NHS Litigation Authority
Report and accounts 2012/13

Supporting the NHS

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Chair's welcome

Over the past year the NHS LA has sharpened its focus on preventing harm

There have been many developments, in the past year, which have underlined the importance of renewing our efforts to promote the safety of both patients and staff in the NHS. Most notable was the publication, in February 2013, of the second report by Robert Francis QC into the failures of care at Mid Staffordshire NHS Foundation Trust. The NHS Litigation Authority (NHS LA) is intimately involved in such failures – compensating patients when things go wrong and trying to ensure that the organisations it indemnifies learn lessons, in order to prevent similar tragedies in the future.

We were pleased to welcome Catherine Dixon as our new Chief Executive, in April 2012, from her previous role as General Counsel at the National Society for the Prevention of Cruelty to Children (NSPCC). Under her leadership the NHS LA has sharpened its focus on preventing harm. There will be further change to come, as we develop the incentives and information which will enhance good practice. We have taken stock of our standard-setting and assessment process, to ensure that we remove duplication and concentrate upon the factors which are the most likely to reduce harm to patients and staff and improve safety.

Although it is part of the brief of the NHS LA to 'resolve disputes fairly', it also aims to defend less meritorious claims robustly and as cost effectively as possible. The emphasis on resolution is also important in our work with primary care practitioners and commissioners. As we will take on responsibility for the National Clinical Assessment Service (NCAS) in April 2013, we will be working even more closely with clinicians, in the future, to resolve concerns about the professional practice of doctors, dentists and pharmacists.

The NHS LA is a membership organisation and we have listened to the views of our members and are developing learning initiatives to reduce harm. The NHS LA manages an NHS-funded risk pool, and it is in everyone's interest to promote efficiency and effective cost control, so that resources are concentrated on front-line services, rather than litigation.

In the pages which follow, it will be clear that my colleagues have achieved increasing success during the year in improving performance across all areas of our work. It has been a challenging time, during a period of considerable change in the NHS and beyond, and I would like to place on record my thanks to them for these marked improvements in the services we provide. They are good for the NHS, good for the staff who work in the service and, most of all, good for the patients who rely upon the care it provides.

Professor Dame Joan Higgins
Chair

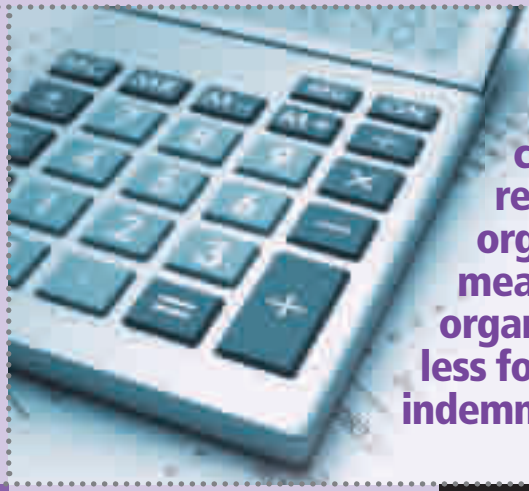
"We have listened to the views of members and are developing learning initiatives to reduce harm."

The year in summary

Clinical claims rose by

10.8%

from 9,143 claims in 2011/12 to 10,129 in 2012/13: but fewer than 1% of cases go on to contested hearing.

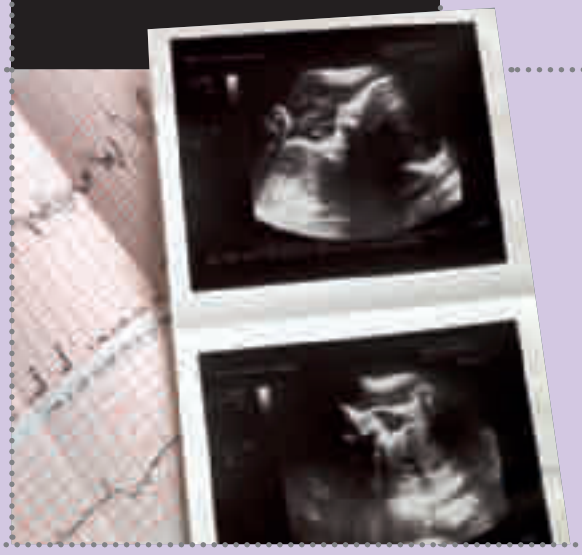


We changed the way we set contributions to reward safer organisations. This means that safe organisations pay less for their indemnity cover.

We will directly indemnify independent healthcare sector providers of NHS care for the first time, from 1 April 2013.

NCAS will join NHS LA on 1 April 2013, extending our remit to helping resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK and overseas.

Our analysis of ten years of maternity claims showed that training and expertise in fetal heart monitoring are central to the safety of mothers and babies.



We listened.

In year we had face-to-face meetings with over 250 member Trusts and key stakeholders to find out their views about the NHS LA and how we can improve our services.

In spite of claims volumes going up, we resolved claims more quickly, CNST claims being resolved on average within 1.25 years and LTPS claims resolved on average within 1.29 years.

An independent review of the NHS LA by Marsh, the independent insurance broker, endorsed our stewardship and administration. On the back of Marsh's endorsement, the NHS LA has made a number of changes to improve and enhance the services it offers.

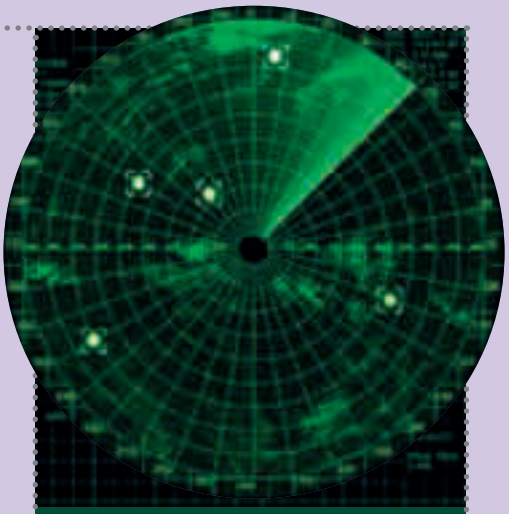
184

assessments were undertaken this year. 2012/13 results show organisations at:

56% finished the year at Level 1 (2011/12 – 54%);

28% at Level 2 (2011/12 – 33%);

and 16% at Level 3 (2011/12 – 11%)



NHS LA extends cover to inquests.
This will allow us to provide support sooner where a claim is likely to be made. We will monitor the extended cover closely to ensure that it delivers value for money and helps prevent claims.

100%

In April 2013, the NHS LA will welcome new members:

England's 211 Clinical Commissioning Groups (CCGs), NHS England, the Care Quality Commission (CQC) and the NHS Property Company – meaning we indemnify all NHS bodies in England.

New chief executive, new management structure. We have a new senior team, and following a thorough review of our members' needs, we are implementing a revised claims team structure which will result in increased capacity to manage claims volumes.

Learning from claims and making data work.

All members were given direct access to view their own claims information via our existing extranet and we have launched a new and improved website.

“The NHS LA indemnifies all NHS bodies in England – a massive vote of confidence in our work.”

Chief Executive's report

This year was tremendously busy, with a key focus on communication and engagement with our members

Listening to our members and learning

We met with over 250 Trusts this year, finding out what they thought about our services. These conversations have helped us to change our approach to our risk management standards and assessment process and the way we set contributions to make them fairer for the NHS.

This coming year we will be introducing a revised approach which will encourage learning, focus on outcomes and support the NHS to reduce harm to patients and staff. We will move away from rigid standards towards an outcome-focused approach which supports our members to learn from mistakes and reduce claims, thereby improving patient and staff safety.

Our revised method for setting contributions will reward safer organisations which have fewer claims and financially incentivise those organisations with higher claims to work with us.

This year saw a significant rise in claims: up 10.8%. In spite of this we resolved claims and responded to them even more quickly. We were also able to keep defence costs low for our members, seeing them reduce as a percentage of the cost of claims.

Studying data from ten years of maternity claims yielded some valuable insights into safety and learning. Our analysis shows that the most significant factor contributing to maternity claims was failure to effectively monitor and respond to changes in fetal heart rate. We are working with clinicians to identify solutions to address this concern which we hope will improve safety for mothers and babies.

Vote of confidence

The NHS LA indemnifies all NHS bodies in England, which I feel is a massive vote of confidence in our work. All 211 new CCGs, which took over from Primary Care Trusts (PCTs) in April 2013, have chosen to be indemnified by us as have NHS England and the CQC.

Regulatory changes will allow us, from 1 April 2013, to welcome members of the independent healthcare sector which provide NHS care, including private sector healthcare companies, social enterprises and other organisations. That means there is a fair playing field across the healthcare sector. They were very keen and enthusiastic about becoming members, which reinforces the strong reputation of the NHS LA for delivering high quality services.

We also worked hard to ensure there will be a smooth transfer of NCAS to the NHS LA from 1 April 2013. We welcome colleagues from NCAS and look forward to working closely together to ensure that NCAS meets the needs of the NHS.

Catherine Dixon
Chief Executive Officer

"We changed the way we calculate member contributions to enable us to financially reward safe organisations."

The year ahead

“We have set out our ambitions for 2013/14 in three strategic aims.”

Strategic aims for 2013/14:

1 **Increasing our operational effectiveness and valuing our people.**
Ensuring that the services offered to NHS LA members represent excellence and value for money by ensuring that our people have the right tools, support and development to offer the best possible service.

2 **Improving patient and staff safety by supporting the NHS to reduce harm through learning and effective incentivisation.**
NHS, providers of NHS care, and other stakeholders are given information which assists and promotes the learning of lessons from things that have gone wrong in order to improve patient and staff safety.

3 **Successfully integrate and develop NCAS.**
We will successfully integrate NCAS into the NHS LA as an operating division and ensure that NCAS's business model meets the needs of a changing NHS.

We will...

... share good and poorer practice in a positive and constructive way, and make better use of our claims experience by analysing our data and turning it into evidence-based advice and information for our members. We will aggregate our claims data with other harm data within the NHS.

... share our learning with members, key stakeholders and influencers, working in partnership with organisations including the Royal Colleges and regulators to enable lessons to be learned throughout the NHS.

... launch our extranet to provide members with real-time information about their claims and support them in analysing this information to help them reduce harm.

... launch a new legal panel delivering legal services for all the Department of Health Arms Length Bodies (ALBs) and the NHS LA. This will deliver savings as well as ensuring that the best quality health legal advice is available to all the DH ALBs and not just the NHS LA.

... review our other indemnity schemes including our cover for employer's liability, public liability and professional negligence to ensure they meet the needs of the changing NHS.

... change our approach to risk management standards and assessment to support a reduction in claims and outcome-focused learning.

Claim trends

A significant growth in the number of new claims presents challenges, but we continue to provide the best possible quality of service to our members

Growth in new claims

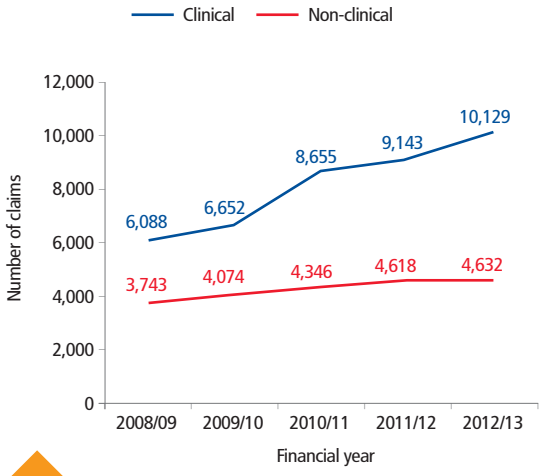
We received 10,129 clinical claims in 2012/13: a rise of 10.8% on 2011/12. After a steady increase in the first part of the year, the claims for employers' and public liability against our members slowed in the last quarter (see figure 1).

It is a testament to the hard work and expertise of the claims teams that they have increased the speed of their investigations over this challenging period, whilst maintaining the quality of investigations. Claims were resolved more quickly than ever where compensation was due, and we increased the speed with which injured patients and staff were given a response to their claim (see figure 2).

We aim to resolve claims without litigation, be innovative in our claims handling and to use alternative dispute resolution wherever possible. Fewer than 1% of our cases proceed to a contested hearing.

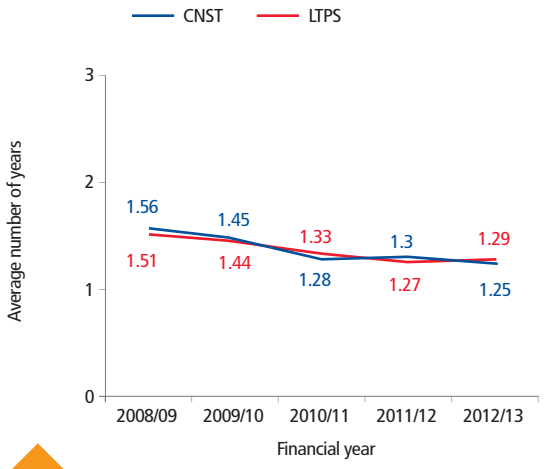
The robust defence of unmeritorious claims has been a priority with increasing claims numbers (approximately 40% of all those received), resolved without a damages payment. Once an early repudiation has been made, very few claims came back, indicating a thorough investigation was undertaken by our teams at an early stage.

Figure 1: New claims reported (all Trusts)



New clinical claims increased by 10.8% from 2011/12 to 2012/13. Volumes of non-clinical claims have levelled off

Figure 2: Average duration of claims (time taken to resolve claims)



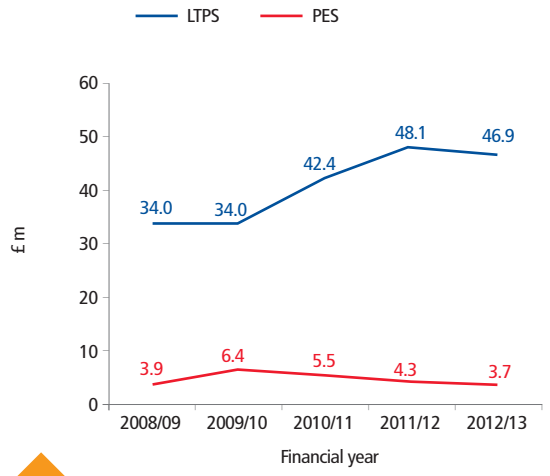
The time taken to resolve claims has further reduced to 1.25 years in CNST and risen to 1.29 years in LTPS

> **“The NHS employs more than 1.7 million people in the UK, which means it is one of the largest employers in the world.”**

We have also strengthened our approach to claims where claimants exaggerate their symptoms, to ensure that payments are made only where it is appropriate and only to those who are entitled to receive compensation.

The value of our most expensive settlements has risen this year. These are claims where claimants require daily care for the rest of their life. The NHS LA deals with these cases with the court by agreeing periodic payment orders (PPO) which involve making a lump sum payment, followed by annual payments, to meet ongoing care needs. This ensures that funds which would otherwise be payable upfront are instead available throughout a patient's lifetime, providing financial security for the patient and safeguarding the public purse.

Figure 3: Expenditure on non-clinical claims



Expenditure on LTPS has fallen by 2.4% from 2011/12 to 2012/13. PES has fallen by 13.9%

Key

Clinical Negligence Scheme for Trusts (CNST) A voluntary membership scheme to which all NHS Trusts, Foundation Trusts and Primary Care Trusts in England currently belong. It covers all clinical claims where the incident took place on or after 1 April 1995. The costs of meeting these claims are met through members' contributions on a pay-as-you-go basis.

Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) Known collectively as the Risk Pooling Schemes for Trusts (RPST), they are two voluntary membership schemes covering non-clinical claims where the incident occurred on or after 1 April 1999. Like CNST, costs are met through members' contributions on a pay-as-you go basis.

Existing Liabilities Scheme (ELS) ELS is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the incident took place before 1 April 1995.

