 September 2022

[2] Mike Pinkerton's Interim Chair term of office ended on 18 September 2022. Mike Pinkerton's term of office as Non-executive Director ended on 15 January 2023, with his last meeting as a Non-executive Director in November 2022.

Table 12: Frequency of key matters discussed at Board meetings from 1 April 2022 to 31 March 2023

Operational matters

- Chief Executive's report **6/6 meetings**
- Performance review **6/6 meetings**
- Business plan (development) **2/6 meetings**
- Complaints report **2/6 meetings**
- Updates on inquries **3/6 meetings**

Management proposals requiring Board input or approval

- Annual report and accounts **3/6 meetings**
- Updates on key contracts and procurement (over £1 million) **4/6 meetings**
- Maternity Incentive Scheme (MIS) update **4/6 meetings**
- 2022 staff survey update **1/6 meetings**
- Responsible Officer's report **1/6 meetings**
- Insights reports **3/6 meetings**

Liaison with key stakeholders

- Liaison with key stakeholders **4/6 meetings**
- Engagement with integrated care systems **3/6 meetings**

Key developments

- Updates on key claims **4/6 meetings**

Project oversight

- Strategic activity update **6/6 meetings**

Other matters requiring Board approval

- Internal policy approvals and updates **5/6 meetings**
- Risk report **2/6 meetings**
- Risk appetite statement **2/6 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 with effectiveness reviews of the Board and ARC also taking the Code into account.

Board effectiveness

In 2022/23 the NHS Resolution Chair commissioned an independent effectiveness review of the Board and its subcommittees which include ARC, the People Committee and the RPC. The review started in January 2023 and concluded in March 2023. The outcome of the review highlighted that there is well established governance through the Board and its subcommittees. The Board and sub-committees are actively considering the report's findings and suggested recommendations, which should further enhance effectiveness.

Committees of the Board

The Board is supported by four committees which have been established to enable the Board, and me as Accounting Officer, to discharge our responsibilities and to ensure that effective financial stewardship and internal controls are in place. A review of the terms of reference for three of the committees was carried out in 2022/23.

Audit and Risk Committee (ARC)

The ARC supports myself and the Board in our responsibilities on matters related to internal and external audit, corporate governance, anti-fraud policies, internal control and risk management, as well as the annual report and accounts. The ARC is also supported by internal and external auditors. The ARC is chaired by a Non-executive Director and has two independent lay members. During the period from 1 April 2022 to 31 March 2023 the committee met on six occasions, which included two supplementary meetings in 2022/23 to consider endorsement of the 2021/22 annual report and accounts. The Chair of DHSC's ARC attended an ARC meeting held in May 2022. Table 13 provides further information on the attendance of ARC at these meetings during the period from 1 April 2022 to 31 March 2023.

Table 13: NHS Resolution ARC meeting attendance from 1 April 2022 to 31 March 2023

Name	Post	Meetings attended
Charlotte Moar	Non-executive Director and Chair of ARC	6/6
Mike Pinkerton[1]	Non-executive Director	4/5
Charles Bellringer[2]	Independent Lay Member	6/6
Julia Wortley[3]	Independent Lay Member	5/6
Marcus Hine[4]	Independent Lay Member	1/1
Kafui Tay[5]	Independent Lay Member	1/1

[1] Attended the May, June and the two supplementary ARC meetings as NHS Resolution Interim Chair.
[2] Last meeting was October 2022.
[3] Last meeting was October 2022.
[4] First meeting was February 2023.
[5] First meeting was February 2023.

During the year ARC particularly focused on:

- consideration of internal, external audit and counter fraud arrangements to inform the Board on the effectiveness of internal control;
- assurance reports on health and safety, cyber security and information governance including progress towards achieving and sustaining ISO 27001, and incidents/actions/learning;
- the plan for independent assurance reviews of the CSP and noting when ARC will review these reports;
- a deep dive on the controls in place to provide assurance risks related to claims fraud are being managed effectively;
- consideration of risk management and governance arrangements;
- NHS Resolution compliance with mandated Government Functional Standards;
- plan to improve forecasting around the cash flow and AME;
- review and recommendation to the Board of the annual report and accounts;
- assurance around Freedom to Speak Up arrangements including details of why some staff only wish to report concerns anonymously;
- receiving a briefing from NHS Resolution's actuarial advisers on the development of assumptions affecting the key estimate in the accounts, the provision for claims liabilities; and
- consideration of outcomes and progress of actions from the Known Claims Advisory Review of the issues resulting in a prior year adjustment to the 2021/22 accounts.

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. The Committee meets quarterly.

People Committee

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

During the year the Committee focused on:

- HR performance reporting;
- assurance on transformation programme processes and potential impacts on staff;
- consideration of the 2022 GPG report, as described on page 114;
- drafting of the People Strategy, as outlined on page 113;
- reviewing the equality, diversity and inclusion (EDI) plan and progress; and
- talent management and succession planning strategy.

Reserving and Pricing Committee

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

The Committee's purpose is to:

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

Key matters considered in 2022/23 included an increased focus on known claims methodology and assumptions due to the issue in the audit of the 2021/22 accounts arising from assessing the time to settlement of claims. This includes greater attention to the controls and assurance framework for the data and models used in calculating the known claims 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 2023 to be included in NHS Resolution's report and accounts have been calculated using an appropriate actuarial methodology and assumptions which are within a reasonable range, given the purpose of the calculation and taking into account discussions held with the working groups and the NHS Resolution's Reserving and Pricing Committee. The actuarial assumptions were selected on a best estimate basis, with no explicit adjustment for risk and uncertainty. I have calculated the IBNR provisions to be £28,539 million for all schemes combined as at 31 March 2023 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.

Whilst GAD's role in determining the known claims provision is more limited (in comparison to the IBNR), based on the methodology that has been chosen, and subject to the limitations that have been communicated to NHS Resolution, it is my opinion that the assumptions used for the known claims are within a reasonable range, and the results are correct given the chosen methodology and assumptions.

Senior Management Team

The SMT includes the directors of each of the business areas. I report on the work of the SMT to the Board and hold members of the SMT to account for delivering against agreed objectives which are linked to delivery of our strategy and business plan. The SMT meets most weeks and discusses issues concerned with the activity of NHS Resolution for which the SMT has oversight or approval is required, including resource management, planning, governance arrangements, complaints and stakeholder management. The SMT reviews particular areas of our activity or areas of development and considers any changes in the external environment that may have an impact on NHS Resolution and its services. There are regular risk review sessions to ensure we have controls and treatments in place to mitigate risks and bring them within appetite.

During 2022/23, the SMT held a series of sessions to consider the delivery of our 2022/23 business plan, the progress of our strategy and the development of our business plan and budgets for 2023/24.

SMT governance sub-groups

We have established internal governance groups which provide operational leadership on matters related to business plan delivery. These groups, described in table 14, provide assurance to the SMT through regular reporting and the escalation of any risks or issues that could impact our business objectives.

Table 14: SMT sub-groups in operation from 1 April 2022 to 31 March 2023

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

The control environment

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

Capacity to handle risk

Effective risk management supports the delivery of our strategic priorities and business plan objectives. Through our risk management framework we regularly considered the risks and issues that could have an impact on the achievement of our business objectives. This included consideration of the controls we have in place to mitigate those risks and then, where required, developing plans to bring those risks within appetite. Risk reporting and escalation is set out in our *Risk management policy and procedure*, which is published on our website. The SMT maintains and updates a strategic risk register which reflects those risks that could have an impact on the delivery of our strategy. The ODG is charged with the review of corporate operational risks that may impact the delivery of our business plan as well as business as usual matters.

We provide regular reports to the ARC, who review the strategic and high scoring corporate operational risks, controls and treatment plans (including overcontrols) and, in relation to those risks which are outside the risk appetite of the organisation, recommend appropriate action to the Board.

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

Risk appetite

The Board has developed a risk appetite statement which is reviewed and updated annually. The Board reviewed the risk appetite statement in line with our Strategy to 2025 and also took the decision to align with the risk appetite statement and risk categories outlined in HMT's *The Orange Book: Management of risk – Principles and concepts*[1] on risk appetite.

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

[1] The Orange Book, publishing.service.gov.uk

Table 15: NHS Resolution's approach to the management of principal risks from1 April 2022 to 31 March 2023

Risk		How we manage the risk	Why the risk score has changed?	Strategic priority
There is a risk that our data is inaccurate leading to misstatements in publications and financial reporting. This could result in decisions being made on incorrect information and/ or reputational impact.	Risk appetite **cautious** Risk trend ↔	Processes in place for FOI requests. Processes in place for DHSC policy requests. Annual Internal Audit reviews of claims data quality. Taking actions following lessons learned and internal audit reviews.	N/A	
Failure to identify insight that indicates a current or emerging patient safety risk from a particular organisation or individual contained within the data we hold in isolation or in conjunction with information from elsewhere in the NHS. This could result in preventable harm (or further harm) to patients/ staff/public.	Risk appetite **cautious** Risk trend ↓	Procedures in place for issuing and reviewing Healthcare Professional Alert Notices (HPANs). Our Early Notification Scheme monitors aspects of risk. Established arrangements in place for managing significant concerns identified from across NHS Resolution. Ongoing liaison with CQC to share insights. Data Insights Programme.	Risk reduced: The Significant Concerns Framework has established escalation arrangements in place. Likelihood of risk occurring was reduced	
Our assets are compromised which could lead to an inability to deliver core services or a significant asset loss such as data or funds.	Risk appetite **cautious** Risk trend ↓	IT policies and procedures in place. System controls including firewalls. IG Group review incidents and take forward learning. 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.	Risk reduced: There has been no actual loss of data or harm to NHS Resolution assets. Likelihood of risk occurring was reduced	
Failure to recognise and respond to changes in the environment in which we operate. This could lead to our services and offerings no longer being fit for purpose.	Risk appetite **Open** Risk trend ↔	The Policy, Strategy and Transformation team ensure horizon scanning to support policy development. SMT strategy session discussions of emerging topics. Monitoring and evaluation of developments in models of care. Monitoring and evaluation of the Maternity Incentive Scheme.	N/A	
Failure to deliver our core functions due to possible impact of planned growth and transformational change initiatives. This could lead to us being unable to deliver services in line with our statutory duties Failure to meet the needs of our members and key stakeholders.	Risk appetite **cautious** Risk trend ↔	Horizon scanning process in place. Board, SMT, CMG and ODG discussions to identify/discuss emergent topics as part of the business planning framework. DHSC quarterly reviews.	N/A	
Defrauding of the NHS not identified, meaning that steps to identify misappropriation of NHS funds cannot be taken. Fraud against public bodies could compromise the ability to deliver services and achieve intended outcomes.	Risk appetite **cautious** Risk trend ↔	Named local counter fraud specialists in place. Internal audit reports. Proactive counter fraud exercises to identify internal fraud. Segregation of duties.	N/A	
We act Ultra Vires or beyond our delegated authorities. This could lead to us making financial commitments beyond our powers. We indemnify organisations or individuals not within our powers to do so. We share personal identifiable data outside of current legal framework.	Risk appetite **cautious** Risk trend ↑	Standing Orders and Standing Financial Instructions in place setting context and boundaries for decision making. Policies and procedures governing the scope of NHS Resolution's remit to support compliance with legal and delegated authorities.	Risk increased: We recognise the changes in DHSC and Cabinet Office controls required us to ensure we enhance our internal controls. Likelihood of risk occurring was increased	

Risk trend (risk movement since 2021/22)

↑ Risk increased ↓ Risk reduced ↔ No change

Risk appetite

Adverse | Minimalist | Cautious | Open | Eager

Internal audit

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

The Head of Internal Audit concluded NHS Resolution has **Adequate and Effective** systems of control, governance and risk management in place for the reporting year 2022/23.

Audit title	Audit opinion
Data Quality	Reasonable
Records and Information Management	Substantial
Safety and Learning	Reasonable
Recruitment	Reasonable
Key Financial Controls	Reasonable
Data Security Protection Toolkit	Reasonable
Claims Evolution Programme	Reasonable
Technology Strategy	Reasonable
Known claims review of the issues resulting in a prior year adjustment to the 2021/22 accounts	Advisory

Substantial

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

Reasonable

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

Advisory

The scope of which is agreed with the client, are intended to add value and improve an organisation's governance, risk management and control processes.

Advisory reviews do not include an internal audit assurance opinion but do provide a conclusion of the findings of the work undertaken. Advisory reviews are often delivered at the request of management and the audit committee.

Partial

Action required to strengthen the control framework.

Minimal

Urgent action required to strengthen the control framework.

Management assurance

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

Business continuity

We have business continuity plans and policies to ensure we can respond to and recover from major operating disruptions which would seriously impact our ability to conduct critical business operations for a significant period of time. Through 2022/23 we carried out a thorough review of our departmental business impact assessments, which take into account the changing external, as well as our own internal, operating environment. We have plans in place to train those charged with business continuity and to test our revised plans to ensure they are fit for purpose.

Data quality

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

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

The external audit of our annual report and accounts includes a focus on data quality in relation to determining the value of the provision.

Performance and financial controls

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

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

Anti-fraud, bribery and corruption

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of NHS Resolution's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members, and we take a zero-tolerance stance towards fraud and bribery. We have established controls in place to mitigate the risk of fraud as far as possible, including an up-to-date Anti-fraud, bribery and corruption policy and procedure, as well as annual mandatory training. These provide guidance for all staff, enabling them to recognise and deal with potential instances of fraud and bribery. Counter fraud services are provided by the Government Internal Audit Agency (GIAA). During 2022/23 we worked closely with our colleagues in DHSC's Anti-Fraud Unit to progress our compliance of the Government Counter Fraud Functional Standard GovS013.

We continue our membership of the Claims and Underwriting Exchange (CUE), a database of non-clinical claims reported to insurers. This enables us to share information with other indemnifiers, 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.

Procurement and contracting

Following an internal audit review of our Legal Panel Tender in 2021/22 we have implemented enhanced controls to ensure our procurement processes are compliant with regulation, Cabinet Office and DHSC requirements. We have pipeline plans in place to ensure that acquisitions for goods and services provide value for money and we are transparent in our procurement approach.

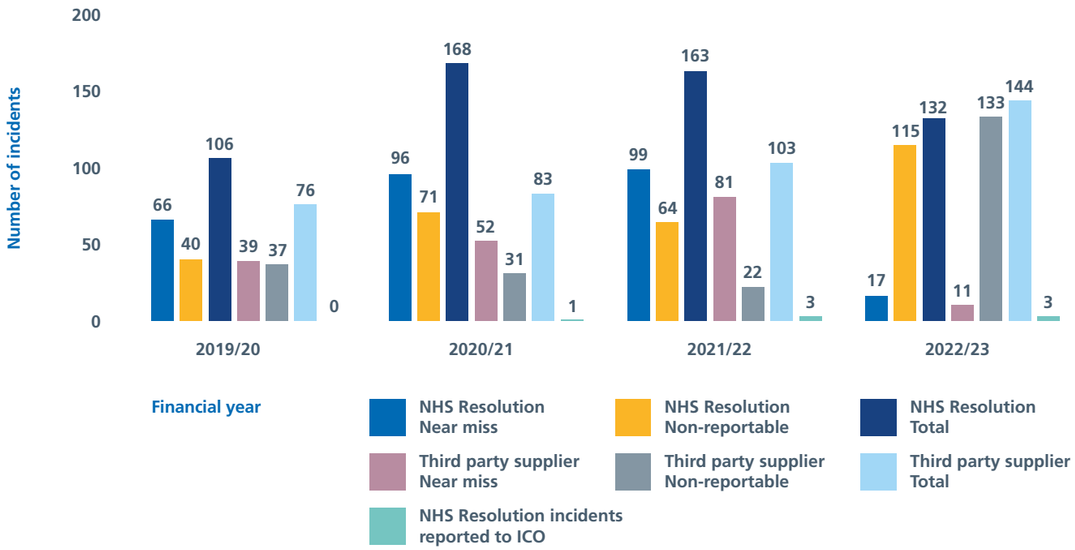
We are committed to ensuring our tenders include matters related to the Public Services (Social Value) Act 2012 and as such have included this as an evaluation criterion in appropriate tenders. All procurement is considered in terms of business need and of being the most economically advantageous for us. We continue to develop and embed best practice in contract management to ensure we achieve good value for money on the contracts we enter into.

Information governance and security

NHS Resolution has maintained ISO 27001 Information Security certification, demonstrating that we have an effective information security management system. The recertification audit carried out in December 2022 reviewed a range of governance and technical security controls against the ISO standards. The audit identified seven minor non-conformances which we have taken action to rectify.

We also continue to maintain Cyber Essentials Plus certification, which is a UK Government scheme of good practice in information security. We are continuing our cycle of improvement by reviewing our ISO 27001 in the context of the new 2022 standards and also in light of learning from our incidents which are described in the following section.

Figure 28: Information governance incidents reported by severity from 1 April 2022 to 31 March 2023[1]



During 2022/23, as figure 28 shows, there were 279 incidents and 'near misses'[2] recorded. Of this total, 28 were near misses. It should also be noted that during the past 12 months we have expanded as an organisation but are not seeing a significant increase in the number of reported incidents relative to this growth.

The difference in our reporting numbers from previous years is largely as a result of us undertaking a review of the definition of an incident and a near miss, in addition to more frequent engagement with our third-party suppliers to inform greater awareness of reporting and learning from incidents.

[1] This includes incidents and near misses reported by third party suppliers.

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

During this reporting period there have been three reports to the Information Commissioner's Office (ICO) which have been directed through the Data Security Reporting Toolkit. While we continue to learn from any incidents and address any gaps in our internal controls, the ICO has concluded that no further action is required on the three reported incidents. We have also completed a review of our incident reporting framework so that we can better report on incidents and derive more insight and learning.

Responding to members of the public

Effective processes were in place throughout the year to ensure we responded to all public enquiries, correspondence, parliamentary questions, issues raised under FOI requests and Data Protection Act (DPA) legislation, and complaints. We received 272 FOI requests of which 69% were responded to within the 20-working-day timescale for responses. Where responses exceeded the 20-working-day time period, it was due to a number of factors such as the complexity of the request. Where we exceeded the 20-working-day time period for responding, we advised the requestor of the likely timescales for a response. We are reviewing the internal processes for responding to FOI requests to consider how we can improve our compliance rate.

