NHS Resolution

Annual report and accounts 2024/25

Advise / Resolve / Learn

HC 1065

NHS Resolution
Annual report and accounts
2024/25

For the period 1 April 2024 to 31 March 2025

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Performance report

Performance overview

The performance overview provides a summary of NHS Resolution and its purpose, the objectives we aim to achieve and our performance against those objectives, and the impact of and management of key risks.

Chair and Chief Executive's welcome

Welcome to our Annual report and accounts for 2024/25. 2025 is the final year of our three-year strategy *Advise, resolve and learn*.

It also marks the 30th anniversary of NHS Resolution's establishment in 1995 with an original mission to deliver reliable and comprehensive indemnity solutions, together with economies of scale, for the NHS in England. This is something we continue to deliver today. Our services have since grown to encompass advice on the performance of healthcare practitioners, and the independent resolution of disputes between commissioners and providers of primary care, as well as further indemnity schemes to cover General Practice and risks arising during the Covid-19 pandemic.

We have continued to develop our services to respond rapidly, innovate in dispute resolution and drive best value for public funds. We have worked closely with our sponsoring department, the Department of Health and Social Care. Our three decades as an expert partner developing and delivering indemnity schemes and fair resolution leave us uniquely placed to inform options for change.

The year has seen an increase in the volume and complexity of our work across many of our functions. This has been coupled with the delivery of substantial changes to our operating model and systems driven by our ambitious transformation programme. The fact we have delivered so much of what we set out to achieve in the year, meeting or exceeding almost all our performance targets, is a credit to the hard work and dedication of our staff and our external partners including the NHS teams with whom we work closely on a daily basis.

Our first strategic priority is to deliver fair and timely resolution, working collaboratively to keep patients and healthcare staff out of formal processes wherever possible to minimise distress and cost. In 2016/17, 66% of clinical claims were kept out of formal processes; in 2024/25, it is 83%. This means 11,110 clinical claims were resolved in 2024/25 without claimants needing to go through the distress of a court process. Our Practitioner Performance Advice service operates in a similar manner to resolve concerns about healthcare practitioners as soon as possible.

We endeavour to investigate compensation claims thoroughly and deliver compensation in a timely manner where it is due. The pace and timing of resolution is, however, also determined by external factors over which we have limited influence. This year, that was exemplified by the unusual volatility in settlement behaviours driven by the uncertain timing and magnitude of the change to the Personal Injury Discount Rate (PIDR). The change to the PIDR in January reduced the amount claimants could expect to receive in settlement. This meant we saw significant activity prior to the new rate taking effect followed by a lull as lawyers took stock of the impact on their clients' cases.

In 2024/25 we paid out £3.1 billion in compensation and associated costs on all of our clinical schemes. Because claims take some time to be reported and settled, and some claims are settled with multi-year payments into the future as Periodical Payment Orders (PPOs), the estimated 'annual cost of harm' for our schemes was £4.9 billion. This means almost £5 billion in compensation costs is currently incurred by the NHS in England each year for incidents that could be avoided. Against a background of constrained public finances, efforts to learn and act to prevent these incidents are crucial, to prevent the same harm happening to others and to avoid the need for compensation payments. We welcome the National Audit Office's current study of clinical negligence costs, where we are sharing our data and insights into the key drivers of scheme expenditure within the current legal framework.

This essential work, to share what we know to inform and drive improvement, is reflected in our second strategic priority. Our Safety and Learning and Practitioner Performance Advice teams work

together and in partnership with others in the health system, supporting frontline clinicians, legal teams and trust board members to learn from and improve the system-wide response to harm. At the same time, our insights and advice allow a more reflective approach to learning from incidents and support the development of a just culture where staff are encouraged to learn from and improve the patient care they provide and are valued for the work they do.

Our third strategic priority, collaborating to improve maternity outcomes, recognises that avoidable errors in maternity and neonatal services still occur all too often. Our collaborative work with our partners supports the Government's ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2025. We can never reverse the damage that has been caused, but we can play our part to support those affected by these incidents and highlight measures to improve maternity care in the future.

Our Early Notification (EN) scheme helps ensure families receive compensation more quickly and via a more compassionate model than litigation can provide, in which learning is integral. Our Maternity Incentive Scheme (MIS) is a financial incentive programme designed to enhance maternity safety within NHS trusts. In 2024/25 we have continued to enhance these schemes. We have also continued our evaluation of them to ensure they are delivering effectively on their remits.

Finally, we continue to work hard to be as efficient as we can be in all of our work, continuing to deliver the best possible value for public funds. The programmes of work that underpin our final strategic priority – investing in our people and systems to transform our business – have made substantial progress and position us well for the future. CaseHub is moving us to a sustainable technology platform which will make it easier to interact with NHS Resolution and enable us to leverage new technology over time, including AI. Our Claims Evolution Programme (CEP) has overseen a complete restructure of our service to deliver a claims handling function which works more closely than ever before with frontline services while delivering savings and a more compassionate approach to resolution. We now have case managers in each region who are working hand-in-hand with local teams to manage cases to resolution end-to-end. Our new Claims Support Service (CSS) is providing expert administrative support to free up our case managers to focus on technical claims management. In parallel, we are exploring the huge potential that technology solutions offer to deliver further efficiencies.