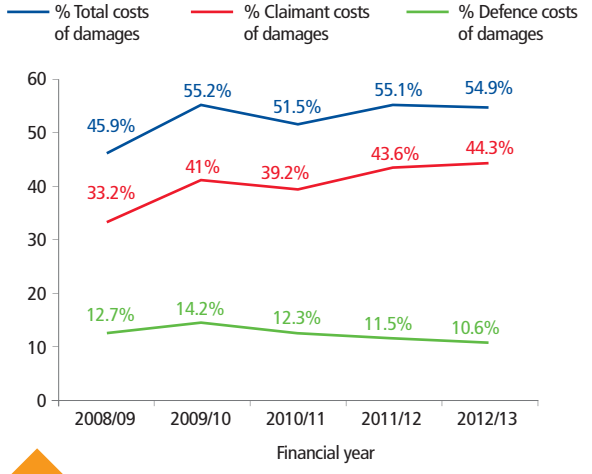
Ex-RHA Scheme (Ex-RHAS) Ex-RHAS is a relatively small scheme covering clinical claims made against the former Regional Health Authorities, which were abolished in 1996. Like the ELS, it is centrally funded by the Department of Health.

The increase in the numbers of claims is driven by factors outside our direct control. We are however, focused upon areas where we can share learning from claims with our members. We have improved the way in which we collate data on claims to make it easier to analyse for learning purposes and to identify trends.

It is important to ensure that we also share the learning from claims made by NHS staff. The NHS employs more than 1.7 million people in the UK, which means it is one of the largest employers in the world. The NHS LA indemnifies all of the NHS in England, excluding primary care delivered by GPs. Therefore, our Liabilities for Third Parties Scheme (LTPS) which indemnifies our members for claims from employees has considerable coverage (see figure 3). Our teams have provided dedicated support to members to help them reduce claims arising from injuries to employees such as from needlestick injuries.

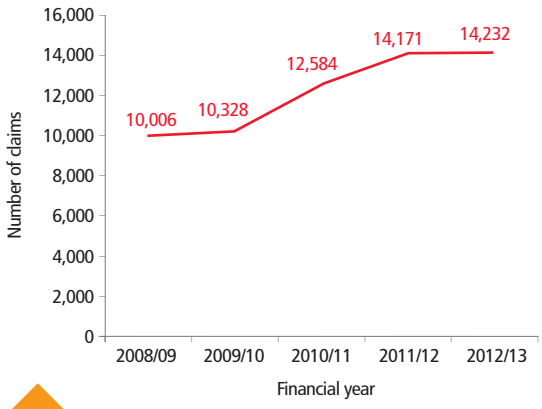
We kept defence costs under control by close management of our lawyers and by managing claims in-house wherever possible, despite the increasing volumes of claims. We saw our defence costs reduce as a percentage of damages paid (see figure 4). We resolved 14,232 claims in year, an increase from the previous year and 42% more than in 2008/2009 (see figure 5).

Figure 4: Ratio of legal costs to damages for clinical claims closed



Defence costs, as a proportion of damages, have fallen in year and claimant costs have increased after a dip in 2010/11 with a steep upward overall trend

Figure 5: Claims closed



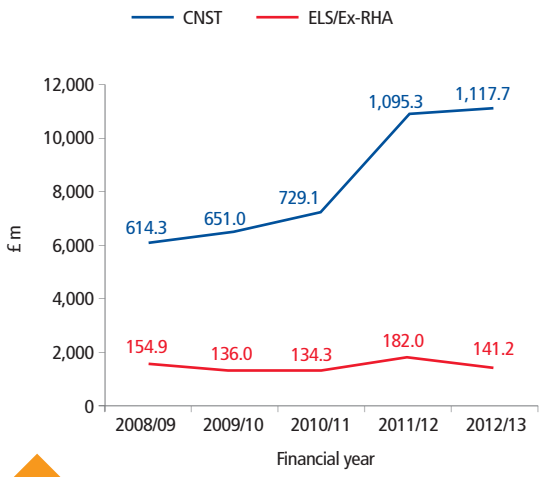
We have resolved increasing numbers of claims and closed 42% more in 2012/13 than we did in 2008/09

Clinical claims expenditure

In spite of the increased numbers of claims, our Clinical Negligence Scheme for Trusts (CNST), which deals with clinical negligence claims occurring after 1995, experienced a 2% increase in expenditure. We were pleased to see a 21.8% reduction in expenditure on the Existing Liabilities Scheme (ELS) which concerns clinical claims arising from incidents occurring prior to 1 April 1995.

“We continue to provide the best possible quality of service to our members.”

Figure 6: Expenditure on clinical claims



There has been an increase in CNST expenditure by 2% from 2011/12 to 2012/13

Director of Finance and Corporate Planning report

Our financial performance for the year has been excellent, against a backdrop of increasing claims

We met all of our financial targets against net operating costs of £4.4 billion and recorded an underspend of £13.8 million against our revenue resource limit, which is an excellent achievement. (See pages 48 and 62).

Provision for claims liabilities

The NHS LA makes provisions in three areas:

- Known claims. These are claims that the NHS LA is aware of, but has not as yet resolved. We do not know the exact amount of settlement so we provide an estimate.
- Estimated cost of future PPOs. These are orders made by the court, generally for high-value claims, where the claim is resolved by way of lump sum payment, together with regular payments for the rest of the claimant's life in order to meet their ongoing care needs. This ensures that the claimant is financially secure and this also protects the public purse.
- Claims which may be brought in the future (estimated based on current trends), but which have not been reported. We estimate the value of claims which may be brought based on incidents and current claims trends. We refer to this estimate as incurred but not yet reported (IBNR).

The values of these provisions are shown on page 49 of this report. 'Provisions for liabilities and charges – known claims' (which includes the estimate for known claims and PPOs) have a combined value of £9.6 billion.

The accounts also show IBNR provision which total £13.4 billion. Since we are required to show in our accounts a value for any potential settlements which we have the ability to value, we are making an estimate for both the number and value of IBNR which may be reported to us into the future.

The timing of the payment of the provisions for PPOs and IBNR are spread over time and the graph (on page 19 and values on page 67 of this report) shows how the provisions as at 31 March 2013 are expected to be paid in the future.

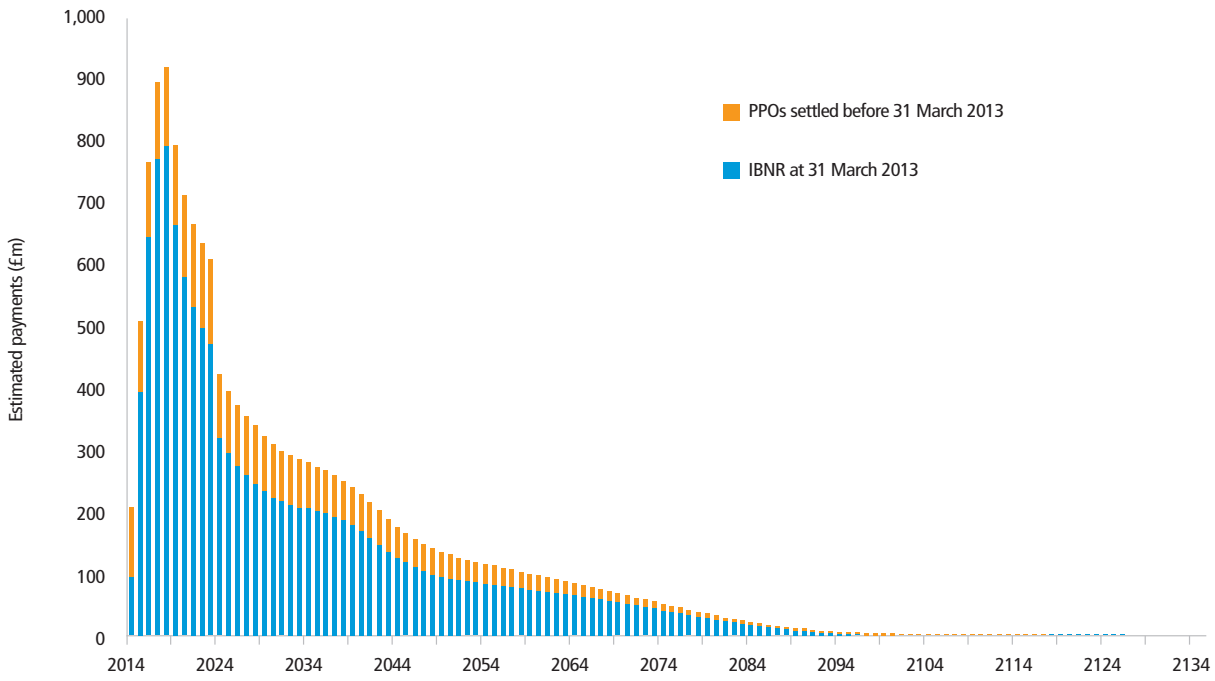
Key changes in values

During 2012/13, HM Treasury required that all long-term provisions have a new rate of discount applied to them that reflects the likely return on a risk-free investment which could be achieved in the economy. The purpose of the discount rate is to ensure that, for example, £1,000 invested today will still be worth £1,000 in the future. The discount rate is therefore the interest applied to money to ensure that it does not depreciate over time.

In year the HM Treasury discount rate was adjusted to recognise that lower investment returns are available than had previously been the case and that this requires more money to be set aside today to meet those future costs. This change resulted in an increase in our total provisions of more than £1.4 billion as at 31 March 2013.

"Provisions for known claims and PPOs have a combined value of £9.6 billion."

Provisions for CNST (excluding known claims)



Also as claims numbers have continued to rise, in particular in CNST which received more than 10,000 new cases during 2012/13, we revised our forecasted volumes. Therefore, the value of our IBNR increased.

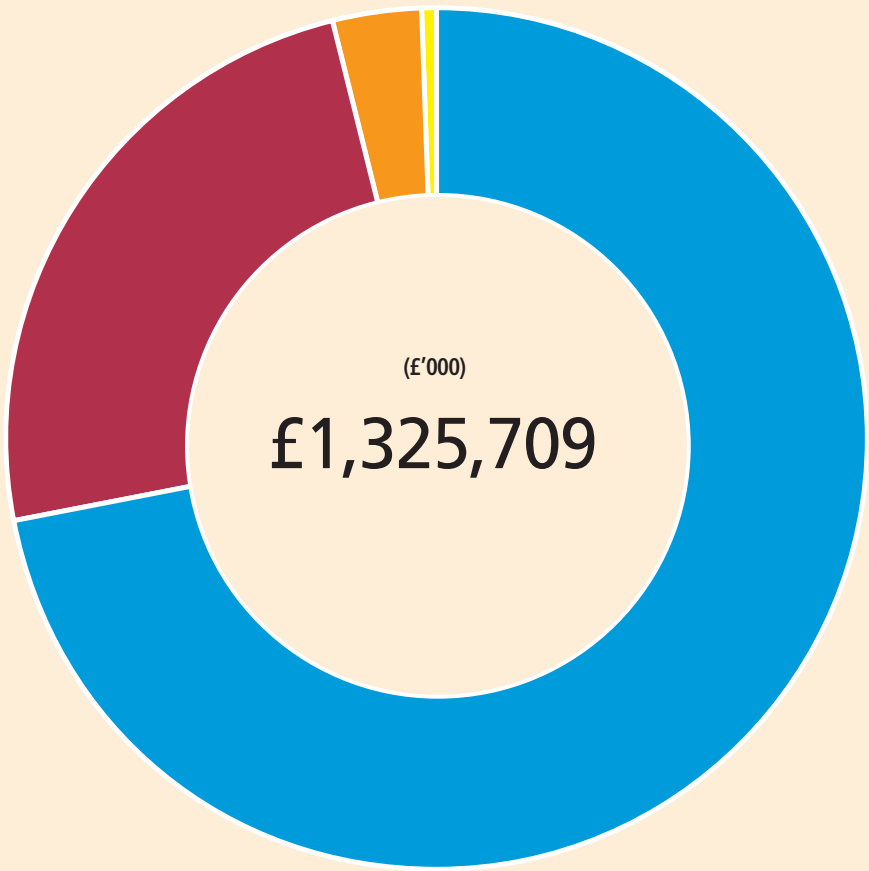
In other words, because claims have gone up we have changed our assumptions to recognise that the number of claims which may arise from incidents in the last 12 months (and previous years) may be higher and so we have increased the size of our IBNR provision as at March 2013. If the rate of increase in the number or value of claims changes, we will readjust this forecast in future years once the impacts of those changes are clearer.

Tom Fothergill
Director of Finance & Corporate Planning

The year in

We met all of our financial targets against net operating costs of

Contributions to our schemes



(£'000)

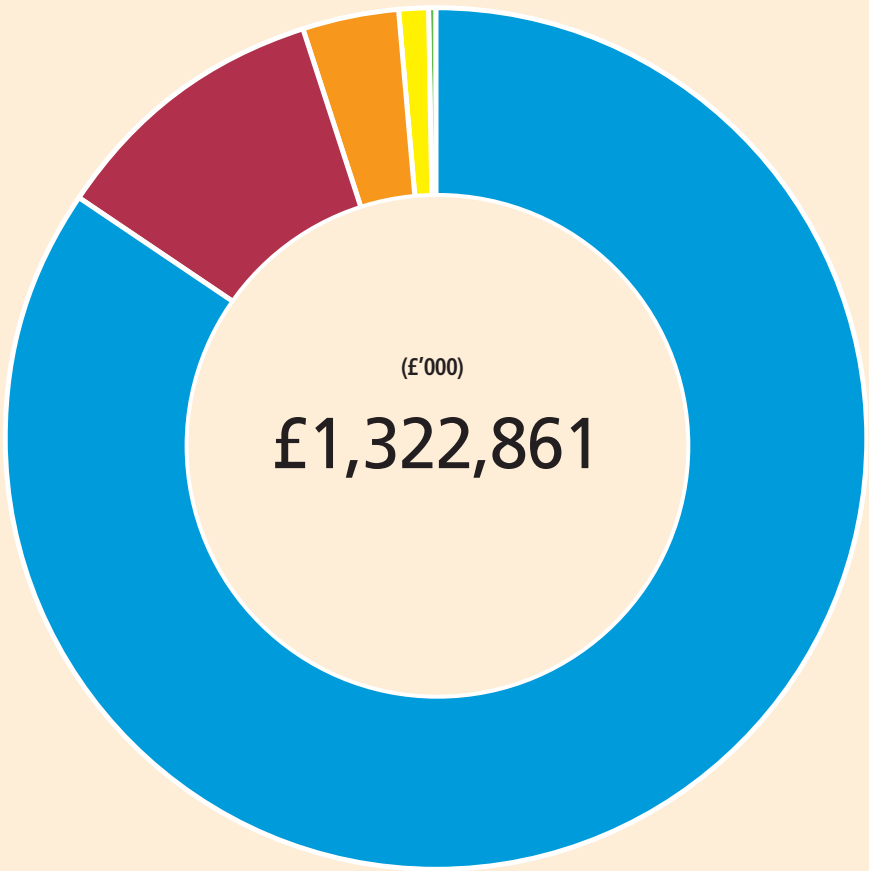
- CNST members **£957,113**
- Department of Health **£319,966**
- LTPS members **£43,362**
- PES members **£5,268**

"Obstetric and gynaecological claims continue to be the highest area of claims expenditure."

numbers

£4.4 billion, which is an excellent acheivement

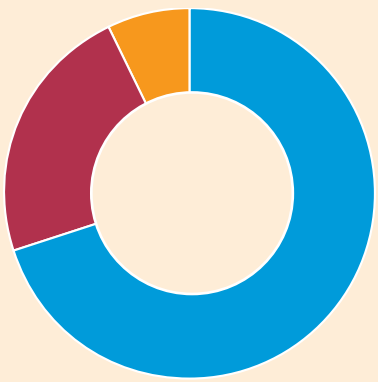
Expenditure



(£'000)

- CNST **£1,117,655**
- ELS & Ex-RHA **£141,225**
- LTPS **£46,949**
- Running costs **£13,382**
- PES **£3,650**

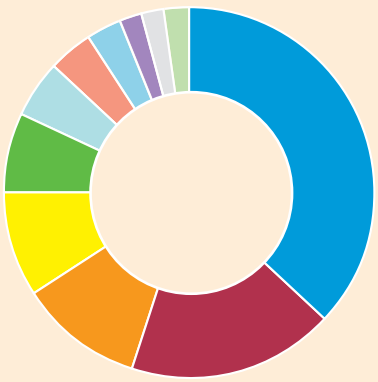
CNST expenditure



- Damages paid to claimants
- Claimant legal costs
- Defence legal cost

CNST expenditure

- Obstetric and gynaecological
- Other
- Orthopaedic surgery
- Casualty / A & E
- General surgery
- Paediatrics
- General medicine
- Neurosurgery
- Psychiatry / Mental health
- Cardiology
- Neurology



Important cases for the NHS

Several significant judgments for the NHS were handed down during the year

We always try to resolve cases before they reach trial, either by negotiating a fair settlement or by rejecting cases which are without legal merit. Sometimes, though, it is necessary to seek a judge's ruling, either to obtain what we hope will be a helpful precedent for the NHS or because other forms of resolution have failed. The most important judgments are summarised below.