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

There also continues to be a growing interest in our claims data and we have continued to publish responses on our Disclosure log and update our Factsheets and our Publication scheme to assist the public to find information about our organisation and our activities. In 2022/23 a significant number of FOI requests relating to claims concerned maternity and obstetrics, orthopedic claims and delayed treatments and misdiagnosis.

Data protection requests

NHS Resolution receives two types of request under the DPA. The first type, Subject Access Requests (SARs), give individuals the right to request any information held about themselves. In 2022/23 131 SARs were received, which is a decrease of 24 (16%) on last year. Of these, 112 (86%) were responded to within the statutory deadline of one calendar month. Where these were not responded to within the specified time period, we advised the requestor of the reasons for delay, such as complexity or volume of information in scope of the request. In 2022/23 we received separate enquiries from the ICO in relation to three SARs we had handled. The queries were in the main points of clarification and as such the ICO concluded no further action was required.

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

Complaints and feedback

In 2022/23 we received 29 complaints, which were reviewed via our formal *Complaints policy*. Of the 29 complaints received, 69% were completed within the 25-working-day deadline (this compares to 35 complaints received in 2021/22). Where we have exceeded the 25-working-day deadline this was due to the complexity of matters to be reviewed and we have engaged with the requestor to explain any delay. These numbers remain small relative to the volume of activity across the organisation. We are, however, always keen to learn from complaints.

There have been five complaints referred to our Chair during 2022/23, none of which were upheld. In addition, there have been no complaints to the PHSO.

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

Freedom to Speak Up

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

- monthly meetings with the HR/OD service to talk through themes from issues raised and remedial actions that can be put in place, as well as ensuring Freedom to Speak Up arrangements, line management and HR procedures are being used appropriately;
- identifying training or policy and procedures knowledge gaps that exist across the organisation;
- sharing intelligence with the mental health first aiders so they can shape their offer;
- inputting into the corporate values and behaviours framework and actions to embed these; and
- participating in corporate induction sessions to promote the commitment to speaking up and how that facilitates change in the organisation.

Health, safety and wellbeing

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures, with staff required to participate in training to ensure they are aware of these. We have ensured all staff have complete display screen equipment assessments to make sure that they are working safely – both in the office and at home. We have also undertaken an individual risk assessment with all staff to identify those who may need extra support. To ensure all our staff are supported we have continued to provide an Employee Assistance Programme, various health and wellbeing tools, and the assistance of mental health first aiders. Further information about the support we provide, including our approach during a period of economic challenge, can be found on page 116.

Respect for human rights

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

People

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

Procurement and our supply chain

Our procurement approach is in line with the Cabinet Office Guidance *Tackling Modern Slavery in Government Supply Chains*[1] and as such includes a mandatory exclusion question regarding the Modern Slavery Act 2015.

NHS Pension scheme regulations

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

Statutory functions

An assurance map, which provides high-level assurance that we are operating within the relevant directions and statutory functions for NHS Resolution, has been maintained. This gives me, as Accounting Officer, the assurance that we have a clear view of those functions and regulations we should be working to.

[1] Cabinet Office Guidance, *Tackling Modern Slavery in Government Supply Chains*, gov.uk.

Government Functional Standards

In 2021/22 we took forward a self-assessment of our position against the mandated requirements of the Government Functional Standards[1] which are relevant to NHS Resolution. As of 31 March 2022, where we considered mandated standards were partially met, we implemented improvement plans. As of 31 March 2023, we were compliant with all the relevant mandated standards. We will continue to enhance our assurance framework, in line with the Government Functional Standards, by adopting best practice where applicable.

Key or significant issues occurring during 2022/23

During the reporting year, an issue emerged in respect of the use of expected settlement date (ESD) data in the calculation of the known claims provision in the 2021/22 accounts. The known claims provision calculation used the ESD from individual claims recorded in the Claims Management System to apply inflation and discounting to reach a valuation. However, an actuarial view was used to determine the disclosure for the timing of cash flows. In the 2021/22 accounts an adjustment to the known claims provision was applied to the estimate technique. This was due to a significant divergence between the two views, most likely as a result of the impact of the Covid-19 pandemic. Following the identification of the issues related to ESD and with insight from an advisory internal audit review we have taken forward work to enhance the processes for the known claims methodology as well as the associated assurance framework, including:

- a review of ESDs on high value claims;
- changes to the known claims model to incorporate an actuarial view of timing of cash flows into the calculations;
- review of other judgements such as probability and reserve values used in the known claims calculation; and
- an enhanced role for the RPC in the process of developing the methodology and assumptions for determining the known claims provision.

[1] HM Government, *Government Functional Standard*, publishing.service.gov.uk.

Accounting Officer's conclusion

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

In summary, I am satisfied that the framework of governance, risk management and system of internal controls are adequate and have been effectively maintained throughout 2022/23.

Remuneration and staff report

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee whose members have a role that includes the determination of the remuneration, benefits and terms of service of all posts covered by the Pay Framework for Executive and Senior Managers (ESMs). The Committee, established by NHS Resolution's Board which also approves its terms of reference, met five times during the 2022/23 financial year. All meetings were quorate with the attendance of members shown in table 16.

Table 16: Remuneration and Terms of Service Committee meeting attendance from 1 April 2022 to 31 March 2023

Sally Cheshire CBE[1]
Chair

Meetings attended
4/4

Mike Pinkerton[2]
Interim Chair

Meetings attended
1/1

Charlotte Moar
Non-executive Director

Meetings attended
4/5

Mike Pinkerton[2]
Non-executive Director

Meetings attended
1/2

Nigel Trout
Non-executive Director

Meetings attended
5/5

Janice Barber
Non-executive Director

Meetings attended
5/5

Professor Dame Lesley Regan
Non-executive Director

Meetings attended
3/5

[1] Sally Cheshire CBE started as Chair from 19 September 2022.
[2] Mike Pinkerton's Interim Chair term of office ended on 18 September 2022 and his term of office as Non-executive Director ended on 15 January 2023.

In July 2022 the Committee considered and noted the annual Directors' performance reviews and objectives setting as presented by the Chief Executive who was in attendance. In addition, the Committee received a verbal update from the Chief Executive on work underway to review the structure, roles and responsibilities of the SMT. The Committee also noted the performance and objectives of the Chief Executive as provided by the Chair of the Committee.

In October, the 2022/23 annual pay award and performance related payments were determined by the Committee based on guidance provided by DHSC and approved.

In March 2023 the Committee considered and noted the updated succession plans for each of the Directors as presented by the Chief Executive who was in attendance.

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

- business case approval for a retiree and return request for a director, including consideration of succession planning for the role; and
- approval to start recruiting for the replacement of the level 1 ESM position.

The Committee considered its performance in 2022 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 three staff members employed under the medical and dental terms and conditions of service.

Full details on the Agenda for Change, including a copy of the current handbook, can be found on the NHS Employers website[1]. The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees which supports modernised working practices. Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system which supports NHS service modernisation and meets the reasonable aspirations of staff.

Full detail on the medical and dental pay and terms and conditions of service can be found on the NHS Employers website[2]. The relevant NHS Resolution policies applied during the financial year in relation to salaries were the *Recruitment and selection policy and procedure (HR16)* and the national *NHS terms and conditions of service* noted above. Allowances to staff in payment during the year other than basic salary were high-cost area supplement, recruitment and retention premia, and on-call allowances for information systems and governance staff.

Remuneration for directors

The following tables provide the contractual salary and pension details of those executive and non-executive directors who had control over the major activities of NHS Resolution during 2022/23, except for the Associate executive director who has no voting rights on the Board. Tables 17, 18 and 19 are subject to audit. There were two changes in Board membership during 2022/23; the new Chair Sally Cheshire CBE started her term of office on 19 September 2022, replacing the Interim Chair, Mike Pinkerton. Mike Pinkerton's Non-executive Director appointment ended on 15 January 2023.

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

Table 17: Executive and non-executive director salaries and allowances[1] for 2022/23 (audited)

Name and title	Salary £000	Expense payments (taxable)	Performance pay and bonuses £000	Long term performance pay and bonuses £000	All pension-related benefits[7] £000	Total £000
	bands of £5,000	total to nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Mike Pinkerton[2] (Interim Chair)	30–35	1,400	0	N/A	N/A	**30–35**
Sally Cheshire CBE[3] (Chair)	30–35	3,300	0	N/A	N/A	**35–40**
Helen Vernon (Chief Executive)	165–170	0	5–10	0	42.5–45	**215–220**
Joanne Evans (Director of Finance and Corporate Planning)	125–130	10,700	0	0	32.5–35	**170–175**
Dr Denise Chaffer (Director of Safety and Learning)	115–120	0	0	0	N/A	**115–120**
Vicky Voller (Director of Advice and Appeals)	115–120	0	5–10	0	30–32.5	**155–160**
Charlotte Moar[4] (Non-executive Member)	10–15	3,000	N/A	N/A	N/A	**15–20**
Mike Pinkerton[2] (Non-executive Member)	0–5	800	N/A	N/A	N/A	**0–5**
Nigel Trout (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Janice Barber (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Professor Dame Lesley Regan (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Dr Mike Durkin OBE[5] (Associate Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Professor Sir Sam Everington OBE[6] (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 expenses and reimbursement policy*. The gross value of this benefit and any taxable expenses reimbursed are included in the expense payments column of this table.

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

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

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

[5] Dr Mike Durkin OBE's appointment as Associate Non-executive Director was extended for a further twelve months with effect from 1 July 2022.

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

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

Table 18: Executive and non-executive director salaries and allowances[1] in 2021/22 (audited)

Name and title	Salary £000	Expense payments (taxable)	Performance pay and bonuses £000	Long term performance pay and bonuses £000	All pension-related benefits[10] £000	Total £000
	bands of £5,000	total to nearest £100	bands of £5,000	bands of £5,000	bands of £2,500	bands of £5,000
Mike Pinkerton[2] (Interim Chair)	10–15	2,500	0	N/A	N/A	**10–15**
Martin Thomas[3] (Chair)	50–55	2,700	0	N/A	N/A	**55–60**
Helen Vernon (Chief Executive)	160–165	0	5–10	0	45–47.5	**215–220**
Joanne Evans (Director of Finance and Corporate Planning)	120–125	1,500	0–5	0	35–37.5	**160–165**
Dr Denise Chaffer (Director of Safety and Learning)	115–120	0	0	0	2.5–5	**120–125**
Vicky Voller (Director of Advice and Appeals)	115–120	0	0	0	32.5–35	**145–150**
Professor Keith Edmonds[4] (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Charlotte Moar[5] (Non-executive Member)	10–15	1,800	N/A	N/A	N/A	**10–15**
Mike Pinkerton[2] (Non-executive Member)	5–10	600	N/A	N/A	N/A	**5–10**
Nigel Trout (Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Janice Barber[6] (Non-executive Member)	0–5	0	N/A	N/A	N/A	**0–5**
Professor Dame Lesley Regan[7] (Non-executive Member)	0–5	0	N/A	N/A	N/A	**0–5**
Dr Mike Durkin OBE[8] (Associate Non-executive Member)	5–10	0	N/A	N/A	N/A	**5–10**
Professor Sir Sam Everington OBE[9] (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 expenses and reimbursement policy*. The gross value of this benefit and any taxable expenses reimbursed are included in the Expense payments column of this table.

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

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

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

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

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

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

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

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

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

Pension entitlements for executive directors

Table 19: Pension entitlements for executive directors (audited)

Name and title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash equivalent transfer value at 31 March 2023	Cash equivalent transfer value at 31 March 2022	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
	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	55–60	90–95	945	856	39	0
Joanne Evans (Director of Finance and Corporate Planning)	2.5–5	0	15–20	0	261	213	24	0
Vicky Voller (Director of Advice and Appeals)	0–2.5	0–2.5	30–35	45–50	461	414	18	0

All directors at NHS Resolution pay into the NHS Pension scheme. Past and present employees are covered by the provisions of the NHS Pension scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions and further details are set out in the Financial Statements section of this report. No further benefits will be receivable by an individual in the event of early retirement.

Cash equivalent transfer values

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

CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement or for loss of office

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

Payments to past directors or past senior managers

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

Fair pay disclosure

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

		25th percentile	Median	75th percentile
2022/23	Total remuneration	£42,750	£53,409	£64,438
	Pay ratio - total renumeration	4.04:1	3.23:1	2.68:1
	Salary component of total remuneration	£38,667	£47,672	£56,164
	Pay ratio - salary component	4.33:1	3.51:1	2.98:1
2021/22	Total remuneration	£39,903	£49,218	£60,316
	Pay ratio - total remuneration	4.20:1	3.40:1	2.78:1
	Salary component of total remuneration	£39,323	£45,839	£54,764
	Pay ratio - salary component	4.35:1	3.55:1	2.97:1

The total banded remuneration of the highest-paid director in NHS Resolution in the financial year 2022/23 was £170,000–£175,000 (2021/22, £165,000–£170,000), which represents an increase of 3.0% from 2021/22. This is as a result of the 3% pay award issued mid-year, however given that it is a lower increase than the organisation's average, ratios have reduced from 2021/22. These figures also include performance pay with a year-on-year increase of 1%.

The basic pay of the highest-paid director in NHS Resolution in the financial year 2022/23 was £165,000-£170,000 (2021/22 £160,00-£165,000), which represents an increase of 3.1% from 2021/22. Whereas the performance and bonus pay of the highest-paid director for 2022/23 was £5,000-£10,000 which was 0% increase on the prior year.

In 2022/23, no employee received remuneration in excess of the highest-paid director (2021/22, was zero). Remuneration ranged from £22,142-£174,528 (2021/22 £22,441-£169,600).

This represents approximately a £5,000 increase in the remuneration for the highest-paid director, and includes performance pay and bonuses that increased 0.90% on average across the full workforce. The percentage change in total remuneration was 5.09% (2021/22 7.35%), with the percentage change in basic pay being 1.50% (2021/22 8.92%).

The increase in basic pay is as a result of the pay award of 3%, with the increase in total remuneration also accounting for the additional pay award of 2% of basic salary and a non-consolidated lump sum payment. Increases are also as a result of the increase in average workforce by 78 FTE at an average remuneration lying between the median and the upper quartile. This remains consistent with the increase in median pay ratio.

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

The fair pay disclosures are subject to audit.

Staff report

During the 2022/23 year there has been a notable increase in average full-time equivalent (FTE) staff, up from 500 in 2021/22 to 578. The increase in budgeted establishment continues to reflect our requirements to successfully operate the CNSGP, CEP and CSP, including the corporate support required for the ongoing increase in remit and establishment. While increasing our budgeted establishment and headcount in 2022/23 we have seen a slight decrease in our annual staff turnover, down to 10% compared to 10.5% in 2021/22. Our voluntary staff turnover rate for 2022/23 was 8.6%.

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

During 2022/23 the People Committee, a sub-committee of the Board, met on a further three occasions following its first meeting in March 2022. The role of the People Committee is to support the Board and the Accounting Officer by reviewing the comprehensiveness and reliability of assurances in relation to its people strategies and activities.

The Committee members provide advice on the adequacy of the organisation's people plans and strategies. They provide support and recommend which issues/matters should be escalated to the Board for further discussion.

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

Throughout 2022/23 we have continued to support our workforce in a range of personal and professional development opportunities both internally and externally. As referenced previously, our ongoing commitment to high standards of people management has been recognised by achieving IiP Gold, following the re-accreditation process in early 2023.

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

Table 20: Staff costs 1 April 2022 to 31 March 2023 compared to 1 April 2021 to 31 March 2022

Staff costs	Permanently employed staff £000	Other £000	2022/23 Total £000	2021/22 Total £000
Salaries and wages	28,764	1,750	**30,514**	26,549
Social security costs	3,431	-	**3,431**	2,741
Employer contributions to NHS Pensions	4,830	-	**4,830**	4,030
NEST pension contributions	6	-	**6**	4
Apprenticeship levy	123	-	**123**	121
Total	**37,154**	**1,750**	**38,904**	**33,445**

Table 21: The average full-time equivalent staff employed broken down by related costs from 1 April 2022 to 31 March 2023 compared to 1 April 2021 to 31 March 2022

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other*	2022/23 Total	2021/22 Total
Core department	531	25	**556**	492
Capital projects	22	-	**22**	8
Total	**553**	**25**	**578**	**500**

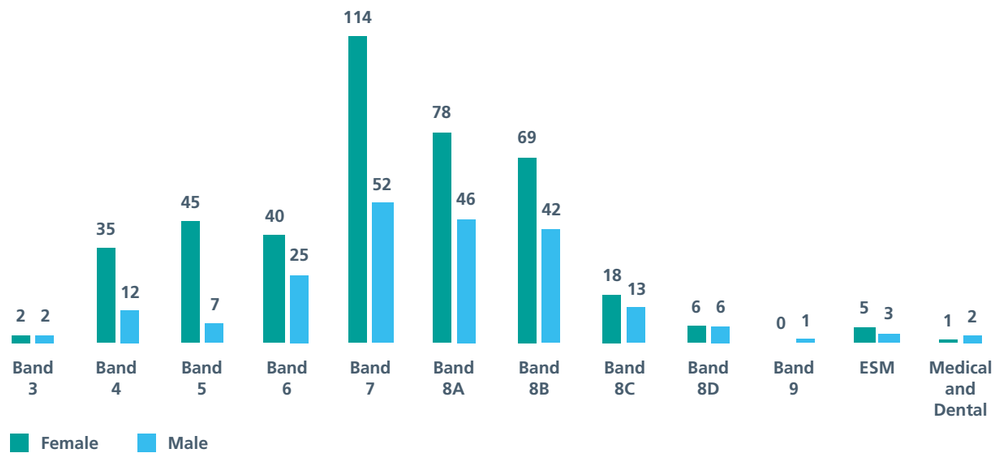
*Other is temporary/agency workers engaged with the organisation.

As at 31 March 2023, of the eight executive and senior managers, three were male (37.5%) and five were female (62.5%). The gender split ratio for all employees was 34% male and 66% female. We regularly report to the People Committee the details of our workforce gender by pay band including executive and senior managers.

