AGM Minutes (Part 1)

26th July 2018
10:00 – 11:00
Room G-1, Ground Floor, 151 Buckingham Palace Road, London

Present	
Ian Dilks	Chair
Keith Edmonds	Non-Executive Director
Mike Pinkerton	Non-Executive Director
Helen Vernon	Chief Executive
Joanne Evans	Director of Finance & Corporate Planning
John Mead	Technical Claims Director (Associate Board Member)
In attendance	
NHS Resolution	
Alan Hunter	Director of Claims
Tinku Mitra	Head of Governance
Nick Rigg	Corporate Communications Lead
Jessica Clinkett	Corporate Communications Lead
Julia Wellard	Executive Assistant (Minutes)
Guests	
Grainne Barton	Hugh James Solicitors
Lynda Reynolds	Hugh James Solicitors
Apologies	
Sam Everington	Non-Executive Director
Nigel Trout	Non-Executive Director
Charlotte Moar	Non-Executive Director
Mike Durkin	Associate Non-Executive Board Member
Vicky Voller	Director of Practitioner Performance Advice
Denise Chaffer	Director of Safety and Learning

1 Welcome and Apologies

1.1 Chair's opening remarks and apologies

The Chair opened the meeting by welcoming everybody to the NHS Resolution AGM and introduced members of the Board.

The main purpose of the AGM was to present the Annual Report and Accounts for

the previous year. A full copy of the report is available on NHS Resolution's website. It was noted that we are required to hold the AGM within a set number of days of publication of the Annual Report and Accounts meaning that the meeting has taken place over the holiday period.

We have a number of new Non-Executive Directors. Charlotte Moar was appointed on 1st September 2017 and is also Chair of the Audit and Risk Committee. Most recently, Nigel Trout and Sir Sam Everington who joined on 1st July 2018.

2 Ian Dilks, Chair

2.1 Introduction

Following our change in name last year, we are now operating under one name which is an important achievement and emblematic of our new way of working.

We have now completed the first year of our 5 year strategy and we have mostly achieved or exceeded our goals set for the first year.

There were a number of events which took place over the last year, namely the NAO report which was published last September and followed by the Public Accounts Committee (PAC) evidence hearing and report the findings of which validated what we have been saying over the last few years. Most of the recommendations that impacted on us directly are aligned with our strategy. The key recommendation from the PAC report was the need for a cross government strategy looking at the costs of clinical negligence and this work is being taken forward. We await the first response to the PAC in September.

Another key point to note is the announcement that we have been asked to put in place and administer a GP indemnity scheme from April 2019 which is currently under development. This is a major commitment for the Executive Team and will have a major impact on the organisation for the current year and years to come.

In terms of the numbers, it has been interesting to see that over the last four years our balance sheet provisions have almost trebled to £77 billion. A large amount of that relates to the changes in the HM Treasury discount rate as well as the personal injury discount rate (PIDR) which accounts for £4.5 billion in the provisions. Another important factor is that although we spent £2.5 billion last year that only represents approximately a third of the cost of harm. There are some encouraging trends however it is important for our members to recognise that unless there are other significant reforms future payments and hence our charges will continue to increase.

The Chair thanked the Board both the continuing members and the two new members who started in July and we look forward to working with them.

3 Helen Vernon, Chief Executive

3.1 An overview

Our annual report for 2017/18 sets out progress against the first year of a 5 year strategy that we launched in April 2017, under our new name, NHS Resolution. The theme of the year, as it has been with our overall strategy, has been to address the

period between an incident occurring and formal litigation and what can be done to resolve issues before they escalate into expensive and often protracted court proceedings.

We set targets against which to measure our progress; in particular to increase the use of mediation and to reduce the number of cases going to litigation. It is encouraging to see 189 mediations have taken place in year, which is more than three times our target of 50 and more than the organisation has undertaken in its entire history. There has been a growing interest from claimants and defendants alike over the course of the year and it is intended to build on that so that mediation is no longer seen as novel in healthcare.

Formal litigation has also reduced to the lowest level since starting to record them and it is pleasing to see that accompanied by a reduction in claimant legal costs after many years of growth in that area.