RH v. NHS Foundation Trust

Nearly all of our largest personal injury claims are settled by way of periodic payment orders. These guarantee the injured person an income for life, usually to meet ongoing care costs. Such payments are index-linked, to ensure that they remain sufficient to cover the claimant's needs. However, in late 2012, the Office for National Statistics (ONS) changed its reporting, which meant certain data on which we relied for our indexation recalculation were not available.

This presented us with a major problem: almost 650 cases were affected, all involving claimants with serious ongoing disabilities. The problem was solved by working closely with claimant representatives and agreeing a mechanism for uplifting annual payments which did not rely upon the conventional data.

This solution was approved in the High Court by Mrs Justice Swift on 1 March 2013. She praised "the spirit of co-operation and joint endeavour" which resulted in this satisfactory outcome for vulnerable patients, and added that it "reflects the greatest credit" on those involved. We have successfully applied the solution to all other affected cases.

F v. Health Protection Agency and Others

A novel attempt was made to impose liability upon our member, the Health Protection Agency (HPA), and a local authority, in respect of an outbreak of e-coli in the late summer of 2009. Many visitors to a farm, most of them children, became infected and some fell seriously ill. The farm's insurers wanted to pass the liability for the outbreak to the HPA and local authority alleging that both the HPA and local authority were aware of the outbreak and failed to take any steps to limit or prevent visitors being exposed to infection.

We applied to have this claim struck out and were successful. The insurers appealed, and that appeal, heard in the High Court in February 2013, held that the claim should be dismissed. To accept such a duty as had been suggested would impose an indeterminate liability on the public bodies involved. There had been no contact

"In the High Court Mrs Justice Swift praised 'the spirit of co-operation and joint endeavour' of the satisfactory outcome for vulnerable patients."

at all between either the HPA or the local authority and visitors to the farm. Decisions as to possible enforcement action, under the relevant statutory powers, should be taken unfettered by exposure to claims for damages. On the other hand, the farm-owner owed an incontrovertible duty to her visitors.

This was a very pleasing result for the HPA because it ensured that the scope of the HPA's legal liabilities was not increased dramatically. Also, this ruling did not mean that the claimants lost the possibility of recovering damages, because they can still pursue potential claims against the farm insurers.

Abdulla and Others v. Birmingham City Council

This was not a case managed by the NHS LA and involved a local government defendant, but it potentially has major implications for the NHS.

Equal pay claims are normally brought via the employment tribunal (ET) system, which has a simpler process than the courts and the losing party does not normally have to pay the winner's costs. Also, there is a shorter limitation period. In other words, claims in the ET must be brought within six months of termination of the relevant employment. However, this group of claimants was advised to bring their equal pay claims via the courts, because of the more favourable limitation position (six years from the alleged breach of contract).

The Supreme Court decided on 24 October 2012, by a majority of three to two, that the claimants were entitled to use the courts to bring equal pay claims. However, this did not mean that the usual costs order (ie, that the loser should pay the winner's costs) would necessarily apply, and the reason why a particular claimant did not lodge an ET claim might well be relevant to the court's decision on costs.

This ruling opens up the possibility of equal pay claims being brought against the NHS via the court system, especially where they will be out of time in the ET. In the months since the decision, we have seen no evidence of such claims being lodged against our members, but it remains early days. A disincentive for potential claimants considering using this route is that they may have to pay the employer's costs if they lose before a County Court judge.

NHS LA remains fully committed to the principles of equality and equal pay, and this decision is flagged in order to alert our members to its potential ramifications. Cases which might otherwise have been considered moribund might be resurrected, and will have to be dealt with on their merits.

Robustly defending unjustified claims

As well as some of the high-profile cases that the NHS LA defends on behalf of the NHS, there is a multitude of claims with very different facts that we see, some of which proceed to court.

One of the key objectives of the NHS LA is to defend unjustified claims robustly, the following cases illustrate this.

Wound infection – case dropped

The claimant alleged a failure of care when presenting themselves at an A&E department with a puncture wound to the head. The claimant maintained that the attending A&E nurse and doctor were negligent in their care of the wound, resulting in the wound becoming infected, requiring incision, drainage and a course of intravenous antibiotics, resulting in scarring.

Our defence was that the risk of the wound becoming infected was so low that the A&E nurse and doctor were correct to not administer antibiotics when the claimant presented. This argument, backed by expert evidence, resulted in the claimant dropping the case the day before it was scheduled for trial.

Carpal tunnel syndrome – Nurse's evidence accepted

The claimant alleged that, due to a failure of care by an attending nurse after day surgery for carpal tunnel syndrome, he did not stop bleeding, which resulted in compartment syndrome and further surgery. The claimant called several factual witnesses, while the defence had only one, the nurse who was alleged to have been negligent. Despite this, the judge found for the defence, concluding that the nurse had given proper treatment and dismissed the claim.

Ambulance crew followed accepted practice

A tragic and very complex case involved an Ambulance Trust. The claimant sought damages against the Trust following the death of his wife, who became unwell and fell down a flight of stairs at home whilst pregnant. The ambulance crew responded to the emergency call, stabilised her and then called for backup. Upon admission to A&E, the patient underwent an emergency caesarean. Sadly, both she and her newborn child died a few days later.

It was argued that the deaths were caused by the Ambulance Service failing to provide adequate care. The Trust maintained that the first crew rightly suspected spinal injury and proceeded appropriately, including summoning a second crew promptly. The judge found for the Ambulance Trust, noting that it was not a straightforward emergency call and that the responding ambulance crew "followed the practice which would be accepted as proper by a reasonable body of Ambulance Technicians and that they genuinely considered they were doing the right thing. It could not be said that there was no logical support for what they did or did not do."

Employer not responsible for neck pain

An employee had suffered from problems with his upper back for several years. While he completed training at work he had two operations for this condition. He alleged that failure by his employers to take proper account of his condition had led to a deterioration in his neck and that this prevented him from pursuing his chosen career. In particular, he claimed that there was a failure to take sufficient notice of his neck problems when deciding at which site he should work and that the excessive driving involved exacerbated his neck pain.

The case raised the issue of an employer's duty of care to employees when they are travelling to and from work and how far this extends. The judge found that the employers could have exercised more care when the claimant returned to work and involved Occupational Health in undertaking a workplace assessment. Despite this, the judge held that the neck pain and deterioration had not been caused by driving to and from the claimant's places of work and that there was no evidence that he had been unable to follow his chosen career because of his neck pain.

Safety and learning

We are improving patient and staff safety by supporting the NHS to reduce harm through learning and effective incentivisation

Listening exercise – the lessons learned

As part of the NHS LA's commitment to engaging and consulting with its members, and to inform the future approach to improving claims, a risk management survey was undertaken in which we asked what chief executives, senior managers and risk managers thought about the NHS LA risk management standards and assessment processes and how we can improve.

Suggestions for the NHS LA to change its approach to standards and assessment were:

- sharing more data and learning with members
- ensuring that any standards we look at are focused on outcome
- ensuring that any assessments are proportionate to organisational risk.

Members were also keen to move away from assessment levels which do not necessarily reflect safety within an organisation whilst maintaining financial incentives for achieving success.

During the year, and following engagement with over 250 members and key stakeholders, the NHS LA decided that a new approach to standards and assessment was required.

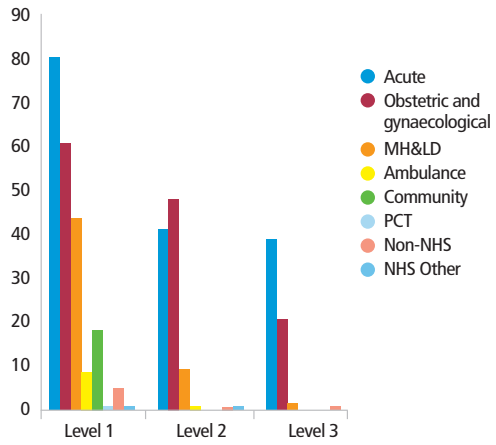
The new approach needed to be outcome-focused with evidential links to claims, avoid duplication by working with key stakeholders and reduce the burden on organisations in preparing for assessment, as well as develop a comprehensive programme for learning from claims.

To support this aim, the NHS LA will not carry out a full schedule of risk management assessments in 2013/14. This will enable the NHS LA to focus on the development of the new approach as well as provide time to Trusts to actively engage, provide feedback and support any testing required.

Risk management assessments

184 assessments were undertaken this year 2012/13. The graph below shows the organisations that opted for an assessment against our standards with 56% (n=220) finishing the year at Level 1 (2011/12 was 54%); 28% (n=111) at Level 2 (2011/12 was 33%); and 16% (n=63) at Level 3 (2011/12 was 11%).

Organisations under assessment at year end



> **“A key finding from the report has demonstrated the need to focus on improving the detection and response to a deteriorating fetal heart rate through better fetal monitoring.”**

Analysis of ten years’ maternity claims

During the year the NHS LA issued a thematic report analysing ten years of maternity claims.

Maternity claims are some of the most expensive clinical negligence claims reported to the NHS LA and the second highest by volume. The report reviewed maternity claims with incident dates of between 1 April 2000 and 31 March 2010. The analysis enabled key trends to be identified and learning to be shared widely within the NHS, with the long-term goal of reducing harm to women and babies accessing maternity care. During the period reviewed, there were 5087 claims with a total value of £3.1 billion. Between 2000 and 2009 there were 5.5 million births in England. In all, 0.1% of births were subject to a clinical negligence claim, meaning that the vast majority of births do not result in a clinical negligence claim, which supports the view that having a baby within the NHS is very safe.

As part of the report, primary and secondary-level studies were undertaken, with the primary study analysing the occurrence of types of maternity claims and the financial costs associated with them.

The report found that three types of case accounted for 70% of the total value of claims: claims arising from mistakes in cardiotocograph (CTG) interpretation, claims arising from mistakes in the management of labour and cases in which the outcome was that the baby suffered cerebral palsy. The primary level study concluded that **management of labour and interpretation of CTGs can be significantly improved with the overall aim of reducing the impact on babies and families, which in turn reduces the cost to the NHS**.

Overall the report noted that there are good practices within maternity services that should be celebrated and that the innovative work and commitment of midwives and obstetricians to reduce poor outcomes should be shared among maternity teams and cascaded throughout the NHS. The report is available in full on the NHS LA website: www.nhsla.com.

Revised approach to learning from claims

Our review of the current risk management standards and assessments process sought to identify whether a different approach to sharing information, learning from claims and incentivising best practice could be used in healthcare and, if so, how best this might be done.

We reviewed relevant literature, talked with members, policy makers, professionals, key stakeholders, risk and safety experts from healthcare and other high risk industries.

As a result we will move from the risk management standards and assessments towards an approach to support our members to reduce their claims through learning from claims and implementing best practice. We are using the following principles:

- focus on improving **outcomes for patients and staff** by reducing claims and harm
- **engage clinicians** and support through peer-to-peer review
- **reduce unnecessary burden** on front-line staff by releasing time to care and ensuring that what we do is **proportionate to organisational risk**
- reduce duplication of activity carried out by others and as such we will work with organisations including the Royal Colleges and the regulators to use their information wherever possible
- be able to **measure** the new approach to identify the impact on outcomes.

Over 2013/14 we will continue to develop a new approach to learning from claims which has **three** interrelated components:

1. Providing information and analysis

- extensively using our claims data, we will create national learning and share this with our members and others via our improved extranet
- creating profiles of patient and staff claims at national, organisational and clinical speciality level
- identifying outliers, ie those organisations with exceptionally high or low levels of claims, and work with them to understand why
- improving understanding and raise awareness of the key areas of high-value and/or high-volume claims to focus on reducing claims and improving patient and staff safety
- building and supporting accountability for claims at Trust board level.

2. Providing support to our members

- using our extranet to provide learning materials, information, advice and support to our members
- using a number of mechanisms to support our members learn from claims and each other, including sharing case studies, stories, using peer-to-peer support and buddy systems, providing tips, tools and resources such as webinars
- developing networks and clinical communities to share good practice
- using expert feedback reports for members.

The NHS LA previously instructed its solicitors to complete risk management reports on litigated claims in an attempt to ensure that learning and information was collated and disseminated back to the NHS LA and its members. The expert feedback pilot commenced in January 2013 with the aim of establishing whether instructing NHS LA experts (on both NHS LA managed claims and those with panel solicitor involvement) to complete separate feedback reports solely addressing learning, would be a more effective and efficient way of delivering learning from claims to members. This project will ascertain whether the NHS LA should routinely obtain expert feedback on all claims for the benefit of the membership.

3. Incentivising best practice

- Identifying the evidence base (solutions and interventions), we will focus on helping others do a few things well, that are already proven to reduce claims. We will look at ways of:
  - incentivising the use of safer practices that will help reduce the high-volume, high-value claims
  - identifying and signposting proven best practice to members for all other types of claims related to patients and staff
  - developing the methodology associated with financial incentives, including rewarding safer practice through incentivising best practice which can be proven to reduce claims.

During this time of change, we are committed to minimising the impact as we transition from the risk management discounts associated with levels 1 to 3.

Evaluation and measuring outcomes

We are committed to ensuring that the NHS LA is making a difference by supporting members to reduce their claims by making sure that what we do is measurable and measured and by reporting this information to our members.

Family Health Services Appeals Unit (FHSAU)

We received fewer appeals than expected this financial year and achieved targets for prompt resolution

The Family Health Services Appeals Unit (FHSAU) deals with disputes arising from dentists, general practitioners, pharmacists and opticians against the decisions made by Primary Care Trusts that affect their contracts with the NHS.

We received fewer appeals than we would normally expect to receive this financial year, particularly those relating to applications to join the Pharmaceutical List. We believe that this was mainly due to a recent change in regulation, with the NHS (Pharmaceutical Services) Regulation 2012 coming into force on 1 September 2012 ('the 2012 regulations'). As usual, the mix of case types varied from previous years, but pharmacy appeals remained the busiest work stream.

Dispute resolution in summary

Disputes relating to general medical services and personal medical services were again the main source of applications for dispute resolution.

We received fewer market rent disputes than in the same period last year. Fully determined current market rent cases (ie, not referred back to the PCT or withdrawn) were marginally higher than in 2011/12. We believe that our local dispute resolution protocol has gone some way to ensuring that such cases are more likely to be resolved at local level.

Medical and dental disputes raised the usual mix of issues from remuneration, from clawback of monies, to payment of quality outcomes framework monies, and termination of contract.

However, we did see a significant number of applications for dispute resolution following refusal by PCTs to pay monies under the Patient Participation Enhanced Service Agreement: in total there were 11 such determinations. There were also 11 termination of contract disputes.

The FHSAU received its first case brought by a pharmacist against sanctions imposed by a PCT under the 2012 regulations. This is referred to as 'market exit' in the regulations and is a new provision, in that a pharmacy contractor can be removed from the Pharmaceutical List for failure to comply with the terms of the pharmaceutical contract.

Appeals

The most significant change was the introduction of the 2012 regulations. These regulations base the commissioning of new pharmaceutical contracts upon a pharmaceutical needs assessment (PNA) carried out by PCTs. From 1 April 2013, PNAs will be carried out by the Health and Wellbeing Boards.