Figures 29 to 35 detail how the organisation's workforce is made up in respect of the other monitored characteristics that are included under the Equality Act 2010. The overall proportions of staff against each of the monitored characteristics have remained broadly comparable to the proportions reported in 2021/22. There are some changes to the regional ethnicity profile information and ethnicity profiles across the pay bands shown in figures 33, 34 and 35 that follow.

Equality, Diversity & Inclusion (EDI) is a core pillar of our people strategy. The graphs and narrative below set out our actions taken to date and intended future actions in tackling barriers to improving diversity in our workforce.

Figure 29: Staff headcount broken down by gender and banding[1] from 1 April 2022 to 31 March 2023



Our GPG report for the 12-month period ending 31 March 2022 showed that we appointed 1.7 times more females into senior roles than males, up from 1.5 times in 2021/22. While bands 7 to 8b and our ESMs are largely reflective of the organisation's gender profile, in 2022/23 there has been upwards trend in employing more female staff at bands 6, 8a and 8b. Further information about our GPG can be found on page 114.

Figure 30: Sexual orientation of staff

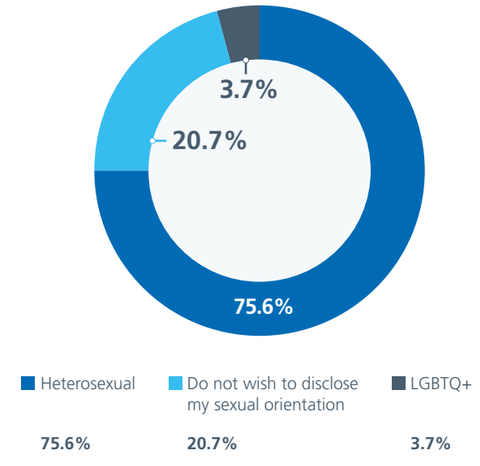
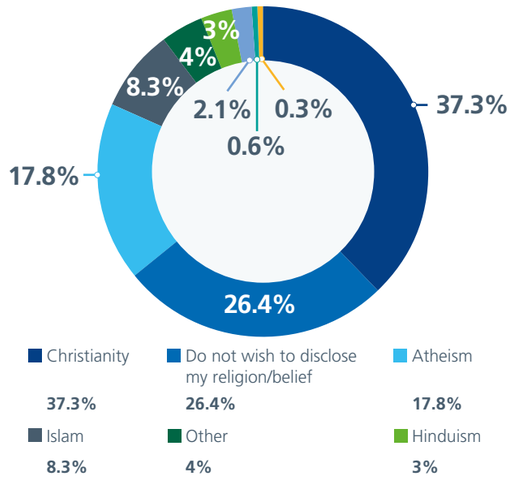


Figure 31: Religion and/or belief[2] of staff



[1] Under the Agenda for Change *NHS terms and conditions of service*, pay band 2 is the lowest grade and pay band 9 is the highest grade.
[2] Note: Total is 99.8% due to rounding

Disability

We have continued to progress our activities within the Government's Disability Confident scheme, with a view of moving from level 2 (Disability Confident Employer), to level 3 (Disability Confident Leader) during 2023/24. Our staff-led Disability Network, established in April 2021, has continued to meet throughout 2022/23. The purpose of this group is to:

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

Table 22 shows the percentage of applications that were shortlisted and the percentage of appointments made from those who consider themselves as having a disability, those who do not consider themselves as having a disability and those who do not wish to disclose this information. It also provides a comparison to 2021/22.

Table 22: A comparison of the proportion of job candidates shortlisted and appointed to roles at NHS Resolution in 2021/22 and 2022/23 with and without a disclosed disability

Application category	% Shortlisted 2022/23	% Shortlisted 2021/22	% Appointed from shortlisting 2022/23	% Appointed from shortlisting 2021/22
Disabled	39.5	24.4	9.9	5.9
Not disabled	38.0	26.9	16.0	19.1
Not disclosed	35.1	31.1	112.1*	69.7
Total	**38.0**	**26.8**	**18.9**	**20.0**

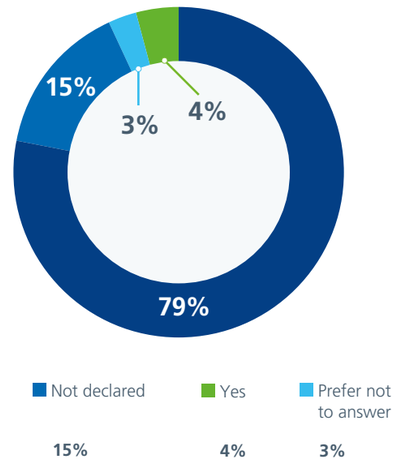
Notes: The above figures exclude appointments made via agencies.

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

Overall, we shortlisted a greater number of candidates across all categories in 2022/23, up to 932 from 823 in 2021/22. While the number of appointments made in 2022/23 increased slightly to 186 from 165 in 2021/22, the percentage of appointments from the number of shortlisted applicants reduced from 20% in 2021/22 to 18.9% in 2022/23. The number of applicants who considered themselves as having a disability and who were shortlisted for interview increased to 39.5% in 2022/23, up from 24.4% in 2021/22. The number of appointments made within this category increased from 5.9% in 2021/22 to 9.9% in 2022/23.

This year we appointed proportionately more individuals with a declared disability than in 2021/22.

Figure 32: Proportion of staff declaring a disability



Ethnicity

In 2022/23, the proportion of ethnic minority employees has remained at 33%.

During this year we continued to grow our workforce in Leeds as well as seeing a number of staff moving to 100% home working. Figure 34 shows the current workforce profile compared to the regional profile information derived from the 2021 census data for our two main office bases.

Figure 33: Ethnicity of staff (organisational profile)

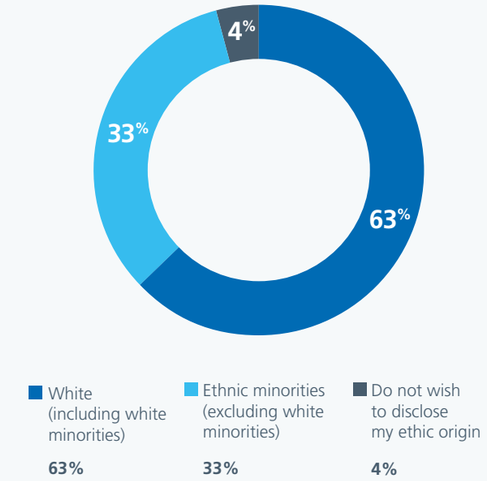


Figure 34: Ethnicity of staff based at NHS Resolution's London and Leeds offices compared to regional ethnicity data[1]

[1] Regional ethnicity data is derived from the data published in the 2021 census.

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

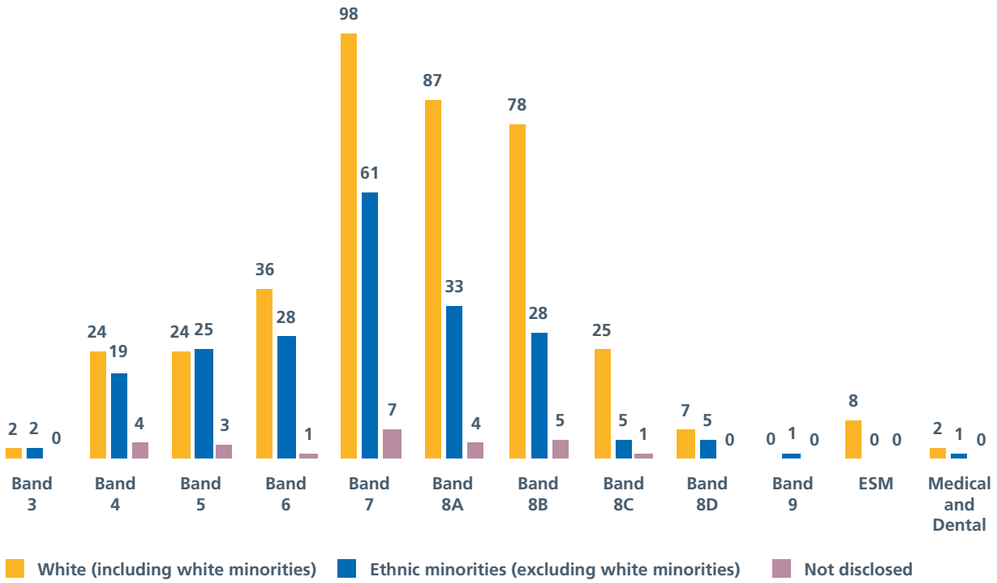
The number of Leeds-based staff who are from an ethnic minority background has increased to 22.1% compared to 21.2% in 2021/22, demonstrating that we continue to employ a higher proportion of ethnic minority groups in Leeds when compared to the regional figures. The regional profile for Leeds (Yorkshire and the Humber region) has also seen an increase in ethnic minority groups, up from 10.4% in the 2011 census to 14.6% in 2021.

The main category of ethnic minority staff in Leeds are those from Asian groups, with an underrepresentation of staff from Black African/Caribbean/British backgrounds in comparison to the regional profile.

Figure 35 shows some areas of underrepresentation and overrepresentation across pay grades. While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is an underrepresentation of ethnic minority staff at the ESM level and across pay bands 8a to 8c. This is consistent with the national data around the underrepresentation of ethnic minority staff at senior level within the NHS. The information also shows that there is an overrepresentation of ethnic minority staff within the lower pay bands. As detailed under the equality, diversity and inclusion section of this report, we continue to take steps to address these issues.

As detailed on page 86, we continue to provide regular reports to our People Committee, detailing the workforce ethnicity by pay band including senior managers.

Figure 35: Headcount by ethnicity from 1 April 2022 to 31 March 2023



Sickness absence

As at 31 March 2023, the organisation's twelve-month cumulative sickness absence rate was 1.39%. The organisation's absence rate has remained below the NHS national average for England and for other similar national NHS organisations. Through our People Committee, we continue oversight of our absence management processes. Overall, we ensure that the required level of support is provided to our workforce while supporting our managers in the management of both informal and formal cases.

Off-payroll engagements

As of 31 March 2023, we had four off-payroll appointments costing more than £245 per day. Two of these appointments have lasted or are likely to last longer than six months. 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 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 23: All off-payroll engagements as of 31 March 2023, for more than £245 per day

Off-payroll engagements as of 31 March 2023	
No. of existing engagements as of 31 March 2023	4
Of which:	
No. that have existed for less than one year at time of reporting	2
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	-
No. that have existed for between three and four years at time of reporting	-
No. that have existed for four or more years at time of reporting	-

Table 24: All off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day

Off-payroll engagements between 1 April 2022 and 31 March 2023	
No. of temporary workers engaged between 1 April 2022 and 31 March 2023	18
Of which:	
No. not subject to off-payroll legislation	-
No. subject to off-payroll legislation and determined as in scope of IR35	-
No. subject to off-payroll legislation and determined as out of scope of IR35	18
No. of engagements reassessed for compliance or assurance purposes during the year	-
No. of engagements that saw a change to IR35 status following the review	-

Table 25: Any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023

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

Exit packages

There were no compulsory or voluntary redundancies during the 2022/23 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 2022 to 31 March 2023.

Table 26: Relevant union officials from 1 April 2022 to 31 March 2023

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

Table 27: Percentage of time spent on facility time from 1 April 2022 to 31 March 2023

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

Table 28: Percentage of pay bill spent on facility time from 1 April 2022 to 31 March 2023

Percentage of pay bill	
Total cost of facility time	£6,638.33
Total pay bill	£38,904,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.02%

Table 29: Paid trade union activities from 1 April 2022 to 31 March 2023

Hours spent by employees who were relevant union officials during 2022/23 on paid trade union activities, as a percentage of total paid facility time hours.

Paid activities	
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	8.23%

People

Our *Being fair charter*, described on page 49, does not just apply to those delivering healthcare, it applies to us too. We recognise that when staff are supported and listened to they will continue to put every effort into helping to deliver value-for-money services and improve patient safety. Our approach to compassionate leadership is reflected in our IiP Gold accreditation, improving on our previous Silver accreditation.

As illustrated in figure 36, our People Strategy, which will support the implementation of our Strategy to 2025, includes five pillars, all of equal importance, built upon foundations of: organisational culture, communication and engagement, and human resources and organisational development digitalisation.

Figure 36: NHS Resolution's People Strategy

While we support our staff through a concerted period of transformational change, we have already begun delivering against our five pillars, as described below.

Equality, diversity and inclusion (EDI)

Our aim is to create an environment where staff respect and value each other's diversity. As an organisation we aspire to the CQC standards of being 'well led'. By this we mean that the leadership, management and governance of the organisation assure the delivery of a high-quality person-centred approach to our work and delivery. We have developed a dedicated equality, diversity and inclusion careers page which details our strategic intentions in this area and helps mitigate any barriers to diversity. In addition, we have progressed the following actions:

- updated our *EDI policy* which provides details of the responsibilities of all staff for promoting EDI to ensure we consistently demonstrate our PEER values and behaviours framework;
- in accordance with our recruitment and retention strategy pillar, continued to review the support available to employees from underrepresented groups when making applications for roles in the organisation;
- monitored the protected characteristics of applicants for each recruitment campaign to ensure any outliers or areas of concerns are highlighted and addressed;
- as highlighted on page 108, progressed to level two of our Disability Confident Scheme and have a clear plan of action on how we intend to progress to level 3; and
- increased the number of Freedom to Speak Up guardians to ensure there is adequate capacity within our organisation, who are also representative of our workforce. The role of the guardians is to listen and act impartially and independently to support staff where concerns have been raised. An annual report is presented to the ARC for completeness to ensure concerns are being acted on.

Gender Pay Gap reporting

In March 2023, in accordance with the requirements under the Equality Act 2010, we published our 2022 GPG report.

What are the key highlights of the 2022 Gender Pay Gap report?

- Our 2022 mean GPG has decreased to 7.9% compared to 8.4% in 2021.
- Our median GPG has increased from 7% in 2021 to 10.4%.
- Our GPG remains lower than the current UK GPG of 14.9%.
- In common with the wider NHS, our workforce is predominantly female; 64% of our workforce is female.
- Only female employees received bonus pay in 2022.
- Over the 12-month reporting period, we appointed 1.7 times more females into senior roles than males, up from 1.5 times in 2021.
- There has been an upwards trend in employing more female staff at bands 6, 8a and 8b.
- There has been a decrease of 3.5 percentage points in the number of female employees in the lower quartile with an increase to the lower and upper middle quartiles and the upper quartile.

The report includes a number of considered impacts that are likely to be affecting our GPG figures, including sector and role specific considerations, length of service, turnover and the application of recruitment and retention premia.

What are we going to do?

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

We want female employees to be proportionately represented across all pay grades.

We have already identified and are working towards a number of actions as part of the EDI pillar of our People Strategy, which will support our aim to close the GPG further.

Workforce Race Equality Standard and Ethnicity Pay Gap reporting

In accordance with our People Strategy and business plan for 2022/23, in February 2023 we completed both our 2022 Workforce Race Equality Standard (WRES) report and ethnicity pay gap report. The final drafts of these reports and actions to be taken in response to the report are currently being considered.

For the reports ending March 2023, we have committed to completing our gender pay gap and ethnicity pay gap in quarter 1 of 2023/24 and our WRES and Workforce Disability Equality Standard reports in quarter 2. Completing the reports closer to the data period ending will provide a timelier overview of our performance across these areas, and therefore the ability to develop a combined action plan to address the areas for improvement.

We now have four individual networks which have retained their individual identities and continue to support the organisation and staff on relevant current topics:

- Diversity Matters
- Disability Network
- Pride and Progress Network
- Sustainability Network

In 2022/23 we have also seen a move towards our staff's interest in intersectionality, which is reflected in the design of network meetings. All the networks continue to be supported by our Executive Director Champion for Equality, Diversity and Inclusion.

You can find out more about how our Disability Network and Sustainability Network contribute to the organisation on page 108.

Recruitment and retention

The recruitment and retention pillar of our People Strategy is closely aligned to the actions taken in relation to our EDI work streams noted above. Using our data to understand where we have under- or overrepresentation of minority groups across all of the protected characteristics enables us to take specific action and make targeted interventions. Our recruitment activities are intended to directly support the aims of our EDI pillar.

In collaboration with various parts of the organisation we have been working on the development of our employer brand and employee value proposition. This will continue to support our recruitment activities and the ability to attract high-calibre candidates.

As noted on page 106, the organisation has seen an increase of more than 15% on our 2021/22 headcount which is in addition to the 10% turnover of staff. To ensure that we have been able to best support the organisation with its recruitment needs, we have progressed the following developments:

- adopted the use of a LinkedIn Recruiter licence, which allows us to directly approach suitable candidates to showcase vacancies and build out talent attraction to a wider audience;
- reviewed and assessed the available routes to market and a wider use of job boards including diversity boards;
- assessed our current applicant tracking system against external systems and agreed the need to consider alternative systems for 2023/24;
- built understanding of business critical roles across the organisation, which will influence workforce and talent planning, risk registers, financial planning, and project and change management planning; and
- undertaken specific market data research to understand specific recruitment challenges.

To ensure that we can continue to appropriately support the organisation's growing recruitment needs and associated equality, diversity and inclusion activities, we are in the process of establishing a professional resourcing service. This service will support the continued growth and talent acquisition plans for the organisation going forward. The service, along with the development of systems and processes, will support increased candidate attraction, engagement, network growth, targeted recruitment, pipelining, and training and support to recruit managers across all parts of the organisation.

Maximising employee health and wellbeing

Throughout 2022/23, we continued to support staff health and wellbeing through the provision of various initiatives including mental health first aiders and our Employee Assistance Programme. Our Health and Wellbeing Toolkit provides staff with details of a range of resources and support for many different areas of health and wellbeing. This is supported by an intranet page providing additional resources and guidance for staff and their line managers.

During January 2023 we ran an internal campaign – 'Time for Me in 2023' – to remind all staff of the significance of focusing on their health and wellbeing, financial wellbeing and career development. This included the provision of Lunch & Learns and workshops on subjects such as mindfulness, preventing burnout, mental health awareness and Emotional Freedom Technique. Recognising the potential impact of the cost of living crisis on our staff, throughout 2022/23 we launched a range of dedicated internal and external financial wellbeing resources.