Looking forward, our next three-year strategy for 2025-28 *Resolution through collaboration* will see us reaffirm our commitment to delivering with our health system partners our first three priorities set out above. Our transformation programmes are now embedding into business as usual and our focus remains on working to identify and implement continuous improvement initiatives right across our organisation. Our commitment to fair resolution and sharing learning for improvement, particularly in maternity and neonatal care, remains central to our plans as well as delivering even greater value for public funds in the future whether through efficiency improvements, closer collaboration with partners or potential legal reform.

We pay tribute to our staff for their professional expertise and dedicated delivery and we are grateful to our partners and our sponsoring department who have worked with us throughout the year and who continue to support our work.

Sally Cheshire CBE
Chair

Helen Vernon
CEO

Who we are and what we do

We are part of the NHS, operating as an arm's-length body of the Department of Health and Social Care (DHSC), tasked with:

- Administering a range of **indemnity schemes** to cover the risks involved in delivering general practice and secondary healthcare services in England and handling associated compensation claims.
- Providing **expert advice and support on the management of concerns** about the performance of doctors, dentists and pharmacists.
- **Resolving contracting disputes** between primary care contractors and commissioners of primary care, operating independently and transparently.
- Using our unique perspective across the causes of claims, performance concerns and contracting disputes to provide insights back to the NHS to help to **improve safety and manage risk.**

Our strategic priorities

Figure 1: Our strategic priorities 2022–25

Our strategic priorities

Priority 1.
Deliver fair resolution.

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

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

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

Priority 3.
Collaborate to improve maternity outcomes.

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

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

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

Our services

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

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

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

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

Enabled by our corporate functions

Our values

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

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

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

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

Our indemnity schemes

The bulk of our work involves managing negligence claims against the NHS in England.

We do this via seven clinical negligence indemnity schemes and four non-clinical indemnity schemes. Figure 2 gives a brief description of each of these schemes.

The members and beneficiaries of our indemnity schemes are predominantly NHS trusts and foundation trusts, together with general practice and independent sector providers of NHS care.

Figure 2: Our indemnity schemes

Clinical negligence schemes

Clinical Negligence Scheme for Trusts (CNST)
This covers clinical negligence claims for incidents occurring on or after 1 April 1995.

Existing Liabilities Scheme (ELS)
This covers clinical negligence claims against NHS organisations for incidents occurring before 1 April 1995.

Ex-Regional Health Authority Scheme (Ex-RHA)
This is a relatively small scheme and covers clinical negligence claims against former regional health authorities abolished in 1996.

DHSC clinical
This covers clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.

Clinical Negligence Scheme for General Practice (CNSGP)
This covers clinical negligence claims for incidents occurring in general practice on or after 1 April 2019.

Clinical Negligence Scheme for Coronavirus (CNSC)
Launched on 3 April 2020, this scheme meets clinical liabilities arising from certain special healthcare arrangements that were put in place in response to the Covid-19 pandemic where no other indemnity or insurance arrangements were already in place to cover such liabilities.

Existing Liabilities Scheme for General Practice (ELSGP)
This covers claims for historical NHS clinical negligence and other tortious incidents that occurred any time before 1 April 2019 involving GPs who were members of participating medical defence organisations.

This scheme covered members of the Medical and Dental Defence Union of Scotland from 6 April 2020 and was extended to Medical Protection Society members from 1 April 2021.

Non-clinical schemes

DHSC non-clinical
This covers non-clinical negligence liabilities that have transferred to the Secretary of State for Health and Social Care following the abolition of any relevant health bodies.

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

Non-clinical schemes managed under the heading of the Risk Pooling Schemes for Trusts (RPST)

Property Expenses Scheme (PES)
This covers 'first party' losses such as property damage and theft for incidents on or after 1 April 1999.

Liabilities to Third Parties Scheme (LTPS)
This covers non-clinical claims such as public and employers' liability for incidents on or after 1 April 1999.

More information about our schemes is available on our website at https://resolution.nhs.uk/services/claims-management

Our operating environment

Recent government reports highlight the continued concern of providers, patients and Government about patient safety across the health and care landscape.

We share these concerns and engage and collaborate at every level, from frontline clinicians to legal teams and board members, so we can play our part in achieving our shared goal of improvements in safety in healthcare.

We also continue to share our unique learning and insights to inquiries and via consultation responses, and provide data, technical and operational advice whenever our expertise is required.

At the same time, an ongoing study by the National Audit Office (NAO)[1] is considering the scale of recent changes to the value of long-term liabilities for clinical negligence claims and associated in-year payments, what is behind those changes and how they could be expected to change in the future.

We recognise the financial pressures the rising costs of claims place on an already stretched system and we do everything we can within our remit to manage these costs. We are working closely with the NAO to support its study, including sharing data and insights into the key drivers of scheme expenditure.