We received fewer appeals this year, probably as a result of the 2012 regulations. The majority of appeals were issued in line with our key performance indicators (KPIs), with over 90% of most types of appeal being issued within target.

"We received fewer appeals than we would normally expect, mainly due to a recent change in regulation."

Figure 1: Restriction checks by profession (2012/13)

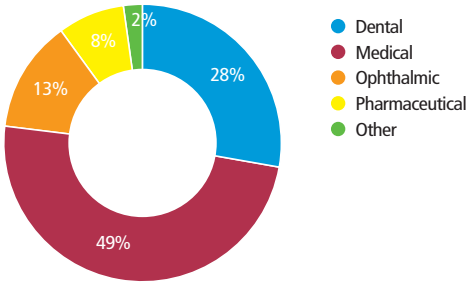
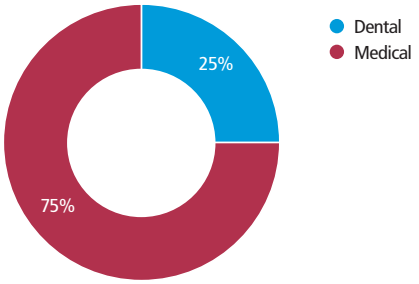


Figure 2: Notifications of suspensions by profession (2012/13)



Of those pharmacy appeals that resulted in a substantive determination (ie, not withdrawn), 24% were allowed; slightly higher than the same period last year. The breakdown of allowed appeals by case type was similar to 2011/12 with cases relating to the 'adequacy test' having the highest number.

The 2012 regulations reflect a substantial change in the way that pharmaceutical services are commissioned and during 2012/13 we received 27 new appeals.

We began an exercise to recruit panel members as due dates for reappointment expire. We have recently re-appointed Michael Beaman, Michael Smith, Phil Bratley and Muriel Loosemore to our Pharmacy Panel Member list and welcomed new Pharmacy Members Fiona Castle and Gail Curphey.

We take this opportunity to thank all Pharmacy Panel members for all their hard work over the years.

Judicial Review

As always, determination of disputes by the FHSAU may be subject to legal challenge by way of Judicial Review (JR). During 2012/13 three medical contractors, who sought permission to JR their respective determinations by the NHS LA, were refused permission at a hearing.

Determination of pharmaceutical appeals may also be subject to legal challenge by way of JR. Of the three applications that were considered by the courts during this year, two were refused permission, and one, having been granted permission, was successful and resulted in the decision of the NHS LA being quashed. However, "no fault" was found with the NHS LA by the court and the decision was quashed on the basis that the NHS LA had not been provided with complete information and as such the decision taken upon the information provided was unsafe.

PCT notifications and checks

The National Health Service (Performers Lists) Regulations 2004 currently apply to the medical, dental and ophthalmic professions, with similar provision for pharmacists in separate regulations. PCTs are required to provide notification to the NHS LA of any adverse decisions relating to those on the lists and those applying to enter them and the NHS LA shall keep a list of such notifications (delegated from the Secretary of State). When a PCT determines new applications to enter each list, they are required to check with the NHS LA for any facts relating to investigations or proceedings involving the proposed applicants.

Between 1 April 2012 and 31 March 2013 we received notification of 60 suspensions. This is marginally down from 2011/12 (64). The breakdown by profession is shown in the first graph. There were 53 suspensions still in force as at 31 March 2013. There were 2,133 other local decisions under the fitness-to-practise procedures, including 66 notifications of withdrawn applications to join a list.

The NHS LA holds details of the notifications on a database for the purpose of responding to PCT requests for checks on performers. During the year, 16,251 requests for information were processed compared to 2011/12 which had 15,713 and the secure online checking system provided immediate clearance for 96.52% of checks. The remaining 3.48% were referred to the NHS LA for further investigation. The breakdown of checks by profession is shown in the second graph and which is similar to 2011/12.

National Clinical Assessment Service (NCAS)

Integration of NCAS in the NHS LA will result in more information sharing on safety

As of 1 April 2013 the National Clinical Assessment Service (NCAS) will become an operating division of NHS LA. Work will be undertaken to integrate processes, systems (including IT) and structures thereby ensuring not only a single identifiable organisation, but releasing operational efficiencies and benefits through shared learning.

The identification and development of synergies between NHS LA and NCAS focuses on the safety agenda. Within this there will be particular areas of work, including information sharing following the Mid Staffordshire inquiries, and improving the sharing of learning and knowledge to the NHS and healthcare generally.

We will review the existing business model of NCAS with a view to moving towards self-funding during 2013/14, as required by the Department of Health, ensuring that the business model has been developed to a stage where a proportion of NCAS income can be raised through self-funding, with the aim of increasing this proportion progressively over the following years. This will involve identifying and responding to the needs of existing and emergent stakeholders and ensuring that the governance arrangements are fit for purpose.

Developing new products and services, where appropriate, will support the move towards self-funding, and will reflect customers' needs for new services, such as case manager and case investigator training for the Revalidation Steering Team.

We will also be building relationships within the restructured NHS. NCAS maintains a strong ongoing relationship with all of its stakeholders following the substantial changes in the NHS structure in England on 1 April 2013 and NCAS will ensure that these relationships continue and are developed.

NCAS will be, as of 1 April 2013, responsible for issuing Healthcare Professional Alert Notices (HPANs) within England, in addition to the work NCAS has undertaken to develop an e-portal for organisations to access HPANs.

NCAS receives up to 1,000 new referrals each year; alongside ongoing and re-opened cases, at any one time there are more than 500 active cases. These are managed through NCAS' referral-to-resolution model with a variety of interventions used as appropriate, including: advice, mediation, assessments (full and modular) and action planning through 'back on track' and 'back to work'.

NCAS, as part of NHS LA, will create an organisational learning culture by supporting staff and building effective leaders and teams. We will maintain our programme of external education, training and awareness raising events, attended by 2,000 delegates each year.

"Developing new products and services will support the move towards self-funding, and reflect customers' needs."

Management commentary

Statutory background

The NHS LA is established under the National Health Service Act 2006. These financial statements have been prepared according to an Accounts Direction issued by the Secretary of State with the approval of HM Treasury.

Functions

The NHS LA is a Special Health Authority primarily set up to manage, on behalf of member Trusts, claims arising from clinical negligence incidents post 1 April 1995 (the Clinical Negligence Scheme for Trusts, or CNST).

It also manages clinical negligence claims against the NHS for incidents pre 1 April 1995 (the Existing Liabilities Scheme or ELS), clinical negligence claims against the former Regional Health Authorities (the ex-RHA Scheme) and the non-clinical claims of member Trusts with the exception of motor vehicle claims. It is also responsible for promoting high standards of risk management throughout the NHS and certain appellate functions on behalf of the Department of Health.

Review of activities and performance against targets

During the year, our net operating costs amounted to £4,408.1 million, which represents an increase of £1,980 million on the figure for the previous year. Of that increase, £1,412 million is a direct result of the change in the discount rate applied by HM Treasury. The NHS LA's net operating costs are required to be managed within a revenue resource limit (RRL) agreed with the Department of Health. For 2012/13 the agreed RRL was £4,421.8 million; thus an underspend of £13.8 million is reported.

The NHS LA is required to pay its creditors in accordance with the Better Payment Practice Code which requires payment of creditors within 30 days of receipt of goods or a valid invoice (whichever is the latter) unless other payment terms have been agreed with the supplier. Of relevant bills, 92.09% (2011/12 was 83.4%), representing 95.17% (2011/12 was 84.2%) by value, were paid within the 30-day target. The NHS LA is required to manage within its cash limits as agreed with the Department of Health. For 2012/13 we received funding of £320 million from the Department of Health. Capital cash limits for the year were £240,000, with reported outturn at £239,000 showing an underspend of £1,000.

Our financial position as at 31 March 2013 shows net liabilities of £22.951 billion. The global valuation recorded, recognises provisions that will crystallise in future years and will be funded by future contribution payments or departmental funding. This future income is calculated to fund annual outgoings, and in the case of the departmental funding is subject to Parliamentary control. There is no reason to believe that this future funding, future Parliamentary authority, and the contribution payments from members will not be forthcoming. It has therefore been considered appropriate to adopt an ongoing concern basis for the preparation of these accounts. In addition, Section 70 of the NHS Act 2006 requires the Secretary of State to exercise his statutory powers to deal with the reported liabilities of this Special Health Authority if it ceases to exist.

These provisions relate predominately to clinical negligence claims which have either already been made or which are considered to have been incurred through treatment delivered by the NHS, but yet to be reported as claims. Inevitably these claims will take time to progress to settlement and so these provisions are recorded using International Accounting Standard 37 (IAS37) to give readers a clear indication of the likely value of these claims were they all made and settled today.

These provisions are essentially a valuation as at 31 March 2013 of all of the clinical and non-clinical liabilities of the NHS in England (excluding primary care delivered by GPs) which are covered by the schemes managed by the NHS LA should they all fall to be settled as at that point in time; ie should the NHS LA cease to exist, this is the estimated value of the liabilities which would need to be met by the NHS relating to treatment delivered up to the 31 March 2013.

In order to assist with the transfer of historic liabilities from SHAs and PCTs, the Department of Health made

additional financial support available to NHS LA during 2012/13, enabling the resolution of historic SHAs and PCTs claims before their demise and maintaining the overall growth in CNST contributions in line with forecasting. This additional support also allowed the NHS LA to minimise any impacts upon NHS patients and staff members that may have occurred had such funds not been made available. The additional financial support from the Department of Health totalled an expenditure of £200 million in year.

The NHS LA's own cash balances reduced by £2.9 million (£18.99 million is held at year end compared to £21.86 million in 2011/12).

All of the contribution schemes managed by the NHS LA are on a 'pay-as-you-go' basis thereby minimising the impact on cash available for patient care in any given financial period although, inevitably, managing such schemes requires us, at all times, to try to balance the level of contributions charged to members against the impacts large variations might have on the wider NHS. Such careful fiscal planning is more acute in the current financial climate and so the NHS LA is very grateful for the support of the Department of Health in year.

Sickness absence

801 days were lost as a result of sickness during 2012/13 (763 days 2011/12).

Pension Liabilities

Our employees are covered by the provisions of the NHS Pension Scheme, details of which are given in notes 1.10 of the accounts. Pension liabilities in respect of Board members are given in the Remunertion Report.

Audit Services

The Comptroller and Auditor General has provided the NHS LA's audit services at a cost of £78,000 for the current year. No non-audit work was undertaken.

The NHS LA has confirmed that there is no relevant information of which the auditors are unaware. The Accounting Officer has taken all the steps she ought to take to ensure that they are aware of relevant audit information and the Accounting Officer has taken all the steps she ought to establish that the entity's auditors are aware of the information.

Professional advisers

The NHS LA maintains two panels of solicitors, the first specialising in clinical claims and the second in non-clinical claims. Current membership is given below. The clinical and non-clinical panels are currently subject to tender, which will be completed during 2013/14.

Clinical negligence claims panel of solicitors

Bevan Brittan LLP
Browne Jacobson LLP
Capsticks LLP
Clyde & Co LLP
DAC Beachcroft LLP
Hempsons
Hill Dickinson LLP
Kennedys Law LLP
Ward Hadaway LLP
Weightmans LLP

Non-clinical claims panel of solicitors

Browne Jacobson LLP
Clyde & Co LLP
Hill Dickinson LLP
Kennedys Law LLP
Veitch Penny
(merged with Brown Jacobson LLP)
Ward Hadaway LLP
Weightmans LLP

Actuaries

Lane, Clark & Peacock

Risk management

Det Norske Veritas

Board members

The NHS LA is led by a board, made up of executive (full-time employees) and non-executive members, chaired since 1 April 2007 by Professor Dame Joan Higgins. The non-executive directors are appointed by the Secretary of State for Health. All executive directors have been appointed through open competition and in accordance with the NHS LA's recruitment and selection policies and Department of Health guidance. All current executive director posts are permanent appointments. Full details of directors' remuneration are given in the remuneration report.

Professor Dame Joan Higgins DBE
BA (Hons), Diploma in Social Administration, PhD
Chair

Catherine Dixon
LLB (Hons), MBA, Solicitor
Chief Executive

Tom Fothergill
BA (Hons), CPFA
Director of Finance and Corporate Planning

Keith Ford OBE
CPFA
Non-executive Director

Professor Rory Shaw
BSc, MD, MBA, FRCP
Non-executive Director

Nina Wrightson OBE
Dip SH, LLB (Hons), CFIOSH
Non-executive Director

Remuneration report

The NHS LA has a Remuneration and Terms of Service Committee, made up of all our non-executive directors, which considers pay and benefits for employees not covered by the national Agenda for Change arrangements, and makes recommendations to the Department of Health based on the Department's *Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts.*

The Committee met six times during the year. Attendance was as follows:

Non-executive director	Meetings attended
Joan Higgins	6 of 6
Keith Ford	6 of 6
Rory Shaw	6 of 6
Nina Wrightson	6 of 6

All senior managers have indefinite contracts; there are no fixed-term or rolling contracts.

On pages 38 and 39 are the contractual, salary and pension details of those senior managers who had control over the major activities of the NHS LA during 2012/13. The information in the following tables is subject to audit.

Salaries and allowances

Name and title	2012/13			2011/12		
	Salary (bands of £5,000) £'000	Other remuneration bands of £5,000) £'000	Benefits in kind (rounded to the nearest £'00) £'00	Salary (bands of £5,000) £'000	Other remuneration (bands of £5,000) £'000	Benefits in kind (rounded to the nearest £'00) £'00
Joan Higgins (Chair)	35–40	N/A	N/A	35–40	N/A	N/A
Catherine Dixon (Chief Executive)	140–145	0	0	N/A	N/A	N/A
Stephen Walker*** (former Chief Executive)	N/A	N/A	N/A	180–185	0	73*
Tom Fothergill (Director of Finance and Corporate Performance)	150–155	0	1	150–155	0	N/A
Keith Ford (Non-executive Director)	10–15	N/A	N/A	10–15	N/A	N/A
Rory Shaw (Non-executive Director)	5–10	N/A	N/A	5–10	N/A	N/A
Nina Wrightson (Non-executive Director)	5–10	N/A	N/A	5–10	N/A	N/A

	2012/13	2011/12
Band of highest paid director's total remuneration (£'000) [1]	150–155	180–185
Median total remuneration [2]	42,989	43,458
Ratio [2]	3.55[3]	4.20[3]

[1] The Chief Executive retired 31 March 2012 and the highest paid director has therefore changed.
[2] There has been an increase in the general workforce and this together with the changes noted above has reduced the pay ratio.
[3] Due to difficulties in separating the agency fee from the actual staff costs, the ratio does not include consideration of agency staff.

Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2013 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'00
Joan Higgins (Chairman)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Catherine Dixon (Chief Executive)	0–2.5	0	0–5	0	25	0	25	195
Stephen Walker*** (former Chief Executive)	N/A	N/A	N/A	N/A	N/A	0**	N/A	N/A
Tom Fothergill (Director of Finance and Corporate Performance)	0–2.5	5–7.5	35–40	110–115	588	516	45	208
Keith Ford (Non-executive Director)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Rory Shaw (Non-executive Director)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nina Wrightson (Non-executive Director)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

* Benefits in kind relate to lease cars.
** When an employee reaches the eligible retirement age, the CETV becomes £0 since the pension benefits can no longer be transferred.
*** Stephen Walker retired with effect from 31 March 2012. The new CEO started with effect from 1 April 2012.

As non-executive directors do not receive pensionable remuneration, there will be no entries in respect of pensions for them.

Cash equivalent transfer values

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

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

Catherine Dixon
Chief Executive and Accounting Officer
Date: 2 July 2013

People

The NHS LA employs (as at 31 March) 138 permanent and fixed-term staff.

We commissioned a staff survey in year which recorded a creditable 65% response rate. Overall the responses indicate a very positive upward trend from the previous survey undertaken in 2011. There are consistently high scores related to working at the NHS LA with 89% of respondents having seen positive change in the past 12 months and 81% of respondents feeling that there will be continued improvement in the next 12 months.