Our staff engagement activities have continued to see a good level of input, with a positive response rate of 59% to the staff survey undertaken as part of the IiP re-accreditation process which contributed to our Gold award.

Talent management and succession planning

We have developed our inclusive talent management and succession planning strategy that will provide opportunities for all our people to meet their potential, internally and externally. By managing talent strategically, we can aim to build a high-performance workplace, encouraging a culture of learning and adding value to our employee value proposition and employer brand.

The organisation reported 95% compliance in the Performance Appraisal and Development Review. Our process has moved to a cyclical process, which encourages managers and direct reports to have regular one-to-one conversations all year round. Supporting paperwork has been developed to include a focus specifically on staff wellbeing and future career aspirations in addition to the review of individual performance.

The HR and OD teams have continued to provide a range of leadership and management development interventions, working in partnership with external providers where appropriate. These interventions include:

- the development of a SMT programme and leadership development programmes for the ODG and Claims leadership service;
- a number of individual and service interventions offered to operational service leaders across the organisation to develop their capacity in leading services through change;
- the development of a suite of policy into practice programmes which are aimed to enhance the quality of line management within the organisation; and
- making best use of our apprenticeship levy and using opportunities such as the National Apprenticeship Week, Lunch & Learn sessions and regular apprenticeship drop-in sessions.

Staff are undertaking apprenticeships in a range of programmes which include:

- Level 3 Operational service leader;
- Level 4 Insurance professional;
- Level 5 Coaching professional; and
- Level 7 Senior leader.

Our coaching and mentoring offer has continued to evolve and as a result we have established a Coaching and Mentoring Steering Network which meets quarterly to consider how coaching can support delivery of the People Strategy. The Network has delivered a Coach to Lead programme (which seeks to equip managers with the skills to lead) to 28 managers. Our coaches work collaboratively with the London Leadership Academy to engage in regular continuing professional development sessions and to undertake supervision to ensure they remain up to date with their practice.

Organisational change and transformation

As well as developing leadership and management capability in areas including change readiness, Coach to Lead and resilience, we have continued to evolve our people-related resources on our intranet. All staff have access to these resources, and we have seen a significant increase in staff using these resources. As mentioned on page 64, the HR and OD teams continue to work closely with the Change Management Office in order to support the organisation's change agenda.

In 2022/23, to ensure that we are offering our workforce access to information and support quickly and efficiently, we have made some important improvements in our systems and technology. These improvements include:

- moving to online annual leave capability, meaning that staff can now request leave electronically, and managers can approve via a simple two-click process. This makes the process quicker for everyone and ensures we are reducing the risk of fraud; and
- developing our 'People Portal', which is a single platform for staff and managers to access quicker help and support in relation to HR and OD matters. The portal provides people with access to the information they need quickly and easily, with the ability to raise a specific request where they are not able to find the information they need. As a result, the HR and OD teams will be freely available to respond to those queries and enquiries that are not routine or require further discussion.

In direct support of our transformation programmes, and in consideration of our existing *Organisational change policy and procedure*, we have developed a robust redeployment process which is overseen by the Workforce Development Group. This approach aims to maximise redeployment opportunities for affected staff and to minimise the impact of change where possible.

Parliamentary accountability and audit report

The following disclosures are subject to audit except where specified.

Losses and special payments

We had losses of £112,242 in 2022/23.
In 2021/22 we had losses of £129,586.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES schemes, are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy in Note 1.3 to the Financial Statements on page 132. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the Financial Statements on page 141.

Expenditure on consultancy (not subject to audit)

Expenditure incurred on consultancy in 2022/23 was nil.
In 2021/22 the expenditure on consultancy was nil.

Regularity of expenditure – gifts

We have not received or made any gifts where the value exceeded £300,000. Staff are required to declare gifts in line with NHS Resolution's Hospitality and Gifts Policy and Procedure (HR04), which states that staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Indemnity scheme cover for NHS Resolution

For 2022/23, NHS Resolution was covered under both LTPS and PES.

Use of Government Functional Standards (not subject to audit)

Our update on the use of Government Functional Standards is included in the Corporate governance report on page 97.

Remote contingent liabilities

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

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

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2022/23.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 5 July 2023

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 2023 under the National Health Service Act 2006.

The financial statements comprise NHS Resolution's

- Statement of Financial Position as at 31 March 2023;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

The financial reporting framework that has been applied in the preparation of the financial statements is applicable law and UK adopted international accounting standards.

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2023 and its net income for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

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

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 *Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2022)*. My responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of my certificate.

Those standards require me and my staff to comply with the Financial Reporting Council's *Revised Ethical Standard 2019*. I am independent of NHS Resolution in accordance with the ethical requirements that are relevant to my audit of the financial statements in the UK. My staff and I have fulfilled our other ethical responsibilities in accordance with these requirements.

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

Conclusions relating to going concern

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

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

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

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

Other information

The other information comprises information included in the Annual Report, but does not include the financial statements and my auditor's certificate and report thereon. The Accounting Officer is responsible for the other information.

My opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in my certificate, I do not express any form of assurance conclusion thereon.

My responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

If I identify such material inconsistencies or apparent material misstatements, I am required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work I have performed, I conclude that there is a material misstatement of this other information, I am required to report that fact.

I have nothing to report in this regard.

Opinion on other matters

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

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

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

Matters on which I report by exception

In the light of the knowledge and understanding of NHS Resolution and its environment obtained in the course of the audit, I have not identified material misstatements in the Performance and Accountability Reports.

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

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

Responsibilities of the Accounting Officer for the financial statements

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

- maintaining proper accounting records;
- providing the C&AG with access to all information of which management is aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;
- providing the C&AG with additional information and explanations needed for his audit;
- providing the C&AG with unrestricted access to persons within NHS Resolution from whom the auditor determines it necessary to obtain audit evidence;
- ensuring such internal controls are in place as deemed necessary to enable the preparation of financial statements to be free from material misstatement, whether due to fraud or error;
- ensuring that the financial statements give a true and fair view and are prepared in accordance with Secretary of State directions made under the National Health Service Act 2006;
- ensuring that the annual report, which includes the Remuneration and Staff Report, is prepared in accordance with Secretary of State directions made under the National Health Service Act 2006; and
- assessing NHS Resolution's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer anticipates that the services provided by NHS Resolution will not continue to be provided in the future.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

Audit response to identified risk

To respond to the identified risks resulting from the above procedures:

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

I also communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

A further description of my responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of my certificate.

Other auditor's responsibilities

I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income 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.

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

Report

I have no observations to make on these financial statements.

Gareth Davies
Comptroller and Auditor General

Date: Friday 7 July 2023

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

Financial statements

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2023

Comprehensive net expenditure	Notes	31 March 2023 £000	31 March 2022 £000
Other operating income	3	**(2,491,070)**	(2,525,620)
Total operating income		**(2,491,070)**	**(2,525,620)**
Staff costs	2	**38,904**	33,445
Purchase of goods and services	2	**7,466**	7,042
Depreciation and impairment charges	2	**2,005**	886
Provision (release)/expense	7/7.1	**(56,497,075)**	45,418,628
Other operating expenditure	2	3,703	2,830
Total operating (income)/expenditure		**(56,444,997)**	**45,462,831**
Net operating (income)/expenditure		**(58,936,067)**	**42,937,211**
Finance expenditure – IFRS 16	2, 9	**71**	-
Finance expenditure – claims	7	251,419	347,620
Net (income)/expenditure for the year		**(58,684,577)**	**43,284,831**
Comprehensive net (income)/expenditure for the year		**(58,684,577)**	**43,284,831**

The Notes on pages 132 to 170 form part of these Financial statements.

Statement of financial position as at 31 March 2023

Statement of financial position	Notes	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Property, plant and equipment		**915**	858
Intangible assets		**8,159**	3,719
Right of use assets		**9,428**	-
Total non-current assets		**18,502**	**4,577**
Current assets			
Trade and other receivables	4	**19,669**	18,117
Cash and cash equivalents	5	**605,728**	548,669
Total current assets		**625,397**	**566,786**
Total assets		**643,899**	**571,363**
Current liabilities			
Trade and other payables	6	**(66,443)**	(60,511)
Lease liability – short term	9	**(923)**	-
Provisions for liabilities and charges – known claims	7	**(3,351,058)**	(2,761,484)
Total current liabilities		**(3,418,424)**	**(2,821,995)**
Total assets less current liabilities		**(2,774,525)**	**(2,250,632)**
Non-current liabilities			
Lease liabilities	9	**(8,621)**	-
Provisions for liabilities and charges – known claims	7	**(37,723,455)**	(61,500,568)
Provisions for liabilities and charges – IBNR	7	**(28,539,000)**	(64,288,000)
Total non-current liabilities		**(66,271,076)**	**(125,788,568)**
Total assets less liabilities		**(69,045,601)**	**(128,039,200)**
Taxpayers' equity			
General Fund		**33,594**	16,764
Ex-RHA reserve		**(43,701)**	(76,013)
ELS reserve		**(833,763)**	(1,536,350)
CNST reserve		**(64,030,919)**	(120,007,174)
DHSC clinical reserve		**(2,213,692)**	(4,124,538)
ELGP reserve		**-**	-
ELSGP reserve		**(731,589)**	(1,100,864)
CNSGP reserve		**(912,928)**	(821,279)
CNSC reserve		**(36,414)**	(92,362)
CTIS reserve		**(2,240)**	(2,085)
DHSC non-clinical reserve		**(97,075)**	(132,741)
PES reserve		**3,835**	3,007
LTPS reserve		**(180,709)**	(165,565)
Total taxpayers' equity		**(69,045,601)**	**(128,039,200)**

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

The Board approved a recommendation on Wednesday 28 June 2023 that the financial statements from page 126 should be signed by the Accounting Officer and these were signed by Helen Vernon on Wednesday 5 July. The Notes on pages 132 to 170 form part of these Financial statements.

Helen Vernon
Chief Executive and Accounting Officer

Date: Wednesday 5 July 2023

Statement of cash flows for the year ended 31 March 2023

Cash flows	Notes	31 March 2023 £000	31 March 2022 £000
Cash flows from operating activities			
Net income/(expenditure)		**58,684,577**	(43,284,831)
Net finance cost – IFRS 16		**71**	-
Other cash flow adjustments	2	**2,005**	886
(Increase) in receivables	4	**(1,552)**	(1,789)
Increase in payables	6	**5,932**	10,383
(Decrease)/increase in provisions	7	**(58,936,538)**	43,307,723
Net cash (outflow)/inflow from operating activities		**(245,505)**	**32,372**
Cash flows from investing activities			
Purchase of property, plant and equipment		**(529)**	(43)
Purchase of intangible assets		**(4,938)**	(2,989)
Net cash outflow from investing activities		**(5,467)**	**(3,032)**
Cash flows from financing activities			
Net Parliamentary funding		**309,022**	221,500
Repayment of lease liability – capital	9	**(920)**	-
Repayment of lease liability – interest	9	**(71)**	-
Net financing		**308,031**	**221,500**
Net increase in cash and cash equivalents		**57,059**	**250,840**
Cash and cash equivalents at the beginning of the period		**548,669**	297,829
Cash and cash equivalents at the end of the period	**5**	**605,728**	**548,669**

The Notes on pages 132 to 170 form part of these Financial statements.

Statement of changes in taxpayers' equity for the year ended 31 March 2023

Changes in taxpayers' equity	Notes	General Fund £000	Ex-RHA Reserve £000	ELS Reserve £000	CNST Reserve £000	DHSC Clinical Reserve £000	ELGP Reserve £000	ELSGP Reserve £000	CNSGP Reserve £000	CNSC Reserve £000	CTIS Reserve £000	DHSC Non-Clinical Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
Balance at 31 March 2021		8,165	(62,451)	(1,135,862)	(78,756,404)	(3,141,362)	(457,482)	(421,168)	(615,083)	(79,098)	(2,006)	(111,635)	1,757	(203,239)	(84,975,868)
Transfers between schemes		-	-	-	-	-	(25,153)	25,153	-	-	-	-	-	-	-
Total recognised income and expense as at 2021/22		(5,801)	(14,841)	(432,343)	(41,250,770)	(1,063,857)	482,635	(788,035)	(209,010)	(13,364)	(79)	(28,291)	1,250	37,674	(43,284,832)
Net Parliamentary funding		14,400	1,279	31,855	-	80,681	-	83,186	2,814	100	-	7,185	-	-	221,500
Balance at 31 March 2022		**16,764**	**(76,013)**	**(1,536,350)**	**(120,007,174)**	**(4,124,538)**	**-**	**(1,100,864)**	**(821,279)**	**(92,362)**	**(2,085)**	**(132,741)**	**3,007**	**(165,565)**	**(128,039,200)**
Changes in taxpayers' equity for 2022/23															
Expenditure															
Authority and claims administration	2	(7,936)	(3)	(49)	(26,919)	(325)	-	(6,873)	(3,241)	(464)	(155)	(142)	(107)	(5,935)	(52,149)
(Increase)/decrease in provision for known claims	7	-	30,687	549,094	18,610,068	1,357,486	-	103,402	(91,661)	(826)	-	(2,337)	(7,110)	(52,147)	20,496,656
(Increase)/decrease in the provision for IBNR	7	-	-	113,000	34,962,000	451,000	-	147,000	(1,000)	56,000	-	29,000	-	(8,000)	35,749,000
		(7,936)	30,684	662,045	53,545,149	1,808,161	-	243,529	(95,902)	54,710	(155)	26,521	(7,217)	(66,082)	56,193,507
Income															
Scheme and other income	3	981	-	-	2,431,108	-	-	-	-	-	-	-	8,045	50,936	2,491,070
Total recognised income and expense for 2022/23		**(6,955)**	**30,684**	**662,045**	**55,976,257**	**1,808,161**	**-**	**243,529**	**(95,902)**	**54,710**	**(155)**	**26,521**	**828**	**(15,146)**	**58,684,577**
Net Parliamentary funding[1]		23,784	1,628	40,542	-	102,685	-	125,746	4,254	1,238	-	9,145	-	-	309,022
Balance at 31 March 2023		**33,593**	**(43,701)**	**(833,763)**	**(64,030,917)**	**(2,213,692)**	**-**	**(731,589)**	**(912,927)**	**(36,414)**	**(2,240)**	**(97,075)**	**3,835**	**(180,711)**	**(69,045,601)**

[1] The net Parliamentary funding represents the cash drawdown of £309.022 million in 2022/23 for DHSC-funded indemnity schemes and administration costs. The Notes on pages 132 to 170 form part of these Financial statements.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2022/23 Government Financial Reporting Manual (FReM) issued by HMT. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged most appropriate to the particular circumstances of NHS Resolution for giving a true and fair view has been selected. The particular policies adopted by NHS Resolution are described in the following text. They have been applied consistently in dealing with items that are considered material to the accounts.

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

1.1 Accounting conventions

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

1.2 New adoption of standards, amendments and interpretations

New standards effective and adopted in these accounts

IFRS 16 has been adopted for the first time in the 2022/23 accounts. A new accounting policy in relation to IFRS 16 has been included in Note 1.12 below.

NHS Resolution has not adopted any IFRS, amendments or interpretations early.

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

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

The following have not been adopted early in these accounts:

IFRS 17 Insurance Contracts

The effective date is for accounting periods beginning on or after 1 January 2021, but has not yet been adopted by the FReM with an expected adoption date from 1 April 2023. NHS Resolution considers that the indemnity schemes are out of scope of IFRS 17 as they are risk-pooling schemes and the significant insurance risk is passed back to the members through annual contributions which cover the expected costs of the schemes, or directly to DHSC through the provision of financing. Therefore, NHS Resolution's assessment is that IFRS 17 will not be applicable to the schemes it operates and so is not anticipated to have an impact on the accounts.

IFRS 14 Regulatory Deferral Accounts

The effective date is for first time adopted of IFRS after 1 January 2016. However, this standard has not been endorsed by the UK and has not been adopted within FReM. DHSC have confirmed that this standard is not applicable to DHSC group bodies for 2022/23. In addition, NHS Resolution's assessment is that this standard would not be applicable to our business and therefore is not anticipated to have any impact on the accounts.

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

1.3 Income

A source of funding for NHS Resolution as a Special Health Authority is a Parliamentary grant from DHSC within an approved cash limit, which is reported within the Statement of Changes in Taxpayers' Equity. This funds the ELS, Ex-RHA, DHSC clinical and non-clinical liabilities schemes, CNSC and CTIS (the Covid-19 schemes created in 2020/21), and some administration costs. In addition, from 1 April 2019, NHS Resolution received funding from NHSE via DHSC for the administration of general practice indemnity arrangements, as directed by the Secretary of State. Parliamentary funding is recognised in the financial period in which it is received.

The operating income disclosed in Note 3 to the accounts is that which relates directly to the operating activities of NHS Resolution. NHS Resolution currently has the following income streams, the accounting treatment of which have been assessed against the requirements of IFRS 15 Revenue Recognition:

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

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

NHS trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. Trusts unable to demonstrate achievement of the ten actions may be able to recover a lesser sum from the fund to help them achieve the actions.

As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead, they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme.

The scheme relaunched for 2022/23 and compliance with the ten safety actions will be assessed by the start of 2023/24, following which the contributions to the MIS will be collected and distributed against achievement of the actions early in the 2023/24 financial year.

1.4 Taxation

NHS Resolution is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.5 Pensions

NHS Resolution offers two pension schemes to staff, the NHS Pension scheme and the National Employment Savings Trust (NEST).

NHS Pension scheme

Past and present employees are covered by the provisions of the two NHS Pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023 is based on valuation data as at 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rates prescribed by HMT have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from the Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enroll workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Pension scheme, NHS Resolution used an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations.

NEST is a defined contribution pension scheme established by law to support the introduction of Automatic Enrolment. Contributions are taken from qualifying earnings, which for the tax year 2022/23 were £6,240 up to £50,270. Total contributions are 9%, with employee contributions at 5%, employer contributions at 3% and Government contributions (basic tax relief) at 1%. More details on NEST can be found on the NEST website www.nestpensions.org.uk/schemeweb/nest/my-nest-pension/contributions-and-fees.