At the beginning of the year we committed to make better use of the data we hold in order to inform improvements in patient and staff safety by continuing to focus on obstetrics and were able to increase our visibility on incidents which may result in a brain injury at birth via the launch of our Early Notification Scheme. Reporting to the EN scheme has accelerated in pace over the course of the year and with over 400 incidents reported in the year in question we are now able to report 100% reporting for the year, bolstered by the introduction of our maternity incentive scheme in November 2017. For the first time we were able to make admissions of liability within months of the birth and to provide much needed payments to support families when it mattered the most. We have also been able to increase the level of support we provide to staff who were involved in these incidents.

A landmark in the year was the publication of our study of Five Years of Cerebral Palsy claims, an important piece of work which was undertaken by our Darzi Fellow in obstetrics. The report made 7 recommendations which received support from our ALB partners and across the healthcare system. Details of our work on maternity can be found at pages 74-75 of the report.

We have also had a focus on mental health with three national sharing and learning events throughout the year which provided an opportunity for national speakers, NHS trusts, patients and families to share their experience and learn from each other.

The year has not been without its challenges and the costs of clinical negligence continue to grow. We welcomed the focus of the NAO and PAC on this issue and the recognition that the drivers of this cost relate primarily to issues, such as the legal environment, which to a degree are beyond the control of one department and which require a cross government strategy and we are pleased to have had and continue to have the opportunity to contribute our expertise and insights in this area.

Our work to test areas of the law where clarity is required continues apace and there were a number of cases during the year which are outlined in pages 41 to 47. Part of our role is to ensure that public money is not expended without good reason and one of the areas where we do this is in relation to claimant legal costs which we continue to challenge rigorously where we think they are unjustified. Illustrated on page 55 is a case which we took to the court of appeal where we noted a pattern of charging which was considered not in the interests either of the NHS or the patients involved.

Our success in this case alone will save millions of pounds for the health service on other cases waiting in the wings.

We also take a tough approach to fraud and illustrated on page 53 is a case where surveillance evidence ensured that an exaggerated claim for over a million was thwarted by the effective use of surveillance. More recently, we have successfully pursued the imprisonment of a fraudulent claimant via contempt of court proceedings.

NHS Resolution is the umbrella for all of our services including the Practitioner Performance Advice service we provide to trusts and individuals where practitioners get into difficulties on performance and the Primary Care Appeals service for disputes between NHS England and primary care contractors. Our strategy here is one and the same, to move upstream, using what we know to ensure that things do not escalate unnecessarily through a combination of education, the provision of analysis and guidance, and, where necessary, intervention. Details of how we have done this are set out from pages 60 – 73. This approach has been very well received and in particular trusts have been complimentary about the regional model and link advisor approach through which we deliver practitioner performance advice which aims to ensure a much deeper understanding of the issues that organisations face locally.

NHS Resolution staff are driven by their values and want to do the right thing for patients and the NHS, whatever their role may be. NHS Resolution is a growing organisation going through a period of change but with huge potential to do more and to build on the hard work and new direction in the past year to do some exciting and positive things. The Chief Executive thanked all staff for everything they have done and their unfailing hard work and commitment throughout the year.

4 Joanne Evans, Director of Finance

4.1 Annual Accounts 2017/18

The most significant feature of the NHS Resolution accounts is the provision for liabilities for our indemnity schemes arising from incidents that have, or that we estimate, will become claims for damages. The headline for 2017/18 is that the total provision has increased from £65bn to £77bn. Details are provided in the Finance report from page 90, and Note 7 to the accounts from page 162.

The waterfall chart on page 90 shows that the largest single element contributing to the increase in the provision are the changes in the HMT discount rate, of which the most critical was the reduction in the long term rate from minus 0.8% to minus 1.56% which increased the provision by £15.6bn.

There is continued underlying growth in the provision from the adding to liabilities arising from another year of activity, compared to the rate at which we settle claims in year - £6.4bn to £2.3bn. The use of periodical payment orders which gives claimants security over their long term care needs contributes to this effect.

Last year we observed a slowing in the rate of growth in inflation in claims costs and updated our assumptions on the likelihood of paying damages and claims volumes, all of which reduced the value of our liabilities by £7.7bn. The table on page 168

provides more detail on how the changes in assumptions have affected the provision.

The sensitivity analysis on pages 170 to 182 outlines how quite small changes in assumptions can affect the value of our provisions. This uncertainty contributes to the Emphasis of Matter in the unqualified audit opinion (pages 141 to 142). This uncertainty and sensitivities are also relevant for explaining the £14bn underspend on the Annually Managed Expenditure budget shown at page 95.