Overall 85% of respondents state that the organisation is a good place to work and 81% of respondents would say to others outside of the organisation that it is a good place to work. With regard to managing change, 69% of respondents state that this is managed well. Job security has significantly increased from 28% in 2011 to 76% in 2013.

The vast majority of respondents (91%) feel that communication has improved over the last 12 months. The vast majority of respondents (93%) have a clear understanding of their role, what's expected of them in the job (91%) in terms of performance (97%) and standards of behaviour (100%). These have all increased from 2011 and are validated by the responses in 'Health, Safety and Welfare'.

Most respondents feel that the values of the NHS LA are moving in a direction that they support (83% in 2013; versus 66% in 2011) and 78% would recommend the NHS LA as a good employer.

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State has directed the NHS LA 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 the NHS LA and of its net expenditure, application of resources, changes in taxpayers' equity and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- prepare the accounts on a going concern basis.

The Accounting Officer of the Department of Health has designated the Chief Executive as Accounting Officer of the NHS LA. 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 the NHS LA'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.

Governance statement

Scope of responsibility

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

I have operational responsibility for the:

- delivery, in conjunction with the Board, of effective governance
- provision, oversight and effective working of systems of internal control
- risk management processes
- NHS LA's claims database and financial system.

The NHS LA senior management team, supported by internal audit and the NHS LA Audit and Risk Committee, make recommendations to the NHS LA Board on the matters outlined in this statement as they relate to effective NHS LA governance.

Day-to-day operational responsibility for the NHS LA's financial systems and internal risk management arrangements is delegated to the Director of Finance and Corporate Planning. The risk management team directed by the Director of Finance and Corporate Planning, acting as the senior information risk owner and data protection officer, is responsible for co-ordinating internal NHS LA risk management activity, including information governance.

The risk management team ensures the dissemination of good risk management practice to NHS LA managers and staff. Risk management policy is regularly reviewed. An internal audit plan is agreed by the Audit and Risk Committee. Close working arrangements exist between internal auditors, Department of Health and other agencies to ensure that the NHS LA draws on experience in the wider NHS.

Governance, assurance and internal risk management are fully integrated within the NHS LA's overall business-planning process. Planning and risk processes are co-ordinated through the senior management team, which I chair, and which reports through me to the Board.

During 2012/13 the internal audit team carried out a review of risk management within the NHS LA and reported findings to the Audit and Risk Committee. The report made three medium- and three low-level recommendations, which are being implemented by the NHS LA.

Corporate performance is reported to the Board on a regular basis. Variations from anticipated performance will, where appropriate, be accompanied by reports from the Audit and Risk Committee and/or senior management team, giving the Board assurance on progress and the action to be taken.

The Board is satisfied that its governance arrangements meet the requirements of the Code of Good Practice required within central government departments and will seek, in 2013/14, to formally verify compliance.

During 2012/13 the Board has reviewed and amended the information supplied to it to ensure it remains satisfied regarding the quality of information, but also that it is relevant to the business of the Board.

During 2012/13 the NHS LA Board met on six occasions and attendance details are as follows:

Name	Post	Meetings attended
Joan Higgins	Chair	6 of 6
Keith Ford	Non-executive Director	6 of 6
Rory Shaw	Non-executive Director	6 of 6
Nina Wrightson	Non-executive Director	6 of 6
Catherine Dixon	Chief Executive	6 of 6
Tom Fothergill	Director of Finance & Corporate Planning	6 of 6

The purpose of the governance arrangements

The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives. Therefore, it can only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the NHS LA of achieving its aims and objectives
- ensure compliance with NHS LA policies
- evaluate the likelihood of risks being realised and the impact should they be realised
- manage the risk efficiently and effectively.

The system of internal control which accords with HM Treasury guidance has been in place in the NHS LA for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. The internal audit team has provided reasonable assurance that there is a sound system of internal control within the NHS LA.

Capacity to handle risk

The NHS LA's approach to risk is outlined in the NHS LA's risk management strategy, which identifies the roles and responsibilities of staff at all levels relating to risk. Training is provided to support staff to carry out their designated responsibilities. The NHS LA's approach to governance, including risk, is included in the induction process for all new staff.

The NHS LA is committed to minimising the risk associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to the management of information governance. The NHS LA's Information Governance Strategy and related policies and protocols outline a consistent approach to information handling. During 2012/13 an audit of information governance was undertaken and made only three low-rated recommendations, which were accepted by the NHS LA.

The NHS LA is well-versed in handling sensitive data and takes its responsibilities seriously. The secure document transfer system (DTS) provides stakeholders with a protected environment to transfer data to and from the NHS LA, so minimising the risk of interception of sensitive documents. The NHS LA's IT equipment is appropriately encrypted and the use of portable media such as USB keys is strictly controlled, so when it is in use it is secure and password protected.

The NHS LA's Assurance Framework brings together governance and quality, linked to the NHS LA's strategic objectives. Its purpose is to ensure that systems and information are available to provide assurance on identified corporate risks and that such risks are being controlled and objectives achieved. For example, the NHS LA's financial and operational performance is reported monthly to the senior management team and the Board. The NHS LA's financial position together with operational KPIs is reported quarterly to the Department of Health to demonstrate that expenditure commitments are in line with forecasts and budgetary limits.

The NHS LA Board receives assurance from the Audit and Risk Committee, which in turn receives assurance from the senior management team and where appropriate the Health, Safety and Risk Committee on the achievement of objectives and mitigation of risk. The Board is accountable for demonstrating that:

- key controls are in place to assist in securing and delivering objectives
- the controls systems, upon which reliance is placed, are effective
- any gaps in controls systems or assurances are addressed within an agreed action plan.

The Board has, in addition to its formal meetings, held several informal sessions including Board away days to facilitate dealing with key issues reviewing board papers and the information available to the Board to ensure its effectiveness.

The risk and control framework

During the financial year 2012/13, the NHS LA has dealt with a number of significant risks (some of which were outside its direct control). Some of the risks are ongoing into 2013/14. The following risks are considered to be significant:

- With effect from 1 April 2013, NCAS became an operating division of the NHS LA. NCAS was hosted by the National Institute for Health and Clinical Excellence (NICE). The NHS LA worked closely with NICE and NCAS during 2012/13 to ensure appropriate due diligence, consult with staff and put in place processes to ensure a smooth transition of the staff and all associated resources. The integration of NCAS is ongoing into 2013/14.
- During 2013/14 the NHS LA will also be working towards transforming NCAS's service delivery, which is currently funded by the Department of Health, with the aim of developing and moving towards a self-funding model.

- During 2012/13 the audit of our financial accounts identified a number of claims where the date of the alleged incident was incorrect. This has not impacted upon the financial accounts of the NHS LA. However, if the incident dates are incorrect, this could make it difficult for the NHS LA to place reliance on its financial forecasting models in the future. During 2012/13 we have, therefore, taken steps to address this concern. During 2013/14 we will be auditing our claims data to ensure that all corrections have been made. In addition the NHS LA is reviewing its data input controls to ensure that further risks of inaccuracy are mitigated as far as practicable.
- The creation of the infrastructure to support the NHS has led to the formation of NHS England, 211 CCGs and the NHS Property Company (which manages property assets). These organisations replaced existing SHAs and PCTs with effect from 1 April 2013. The NHS LA is working with all the new organisations to ensure appropriate indemnity arrangements are in place. The Department of Health has published guidance that deals with the transfer of all historical liabilities as at 31 March 2013 which the NHS LA will follow to ensure the appropriate allocation of liabilities.
- To assist with the transfer of historic SHA and PCT liabilities, the NHS LA received additional financial support by the Department of Health in 2012/13. This enabled the NHS LA to resolve a number of outstanding PCT/SHA claims (prior to their demise) while maintaining the overall current growth in CNST contributions for 2013/14 in line with previous forecasts to members.
- Changes to the regulations for CNST have enabled the NHS LA to welcome the independent sector (IS) providing NHS care as direct members of CNST. The NHS LA maintained consistent contributions for the IS in 2012/13 and has committed to work with the IS to agree a methodology for contribution setting in 2013/14.
- It is important that we take account of members' views, given that membership of the NHS LA's schemes is voluntary. Our objective is to communicate and, where appropriate, consult with stakeholders in all areas of our activities, including in connection with the management of any significant risks or changes to our schemes. Stakeholders include not only the members of our schemes, but also royal colleges, patient associations, medical defence organisations, the broader health community and the public.
- Following the publication of the Marsh review of NHS LA in January 2012 by the Department of Health, we have implemented a number of the report's recommendations during 2012/13. In particular, we have reviewed and implemented a revised pricing methodology for calculating member contributions to the NHS LA's Clinical Negligence Scheme for Trusts (CNST) with effect from 1 April 2013.
- During 2012/13 the NHS LA communicated its revised approach to contributions, proposed changes to its risk management standards and assessment, and initiatives to better enable learning from claims to members and other key stakeholders. We met with over 250 NHS organisations and other stakeholders to outline and discuss these changes.
- The change to contribution setting for individual CNST members takes greater account of claims experience. It also takes activity levels into account when looking at future risk. This ensures that members' costs are smoothed over a 5-year period. Therefore, the amount paid by members is reflective of a member's organisational risk. This ensures that CNST pricing is transparent and supports a fair playing field for members which is equitable and better reflects organisational risk profiles. Members with a better claims experience will have been financially rewarded in that the contribution they pay into the scheme has been reduced in 2012/13.
- NHS LA staff are entitled to membership of the NHS Pension Scheme. Control measures are in place to ensure compliance with all employer obligations in the pension scheme regulations. This includes ensuring that deductions from salary, employer contributions and payments into the scheme are in accordance with the pension scheme rules, and that member pension scheme records are updated in accordance with the timescales detailed in regulations.
- As with all NHS organisations, the risk of fraud is a significant consideration. The nature of the NHS LA's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members. Great care is taken to review the appropriateness of our systems, with reporting to the Audit and Risk Committee by our Counter Fraud Team. Where possible fraud is identified, the NHS LA immediately involves the appropriate authorities, as well as discussing the matter with any affected stakeholder and their local counter-fraud specialists. Staff awareness regarding fraud is maintained by regular updates, newsletters and training and following consideration of the results of a survey in year a number of staff received additional fraud awareness training.

- The NHS LA holds and maintains data regarding its staff. It also holds claimant information. This is sensitive personal information and as such requires safeguards to be in place to protect the data. The NHS LA maintains policies and systems, which are regularly reviewed, to minimise the risk of data security breaches.

Review of effectiveness

As Accounting Officer, I am responsible for reviewing the effectiveness of the system of internal control. This is undertaken in the following ways:

- The head of internal audit (a role delivered as part of our outsourced internal audit function), provides assurance that there is generally a sound system of internal control (designed to meet the organisation's objectives) and that controls are generally applied consistently. There were no 'limited assurance' opinions provided in year and only one high-priority action identified in the audit programme.
- Members of the senior management team, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance.
- The Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation, thereby supporting and achieving its objectives.
- I regularly meet with members of the senior management team to discuss the performance of the NHS LA and to receive assurance and feedback on their areas of responsibility. Throughout this financial year we have discussed and agreed the changes we are making to our services, including preparing for the new NHS structure (and new NHS LA members) and also the transition of our new NCAS colleagues from NICE.
- I am also informed by the NHS LA's external auditors in their management letters and other reports on aspects of the system of internal control. The final accounts process for 2012/13 incorporated actions identified during the previous audits to improve the presentation and clarity of the accounts including detailed sensitivity analysis regarding our provisions at note 9 in the attached accounts.
- The Audit and Risk Committee meets regularly and reports to the Board after each meeting, but also by way of a formal annual report. During the year the Committee has reviewed its own effectiveness, membership and terms of reference and remains satisfied that it has sufficient flexibility in those areas to deal with the business of the Committee. In addition the Committee has commissioned additional assurance regarding actuarial forecasts by introducing a peer review carried out by an independent firm of actuaries. The Committee also monitors compliance with all audit recommendations to ensure that they are effectively implemented. Both the internal and external auditors are present at the Audit and Risk Committee meetings and the Internal Audit Team has reported on corporate governance during 2012/13.

Attendance records for Audit and Risk Committee meetings was as follows:

Name	Post	Meetings attended
Keith Ford	Non-executive Director	4 of 4
Nina Wrightson	Non-executive Director	4 of 4
Rory Shaw	Non-executive Director	3 of 4

These arrangements aim to help the NHS LA maximise its understanding and use of all available information about the quality and effectiveness of its systems to help us improve services and satisfy the increasing need for assurance about the effectiveness of systems of internal control. Based on my review I am not aware of any significant control issues.

Catherine Dixon
Chief Executive and Accounting Officer
Date: 2 July 2013

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

I certify that I have audited the financial statements of the NHS Litigation Authority for the year ended 31 March 2013 under the National Health Service Act 2006. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and Auditor

As explained more fully in the 'Statement of accounting officer's responsibilities', the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Litigation Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Litigation Authority; and the overall presentation of the financial statements. In addition I read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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.

Opinion on regularity

In my opinion, in all material respects 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.

Opinion on financial statements

In my opinion:

- The financial statements give a true and fair view of the state of the NHS Litigation Authority's affairs as at 31 March 2013 and of its net expenditure for the year then ended; and
- The financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

Without qualifying my opinion, I draw attention to the disclosures made in note 9 to the financial statements concerning the uncertainties inherent in the incidents incurred but not reported claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 9, 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 the NHS Litigation Authority. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by the NHS Litigation Authority.

Opinion on other matters

In my opinion:

- The part of the 'Remuneration report' to be audited has been properly prepared in accordance with Secretary of State directions issued under the National Health Service Act 2006.
- The information given in the 'Management commentary' and the 'Governance statement' for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse Date: 3 July 2013
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road, Victoria, London, SW1W 9SP

Financial statements

Statement of comprehensive net expenditure
for the year ended 31 March 2013

	Notes	2012/13 £'000	2011/12 £'000
Programme costs			
Authority and claims administration	2.1	**13,382**	12,585
Unwinding of discounts	2.1	**19,209**	(3,867)
Change in discount rate *	2.1	**1,411,694**	0
Other claims and associated costs	2.1	**3,969,595**	3,353,776
		5,400,498	3,349,909
Total programme costs	2.1	**5,413,880**	3,362,494
Operating income	4	**(1,005,743)**	(934,418)
Net expenditure	3.1, 10	**4,408,137**	2,428,076

Other comprehensive expenditure

* In 2012/13 Treasury changed the discount rate for general provisions (Note 1.12)

The NHS LA incurred no other comprehensive expenditure

All income and expenditure is derived from continuing operations

The notes on pages 52 to 78 form part of these accounts.

Statement of financial position
as at 31 March 2013

	Notes	31 March 2013 £'000	31 March 2012 £'000
Non-current assets:			
Property, plant & equipment	5.3, 5.4	**1,737**	2,040
Intangible assets	5.1, 5.2	**402**	349
Total non-current assets		**2,139**	2,389
Current assets:			
Trade and other receivables	6	**6,790**	19,144
Cash and cash equivalents	7	**18,992**	21,860
Total current assets		**25,782**	41,004
Total assets		**27,921**	43,393
Current liabilities:			
Trade and other payables	8	**(21,432)**	(39,752)
Provisions for liabilities and charges – known claims	9.1, 9.2	**(1,127,693)**	(2,118,532)
Provisions for liabilities and charges – IBNR	9.1, 9.2	**(105,000)**	(75,000)
Total current liabilities		**(1,254,125)**	(2,233,284)
Non-current assets plus/less net current assets/liabilities		**(1,226,204)**	(2,189,891)
Non-current liabilities			
Provisions for liabilities and charges – known claims	9.1, 9.2	**(8,466,262)**	(6,267,404)
Provisions for liabilities and charges – IBNR	9.1, 9.2	**(13,259,000)**	(10,406,000)
Total non-current liabilities		**(21,725,262)**	(16,673,404)
Assets less liabilities		**(22,951,466)**	(18,863,295)
Taxpayers' equity			
General Fund		**4,613**	4,374
ELS Reserve		**(2,238,540)**	(2,249,025)
Ex-RHA Reserve		**(37,519)**	(32,089)
CNST Reserve		**(20,408,882)**	(16,340,952)
PES Reserve		**(1,814)**	(3,244)
LTPS Reserve		**(269,324)**	(242,359)
Total taxpayers' equity		**(22,951,466)**	(18,863,295)

The General Fund and individual scheme reserves are used to account for all financial resources.
The notes on pages 52 to 78 form part of these accounts.