1.6 Short-term employee benefits

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

1.7 Provisions and contingent liabilities

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

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

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

NHS Resolution does not consider that any of our indemnity schemes fall under the definition of an insurance contract as per IFRS 4 Insurance Contracts. This is because significant insurance risk is passed back to the members of risk-pooling schemes through annual contributions, to the GP Contract funding held by NHSE transferred via DHSC as provision of financing, or directly to DHSC through the provision of financing.

The difference between the gross value of claims and the probable cost of each claim as calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in Note 8.

The methodology with key assumptions, uncertainties and sensitivities in determining the various provisions are detailed in Note 7 to the accounts.

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 ALBs 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 2021/22).

1.9 Financial liabilities

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

1.10 Critical judgements and key sources of estimation uncertainty

In the application of NHS Resolution's accounting policies, which are described elsewhere in Note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. The judgements that have the most significant effect on the amounts recognised in the financial statements relate to the calculation of the provisions for known claims and for IBNR, as explained in Note 7.2.

1.11 IFRS 8 – operating segments

NHS Resolution has one reportable segment under IFRS 8: income and expenditure are separated into different scheme types in the Statement of Changes in Taxpayers' Equity.

1.12 IFRS 16 – Leases

NHS Resolution has adopted IFRS 16 in line with FReM adoption effective 1 April 2022. The adoption of the standard has not had a material impact on the financial statements.

The transition to IFRS 16 has been completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application and therefore there is no prior year adjustment.

Hindsight has been used to determine the lease term when contracts or arrangements contain options to extend or terminate the lease. Upon review of the leases it was determined that at initial application there were four leases that fell under the scope of IFRS 16, the two main leases being the London and Leeds offices. The London lease is for 10 years and the Leeds lease is for 20 years, with 5-year break clauses. Management took the decision to recognise both leases for a 10-year period as they were, at the time, reasonably certain that both leases will continue to run for that length of time and no earlier break clauses will be exercised.

On initial application NHS Resolution has measured the right of use assets for leases previously classified as operating leases, at an amount equal to the lease liability adjusted for accrued or prepaid lease payments. Subsequent measurement will be done by applying a cost model as defined in IFRS 16 sections 30-33.

The right of use assets are depreciated on a straight line basis over the term of lease recognised and the depreciation is charged to the Statement of Comprehensive Net Expenditure.

Lease payments are apportioned between finance charges and repayment of the principal. Finance charges are recognised in the Statement of Comprehensive Net Expenditure.

Irrecoverable VAT is expensed in the period to which it relates and therefore not included in the measurement of the lease liability and consequently the value of the right of use asset.

The incremental borrowing rate of 0.95% has been applied to the lease liabilities recognised at the date of initial application of IFRS 16.

Short term leases of low value assets

NHS Resolution has elected not to recognise right of use assets and lease liabilities for short-term leases of machinery that have a lease term of 12 months or less and of low-value assets (less than £5,000). NHS Resolution recognises the lease payments associated with these leases as an expense on a straight-line basis over the lease term.

Under IAS 17

In the comparative period, as a lessee NHS Resolution classified leases that transfer substantially all of the risks and rewards of ownership as finance leases. When this was the case, the leased assets were measured initially at an amount equal to the lower of their fair value and the present value of the minimum lease payments. Minimum lease payments were the payments over the lease term that the lessee was required to make, excluding any contingent rent.

Assets held under other leases were classified as operating leases and were not recognised in NHS Resolution's statement of financial position. Payment made under operating leases were recognised in profit or loss on a straight-line basis over the term of the lease. Lease incentives received were recognised as an integral part of the total lease expense, over the term of the lease.

2. Expenditure

Expenditure	Notes	2022/23 £000	2021/22 £000
Non-executive members' remuneration[1]		**142**	129
Other salaries and wages[2]			
Salaries and wages		**30,514**	26,549
Social security costs		**3,431**	2,741
Pension costs		**4,836**	4,034
Apprenticeship levy		**123**	121
Education, training and conferences		**188**	118
Establishment expenses		**1,193**	1,061
Low-value and short-term leases[3]			
Land and buildings		**57**	730
Lease cars		**5**	4
Photocopiers		**2**	-
Insurance		**176**	211
Transport (business travel)		**109**	22
Premises and fixed plant		**5,194**	4,395

[1,2] Additional explanations can be found in the Remuneration and staff report in the Accountability report section.

[3] Building lease costs reduced due to IFRS 16 adjustments.

Expenditure continued	Notes	2022/23 £000	2021/22 £000
External contractors			
Actuary's advice		**1,433**	1,322
Appeals advisory expenditure		**26**	29
External corporate legal fees[4]		**183**	188
Practitioner Performance Advice assessment expenditure		**144**	182
Advice professional services		**5**	-
Other[5]		**1,941**	1,156
Auditor's remuneration: audit fees[6]		**265**	250
Internal audit fees		**94**	63
Bank charges and interest		**12**	13
		50,073	**43,317**
Depreciation		**471**	454
Depreciation – Right of use assets[7]		**1,036**	-
Amortisation		**498**	376
Loss on disposal		**-**	20
Impairment		**-**	36
Total depreciation and amortisation		**2,005**	**886**
Total expenditure before provisions and finance costs[8]		**52,078**	**44,203**
Other finance costs – unwinding of discount	7	**251,419**	347,620
Increase in provision for known claims (excl. unwinding of discounts and change in the discount rates)	7	**17,116,295**	6,174,216
Change in the discount rates[9]	7	**(74,604,370)**	42,623,207
Increase/(decrease) in the provision for IBNR	7	**991,000**	(3,378,795)
Total provision (release)/expense	2.1/7.1	**(56,245,656)**	**45,766,248**
Finance costs – interest on lease liability		**71**	-
Total provision (release)/expense and finance costs		**(56,245,585)**	**45,766,248**
Total (income)/expenditure		**(56,193,507)**	**45,810,452**

[4] External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included in Note 7: Provisions.

[5] Other external contractor costs have increased due to activity on IT projects, improvements in IT architecture and security and on academic partnership work with the Safety and Learning team.

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

[7] Depreciation costs increased due to IFRS 16 adjustments to recognise right of use assets.

[8] Of the £52.1 million total expenditure for 2022/23, £5.4 million is shown as administration expenditure in DHSC consolidated group accounts.

[9] The discount rates used are mandated by HMT and are set out in Note 7.3 to the accounts.

2.1 Analysis of the provision expense

2022/23	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	LTPS £000	PES £000	Total £000
2022/23 incidents													
Known claims	-	-	40,321	-	-	-	1,778	-	-	14	7,060	2,089	51,262
IBNR	-	-	6,238,130	-	-	-	276,508	300	856	-	44,490	2,730	6,563,014
Total 2022/23	**-**	**-**	**6,278,451**	**-**	**-**	**-**	**278,286**	**300**	**856**	**14**	**51,550**	**4,819**	**6,614,276**
Prior year incidents													
Known claims	(30,687)	(549,094)	(18,650,389)	(1,357,486)	-	(103,402)	89,883	826	-	2,323	45,087	5,021	(20,547,918)
IBNR	-	(113,000)	(41,200,130)	(451,000)	-	(147,000)	(275,508)	(56,300)	(856)	(29,000)	(36,490)	(2,730)	(42,312,014)
Total prior years	**(30,687)**	**(662,094)**	**(59,850,519)**	**(1,808,486)**	**-**	**(250,402)**	**(185,625)**	**(55,474)**	**(856)**	**(26,677)**	**8,597**	**2,291**	**(62,859,932)**
Total	**(30,687)**	**(662,094)**	**(53,572,068)**	**(1,808,486)**	**-**	**(250,402)**	**92,661**	**(55,174)**	**-**	**(26,663)**	**60,147**	**7,110**	**(56,245,656)**

2021/22	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	LTPS £000	PES £000	Total £000
2021/22 incidents													
Known claims	-	-	67,880	-	-	-	1,136	72	-	39	6,344	6,053	81,524
IBNR	-	-	13,216,979	-	-	-	339,523	15,000	-	-	49,913	2,631	13,624,046
Total 2021/22	**-**	**-**	**13,284,859**	**-**	**-**	**-**	**340,659**	**15,072**	**-**	**39**	**56,257**	**8,684**	**13,705,570**
Prior year incidents													
Known claims	20,840	397,286	22,214,328	1,034,592	-	441,864	57,845	55	-	13,128	39,179	2,607	24,221,724
IBNR	(6,000)	35,000	8,187,021	29,000	-	(142,000)	(192,523)	(2,000)	-	15,000	(80,913)	(3,631)	7,838,954
Total prior years	**(14,840)**	**432,286**	**30,401,349**	**1,063,592**	**-**	**299,864**	**(134,678)**	**(1,945)**	**-**	**28,128**	**(41,734)**	**(1,024)**	**32,060,678**
Total	**(14,840)**	**432,286**	**43,686,208**	**1,063,592**	**-**	**299,864**	**205,981**	**13,127**	**-**	**28,167**	**14,523**	**7,660**	**45,766,248**

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 2022/23 totals £6,614 million across all schemes. This compares to £13,706 million in 2021/22.

The estimated cost of incidents arising from the clinical activity in 2022/23 covered by the largest scheme, CNST, was £6,278 million. This figure is materially lower than the £13,285 million reported in 2021/22, reflecting the change in HMT long-term discount rates, which places a much lower value on projected claims costs. If the 2021/22 discount rates were applied for the reporting year, the equivalent cost of harm figure would have been £12,631 million. There has been a £654 million reduction arising from lower-than-expected claims numbers and average cost of PPO claims, and from claims inflation assumptions.

The prior year's incidents figures show the changes in provisions that have been recognised in previous reporting years. In 2022/23 the total release of the provision to the Statement of Comprehensive Net Expenditure was £56,245 million. The factors affecting change in the provision are described in the Finance report on pages 67 to 74.

The approach taken to valuing the provision is shown in Note 7.2 on page 148.

3. Operating income

Operating income	2022/23 £000	2021/22 £000
CNST contributions	**2,431,108**	2,458,741
LTPS contributions	**50,936**	56,937
PES contributions	**8,045**	9,007
Practitioner Performance Advice	**981**	935
Total	**2,491,070**	**2,525,620**

4. Receivables

Receivables	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	PES £000	LTPS £000	Administration £000	Total 31 March 2023 £ 000	Total 31 March 2022 £ 000
NHS receivables – revenue	-	-	(28)	-	-	-	-	-	-	-	83	2,114	49	2,218	2,136
Accrued income	-	174	2,230	14	-	25	13	-	-	-	-	5	41	2,502	23
Prepayments	44	809	672	2,032	-	-	-	-	-	-	-	-	1,945	5,502	5,119
VAT	-	5	3,724	36	-	223	94	2	-	17	7	184	321	4,613	7,118
Other receivables	-	154	4,754	150	(425)	-	-	-	-	-	2	61	138	4,834	3,721
	44	**1,142**	**11,352**	**2,232**	**(425)**	**248**	**107**	**2**	**-**	**17**	**92**	**2,364**	**2,494**	**19,669**	**18,117**

5. Cash and cash equivalents

Cash and cash equivalents	Ex-RHA £000	ELS £000	CNST £000	ELSGP £000	CNSGP £000	PES £000	LTPS £000	Administration £000	Total 31 March 2023 £ 000	Total 31 March 2022 £ 000
At 1 April 2022	113	37,766	420,438	100	100	15,739	62,321	12,092	548,669	297,829
Change during the year	1,086	33,541	(54,697)	61,052	999	127	15,410	(459)	57,059	250,840
At 31 March 2023[1]	**1,199**	**71,307**	**365,741**	**61,152**	**1,099**	**15,866**	**77,731**	**11,633**	**605,728**	**548,669**

6. Trade payables and other current liabilities

Trade payables	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	PES £000	LTPS £000	Administration £000	Total 31 March 2023 £ 000	Total 31 March 2022 £ 000
NHS payables – revenue	-	-	1,245	-	-	-	-	-	-	59	249	32	1,585	827
Prepaid income	-	-	12,786	1,198	-	-	-	-	-	-	-	26	14,010	15,722
Accruals	39	431	17,619	1,296	1,008	413	6	-	50	28	390	2,929	24,209	28,214
Other payables	-	261	17,943	4,351	319	183	-	-	202	(1)	169	3,212	26,639	15,748
	39	**692**	**49,593**	**6,845**	**1,327**	**596**	**6**	**-**	**252**	**86**	**808**	**6,199**	**66,443**	**60,511**

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

7. Provisions for liabilities and charges

Provisions	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	75,325	1,380,007	58,315,683	3,544,243	-	762,387	69,923	100	-	16,930	11,033	86,420	64,262,051
Opening provisions for IBNR	-	180,000	62,043,000	647,000	-	338,000	745,000	92,000	2,000	120,000	4,000	117,000	64,288,000
Total provisions as at 1 April 2022	**75,325**	**1,560,007**	**120,358,683**	**4,191,243**	**-**	**1,100,387**	**814,923**	**92,100**	**2,000**	**136,930**	**15,033**	**203,420**	**128,550,051**
Movement in known claims													
Provided in the year	4,009	156,462	20,270,314	393,608	-	307,635	165,229	927	-	8,734	8,514	80,841	21,396,273
Provision not required written back	-	(21,601)	(3,946,717)	(108,208)	-	(144,805)	(29,678)	(46)	-	(6,064)	(1,012)	(21,847)	(4,279,978)
Unwinding of discount	598	10,516	215,841	23,740	-	587	61	-	-	29	-	47	251,419
Change in discount rates	(35,294)	(694,471)	(35,149,506)	(1,666,626)	-	(266,819)	(43,951)	(55)	-	(362)	(392)	(6,894)	(37,864,370)
Provisions utilised in the year	(1,376)	(29,044)	(2,381,702)	(99,707)	-	(117,943)	(11,715)	(213)	-	(6,200)	(7,808)	(35,174)	(2,690,882)
Movement in known claims	**(32,063)**	**(578,138)**	**(20,991,770)**	**(1,457,193)**	**-**	**(221,345)**	**79,946**	**613**	**-**	**(3,863)**	**(698)**	**16,973**	**(23,187,538)**
Movement in IBNR													
Change in discount rates	-	(67,000)	(35,994,000)	(287,000)	-	(91,000)	(220,000)	(27,000)	-	(35,000)	-	(19,000)	(36,740,000)
Provided in the year	-	(46,000)	1,032,000	(164,000)	-	(56,000)	221,000	(29,000)	-	6,000	-	27,000	991,000
Movement in IBNR	**-**	**(113,000)**	**(34,962,000)**	**(451,000)**		**(147,000)**	**1,000**	**(56,000)**	**-**	**(29,000)**	**-**	**8,000**	**(35,749,000)**
Closing provision for known claims	43,262	801,869	37,323,913	2,087,050	-	541,042	149,869	713	-	13,067	10,335	103,393	41,074,513
Closing provisions for IBNR	-	67,000	27,081,000	196,000	-	191,000	746,000	36,000	2,000	91,000	4,000	125,000	28,539,000
Total provision as at 31 March 2023	**43,262**	**868,869**	**64,404,913**	**2,283,050**	**-**	**732,042**	**895,869**	**36,713**	**2,000**	**104,067**	**14,335**	**228,393**	**69,613,513**
Analysis of expected timing of discounted cash flows[1]													
Not later than one year[2]	1,432	25,938	3,017,187	97,003	-	124,410	27,568	169	-	13,352	6,143	37,856	3,351,058
Later than one year and not later than five years	7,043	123,038	11,274,450	370,582	-	342,219	336,044	5,022	1,000	23,009	7,542	127,850	12,617,799
Later than five years	34,787	719,893	50,113,276	1,815,465	-	265,413	532,257	31,522	1,000	67,706	650	62,687	53,644,656
Total provision as at 31 March 2023	**43,262**	**868,869**	**64,404,913**	**2,283,050**	**-**	**732,042**	**895,869**	**36,713**	**2,000**	**104,067**	**14,335**	**228,393**	**69,613,513**

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

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

[2] The one-year projected cash flow figures shown above reflect an updated view of 2023/24 cash flow based on the latest provisioning exercise. As well as using the most up-to-date data and assumptions, the provisioning exercise more generally focuses on long-term (rather than short-term) view. This leads to differences in projected cash flows from those budgeted for 2023/24 as part of the 2023/24 cash flow projection exercise that was performed during the summer of 2022, where the emphasis was on short-term cash flows and assumptions that materially impact the short-term view. Both results are considered equally valid for their respective purposes.