The AME budget is a non-cash non-fiscal budget in respect of the movement on the provisions that is set annually in the Parliamentary Supply process at a point in the year before our work has been done to update our provisions assumptions. Given the risk that small adverse assumptions could lead to a large increase in the provision, we have generally taken a prudent approach to setting the budget with DHSC. This has been the first year, putting the discount rate to one side, that the provision has gone down year on year, which resulted in the large favourable variance..

The favourable trends that form the basis of the provision assumptions are also reflected in in-year expenditure. Baseline costs for clinical claims have not increased as rapidly as we expected when we set the cashflow budget requirements for 2017/18 in August 2016.

Table 1 on page 15 shows damages for clinical claims increasing by 13.4% from £1,083m to £1,228m, defence costs up by 2.5% to £128.9m and claimant legal costs actually reducing by 6.4% (after recent years of quite high growth rates) from £498.5m to £466.6m, when our 2016 forecast expected a year on year growth in costs of 17.5%.

This contributed to our underspend of £237m on clinical schemes shown on page 93. We are continuing discussions with DHSC about how we can return surplus cash to the health system.

These favourable trends have enabled us to set our contributions levels for CNST at a much lower rate of growth for 2018/19 – only 1.8%, with some NHS providers having the benefit of year on year reductions in their CNST costs of up to 30%.

Non clinical schemes are of a much smaller scale (£57.6m in 2017/18), but nevertheless warrant close management. Positive trends in relation to reducing claims volumes, damages and legal costs continue which is reported on page 27, and are attributed to the introduction of fixed recoverable costs for employers‘ and public liability claims.

The costs of settling clinical negligence claims, in particular, has increased significantly by £404m, adding a third to damages costs which is due to the change in the Personal Injury Discount Rate. These costs have been funded centrally out of the budget set aside by the Chancellor of the Exchequer in the 2017 Budget Statement, and we have similar guarantees for funding from DHSC for the current financial year.

Despite the favourable movements in the provision, we are still looking at relatively high claims volumes historically, and an inflation rate of around 9% in the cost of settling claims. The ongoing financial pressures arising from these trends in clinical

negligence costs has attracted much attention with the NAO Value for Money study and Public Accounts Committee hearing which took place during 2017.

Page 30 sets out the various policy and legal developments that are likely to have an impact on our costs over the longer term and our operations, in addition to the ambitions we have set out in our five year strategy.

To be in a position to deliver our ambitions and support the Department of Health in developing the policy agenda through the provision of data and evidence drawing on our experience, we have been adding to our establishment. We have been broadening our skills base to enable us to review and refresh our systems and processes, as well as make better use of our data and our expertise. Whilst our administration costs and staffing levels have increased, our administration costs as a proportion of claims settlements continue to fall (pages 96 and 97 provide more detail). We consider that this is a necessary and worthwhile investment to support current efforts to manage costs over the long term.

5 Questions and Answers

Grainne Barton
In terms of the EN Scheme, I was wondering re the care provided to families after an admission what vetting is done on the clinicians that would be involved in their care i.e. case managers, OT's and physios - how are they located and sourced?

Response: We are only in the first year of the Scheme but we are starting to look at how we might respond to the emerging care needs of families as well as other needs. We are keen to talk to those who have experience of working with families but it is early days and by definition we are dealing with very young babies.

Lynda Reynolds
I don't know if you are aware that there is a consultation out about legal aid for inquests. What part is NHS Resolution going to play and can you provide the figures?

Response: We are aware of the consultation and because it is something that is relevant to us we will be considering what our response will be but we generally input both data and our experience and our own perspective on government consultations where we have insights. However, as it is still out for consultation we cannot commit to what we might say at the moment.

Grainne Barton
Delighted about the mental health collaboration which is going on. There was one event advertised recently which I knew that one of my clients had lost somebody and it was advertised to everybody but because there were so many clinicians going which I fully appreciate and great for learning that meant that both of us were discouraged from going. In terms of patient involvement and learning experiences if there could be space for families I think there is a huge amount to be learnt from clinicians at those meetings. I think there was some family involvement but it would be good in terms of them being able to contribute something back.

Response: The format of these events is for mutual sharing of experience and learning and to involve families, patients and clinicians and so we will feed that back.

6 Close

6.1 The meeting closed at 10.30am.

Signed …Ian Dilks……..……

Date ……8 August 2018…….