Signed: Date: 2 July 2013
Catherine Dixon, Chief Exectutive and Accounting Officer

Statement of changes in taxpayers' equity
for the year ended 31 March 2013

	Notes	General Fund £'000	ELS Reserve £'000	Ex-RHAS Reserve £'000	CNST Reserve £'000	PES Reserve £'000	LTPS Reserve £'000	Total Reserves £'000
Balance at 1 April 2011		4,121	(2,058,066)	(32,931)	(14,562,473)	(4,320)	(189,763)	(16,843,432)
Changes in taxpayers' equity for 2011/12								
Net expenditure for the year	9.6	(1,521)	(362,497)	(2,115)	(2,010,423)	1,076	(52,596)	(2,428,076)
Total recognised income and expense for 2011/12		(1,521)	(362,497)	(2,115)	(2,010,423)	1,076	(52,596)	(2,428,076)
Net Parliamentary funding *		1,774	171,538	2,957	231,944	0	0	408,213
Balance at 31 March 2012		**4,374**	**(2,249,025)**	**(32,089)**	**(16,340,952)**	**(3,244)**	**(242,359)**	**(18,863,295)**
Changes in taxpayers' equity for 2012/13								
Net expenditure for the year	9.6	(1,170)	(133,349)	(6,653)	(4,240,930)	1,430	(27,465)	(4,408,137)
Total recognised income and expense for 2012/13		(1,170)	(133,349)	(6,653)	(4,240,930)	1,430	(27,465)	(4,408,137)
Net Parliamentary funding **		1,409	143,834	1,223	173,000	0	500	319,966
Balance at 31 March 2013		**4,613**	**(2,238,540)**	**(37,519)**	**(20,408,882)**	**(1,814)**	**(269,324)**	**(22,951,466)**

* During 2011/12 the Department of Health made additional non-refundable cash available to the ELS Scheme (£33.1m) and the member-funded CNST (£231.9m) Scheme.
** During 2012/13 the Department of Health made additional non-refundable cash available to the ELS Scheme (£26.5m), the member-funded CNST (£173m) and LTPS (£0.5m) Schemes.
The notes on pages 52 to 78 form part of these accounts.

Statement of cash flows
for the year ended 31 March 2013

	Notes	2012/13 £'000	2011/12 £'000
Cash flows from operating activities			
Net expenditure		**(4,408,137)**	(2,428,076)
Other cash flow adjustments	10	**489**	459
Movement in working capital	10	**4,085,053**	2,010,223
Net cash (outflow) from operating activities		**(322,595)**	(417,394)
Cash flows from investing activities			
Purchase of property, plant and equipment	5.3, 5.4	**(72)**	(153)
Purchase of intangible assets	5.1, 5.2	**(167)**	(100)
Net cash inflow/(outflow) from investing activities		**(239)**	(253)
Cash flows from financing activities			
Net Parliamentary funding		**319,966**	408,213
Net financing		**319,966**	408,213
Net increase/(decrease) in cash and cash equivalents		**(2,868)**	(9,434)
Cash and cash equivalents at the beginning of the period		**21,860**	31,294
Cash and cash equivalents at the end of the period	7	**18,992**	21,860

The notes on pages 52 to 78 form part of these accounts.

Notes to the accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2012/13 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Authority for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHS LA are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

The accounts are presented in pounds sterling and all values are rounded to the nearest thousand pounds (£'000). The functional currency of the NHS LA is pounds sterling.

1.1 Accounting conventions

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

1.2 Early adoption of standards, amendments and interpretations

The NHS LA accounts has not adopted any IFRSs, amendments or interpretations early.

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

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

The following have not been adopted early in these accounts:

- IAS 1 Presentation of financial statements, on other comprehensive income (OCI): Effective date of 2013/14 under EU and HM Treasury adoption.
- IAS 19 (Revised 2011) Employee Benefits: Effective date of 2013/14 under EU and HM Treasury adoption.
- IFRS 7 Financial Instruments: Disclosures – amendment for offsetting financial assets and liabilities: Effective date of 2013/14 under EU adoption.
- IFRS 10 Consolidated Financial Statements: Effective date of 2014/15 under EU adoption.
- IFRS 11 Joint Arrangements: Effective date of 2014/15 under EU adoption.
- IFRS 12 Disclosure of Interests in Other Entities: Effective date of 2014/15 under EU adoption.
- IFRS 13 Fair Value Measurement: Effective date of 2013/14 under EU adoption, however this Standard is unlikely to be adopted by HM Treasury until 2014/15.
- IAS 27 Separate Financial Statements: Effective date of 2014/15 under EU adoption.
- IAS 28 Associates and Joint Ventures: Effective date of 2014/15 under EU adoption.
- IAS 32 Financial Instruments: Presentation – amendment for offsetting financial assets and liabilities: Effective date of 2014/15 under EU adoption.
- IFRS 9 Financial Instruments: The effective date is for accounting periods beginning on, or after 1 January 2015. The timing for EU adoption is uncertain.

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

1.3 Income

Income is accounted for by applying the accruals convention. A major source of funding for the Special Health Authority is a Parliamentary grant from the Department of Health from Request for Resources 1 within an approved cash limit, which funds the ELS and Ex-RHA clinical negligence schemes. Parliamentary funding is recognised in the financial period in which it is received.

Operating income is that which relates directly to the operating activities of the NHS LA. It principally comprises annual contributions charged to member NHS bodies for likely claims payments in year. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Taxation

The NHS LA 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 Property, plant and equipment (PPE)

PPE are measured at cost including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year.

i) Capitalisation

Plant, property and equipment are capitalised where they are capable of being used for more than one year, and they:

- individually have a cost equal to or greater than £5,000;
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building irrespective of their individual or collective cost.

ii) Valuation

PPE are measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Equipment surplus to requirements is valued at net recoverable amount.

iii) Depreciation

Depreciation is charged on a straight-line basis on each main class of fixed asset as follows:

Furniture and fittings	10 years
Information technology	5 years

iv) Leased assets

NHS LA holds no finance leases.

Other leases are regarded as operating leases and the rentals are charged to the Statement of Comprehensive Net Expenditure on a straight-line basis over the term of the lease.

1.6 Intangible assets

i) Capitalisation

Intangible assets which can be valued and are capable of being used in the NHS LA's activities for more than one year and have a cost equal to or greater than £5,000;

Purchased computer software licences are capitalised where expenditure of at least £5,000 is incurred and the software has service potential for the organisation.

ii) Internally generated intangible assets

Expenditure on research is not capitalised. An internally generated intangible asset arising from the NHS LA's development is recognised only if all of the following conditions are met:

- an asset is created that can be identified (such as bespoke software);
- it is probable that the asset created will generate future economic benefits; and
- the development cost of the asset can be measured reliably.

Intangible fixed assets are valued at cost.

iii) Amortisation

For intangible assets with finite useful lives, amortisation is calculated so as to write off the cost of an asset, less its estimated residual value, over its useful economic life.

Software is amortised on a straight-line basis over five years.

1.7 Impairment of non-financial assets

Non financial assets are reviewed at each reporting date for indications of impairment. Where an asset is found to be impaired, it is written down through the Statement of Comprehensive Net Expenditure to its estimated recoverable amount. The recoverable amount is the higher of value in use and the fair value less costs to sell the asset.

Value in use is the net present value of the estimated future cash flows of that asset. Present values are computed using discount rates that reflect the time value of money and the risks specific to the unit whose impairment is being measured.

1.8 Assets held for sale

A non-current asset held for sale represents assets whose carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are included in the Statement of Financial Position at fair value less costs to sell, if this is lower than the previous carrying amount. Once an asset is classified as held for sale or included in a group of assets held for sale no further depreciation or amortisation is recorded.

1.9 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Net Expenditure (SOCNE) on an accruals basis, including losses which would have been made good through insurance cover had the NHS LA not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 12 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.10 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the 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:

i) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

ii) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value-for-money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

iii) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the 12 months ending 30 September in the previous calendar year. From 2011/12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other free standing additional voluntary contributions (FSAVC) providers.

1.11 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, as it is not material.

1.12 Provisions

The NHS LA 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 risk-adjusted cash flows are discounted using the Treasury's discount rate. The Treasury discount rate was adjusted in November 2012 from the previous 2.2% and has been replaced by three rates, short (-1.8%), medium (-1.0%) and long term (2.2%).

The ELS and Ex-RHA schemes are funded by the Department of Health, CNST, LTPS and PES from Trust contributions, and the accounts for the schemes are prepared in accordance with IAS 37. A provision for these schemes is calculated in accordance with IAS 37 by discounting the gross value of all claims received: this is disclosed in note 9.1.

The calculation is made using:
i) probability factors. The probability of each claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and
ii) a discount factor calculated using the real discount rates noted above, RPI of 3% and claims inflation (varying between schemes) of between 5% and 10%, is applied to the probable cost to take into account the likely time to settlement.

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 9.7.

Resolution of claims is difficult to predict as many factors can lead to delay during the settlement process whilst emerging evidence can alter valuation and thus the Authority makes a best estimate regarding the likely year of settlement and expected value of the claim against each notified claim. These estimates are reviewed throughout the life of the claim and amended to reflect variations in expectations which inevitably alters the value provided.

1.13 Financial assets and liabilities

i) Initial recognition and measurement

The NHS LA recognises financial assets and liabilities on its Statement of Financial Position when, and only when, it becomes a party to the contractual provisions of the instrument. On initial recognition IAS 39 requires the NHS LA to recognise all financial assets and liabilities at fair value. The fair value of a financial asset on initial recognition is normally represented by the transaction price.

The transaction price for financial assets other than those classified at fair value through profit and loss includes the transaction costs that are directly attributable to the acquisition or issue of the financial asset. Transaction costs incurred on the acquisition or issue of financial assets classified at fair value through profit are expensed immediately.

The NHS LA recognises financial assets using settlement date accounting. The settlement date is the date that an asset is delivered to or by an entity. Settlement date accounting refers to the recognition of an asset on the day it is received by the entity, and the derecognition of an asset and recognition of any gain or loss on disposal on the day that it is delivered by the entity.

ii) Subsequent measurement

Subsequent measurement of financial assets depends on their classification on initial recognition under IAS39. The categories relevant to the NHS LA are as follows:

Loans and Receivables: loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Assets that the NHS LA intends to sell immediately or in the near term cannot be classified in this category. These assets are carried at amortised cost using the effective interest method minus any reduction for impairment or uncollectibility. Interest income is recognised by applying the effective interest rate method, except on short-term receivables when the recognition of interest would be immaterial. Impairment charges are provided only when there is objective evidence that an impairment loss has been incurred. If that is the case, the carrying amount of the asset is reduced through use of an allowance account. The amount of the loss is recognised in the Statement of Comprehensive Net Expenditure.

Typically trade and other receivables are classified in this category.

iii) Fair value determination

Whenever available, the fair value of a financial instrument is derived from an active market. The appropriate quoted market price for an asset held or liability to be issued is usually the current bid price and, for an asset to be acquired or liability held, the asking price. If there is no market, or the markets available are not active, the NHS LA establishes fair value by using a valuation technique. Valuation techniques include using recent arm's length market transactions between knowledgeable, willing parties, if available, reference to the current fair value of similar instruments and incorporates all factors that market participants would consider in setting a price and is consistent with accepted economic methodologies for pricing financial instruments. As far as unquoted equity instruments are concerned, in cases where it is not possible to reliably measure the fair value, such instruments are carried at cost.

iv) Derecognition of financial assets

Irrespective of the legal form of the transactions, financial assets are derecognised when they pass the 'substance over form' based derecognition test prescribed. That test comprises two different types of evaluations which are applied strictly in sequence:

- evaluation of the transfer of risks and rewards of ownership
- evaluation of the transfer of control.

Whether the assets is recognised / derecognised in full or recognised to the extent of NHS LA's continuing involvement depends on accurate analysis which is performed on a specific transaction basis.

v) Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, on demand deposits and other short-term highly liquid investments that are readily convertible to a known amount of cash and are subject to insignificant risk of changes in value.

vi) Financial liabilities

Financial liabilities are classified according to the substance of the contractual arrangements entered into. The NHS LA has the following class of financial liabilities.

Other financial liabilities: all liabilities, which have not been classified at fair value through profit or loss. These liabilities are carried at amortised cost using the effective interest method. Typically, trade and other payables and borrowings are classified in this category.

vii) Derecognition of financial liabilities

The NHS LA derecognises financial liabilities when, and only when, the NHS LA's obligations are discharged, cancelled or they expire.

viii) Embedded derivatives

Derivatives embedded in other financial instruments or other host contracts are treated as separate derivatives when their risks and characteristics are not closely related to those of the host contracts and the host contract is not measured at fair value with changes in fair value recognised in profit or loss.

1.14 Critical judgements and key sources of estimation uncertainty

In the application of the NHS LA's accounting policies, which are described in note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. The judgements that have the most significant effect on the amounts recognised in the financial statements relate to the calculation of the provisions for known claims and for IBNR, as explained in Note 9. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

2.1 Authority programme expenditure

	Notes	£'000	2012/13 £'000	2011/12 £'000
Non-executive members' remuneration	2.2	**71**		71
Other salaries and wages	2.2	**7,163**		6,777
Redundancy costs	2.2	**91**		35
Supplies and services – general		**2**		1
Establishment expenses		**456**		400
Hire and operating lease rental				
Land & buildings		**404**		397
Lease cars		**5**		9
Photocopiers		**7**		7
Franking machine		**6**		4
Vending machine		**4**		4
Transport and moveable plant		**3**		5
Premises and fixed plant		**1,394**		1,195
External contractors				
Actuary's advice		**579**		308
Appeals Unit advisory expenditure		**131**		113
External corporate legal fees****		**187**		615
Risk management		**1,995**		2,001
Consultancy		**185**		0
Other***		**90**		56
Auditor's remuneration: audit fees**		**78**		78
Internal audit fees		**38**		44
Bank charges & interest		**4**		6
			12,893	12,126
Depreciation	5.3, 5.4	**375**		357
Amortisation	5.1, 5.2	**114**		102
			489	
			13,382	12,585
Other finance costs – unwinding of discount	9.1, 9.2		**19,209**	(3,867)
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	9.1, 9.2	**2,039,595**		2,209,776
Change in the discount rate *		**458,694**		0
Increase / (decrease) in the provision for IBNR *	9.1, 9.2	**2,883,000**		1,144,000
			5,381,289	
			5,413,880	3,362,494

* Included within the provision for IBNR is £953m relating to the change in discount rate. The total change in discount rate for known claims and IBNR is £1.4bn.

** The NHS LA did not make any payments to auditors for non-audit work

*** Other expenditure includes counter fraud, payroll and professional services

**** External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included within note 9.

2.2 Staff numbers and related costs

	2012/13 Total	Permanently employed staff	Other*	2011/12 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**6,071**	5,755	316	5,724
Social security costs	**534**	534		499
Employer contributions to NHS Pensions	**720**	720		660
	7,325	**7,009**	**316**	6,883

The average number of employees during the year was:

	Total	Permanently employed staff	Other *	2011/12 Total
Total	**132**	**126**	**6**	**124**

Redundancy costs

The cost to the NHS LA of redundancies in 2012/13 was £90,684 (2011/12: £34,876).

Expenditure on staff benefits

The amount spent on staff benefits during the year mainly on lease cars totalled £8,215 (2011/12: £15,000).

* Noted under 'other' is the NHS LA's expenditure on temporary members of staff.

Details of the salaries of board members are contained within the remuneration report.