Provisions for liabilities and charges (prior year)

Provisions	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGP £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	PES £000	LTPS £000	Restated total £000
Opening provision for known claims	55,751	1,002,628	38,247,332	2,592,424	193,635	207,462	15,403	-	-	10,681	6,694	85,318	42,417,328
Opening provisions for IBNR	6,000	145,000	40,639,000	618,000	289,000	191,000	598,000	79,000	2,000	105,000	5,000	148,000	42,825,000
Restated total provisions as at 1 April 2021[1]	**61,751**	**1,147,628**	**78,886,332**	**3,210,424**	**482,635**	**398,462**	**613,403**	**79,000**	**2,000**	**115,681**	**11,694**	**233,318**	**85,242,328**
Movement in known claims													
Transfer between schemes	-	-	-	-	(193,635)	193,635	-	-	-	-	-	-	-
Provided in the year	1,198	38,279	8,408,657	221,273	-	481,934	58,235	125	-	15,341	10,016	69,701	9,304,759
Provision not required written back	(546)	(18,744)	(2,827,151)	(91,359)	-	(159,697)	(5,822)	-	-	(2,099)	(1,317)	(23,809)	(3,130,544)
Unwinding of discount	953	16,590	290,785	36,571	-	2,259	427	-	-	9	-	26	347,620
Change in discount rates	19,234	361,160	16,409,916	868,107	-	117,368	6,141	3	-	(84)	(39)	(394)	17,781,412
Provisions utilised in the year	(1,265)	(19,906)	(2,213,856)	(82,773)	-	(80,574)	(4,461)	(28)	-	(6,918)	(4,321)	(44,422)	(2,458,524)
Movement in known claims	**19,574**	**377,379**	**20,068,351**	**951,819**	**(193,635)**	**554,925**	**54,520**	**100**	**-**	**6,249**	**4,339**	**1,102**	**21,844,723**
Movement in IBNR													
Transfer between schemes	-	-	-	-	(289,000)	289,000	-	-	-	-	-	-	-
Change in discount rates	-	68,768	24,463,000	285,027	-	5,000	11,000	-	-	15,000	-	(6,000)	24,841,795
Provided in the year	(6,000)	(33,768)	(3,059,000)	(256,027)	-	(147,000)	136,000	13,000	-	-	(1,000)	(25,000)	(3,378,795)
Movement in IBNR	**(6,000)**	**35,000**	**21,404,000**	**29,000**	**(289,000)**	**147,000**	**147,000**	**13,000**	**-**	**15,000**	**(1,000)**	**(31,000)**	**21,463,000**
Closing provision for known claims	75,325	1,380,007	58,315,683	3,544,243	-	762,387	69,923	100	-	16,930	11,033	86,420	64,262,051
Closing provisions for IBNR	-	180,000	62,043,000	647,000	-	338,000	745,000	92,000	2,000	120,000	4,000	117,000	64,288,000
Total provision as at 31 March 2023	**75,325**	**1,560,007**	**120,358,683**	**4,191,243**	**-**	**1,100,387**	**814,923**	**92,100**	**2,000**	**136,930**	**15,033**	**203,420**	**128,550,051**
Analysis of expected timing of discounted cash flows[2]													
Not later than one year	1,297	36,975	2,393,405	162,955	-	109,373	11,345	-	-	6,884	6,766	32,484	2,761,484
Later than one year and not later than five years	5,422	125,467	10,005,727	611,766	-	327,042	249,604	5,006	1,000	130,046	8,267	170,936	11,640,283
Later than five years	68,606	1,397,565	107,959,551	3,416,522	-	663,972	553,974	87,094	1,000	-	-	-	114,148,284
Total provision as at 31 March 2022	**75,325**	**1,560,007**	**120,358,683**	**4,191,243**	**-**	**1,100,387**	**814,923**	**92,100**	**2,000**	**136,930**	**15,033**	**203,420**	**128,550,051**

[1] In the 2021/22 financial statements a restatement was made of the 2020/21 comparators and 1 April 2021 opening position in respect of the revaluation of the known claims provision. Further information is available in Note 7.4 of the 2021/22 accounts.

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

7.1 Reconciliation of Note 7 to Statement of comprehensive net expenditure

Reconciliation of Note 7 to comprehensive net expenditure	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELSGP £000	CNSGP £000	CNSC £000	CTIS £000	DHSC Non-Clinical £000	PES £000	LTPS £000	Total £000
Unwinding of discount/finance charge	**598**	**10,516**	**215,841**	**23,740**	**587**	**61**	**-**	**-**	**29**	**-**	**47**	**251,419**
Increase in known claims provision	4,009	156,462	20,270,314	393,608	307,635	165,229	927	-	8,734	8,514	80,841	21,396,273
Provision not required written back	-	(21,601)	(3,946,717)	(108,208)	(144,805)	(29,678)	(46)	-	(6,064)	(1,012)	(21,847)	(4,279,978)
Change in discount rates (known claims and IBNR)	(35,294)	(761,471)	(71,143,506)	(1,953,626)	(357,819)	(263,951)	(27,055)	-	(35,362)	(392)	(25,894)	(74,604,370)
Increase/(decrease) in provision for IBNR	-	(46,000)	1,032,000	(164,000)	(56,000)	221,000	(29,000)	-	6,000	-	27,000	991,000
Provision expense charged to Statement of comprehensive net expenditure	**(31,285)**	**(672,610)**	**(53,787,909)**	**(1,832,226)**	**(250,989)**	**92,600**	**(55,128)**	**-**	**(26,692)**	**7,110**	**60,100**	**(56,497,075)**
Total charge to Statement of comprehensive net expenditure	**(30,687)**	**(662,094)**	**(53,572,068)**	**(1,808,486)**	**(250,402)**	**92,661**	**(55,174)**	**-**	**(26,663)**	**7,110**	**60,147**	**(56,245,656)**

7.2 Explanatory notes

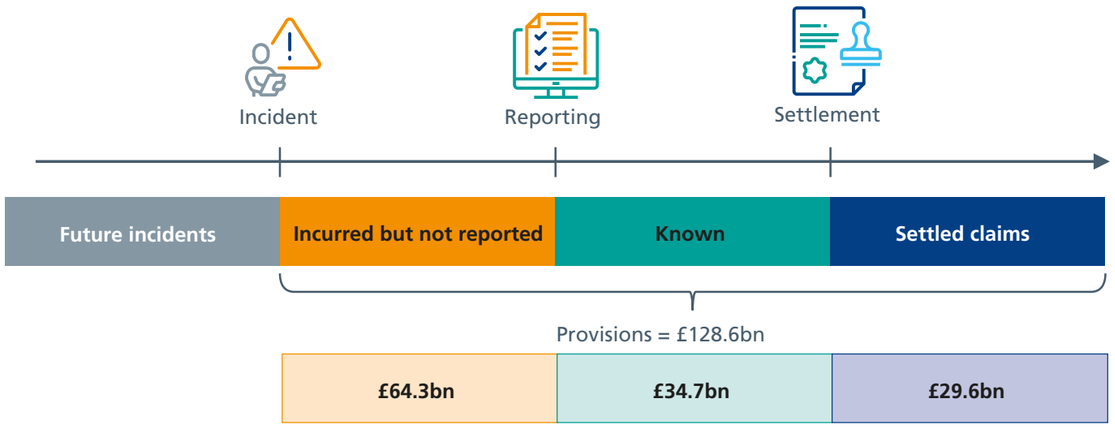
Nature and scope of the obligation

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

- **Known claims** – provisions for claims received by NHS Resolution but not yet settled
- **Settled periodical payment orders (PPOs)** – where the past settlement of a claim involves ongoing payments to the claimant into the future, generally for their lifetime
- **Incurred but not reported (IBNR)** – provision for claims that have not yet been received but where it can be reasonably predicted that:
  - an adverse incident has occurred; and
  - a transfer of economic benefits will occur; and
  - a reasonable estimate of the likely value can be made.

The different parts of the provision and their link to the claims journey is shown in figure 37 below.

Figure 37: Provision and the claims journey



The schemes we administer are shown in the Appendix on page 174.

Developments over the year affecting the provisions

Discount rates

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

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

This year, there was a significant increase in the discount rates prescribed by HMT, across all durations. These rates are used to convert future payments into a present value, as outlined in the explanatory box on page 17. This update has decreased the provision by £74.6 billion. Although the change in discount rates prescribed by HMT has a material effect on the value of the provisions, it does not alter the cost of settling claims, which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (e.g. the personal injury discount rate). As such, the £74.6 billion decrease in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

Short-term inflation

Short-term inflation expectations for the next year have increased relative to last year owing to the post-pandemic economic recovery, higher energy prices, and supply and labour constraints. The provisions are determined assuming that claims inflation will be significantly higher in the next year, reflecting the assumption that a higher cost of living in the general economic environment will lead to higher claim settlement costs. Claims inflation is assumed to fall (below the long-term average) the following year, before returning to the long-term view thereafter. The impact on the CNST IBNR provision is shown in table 30 on page 156.

Long-term claims inflation trends

Notwithstanding the higher short-term inflation expectations in the general economic environment, average settlement costs have generally increased at the rates previously assumed. As such, we have mostly maintained our long-term claims inflation assumptions. The notable exception is for PPO damages, where recent trends in settled claim costs support a slight reduction in the long-term view of inflation. See page 159 for details of the impact of the changes to the claims inflation assumption on CNST IBNR.

Indemnity arrangements for coronavirus

The coronavirus pandemic has had a significant impact on the NHS over the last three years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes that were established for 2020/21 (CNSC and CTIS), the liabilities covered under the arrangements that were already in place (i.e. through CNST, CNSGP and LTPS) have also been affected owing to changes in healthcare provision.

As was the case last year, the estimated effect on the NHS Resolution provision is fairly limited (£1.5 billion) at this stage because:

- A large share of the total provision is in relation to incidents that occurred prior to 2020/21. While these claims might still be affected by any potential disruption in the reporting and settlement of claims, this is not expected to significantly alter the liabilities due.
- A large proportion (63% for 2022/23 compared to approximately 70% in 2021/22) of the CNST IBNR provision is as a result of claims arising from maternity activity. Although there were some changes to maternity activities during the pandemic, activities generally continued and we assume that there will be a similar level of claims as in previous years. The estimated value of CNST IBNR PPO claims, which mainly relate to maternity, for incidents in 2022/23 is approximately £4.4 billion.
- The success of the vaccination programme meant that clinical activity wasn't as severely disrupted in 2021/22 and 2022/23.
- Although we continue to allow for the possibility of new risks and potential claims arising from Covid-19, these have been towards the lower end of the ranges that we have previously considered.

As a result of the limited experience from which to quantify the impacts of Covid-19 on the provisions, our estimates are subject to uncertainty. Our approach to determining the impact of Covid-19 on the provisions is similar to that adopted in 2021/22, where we have separately considered:

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

Early notification

The majority of the CNST provision is as a result of claims arising from maternity activities, such as babies brain damaged at birth following negligent care.

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

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

Within the IBNR provision, we continue to separately model claims reported under the ENS and those expected to be reported outside of the ENS, but still within CNST. In arriving at our assumed number of claims, we have considered the rate at which ENS cases have been opened to date while assuming that the overall level of risk in relation to brain damage at birth is broadly similar to the period before ENS. Hence, we assume that the overall number of successful high-value claims after the introduction of the ENS will be similar to the period before, reflecting that the ENS only alters the reporting and claim settlement process, rather than the exposure to risk. Since only a very small number of high-value ENS claims have been settled so far, other assumptions in respect of claim costs and settlement lags are set with reference to standard maternity claims.

Known claims provisions – probabilities

The known claims provision calculation relies on probability assumptions that reflect the case handlers' views on the likelihood of each claim being successful. These probabilities have been reviewed this year and updated where appropriate. This change has led to an increase in the known claims provision.

Known claims provisions – timing of cash flows

For the 2021/22 accounts, the known claims provisions were determined using an actuarial view of settlement patterns to apply inflation and discounting. This was instead of using the estimated settlement date (ESD) for each claim recorded in the Claims Management System, as had been used historically. This actuarial approach has been further refined this year, ensuring consistency across IBNR and known claims provision calculations. The calculation is also consistent with disclosures of the expected timing of cash flows.

Risk and uncertainty

The risk and uncertainty inherent in the provision continue to be demonstrated via presentation of sensitivity analysis and the reasonable range. The reasonable range has been extended this year to capture uncertainty in the known claims provision calculation.

Assumption of liabilities upon cessation

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

Process and methodology for setting the provision

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

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

In addition to the discount rates, there are other factors that influence the provision that are also outside NHS Resolution's control; for example, patients (and their legal representatives) have an element of control over the timing of the reporting of claims. The RPC keeps all the factors affecting the calculation of provisions under review to ensure that the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

Methodologies

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

- **Known claims –** The provision is based on the case estimates of individual reported claims received by NHS Resolution. The case estimates are adjusted for:
  - the case handlers' estimated probability of each claim being successful;
  - expected future claims inflation to settlement, based on an actuarial view of the expected timing of settlement of the provision;
  - the likelihood that they will go on to settle under a periodical payment regime, with part of the claim paid over the life of the claimant as a regular stream of compensation income rather than purely as a lump sum; and
  - the assumed additional cost if the case were to settle as a PPO.

The resulting adjusted claim values are then discounted for the time value of money (at HMT-prescribed rates) to give a present value at the accounting date.

- **Settled PPOs –** The provision is determined on an individual claim-by-claim basis and then aggregated across all settled PPOs. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation). A probability of survival is then applied to each projected payment, based on the individual's life expectancy and the relevant mortality tables. This provides a weighting that allows for the relative probability of each payment being made. This forms the cash flows which are then discounted using HMT-prescribed discount rates to calculate a present value of the liability.
- **IBNR –** To estimate the IBNR provision at the accounting date, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a present value (at HMT-prescribed discount rates). The steps to arrive at an estimate are:
  - A characteristic pattern of claims reporting from claim incident year is identified to determine the ultimate number of claims that are expected to arise from incidents that have occurred in each past year up to the accounting date. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.
  - Assumptions are then made about the average claim cost for different types of claim. Adjustments are made to these assumed claim costs to allow for expected future claims inflation.
  - By combining the average claim sizes with the claim numbers and patterns for the reporting to payment time-lag appropriately, a projection is made for the total value of claim payments for IBNR claims in each future year.
  - For claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows, based on mortality assumptions derived from the settled PPO claims. Lump sum settlements are assumed to be paid out in full around settlement time.
  - The final step in the process is to calculate the present value of the projected future cash flows (using the HMT-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.

These steps are applied across all schemes, noting the following differences:

- For CNST, ELS and DHSC clinical liabilities, calculations are carried out separately for damages, NHS legal costs and claimant costs, and for PPO and non-PPO type claims. We continue to set separate assumptions for the maternity claims reported under the ENS within the IBNR provision.
- For ELSGP, the reserving assumptions are based upon the combined historical claims experience from periods where claims were handled by MDDUS and/or MPS, and also more recently where claims have been handled by NHS Resolution.
- For CNSGP, the assumptions used to determine the provisions are based mainly on ELSGP experience, scaled up to allow for the fact that CNSGP has wider exposure coverage.
- For CNSC and other coronavirus liabilities, approximate methods have been used based on levels of activity and assumed claim frequency and severity based on similar clinical risks.

7.3 Key assumptions and areas of uncertainty

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

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

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

Key areas of uncertainty in the estimation of the claims provision

The number of clinical claims reported to NHS Resolution and lag patterns: The number of claims reported to NHS Resolution's long-established schemes has reduced over the last couple of years, excluding claims reported under the ENS. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in past claim trends. Covid-19 has reduced the number of claims being received from activity in 2020/21; however, clinical activity appears to have recovered to pre-pandemic levels.

Estimating the ultimate number of claims is complicated by the fact that clinical negligence claims can take a number of years to be reported following the incident that gives rise to the claim. The IBNR provision depends on an assumed time-lag pattern for how claims are reported to NHS Resolution following the incident. If the true pattern of reporting is faster than that assumed, this may mean that the number of IBNR claims has been overestimated, and vice versa. Changing trends in this pattern over time, for example as a result of changes to the legal environment, the introduction of the ENS (leading to earlier reporting of incidents and claims), increased awareness of the availability of compensation, potential disruptions owing to Covid-19 and growing waiting lists, increase the uncertainty in this assumption.

Claims settling as PPOs: PPOs remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

Claims inflation: Because of the long-term nature of the liabilities, even small changes to the assumed rate of future claim value inflation can have a significant impact on the estimated provisions. Claim value inflation has historically been much higher than price inflation. For clinical negligence claims, inflation is affected by a number of external factors such as the PIDR, changes in legal precedent (e.g. rules relating to accommodation costs determined by Swift v. Carpenter) and changes in legal costs. The variety of potential external influences on future claims inflation means that this assumption is subject to significant uncertainty.

The HMT PES discount rate note from December 2022 (which specifies the financial assumptions to be used for valuing provisions at March 2023) states that all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) Consumer Prices Index (CPI) forecasts unless certain conditions are met for this assumption to be rebutted. These conditions are set out in Paragraph 40 of Annex B of the HMT PES note PES (2022) 08.

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

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

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

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

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

- first, looking at nominal increases in average claim costs over past years by reserving segment; and
- then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past.

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

Life expectancy: The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Each claimant's life expectancy is estimated at settlement by medical experts. The actual future lifetime of the claimant may differ significantly from this estimate. Furthermore, it is difficult to determine whether the life expectancies estimated by medical experts will prove to be too long or too short on average across all claimants. The average life expectancy of claimants could also be influenced by future advances in medical care or other events (e.g. epidemics).

Covid-19: As with last year's provisions, there are additional assumptions made, and hence uncertainties in the provision, as a result of the impact of Covid-19. Among other risks, the provision continues to allow for clinical negligence claims resulting from the treatment of Covid-19 and vaccine administration. Broadly speaking, claim numbers received to date are towards the lower end of ranges previously considered. However, this is offset by risks and potential sources of claims from a further year of clinical activity, as well as additional potential claims arising from misdiagnosis and delay.

Legal environment: The provisions have been valued using the current PIDR of minus 0.25%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR. The next review is scheduled for 2024. However, as there is no certainty on the outcomes of future reviews, no adjustments have been made to the IBNR or known claims provisions for the potential effects of such changes at this stage.

Scheme developments: There is additionally some uncertainty in relation to the impact of the ENS, which impacts some maternity incidents that occurred on or after 1 April 2017, on claims costs and reporting trends.

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

Key assumptions

Table 30 shows a summary of the key assumptions used to determine the CNST IBNR provision. The CNST IBNR provision is the largest single element of the total provision, and therefore where uncertainty has the greatest effect. For each assumption, the degree of uncertainty in the assumption and the impact of the assumption on the level of provisions has been categorised as 'high', 'medium' or 'low'. These categories are colour coded in the table, with red shading to highlight the areas of greatest uncertainty and sensitivity, and green shading to highlight the areas where uncertainty and sensitivity is relatively low. Where appropriate the same assumptions are used for the CNST settled PPOs and known claims provisions.

The impacts of the various assumptions can be found detailed in figure 38: CNST IBNR sensitivities as at 31 March 2023 (page 161).