2.3 Exit packages for staff leaving in 2012/13

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Payment Bands			
< £10,000	0	0	0
£10,001 – £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	1	0	1
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	**1**	**0**	**1**
Total cost (£'000s)	**91**	**0**	**91**

2.4 Exit packages for staff leaving (prior year)

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Payment bands			
< £10,000	0	0	0
£10,001 – £25,000	2	0	2
£25,001 – £50,000	0	0	0
£50,001 – £100,000	0	0	0
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	2	0	2
Total cost (£'000s)	**35**	**0**	**35**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the NHS LA has agreed early retirements, the additional costs are met by the Authority and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

3.1 Reconciliation of net expenditure to revenue resource limit

	2012/13 £'000
Net expenditure	4,408,137
Revenue resource limit	4,421,980
Underspend against revenue resource limit	13,843

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2012/13 £'000
Gross capital expenditure	239
NBV of assets disposed	0
Net capital expenditure	239
Capital resource limit	240
Underspend against capital resource limit	1

4 Operating income

Operating income, analysed by classification and activity, is as follows:

	Appropriated in aid 2012/13 £'000	 2011/12 £'000
Programme income:		
CNST contributions	957,113	890,757
PES contributions	5,268	5,669
LTPS contributions	43,362	37,992
Total	1,005,743	934,418

5.1 Intangible assets

	Information technology £'000	Software licences £'000	Total £'000
Gross cost at 1 April 2012	1,655	357	2,012
Additions – purchased	77	90	167
Disposals			0
Gross cost at 31 March 2013	**1,732**	**447**	**2,179**
Accumulated amortisation at 1 April 2012	1,382	281	1,663
Charged during the year	86	28	114
Disposals			0
Accumulated amortisation at 31 March 2013	**1,468**	**309**	**1,777**
Net book value at 1 April 2012	273	76	349
Net book value 31 March 2013	**264**	**138**	**402**

5.2 Intangible assets (prior year)

	Information Technology £'000	Software Licences £'000	Total £'000
Gross cost at 1 April 2011	1,585	328	1,913
Additions – purchased	70	30	100
Disposals		(1)	(1)
Gross cost at 31 March 2012	1,655	357	2,012
Accumulated amortisation at 1 April 2011	1,305	257	1,562
Charged during the year	77	25	102
Disposals		(1)	(1)
Accumulated amortisation at 31 March 2012	**1,382**	**281**	**1,663**
Net book value at 1 April 2011	280	71	351
Net book value 31 March 2012	**273**	**76**	**349**

5.3 Property, plant and equipment

	Information technology £'000	Furniture & fittings £'000	Total £'000
Valuation at 1 April 2012	1,249	1,649	2,898
Additions – purchased	72	0	72
Disposals	0	0	0
Valuation at 31 March 2013	**1,321**	**1,649**	**2,970**
Accumulated depreciation at 1 April 2012	649	209	858
Charged during the year	210	165	375
Disposals	0	0	0
Accumulated depreciation at 31 March 2013	**859**	**374**	**1,233**
Net book value at 1 April 2012	600	1,440	2,040
Net book value at 31 March 2013	**462**	**1,275**	**1,737**

No assets are held under finance leases or hire purchase contracts and the NHS LA does not own any land or buildings.
Capital commitments: The NHS LA has no capital commitments at 31 March 2013(2011/12: nil).

5.4 Property, plant and equipment (prior year)

	Information technology £'000	Furniture & fittings £'000	Total £'000
Valuation at 1 April 2011	1,136	1,649	2,785
Additions – purchased	152	1	153
Disposals	(39)	(1)	(40)
Valuation at 31 March 2012	**1,249**	**1,649**	**2,898**
Accumulated depreciation at 1 April 2011	496	45	541
Charged during the year	192	165	357
Disposals	(39)	(1)	(40)
Accumulated depreciation at 31 March 2012	**649**	**209**	**858**
Net book value at 1 April 2011	640	1,604	2,244
Net book value at 31 March 2012	**600**	**1,440**	**2,040**

6 Receivables

	Ex-RHAS	ELS	CNST	PES	LTPS	Admin	Total 31 March 2013	Total 31 March 2012
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS receivables – revenue			132	32	944		**1,108**	13,024
Prepayments	33	1,608	356			209	**2,206**	1,982
Other receivables		117	158		4	3,197	**3,476**	4,138
	33	**1,725**	**646**	**32**	**948**	**3,406**	**6,790**	**19,144**
Intra-government balances								
Balances with other central government bodies						3,150	**3,150**	3,100
Balances with NHS Bodies			131	30	727		**888**	6,007
Balances with public corporations and trading funds *				2	218		**220**	7,623
Subtotal of intra-government balances	0	0	131	32	945	3,150	**4,258**	16,730
Balances with bodies external to government	33	1,725	514	0	4	256	**2,532**	2,414
	33	**1,725**	**645**	**32**	**949**	**3,406**	**6,790**	**19,144**

* Balances with NHS Foundation Trusts are included under public corporations.

7 Cash and cash equivalents

	Ex-RHAS	ELS	CNST	PES	LTPS	Admin	Total 31 March 2013	Total 31 March 2012
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
At 1 April	1	2,904	10,939	2,026	5,783	207	21,860	31,294
Change During the year	26	(698)	1,042	2,467	(5,641)	(64)	(2,868)	(9,434)
At 31 March	27	2,206	11,981	4,493	142	143	18,992	21,860
Made up of								
Cash with the Government Banking Service	**27**	**2,206**	**11,981**	**4,493**	**142**	**143**	**18,992**	21,860
Cash and cash equivalents as in statement of financial position	**27**	**2,206**	**11,981**	**4,493**	**142**	**143**	**18,992**	21,860
Cash and cash equivalents as in statement of cash flows	**27**	**2,206**	**11,981**	**4,493**	**142**	**143**	**18,992**	21,860

8 Trade payables and other current liabilities

	Ex-RHAS	ELS	CNST	PES	LTPS	Admin	Total 31 March 2013	Total 31 March 2012
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS payables revenue			124	15	259		**398**	2,291
Prepaid Income		2,484	2,940			180	**5,604**	3,253
Accruals		303	7,792		604	307	**9,006**	13,990
Other payables		316	6,004		94	10	**6,424**	20,218
	0	**3,103**	**16,860**	**15**	**957**	**497**	**21,432**	39,752

Intra-government balances

							£'000	£'000
Balances with other central government bodies		0					**0**	813
Balances with NHS Bodies			3,054	15	226		**3,295**	1,978
Balances with public corporations and trading funds*			10		73		**83**	1,100
Subtotal of intra-government balances	**0**	**0**	**3,064**	**15**	**299**	**0**	**3,378**	3,891
Balances with bodies external to government		3,103	13,796	0	658	497	**18,054**	35,861
	0	**3,103**	**16,860**	**15**	**957**	**497**	**21,432**	39,752

* Balances with NHS Foundation Trusts are included under public corporations.

9.1 Provisions for liabilities and charges

	Ex-RHAS £'000	ELS £'000	CNST £'000	PES £'000	LTPS £'000	Total £'000
Opening provision for known claims	(26,419)	(1,686,076)	(6,540,504)	(8,201)	(124,736)	(8,385,936)
Opening provisions for IBNR	(6,000)	(587,000)	(9,774,000)	(1,000)	(113,000)	(10,481,000)
Total provisions as at 1 April 2012	**(32,419)**	**(2,273,076)**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**
Movement in known claims						
Discounting	(12,016)	97,778	453,631	0	1,316	**540,709**
Arising during the year	(6,047)	(736,842)	(4,346,829)	(6,301)	(90,793)	**(5,186,812)**
Reversed unused	13,675	606,731	1,941,092	2,597	42,413	**2,606,508**
Unwinding of discount	(1,400)	(46,425)	28,581		35	**(19,209)**
Change in discount rate*	(1,865)	(92,355)	(364,107)	0	(367)	**(458,694)**
Utilised during the year	1,223	140,002	1,117,655	3,650	46,949	**1,309,479**
	(6,430)	(31,111)	(1,169,977)	(54)	(447)	**(1,208,019)**
Movement in net IBNR*	1,000	38,000	(2,902,000)	0	(20,000)	**(2,883,000)**
Closing provision for known claims	(32,849)	(1,717,187)	(7,710,481)	(8,255)	(125,183)	(9,593,955)
Closing provisions for IBNR	(5,000)	(549,000)	(12,676,000)	(1,000)	(133,000)	(13,364,000)
At 31 March 2013	**(37,849)**	**(2,266,187)**	**(20,386,481)**	**(9,255)**	**(258,183)**	**(22,957,955)**
Expected discounted timing of cash flows						
Within 1 year	(1,000)	(117,000)	(1,057,297)	(5,490)	(51,906)	(1,232,693)
1–5 years	(6,153)	(368,851)	(6,997,500)	(3,765)	(188,551)	(7,564,820)
More than 5 years	(30,696)	(1,780,336)	(12,331,684)	0	(17,726)	(14,160,442)
	(37,849)	**(2,266,187)**	**(20,386,481)**	**(9,255)**	**(258,183)**	**(22,957,955)**

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

* Included within movement in net IBNR is £953m relating to the change in discount rate. The total change in discount rate for known claims and IBNR is £1.4bn.

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 periodic basis rather than lump sum, claims which take longer than anticipated to resolve and changes in the value and timing of payments.

9.2 Provisions for liabilities and charges (prior year)

	Ex-RHAS £'000	ELS £'000	CNST £'000	PES £'000	LTPS £'000	Total £'000
Opening provision for known claims	(27,261)	(1,674,917)	(5,692,316)	(8,013)	(107,281)	**(7,509,788)**
Opening provisions for IBNR	(6,000)	(415,000)	(8,824,000)	(1,000)	(91,000)	**(9,337,000)**
Total provisions as at 1 April 2011	**(33,261)**	**(2,089,917)**	**(14,516,316)**	**(9,013)**	**(198,281)**	**(16,846,788)**
Movement in known claims						
Discounting	27,388	572,461	2,008,952		69	**2,608,870**
Arising during the year	(33,933)	(1,059,160)	(5,009,942)	(8,013)	(102,381)	**(6,213,429)**
Reversed unused	5,530	334,954	1,013,987	3,563	36,749	**1,394,783**
Unwinding of discount	(1,100)	(38,526)	43,513		(20)	**3,867**
Utilised during the year	2,957	179,112	1,095,302	4,262	48,128	**1,329,761**
	842	(11,159)	(848,188)	(188)	(17,455)	**(876,148)**
Movement in net IBNR	0	(172,000)	(950,000)	0	(22,000)	**(1,144,000)**
Closing provision for known claims	(26,419)	(1,686,076)	(6,540,504)	(8,201)	(124,736)	**(8,385,936)**
Closing provisions for IBNR	(6,000)	(587,000)	(9,774,000)	(1,000)	(113,000)	**(10,481,000)**
At 31 March 2012	**(32,419)**	**(2,273,076)**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**
Expected discounted timing of cash flows:						
Within 1 year	0	(187,731)	(1,874,864)	(8,201)	(122,736)	**(2,193,532)**
1–5 years	(1,000)	(385,515)	(4,367,645)	(1,000)	(99,000)	**(4,854,160)**
More than 5 years	(31,419)	(1,699,830)	(10,071,995)	0	(16,000)	**(11,819,244)**
	(32,419)	**(2,273,076)**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**

Existing Liabilities Scheme (ELS) and Ex-Regional Health Authorities (Ex-RHAS) Scheme

Claims are included in the ELS provision on the basis that the incident occurred on or before 31 March 1995. Qualifying claims under the ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the NHS LA with effect from 1 April 1996.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with IAS 37 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2013 and on or after 1 April 1995. Claims are included in the provision on the basis that the CNST members have assessed:

i) the probable cost and time to settlement in accordance with scheme guidelines;
ii) that they are qualifying incidents; and
iii) that the Trust remains a member of the scheme.

As at 31 March 2002 all outstanding claims for incidents post 1 April 1995 became the direct responsibility of the NHS LA. This 'call in' of CNST claims effectively means that member Trusts are no longer responsible for accounting for claims made against them although they do remain the legal defendant.

Property Expenses Scheme (PES) and Liability to Third Parties Scheme (LTPS)

In April 1999 the NHS LA introduced the PES and LTPS following the Secretary of State's decision that NHS Trusts should not insure with commercial companies for non-clinical risks, other than motor vehicles and other defined areas (eg, PFI schemes).

The schemes are managed and funded via the same mechanisms as the CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to the NHS LA's proportion of each claim. The accounts for these schemes have been prepared in accordance with IAS 37.

Assumption of liabilities upon cessation

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the NHS LA in respect of the ELS, ex-RHAS and CNST schemes.

Incidents incurred but not reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS LA as at 31 March 2013 where the following can be reasonably forecast:
i) that an adverse incident has occurred; and
ii) that a transfer of economic benefit will occur; and
iii) that a reasonable estimate of the likely value can be made.

The NHS LA uses its actuaries, Lane, Clark & Peacock, to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records, and using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown above. The sums concerned are accounting estimates, and although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

Estimation of provisions and contingent liabilities

Owing to the uncertain nature of the NHS LA's liabilities, the preparation of these financial statements requires the use of judgements and assumptions that have a significant impact on the estimated provisions.

The NHS LA uses its actuaries, Lane Clark & Peacock LLP, to provide estimates of the provisions. The actuaries analyse past trends in claims and combine this with a knowledge of the current economic and claims environments in order to make projections of how claims will emerge and be settled in the future. This process is performed in consultation with the NHS LA to ensure that the projections reflect a common understanding of the expected future development of claims.

The NHS LA's provisions are mostly in respect of clinical negligence claims exposure. Such claims can take a significant length of time to be reported to the Authority, and the settlement of claims can also take a long time depending on the circumstances of the claim. Claims can take over 30 years to be reported, over ten years to be settled and, if the claim is settled as a PPO, the claim payments can potentially span a further period of over 50 years.

Given the long-term nature of the liabilities, the most significant and uncertain part of the provisions is the incurred but not reported (IBNR) claims provision. The estimation of IBNR claims is inherently more uncertain than the estimation of the cost of claims already reported to the NHS LA, for which case-by-case information about the claim event is available.

The long-term nature of the claims means that it is to be expected that actual future claims experience will differ, potentially significantly, from the current estimates.

Process and methodology

There are three key elements to the NHS LA provisions: the reported outstanding claims provision, the IBNR provision and the provision for settled PPOs.

i) Reported outstanding claims provision

The reported outstanding provision is based on the case estimates of the individual reported claims. The case estimates are adjusted for the case handlers' estimated probability of settlement, for expected future claims inflation to settlement, for the estimated probability that they will go on to settle as PPOs (rather than as lump sums) and for 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 the Treasury-prescribed rate) to give a net present value at the accounting date.

ii) IBNR provision

To estimate the IBNR provision, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a net present value (at the Treasury-prescribed discount rate) to estimate the provision at the accounting date.

First an assumption is made about the expected number of incidents that have occurred in each past year up to the accounting date that will give rise to a claim. An assumption is then made about the pattern of delays from incident to reporting. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.

Assumptions are also made about the pattern of reporting to settlement delays. This allows a projection to be made of the numbers of IBNR claims expected to be settled in each future year.

Assumptions are then made about the average claim sizes for different types of claim. These assumptions allow for the fact that larger claims take longer to be reported and settled. Adjustments are also made to these assumed claim sizes to allow for expected future claim value inflation.

By combining the average claim sizes with the claim numbers appropriately, a projection is made for the total value of claim settlements for IBNR claims in each future year. For the proportion of claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows and lump sum settlements are assumed to be paid out in full at settlement.

The final step in the process is to calculate the net present value of the projected future cash flows (using the Treasury-prescribed discount rate), and this gives the estimated IBNR provision at the accounting date.

iii) Settled PPOs provision

To estimate the provision for settled PPO claims, the actuaries project the expected future cash flows from each individual settled PPO weighted by the claimants' probability of survival to each payment and then calculate the net present value of these cash flows (using the Treasury-prescribed discount rate). Future cash flows are modelled based on individual claim data. This includes the agreed annual payments and any agreed future steps in those payments, the index to which payments are linked and the assumed probabilities of survival to each future payment, which is based on the estimated life expectancy of the claimant agreed by medical experts in each case.

Key assumptions and areas of uncertainty

As with any actuarial projection there are areas of uncertainty within the estimates of the claims provisions. This is particularly so for the CNST and ELS schemes given the long-term nature of the liabilities.

The table below illustrates the key assumptions used to determine the IBNR and settled PPO provisions. 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'. This is a subjective classification and is intended only to give a broad illustration for the purpose of comparing the various assumptions.

As an example, the table shows that there is a medium level of uncertainty in the assumed number of claims incurred in each past year and that this assumption has a high impact on the estimated provisions.

Key assumptions, uncertainty in assumptions and impact on resulting provisions

Assumption	*Degree of uncertainty in assumption*	*Impact on estimated provisions*
IBNR provision		
Number of claims incurred each year	Medium	High
Incident to reporting pattern for all claims	Medium	High
Reporting to settlement pattern for all claims	Low	Low
Incident to reporting pattern for PPO claims	High	High
Reporting to settlement pattern for PPO claims	Low	Low
Claims		
Average claim size	Medium	High
Claim value inflation	High	High
Settlement to payment pattern for PPO claims	Medium	Medium
Settled PPO provision		
Life expectancy	High	Medium
Assumed level of inflation in ASHE 6115	Medium	High

The following are key areas of uncertainty in the estimation of the claims provisions.

Clinical negligence claims can take over 30 years to be reported following the incident that gives rise to the claim. The IBNR provisions depend on the delay pattern of how claims are reported to the NHS LA 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 over-estimated, and vice versa. Changing trends in this pattern over time (for example as a result of increased awareness of the availability of compensation) and also a lack of past data preceding the formation of the NHS LA mean that there is ongoing uncertainty in this assumption.

The numbers of clinical claims reported to the NHS LA have increased in recent years. This is believed to be the result of more incidents converting to claims as well as claims being reported to the Authority more quickly. It is uncertain to what extent each of these factors is driving the change in the number of claims being reported. This means there is increased uncertainty in our estimate of the number of claims that will ultimately be reported in relation to each incident year.

The uncertainty in the average claim size assumption is currently higher than it might normally be expected to be as a result of the changing numbers of claims. It is not unusual to observe an inverse relationship between claim numbers and average claim sizes and the increasing claim numbers appear to be leading to falling average claim sizes. This could be the result of a link between higher claim numbers and a lower proportion of claims settling with a damages payment, eg if there are more speculative claims being made. It may also be the result of a change in the distribution of claim sizes in that the extra claims being reported are mostly smaller in size.

The effect of even small changes to the assumed annual rate of future claim value inflation can have a significant impact on the estimated provision.

This is because of the long-term nature of the liabilities. Claim value inflation has historically run at a significantly higher rate than price inflation. For clinical negligence claims the inflation is affected by a number of external factors such as the Lord Chancellor's discount rate, changes in legal precedent (eg rules relating to accommodation costs determined by Roberts vs Johnstone) and changes in legal costs. In particular, the review of the discount rate by the Lord Chancellor and the introduction of LASPO could have a significant impact on claim value inflation in the near future, although the extent of this impact is uncertain. The variety of potential external influences on future claims inflation means that it is subject to significant uncertainty.

Trends in the NHS LA's historical claims experience have been distorted over time by changes in the external environment. For example, increased litigiousness, changes in the legal environment relating to legal costs, changes in the legal environment determining new heads of damage or methods of settlement and changes in the process of reporting claims have all had effects on the historical pattern of claim reporting and settlement. This makes it more difficult to interpret the past trends and use these to make assumptions about the expected future patterns of claim reporting and settlement.

Similar uncertainties also arise as a result of impacts on past trends resulting from distortions caused by internal changes such as changes in the scheme structure (for example the abolition of excess levels), changes in claims handling processes and the NHS LA's budgetary constraints.

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 in the case. 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 (eg epidemics).

The majority of PPOs have payments linked to the retail price index (RPI) and/or ASHE 6115, a wage inflation index. The future rates of increase in these indices is uncertain. In particular, ASHE 6115 relates specifically to care and home workers and external factors impacting this market in recent years mean that past inflation in this index may be of limited relevance as a basis for future projection. The current difficult economic environment combined with the limited relevance of past data to make future projections means the uncertainty in this assumption is currently more than might normally be the case.

9.3 Sensitivity of estimated total provisions as at 31 March 2013 to movements in the tiered real discount rate

In 2012/13 HM Treasury changed the discount rate for general provisions from the previous 2.2% to three 'tiered' rates, short (-1.8%), medium (-1.0%) and long-term (2.2%) as set out in HM Treasury's Public Expenditure System (2012) 15 paper published 30 November 2012. As can be seen in the SOCNE the impact of this adjustment was £1.4 billion.

Note 9 details the value of the provisions recorded in the Statement of Financial Position (SOFP) which have been calculated using the methods outlined in the narrative at 9.1 and 9.2 and elsewhere in this report. The following tables show the potential impact on the various provisions in the event that those assumptions were changed. For example the first table below shows that if the Treasury Discount Rates were to be further increased by 0.1% the total provisions recorded in the SOFP would increase by £394 million and likewise a reduction of 0.1% would reduce the provisions by £381 million. This sensitivity analysis is included in these notes to enable readers to understand the impacts such adjustments would have on the accounts although it should be noted that the relationship is not purely linear in all cases as can be seen by the changes outlined in the first table.

Summary of provisions	Estimated IBNR provision £m	Provision for known claims £m	Total provisions £m	Change to the original estimate £m	Change to the original estimate %
0.1% decrease in the discount rate	13,620	9,732	23,352	394	1.7%
Tiered real discount rate structure	13,364	9,594	22,958	0	0.0%
0.1% increase in the real discount rate	13,119	9,458	22,577	(381)	-1.7%

9.4 Sensitivity of estimated IBNR provisions to key assumptions for CNST

The following tables show the impacts of adjusting our key assumptions for the creation of the IBNR estimate for CNST. In each case the assumption used in the accounts is the middle set of data, so for example claims value inflation is currently assumed to be 10% giving a £12,676m provision.

Sensitivity to claims value inflation assumption

Claims value inflation	IBNR as at 31 March 2013 £m	% change to original estimate
8%	10,393	-18%
10%	12,676	0%
12%	15,714	24%

Sensitivity to claims frequency assumption

Claim frequency assumption	IBNR as at 31 March 2013 £m	% change to original estimate
No adjustment prior to 2006/07; 10 % decrease thereafter	12,139	-4%
No adjustment	12,676	0%
No adjustment prior to 2006/07; 10 % increase thereafter	13,213	4%

Sensitivity to incident to creation delay pattern

Average term based on assumed delay pattern	IBNR as at 31 March 2013 £m	% change to original estimate
For all claims = 2.33 yrs; for large claims = 4.35 yrs	10,171	-20%
For all claims = 2.91 yrs; for large claims = 5.43 yrs	12,676	0%
For all claims = 3.49 yrs; for large claims = 6.52 yrs	15,114	19%

Sensitivity to average claim severity assumption

Factor applied to all average claim size patterns	IBNR as at 31 March 2013 £m	% change to original estimate
-20%	10,141	-20%
0%	12,676	0%
20%	15,211	20%

Sensitivity to differential between ASHE and RPI

Differential between ASHE and RPI assumption	IBNR as at 31 March 2013 £m	% change to original estimate
-20% (ASHE less RPI assumption is equal to 0.96%)	12,917	2%
0% (ASHE less RPI assumption is equal to 1.2%)	12,676	0%
20% (ASHE less RPI assumption is equal to 1.44%)	12,452	-2%

9.5 Sensitivity of provision for settled PPOs to key assumptions

Differential between Retail Price Index (RPI) and Annual Survey of Hourly Earnings (ASHE) Index over the long-term assumption.

	Provision for settled PPOs at 31 March 2013				
Differential between RPI and ASHE	**Total**	**CNST**	**ELS**	**Ex-RHA**	**LTPS**
	£m	**£m**	**£m**	**£m**	**£m**
0.96%	3,468	2,170	1,271	26	1
1.20%	3,598	2,262	1,309	27	1
1.44%	3,739	2,361	1,350	28	1

	Percentage change to provision				
	Total	**CNST**	**ELS**	**Ex-RHA**	**LTPS**
-20%	-3.6%	-4.0%	-2.9%	-2.9%	-3.8%
0%	0.0%	0.0%	0.0%	0.0%	0.0%
20%	3.9%	4.4%	3.1%	3.1%	4.0%

Life expectancy assumptions

(The life expectancy of each claimant has been varied by the percentage shown)

	Provision for settled PPOs at 31 March 2013				
Change applied to life expectancy at settlement	**Total**	**CNST**	**ELS**	**Ex-RHA**	**LTPS**
	£m	**£m**	**£m**	**£m**	**£m**
-20%	2,968	1,857	1,088	22	1
0%	3,598	2,262	1,309	27	1
20%	4,147	2,619	1,497	30	1

	Percentage change to provision				
	Total	**CNST**	**ELS**	**Ex-RHA**	**LTPS**
-20%	-17.5%	-17.9%	-16.9%	-17.2%	-15.2%
0%	0.0%	0.0%	0.0%	0.0%	0.0%
20%	15.3%	15.8%	14.4%	13.4%	7.7%

9.6 Allocation of income and expenditure to the schemes

	Ex-RHAS	ELS	CNST	PES	LTPS	Equal pay	Total 31 March 2013	Total 31 March 2012
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Expenditure								
NHS LA and claims administration		236	8,411	134	3,431	269	13,382	12,585
Claims and associated costs								
Increase/(decrease) in provision for known claims	7,653	171,113	2,287,632	3,704	47,396	0	2,517,498	2,205,909
Increase/(decrease) in provision for IBNR	(1,000)	(38,000)	2,902,000	0	20,000	0	2,883,000	1,144,000
	6,653	133,349	5,198,043	3,838	70,827	269	5,413,880	3,362,494
Income								
Scheme income	0	0	(957,113)	(5,268)	(43,362)	0	(1,005,743)	(934,418)
Net expenditure – (surplus)/deficit	**6,653**	**133,349**	**4,240,930**	**(1,430)**	**27,465**	**269**	**4,408,137**	**2,428,076**

9.7 Contingent liabilities

	Ex-RHAS £'000	ELS £'000	CNST £'000	PES £'000	LTPS £'000	Total £'000
Contingent liability for claims 2012/13	**5,055**	**548,332**	**9,752,250**	**5,204**	**142,012**	**10,452,853**
Contingent liability for claims 2011/12	3,000	631,410	7,694,740	4,686	130,814	8,464,650

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

10 Reconciliation of operating costs to operating cash flows

	Notes		2012/13 £'000	2011/12 £'000
Net expenditure			**(4,408,137)**	(2,428,076)
Adjustments for non-cash transactions				
Depreciation	5.3, 5.4	**375**		357
Amortisation	5.1, 5.2	**114**		102
			489	459
Adjustments for movements in working capital other than cash				
(Increase)/decrease in receivables	6	**12,354**		(11,252)
Increase/(decrease) in payables	8	**(18,320)**		1,327
Increase/(decrease) in provisions	9.1, 9.2	**4,091,019**		2,020,148
			4,085,053	2,010,223
Net cash outflow from operating activities			**(322,595)**	(417,394)

11 Commitments under operating leases

The total future minimum lease payments under non-cancellable operating leases payable in each of the following periods are:

		2012/13 £'000	2011/12 £'000
Land and buildings			
Amounts payable:	within 1 year	**283**	283
	between 1 and 5 years	**1,525**	1,394
	after 5 years	**1,242**	1,655
		3,050	3,332
Other leases			
Amounts payable:	within 1 year	**13**	17
	between 1 and 5 years	**7**	6
	after 5 years	**0**	0
		20	23

12 Losses and special payments

There were no losses or special payments (prior year: one case totalling £21,345) approved during 2012/13.

13 Related parties

The NHS LA is a corporate body established by order of the Secretary of State for Health.

The Department of Health is regarded as a controlling related party. During the year the NHS LA has had a significant number of material transactions with the Department, and with other entities, to whom the NHS LA provides clinical and non-clinical risk pooling services, for which the Department is regarded as the parent Department, ie:

All English Strategic Health Authorities
All English NHS Trusts and PCTs
All English NHS Foundation Trusts
NHS Blood and Transplant
The National Patient Safety Agency
NHS Business Services Authority
NHS Institute for Innovation and Improvement
NHS Information Centre
National Treatment Agency
Health Protection Agency
NHS Direct
The Health Research Authority
NHS Trust Development Authority
National Institute for Clinical Excellence
The Business Services Authority

In addition Professor R Shaw, non-executive director of the NHS LA, is also employed by North West London Hospitals NHS Trust as the Medical Director.

Trust	Income £'000	Expenditure £'000	Receivables £'000
North West London Hospitals NHS Trust	8,174	34	0

The NHS LA also holds provisions and contingent liabilities in relation to these bodies which are included in the overall notes 9.1 and 9.7.

14 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. The NHS LA is not exposed to the degree of financial risk faced by business entities because of the way Special Health Authorities are financed. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. The NHS LA has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS LA in undertaking its activities.

The NHS LA holds financial assets in the form of NHS and other receivables, and cash, as set out in Notes 6 and 7 respectively, and financial liabilities in the form of NHS and other payables, as set out in Note 8. As these receivables and payables are due to mature or become payable within 12 months from the Statement of Financial Position date, the NHS LA considers that the carrying value is a reasonable approximation to fair value for these financial instruments.

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit Risk

As noted, the NHS LA receives its income from NHS member organisations. As a consequence, its NHS and other receivables are not impaired, and there are no significant receivable balances with bodies external to government. The NHS LA is, therefore, not exposed to significant credit risk.

15 Events after the reporting period

On 1 April 2013 The National Clinical Assessment Service (NCAS) became an operating division of the NHS LA. NCAS helps resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK and expended £7.8 million in 2012/13.

These financial statements were authorised for issue on 3 July 2013 by the Accounting Officer.

Glossary

CCGs	Clinical Commissioning Groups which have taken over commissioning from PCTs
CNST	Clinical Negligence Scheme for Trusts. This scheme indemnifies members for negligence claims
CSU	Commissioning Support Units provide centralised support services for CCGs
CTG	A carditocograph is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy, typically in the third trimester
DH	Department of Health
DNV	Det Norske Veritas, the organisation that provides risk assessments for NHS LA
ELS	Existing Liabilities Scheme, is a clinical negligence claims scheme that existed pre-April 1995 incidents, funded by the Department of Health
DTS	Document transfer system
ET	Employment tribunal
FHSAU	Family Health Services Appeals Unit
HPA	Health Protection Agency
HPAN	Healthcare Professional Alert Notice is an alert system managed nationally by NCAS to alert employers to the existence of serious grounds for concern about a regulated health practitioner who has departed the organisation and for whom the concerns were unresolved. NB, this is different from performers' list concerns (restrictions on practice) which are logged centrally by FHSAU and shared with requesting health bodies
IBNR	Incurred but not yet reported claims, ie claims which may be brought in the future
IS	Independent sector providers of healthcare
ISTC	Independent Sector Treatment Centre (designated by the Department of Health for treatment of NHS patients and insured under CNST by referring PCT or (in future) directly)
Jackson reforms	Legal reforms which came into force 1 April 2013. These reforms change, amongst other matters, the amount which claimant solicitors can charge under conditional fee agreements and limit after the event insurance
JR	Judicial Review
Legal costs	Amounts paid out by NHS LA in legal costs for claims, including defence and claimant costs
LTPS	Liabilities to Third Parties Scheme
NCAS	National Clinical Assessment Service
NHS LA	National Health Service Litigation Authority
NHSCB	National Commissioning Board of the NHS. Formerly the National NHS commissioner, now called NHS England
NICE	National Institute for Health and Clinical Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
ONS	Office for National Statistics
PCT	Primary Care Trust (replaced by CCGs from 1 April 2013)
PNA	Pharmaceutical needs assessment
PPO	Periodical payment order, ie court order which grants the claimant a lump sum payment followed by regular payments over the life of claimant
VBAC	Vaginal birth after a previous caesarean section

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