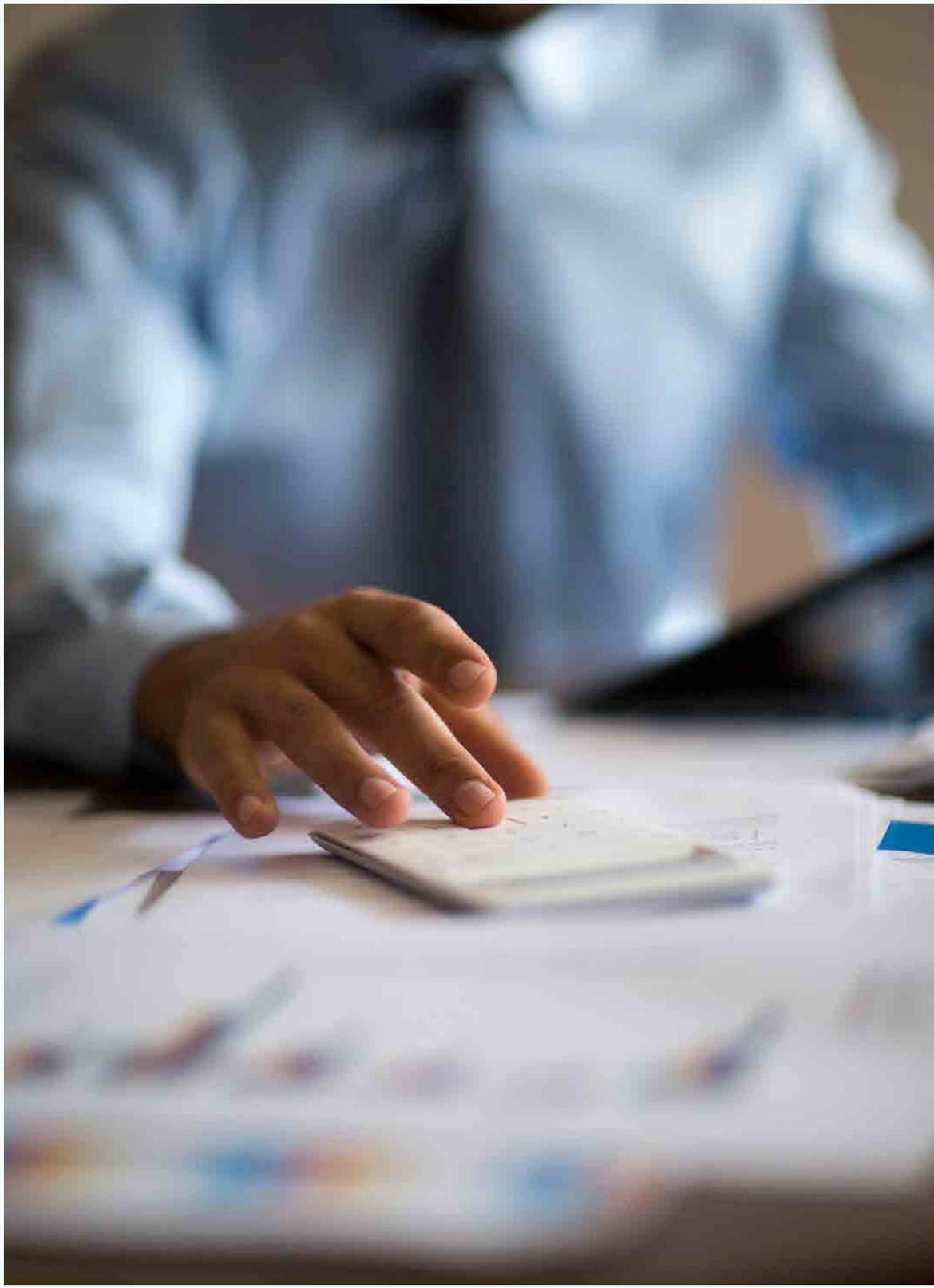


Table 30: Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes	Change in assumption between 31 March 2022 and 31 March 2023	Effect of change (CNST IBNR)
Nominal discount rates	HMT prescribed	Prescribed	High	All discount rates have been updated. Short- and medium-term rates have increased by 2.80 percentage points and 2.50 percentage points respectively. The long-term and very long-term rates have increased by 2.56 percentage points and 2.34 percentage points respectively.	-£35.9 billion
Ultimate number of claims and propensity to settle as PPO	Derived from past claim numbers and development patterns and assumptions that the level of risk will be similar to previous years, adjusted for levels of activity	Medium	High	The ENS has accelerated the reporting of potential PPO claims. We allow for this by specifying separate assumptions for claims that are expected to be reported under the ENS. Generally, we assume that there will be a similar number of successful PPO claims but there has been a slightly lower number of potential PPO claims reported over the year which leads to a slight decrease in the assumed number of claims and IBNR provision. The expected number of future non-PPO claims is similar to last year.	-£2.6 billion
	Value threshold derived from recent years' settled claims data	Medium	Medium	A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has increased from £3.50 million to £4.25 million.	
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High	The average cost per claim assumptions have increased for non-PPOs, generally in line with the expected level of claims inflation. For PPO damage claims, average costs have increased at a slightly slower rate than previously assumed. The assumed average cost for PPOs depends on the HMT discount rate used to place a present value on structured settlement payments. An increase to these rates has resulted in a significant decrease to the average cost assumption for PPO damages. This has been accounted for under the nominal discount rate impact shown above.	-£0.6 billion
Claims inflation	Long-term claims inflation: derived from past settled claims Short-term claims inflation: derived from short-term HMT prescribed CPI forecasts	High	High	The inflation assumption for PPO damages has decreased by 0.25 percentage points per annum from the previous year. We are assuming that the higher short-term inflationary environment will feed through to higher short-term claims inflation.	-£0.7 billion +£0.1 billion
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium	This assumption has been reduced for the 2017/18 and 2018/19 incident years, due to different experience being observed for these years. The assumption is unchanged for other incident years.	-£0.1 billion
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)	Lag range from 2.9 to 7.3 years, unchanged at the lower end and decreasing by 0.2 years at the higher end of the range.	-£0.1 billion
Life expectancy for PPO payments	Based on analysis of past settled PPO claims	Medium	Low	Separate assumptions are specified for ENS claims (42 years) and non-ENS claims (39 years), with the assumption for non-ENS claims increasing by two years.	+£0.4 billion
ASHE 6115 (80th percentile)	Based on earnings increases relative to CPI over the longer term	Medium	High	The ASHE assumption is unchanged at CPI+1.75%.	-

Sensitivities as at 31 March 2023

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

- Sensitivity of the total provisions (known claims, settled PPOs and IBNR) to changes in the following key assumptions:
  - HMT discount rates;
  - ASHE assumption;
  - claims inflation;
  - life expectancy; and
  - payment pattern.
- For CNST IBNR provisions, which represent the single most uncertain element of the total provision, sensitivity of the provisions to other assumptions.
- For CNST, which is the largest scheme, a reasonable range based on different plausible assumptions.

Sensitivity of provision to key assumptions

The following tables show the effect on the valuation of the total provisions if different rates and assumptions were applied for HMT discount rates, the differential between CPI and ASHE, claims inflation, life expectancy and payment patterns. The tables show the separate impact on:

- The **known claims** provision. This represents 35% of total provisions.
- The **settled PPO** provision. This represents 24% of total provisions. They are typically high-value claims, and their long-term nature means they are highly sensitive to changes in key assumptions.
- The **IBNR** provision. This represents 41% of total provisions.

Note that the tables that follow show the sensitivity of the total provision across all schemes. However, the provision, and sensitivity of the provision, is dominated by CNST which accounts for 93% of the total provisions.

Note also that, historically, the IBNR provision has represented over 50% of the total provision, exceeding the provision for known claims and settled PPOs. However, this is no longer the case because:

- much of the known claims provision is driven by a growing book of settled PPOs that are particularly exposed to claims inflation due to the long-term nature of structured settlement payments;
- ENS has accelerated the movement of claims from IBNR into the known claims;
- due to potentially lengthy delays between claim incident, reporting and settlement, the IBNR is heavily discounted and sensitive to the discount rate. This reduces the IBNR provision, particularly when the discount rates are relatively high; and
- the use of an actuarial view of settlement patterns to apply inflation and discounting to reach a known claims valuation, rather than the expected settlement date, and updates to the case handlers' estimated probability of each claim being successful have both contributed to increases in the known claims provision since 2021/22.

Sensitivity to HMT tiered nominal discount rates

Since 2018/19, HMT specifies discount rates in nominal terms. These rates have increased this year across all durations, which has led to decreases in the provision across all schemes. Due to the long-term nature of the liabilities, claims that have settled, or are expected to settle as a PPO are very sensitive to changes in HMT-prescribed discount rates, especially the long-term and very long-term discount rates.

Discount rates term	31 March 2022 nominal rates (%pa)	31 March 2023 nominal rates (%pa)	Change
Short-term (<5 years)	0.47%	3.27%	+2.80%
Medium-term (5–10 years)	0.70%	3.20%	+2.50%
Long-term (10–40 years)	0.95%	3.51%	+2.56%
Very long-term (over 40 years)	0.66%	3.00%	+2.34%

As shown in the following material, the relationship between the value of the total provision and the effect of changes in the discount rates is not a symmetrical one, due to the impacts of compound discounting. The table below is based on adjusting the nominal discount rates by +1% and -1%. A reduction of 1% in the discount rates will increase the total provision by 25%, but a 1% increase will reduce the provision by 17%.

Sensitivity of total provisions to HMT discount rates (£m)

Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1.0% pa	%		1.0% pa	%
Known claims	29,933	21%	**24,657**	20,980	-15%
Settled PPOs	21,399	30%	**16,418**	13,041	-21%
IBNR	35,485	24%	**28,538**	23,686	-17%
Total provisions	**86,818**	**25%**	**69,613**	**57,708**	**-17%**

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

Sensitivity to differential between ASHE and CPI

The ASHE index, used in the calculation of damages in PPO claims where care costs are a component, measures the rate of change in the wages of carers. The current assumption is that the rate of inflation in carers' wages is 1.75% higher than CPI price inflation each year.

The table that follows shows the effect on the value of the CNST provisions where this differential is varied and this is a non-linear relationship. An additional +/- 1.0% difference between ASHE and CPI will either reduce the provision by 13% or increase it by 19% respectively. Further changes to the assumption are considered in figure 38 below.

Sensitivity of total provisions to ASHE assumptions (£m)

Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1.0% pa	%		1.0% pa	%
Known claims	21,754	-12%	**24,657**	28,706	16%
Settled PPOs	13,165	-20%	**16,418**	21,143	29%
IBNR	25,880	-9%	**28,538**	32,685	15%
Total provisions	**60,800**	**-13%**	**69,613**	**82,535**	**19%**

Claims inflation

The following table shows the effect on the value of the provisions of a +/- 1% change to the claims inflation assumptions. An addition of +/- 1% to the claims inflation assumptions will reduce the value of the claims by 7% or increase it by 8% per annum. The effect of changes in the rate of claims inflation is not a symmetrical one, due to the impacts of compound inflation and discounting.

Sensitivity of provisions to claims inflation (£m)					
Provisions	**All rates reduced by**		**Base assumptions**	**All rates increased by**	
	1.5% pa	**%**		**1.5% pa**	**%**
Known claims	23,279	-6%	**24,657**	26,170	6%
Settled PPOs	16,418	0%	**16,418**	16,418	0%
IBNR	24,915	-13%	**28,538**	32,878	15%
Total provisions	**64,612**	**-7%**	**69,613**	**75,466**	**8%**

Life expectancy

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

Sensitivity of total provisions to life expectancy (£m)					
Provisions	**All life expectancies reduced by**		**Base assumptions**	**All life expectancies increased by**	
	30% pa	**%**		**30% pa**	**%**
Known claims	20,103	-18%	**24,657**	30,051	22%
Settled PPOs	10,100	-38%	**16,418**	23,326	42%
IBNR	23,889	-16%	**28,538**	33,332	17%
Total provisions	**54,092**	**-22%**	**69,613**	**86,710**	**25%**

Payment pattern

Payment patterns are used to express the timing of when a claim is expected to be paid, defining the lag between the claim being reported and the claim paying out. The following table shows the effect on the value of the provisions of a +/- 1 year adjustment to the claims payment pattern. Lengthening the assumed payment dates by 1 year will increase the provision by 1%, while shortening the payment pattern by 1 year reduces the provision by 1%.

Sensitivity a total provisions payment to payment pattern (£m)					
Provisions	**Creation to payment lag reduced by**		**Base assumptions**	**Creation to payment lag increased by**	
	1 year	**%**		**+1 year**	**%**
Known claims	24,441	-1%	**24,657**	24,853	1%
Settled PPOs	16,418	0%	**16,418**	16,418	0%
IBNR	27,812	-3%	**28,538**	29,280	3%
Total provisions	**68,670**	**-1%**	**69,613**	**70,550**	**1%**

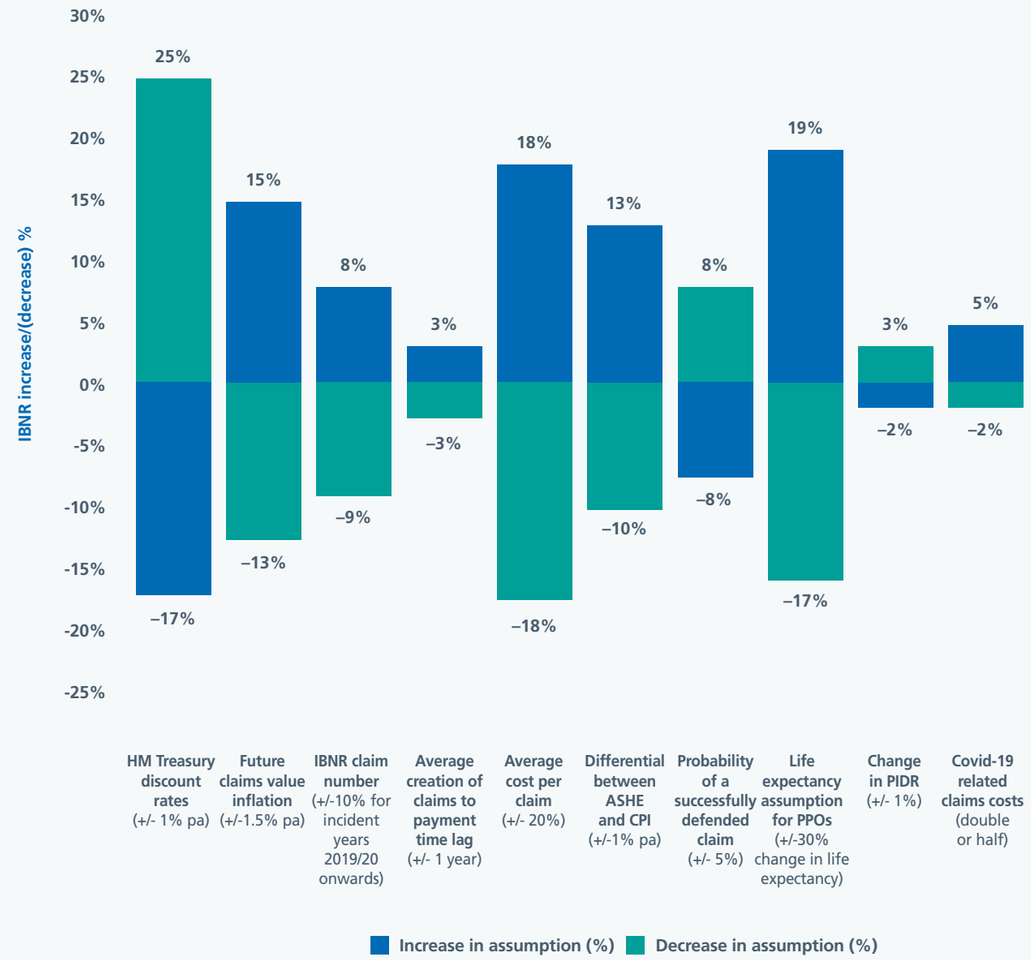
CNST IBNR: sensitivity of provision to other assumptions

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

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

CNST IBNR sensitivities as at 31 March 2023

Figure 38: The value and percentage impact of variations in the key assumptions within the CNST IBNR estimate



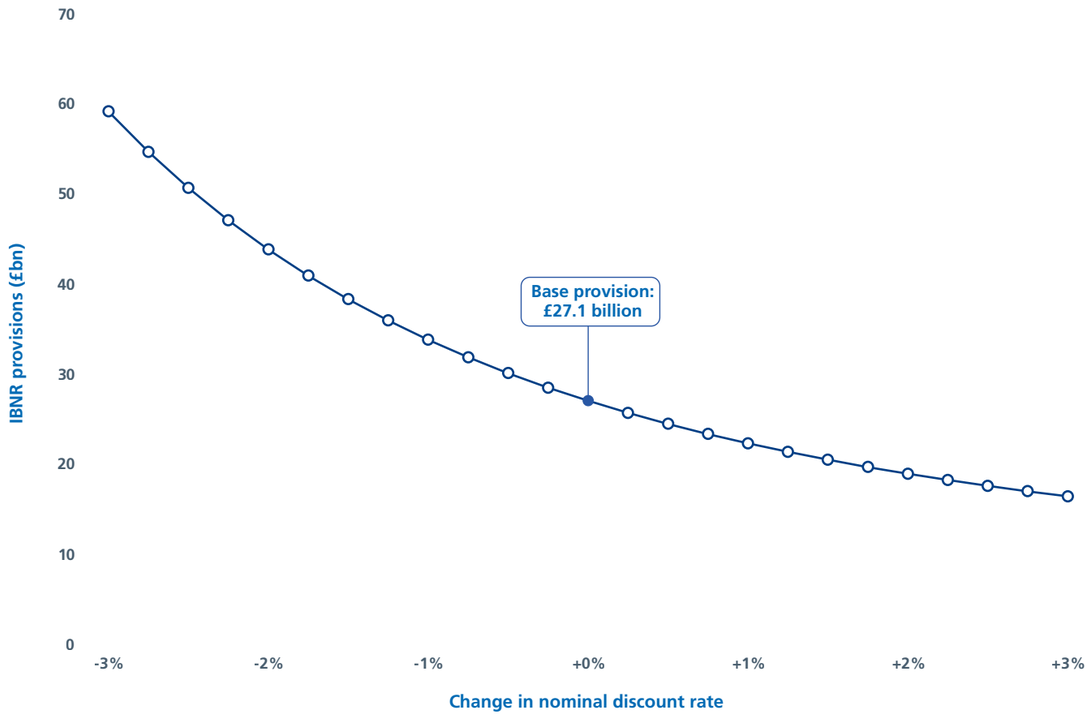
The sensitivities around the key assumptions are explained earlier in this note.

Sensitivity to changes in the nominal discount rate

Figure 39 is based on adjusting the nominal discount rate by the increments shown. A change in the nominal interest rate of +1% would represent short-, medium-, long-term and very long-term nominal interest rates of 4.27%, 4.20%, 4.51% and 4.00% respectively.

This year, there was a significant increase to discount rates across all durations, as prescribed by HMT, which has decreased the provision significantly.

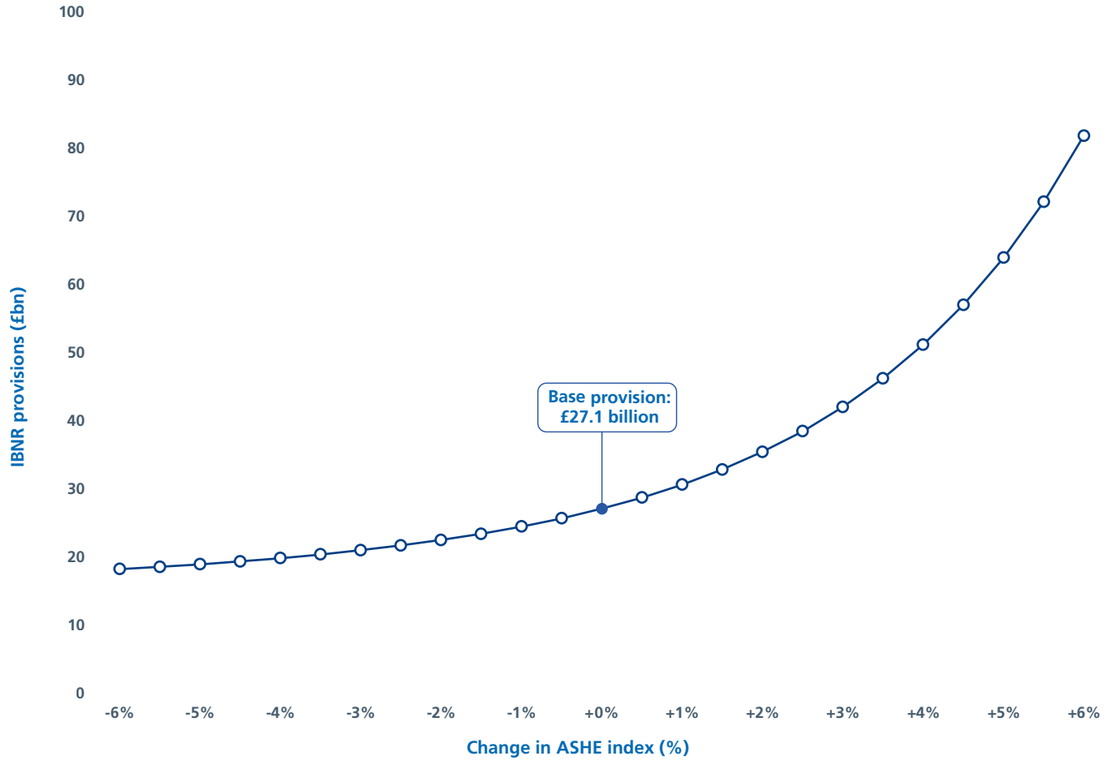
Figure 39: Sensitivity to changes in the nominal discount rate



Sensitivity to differential between ASHE and CPI

The ASHE index, used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The current assumption is that the rate of inflation in carers' wages is 1.75% higher than CPI price inflation each year. Figure 40 shows the effect on the value of the CNST IBNR provision where this differential is varied. This is a non-linear relationship; an additional +/- 1.0% difference between ASHE and CPI will either increase the provision by 13% or reduce it by 10% respectively.

Figure 40: Sensitivity to differential between ASHE and CPI



CNST: reasonable range

The CNST provision is the single largest element within the total provision. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision.

The CNST IBNR and known claims provisions in the accounts are based on a set of chosen assumptions. It is possible to have a range of different results if a different set of assumptions had been chosen. To illustrate this, a reasonable range is shown in the following material to demonstrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision. For this assessment, a number of assumptions are varied together but the variations are limited to those that could have reasonably been chosen based on the same analysis of past data. Changes in individual assumptions may have a greater or smaller impact on the provisions estimate.

Although it should be noted that this in itself does not reflect the potential uncertainty in the assumptions underpinning the provision as future experience may differ to the past, changes may occur in the claims and legal environment, and the modelling approach may not be a perfect representation of real life.

In prior years, the reasonable range has been derived by varying the assumptions specified for IBNR only, as this has historically been the most material element of the total CNST provision. However, the reasonable range presented for 2022/23 also varies the assumptions specified for known claims (excluding settled PPOs), to reflect the increased contribution of the known claims to the total provision, the additional consideration and scrutiny being applied to the known claims assumptions this year, and the underlying uncertainty inherent in selecting these assumptions.

CNST reasonable range	Baseline provision £m	Reasonable upper range £m	Difference to accounts estimate	Reasonable lower range £m	Difference to accounts estimate
IBNR	27,081	35,271	30.2%	19,795	-26.9%
Known claims	23,443	26,471	12.9%	20,248	-13.6%
Settled PPOs	13,881	13,881	0.0%	13,881	0.0%
Total	**64,405**	**75,623**	**17.4%**	**53,924**	**-16.3%**

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

- the estimate for numbers of PPO damages claims for the incident years 2017/18 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; and
- the Covid-19 related claims costs.

The known claims (excluding settled PPOs) results above were achieved by varying the following assumptions, all of which could have reasonably been applied:

- case estimates in respect of each known claim;
- the probability of a claim being successful;
- PPO damages claims inflation; and
- the creation to settlement lag for PPO claims.

In summary, the provision in the accounts for CNST could have been reasonably set at a value between £53.9 billion and £75.6 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 £64.4 billion.

This range of £21.7 billion is quite wide due to the sensitivity of the provision to relatively small changes in the assumptions, as summarised in figure 38. The range is mainly driven by the IBNR (£15.5 billion), which is the most uncertain element of the provision as these claims are yet to be reported. The change in the estimate for the numbers of PPO damages claims has the largest impact on the IBNR reasonable range calculation. This is further compounded by the sensitivity of other factors and an aggregation of smaller changes. The remainder of the reasonable range (£6.2 billion) is driven by the known claims provision, where claims have been reported and there are fewer uncertainties, but judgement is still required as to the timing and cost of settlement.

Note that last year's accounts only disclosed a reasonable range in respect of the IBNR and was valued on different discount rates. The range was -29.4% to +30.7%, which is broadly comparable to the corresponding figures shown above.

8. Contingent liabilities

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

The contingent liability represents an estimation of the additional provision NHS Resolution would recognise in its accounts if damage payments were awarded on all claims, rather than taking into account the probability of damages being paid (i.e. reflecting that typically many claims settle at nil).

The known claims provision is calculated as the sum of outstanding reserve values (i.e. total claim value less payments) multiplied by the probability of damages being paid, inflated and discounted to provide a present value of the claim based on the expected settlement dates. The IBNR provisions calculation also includes probabilities of a claim being paid for each of the schemes. The contingent liability is then the difference between the total valuation of IBNR and known claims (including estimations on claims which are ultimately expected to settle at nil) and the main valuation of known claims and IBNR (which excludes claims expected to settle at nil).

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.

Contingent liabilities	Ex-RHA £000	ELS £000	CNST £000	DHSC Clinical £000	ELGSP £000	CNSGP £000	CNSC £000	DHSC Non-Clinical £000	CTIS £000	PES £000	LTPS £000	Total £000
Contingent liability as at 31 March 2023	-	179,660	30,827,013	305,460	346,776	496,474	21,574	74,626	2,000	8,632	179,370	32,441,585
Contingent liability as at 31 March 2022	-	446,084	70,798,022	936,759	670,183	462,758	54,077	108,543	2,000	9,181	177,015	73,664,622

9. Lease liabilities

The total future minimum lease payments under lease liabilities payable in each of the following periods are as below.

Maturity analysis – contractual undiscounted cash flows lease liabilities	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2022/23 £000	2021/22[1] £000
Within 1 year	178	822	11	**1,011**	-
Between 1 and 5 years	747	3,456	6	**4,209**	-
After 5 years	783	3,987	-	**4,770**	-
Total undiscounted lease liabilities at 31 March	**1,708**	**8,265**	**17**	**9,990**	**-**

Lease liabilities included in the statement of financial position at 31 March	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2022/23 £000	2021/22[1] £000
Current	178	822	11	**923**	-
Non-current	747	3,456	6	**8,621**	-
	1,708	**8,265**	**17**	**9,544**	**-**

Amounts recognised in profit and loss	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2022/23 £000	2021/22 £000
Interest on lease liabilities	12	59	-	**71**	-
Expenses related to low-value assets	-	-	64	**64**	734

Amounts recognised in the statement of cash flows	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2022/23 £000	2021/22[1] £000
Repayment of lease liability – capital	162	174	11	**920**	-
Repayment of lease liability – interest	12	59	-	**71**	-
	174	**806**	**11**	**991**	**-**

[1] No prior year figures as IFRS 16 was transitioned in financial year 2022/23.

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 [now integrated care boards with effect from 1 July 2022]
- All commissioning support units
- All English NHS foundation trusts
- All English NHS trusts
- All integrated care boards
- Care Quality Commission
- NHS Digital[1]
- Health Education England[1]
- Health Research Authority
- NHS Blood and Transplant
- NHS Business Services Authority
- NHS England[1] [which legally merged with NHS Improvement as a result of the Health and Care Act 2022]
- NHS Property Services Limited
- NHS Trust Development Authority [now part of NHS England with effect from 1 July 2022]
- Public Health England
- NHS Counter Fraud Authority

[1]NHS Digital merged with NHS England on 1 February 2023; this was followed by the integration of Health Education England into NHS England on 1 April 2023. NHS England has now assumed responsibility for all activities previously undertaken by Health Education England.

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out in the following material. The remuneration for executive and non-executive directors for the roles they perform for NHS Resolution is disclosed in the Remuneration and staff report on page 98.

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

Name and position in NHS Resolution	Party	Nature of relationship	Payments to related organisation (£000)	Reciepts from related organisation (£000)	Amount owed to related organisation (£000)	Amount due from related organisation (£000)
Sally Cheshire CBE Chair	Audit & Risk Assurance Committee of Department of Work and Pensions	Committee member	35,156	-	247	-
Professor Sir Sam Everington OBE Associate Non-executive Director	East London Foundation Trust	Non-executive Director	5	1,478	-	3
	Medical Apprenticeship Committee of Health Education England	Committee Chair	4	137	-	-
	GP Pilot Committee of Health Education England	Committee member	4	137	-	-
Helen Vernon Chief Executive Officer	Tameside and Glossop Integrated Care NHS Foundation Trust	Clinical Director & Consultant (family member)	-	8,819	-	2
	North West Clinical Senate, NHS England	Chair (family member)	20	9,943	-	3
	Mid Cheshire Hospitals NHS Foundation Trust	Non-executive Director (family member)	9	8,743	-	19
DHSC[1]	Hodge Jones & Allen LLP	Related party to DHSC	7,834	-	9	-
DHSC[1]	Leeds Teaching Hospital NHS Trust	Related party to DHSC	91	40,109	3	4
DHSC[1]	Milton Keynes University Hospital NHS Foundation Trust	Related party to DHSC	16	9,718	-	4
DHSC[1]	NHS England	Related party to DHSC	20	9,943	-	3
DHSC[1]	The Royal Airforce	Related party to DHSC	-	-	-	1

[1] DHSC have provided us with a list of individuals and entities which are deemed to be related parties of theirs for this financial year. These entities are deemed to be related parties of NHS Resolution for the purposes of IAS 24 Related Party Disclosures.

11. Financial instruments

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

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

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

12. Events after the reporting period

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

In April 2023 the Ministry of Justice announced an extension to the arrangements for fixed recoverable legal costs (FRC) in civil litigation. These changes have no impact on the reporting period because, in relation to personal injury claims relevant to NHS Resolution, they apply only where the incident occurs on or after 1 October 2023.

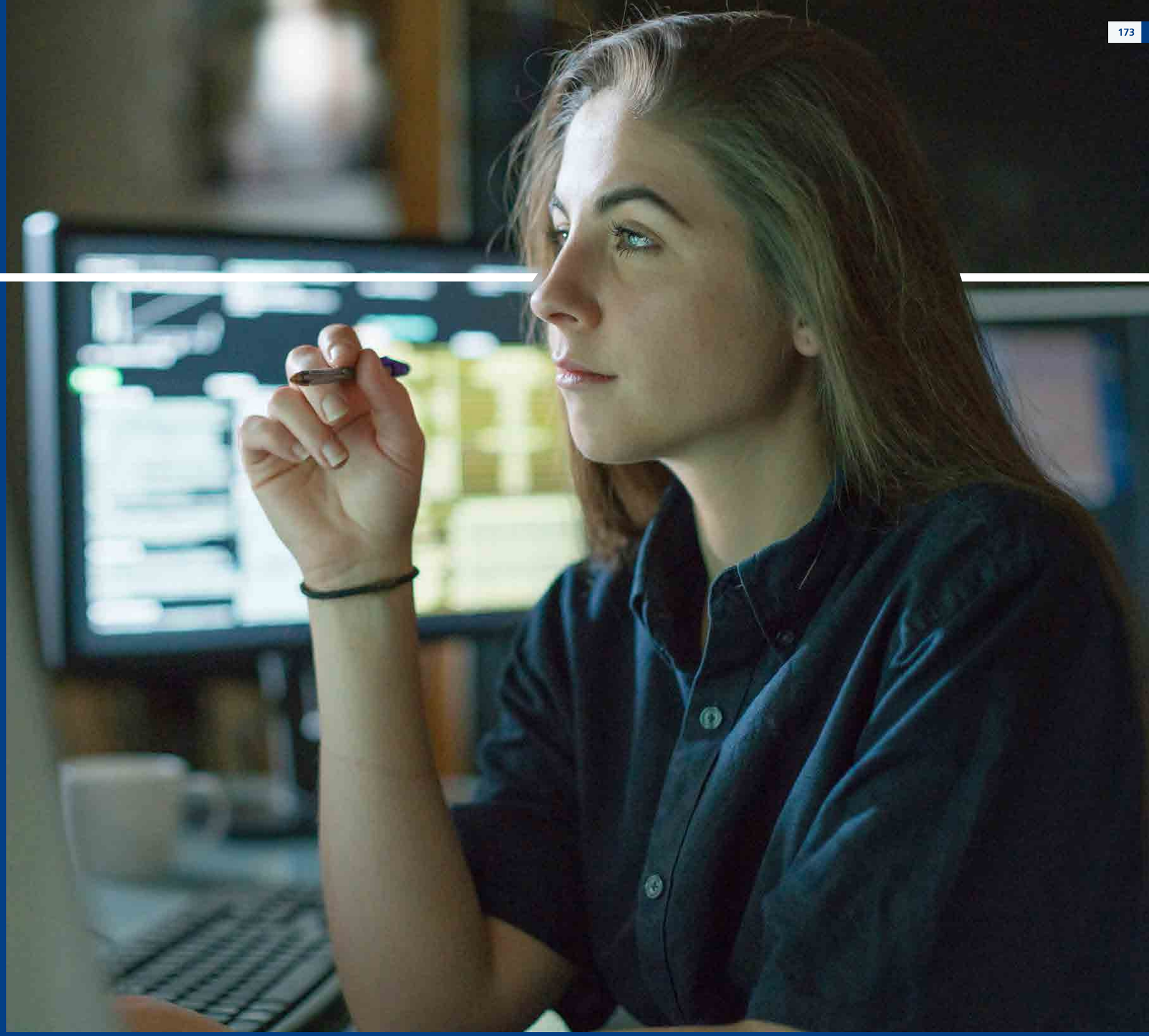
Further analysis is being undertaken to quantify the potential medium to longer term impact of these recently announced FRC changes.

References

Glossary

An online glossary is now available to support this document at

https://resolution.nhs.uk/glossary/?fwp_glossary_topic=annual-report-and-accounts



Appendix

Our indemnity schemes

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

The eight clinical negligence schemes we manage are:

- **Clinical Negligence Scheme for Trusts** (CNST) which covers clinical negligence claims for incidents occurring on or after 1 April 1995.
- **Existing Liabilities Scheme** (ELS) which is centrally funded by DHSC and covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.
- **Ex-Regional Health Authority Scheme** (Ex-RHA) which is a relatively small scheme, centrally funded by DHSC, covering clinical negligence claims against former regional health authorities abolished in 1996.
- **DHSC clinical** which covers clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies: these are centrally funded by DHSC.
- **Clinical Negligence Scheme for General Practice** (CNSGP) which covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.
- **Existing Liabilities for General Practice** (ELGP) which covered interim arrangements relating to existing liabilities agreed with a medical defence organisation (MDO) under which NHS Resolution carried out the Secretary of State's oversight and governance responsibilities, and having completed this work this scheme is now closed. The legal and operational responsibility of handling claims within scope of those interim arrangements remained with the MDO until 31 March 2021 and now operational responsibility of handling claims has transferred to NHS Resolution.
- **Existing Liabilities Scheme for General Practice** (ELSGP) which covers claims for historical NHS clinical negligence and other tortious incidents of GP members of participating medical defence organisations occurring at any time before 1 April 2019. This scheme covered members of the Medical and Dental Defence Union of Scotland (MDDUS) from 6 April 2020 and was extended to Medical Protection Society members from1 April 2021.
- **Clinical Negligence Scheme for Coronavirus** (CNSC), a scheme launched on 3 April 2020 to meet clinical liabilities arising from certain special healthcare arrangements that were put in place in response to the coronavirus pandemic where no other indemnity or insurance arrangements are in place already to cover such liabilities.

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

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

In addition, we manage two other non-clinical schemes:

- **DHSC non-clinical** which covers non-clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.
- **Coronavirus Temporary Indemnity Scheme** (CTIS) which provided state cover until 31 March 2022 for employer's liability and public liability, to fill gaps where designated care home settings were unable to secure sufficient private insurance cover.

8th Floor
10 South Colonnade
Canary Wharf
London, E14 4PU
Telephone 020 7811 2700
Fax 020 7821 0029

Arena Point, Merrion Way
Leeds, LS2 8PA
Telephone 0113 866 5500

www.resolution.nhs.uk

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