The risks we face

Like every organisation, we face risks that, unless carefully managed, have the potential to impact our performance. In this section, we explore our strategic risks and outline the steps we take to manage them.

Clinical negligence costs

External factors, such as legal market responses to PIDR changes and recovery from the pandemic present challenges to us and have the potential to impact the management of spend and budgets.

We work hard to ensure claims are settled fairly, paying appropriate compensation when it is right to do so. At the same time, we recognise the cost of resolving clinical negligence claims in the NHS is substantial and rising.

We continue to work to identify further opportunities within our direct control that will help to effectively manage the rising cost of clinical negligence within the legal frameworks in which we operate.

Further information on our claims values and volumes can be found in table 2: Claims – year in numbers on page 23.

Responding to the policy environment

We operate in a dynamic policy environment and through identification of emerging issues we consider their potential impact on our strategic objectives and delivery.

We continue to work closely with system partners, nationally and locally, to ensure we are sighted on upcoming policy changes and are well-placed to contribute, respond and adapt services as required. We maintain a close working relationship with DHSC, providing input and technical support where required to support the Government to develop related policy.

Maintaining operational delivery during transformation

Our two change programmes, CaseHub and our Claims Evolution Programme, are designed to enhance our ability to deliver an efficient, effective and modern public service.

However, as with any transformation, there is a risk of disruption to business-as-usual activities. Robust governance of these programmes means we are continuing to plan our resources carefully to ensure high-quality rollout are planned and timed to minimise disruption.

1 See National Audit Office: Clinical negligence costs (https://www.nao.org.uk/work-in-progress/clinical-negligence-costs/)

Maintaining operational delivery in a system under pressure

As an organisation that works closely with – and relies on the expertise of – multiple stakeholders and partners, we are indirectly affected by the pressures that affect them.

We are consistently mindful of the pressures on our NHS colleagues and continue to work with them in a way that respects this. Factors such as access to clinicians to progress claims and extended court deadlines have, over the course of 2024/25, had an impact on our time to resolution key performance indicator (KPI; see page 27). Despite this turbulence, as of 31 March 2025, this KPI is back within tolerance.

Escalating concerns

As an NHS body, patient safety and public protection are of paramount concern to us. On occasion, the data we hold may indicate a significant concern.

However, there are challenges in identifying within our data where those concerns may exist. Indemnity scheme claims may take many years to be reported to us and may represent only a fraction of incidents that occur in the NHS. As a result, it may not become apparent for some time that there have been particular risks to patient safety from the data we hold.

To mitigate this risk, we operate a Significant Concerns Framework (see page 58). It acts as a guide when there is concern about serious harm, ensuring that confidential information relating to notifications is managed appropriately.

Maintaining data quality

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

A significant part of our second strategic priority, to share data and insights as a catalyst for improvement (see page 54), is to develop the use of technology to make our data more easily manageable and accessible so we can provide rapid and accurate analysis and insight.

We are committed to transparency, publishing data directly such as in the annual report statistics derived from our claims data, and indirectly via system partners such as Getting It Right First Time or the Model Hospital.

For more information on our approach to managing risk, see the Capacity to handle risk section in our Governance statement on page 100.

Fraud

The risk of fraud is ever-present. We continually review and monitor potential threats, drawing on support from our local counter-fraud specialist providers and our participation in DHSC's Counter Fraud Liaison Group. We ensure staff are trained in fraud awareness and undertake proactive exercises to detect potential fraud and improve our control framework where there is evidence of a fabricated or exaggerated claim. For an example of the success of our approach, see Exaggerated or false claims on page 49.

Protecting our assets

The risks posed by increasing and evolving cyber security threats are a reality for every organisation.

To mitigate the risk to our systems, we continue to work on implementing proactive cyber security measures. For more information on our approach, see Information governance and security in the Governance statement on page 103.

Our Board and our Audit and Risk Committee (ARC) are kept informed of emerging threats and our approach to dealing with them.

Going concern

The Board has reviewed the financial position of the organisation and discussed future funding arrangements with DHSC, given that NHS Resolution reports significant net liabilities. The indemnity schemes that NHS Resolution administers on behalf of the Secretary of State for Health and Social Care (as per Regulations) are funded on a "pay-as-you-go" basis. Members and funders of schemes contribute sufficient funds to meet the liabilities required on a yearly basis rather than holding reserves for future settlements. Based on discussions with DHSC the Board has reasonable expectation that the provision of clinical negligence schemes for the NHS, to be managed within the public sector, will continue for the foreseeable future. To this end there is a further reasonable expectation that the Government, via DHSC and the NHS, will continue to fund future liabilities, and therefore the Board is assured that it will be able to meet all the liabilities falling due twelve months from the reporting date.

Therefore, the Board has concluded that it is appropriate to apply the going concern basis of accounting to the financial statements for the year ending 31 March 2025.

Performance summary

Key highlights against our four strategic priorities

Deliver fair resolution

83%

clinical claims kept out of formal court proceedings, providing earlier resolution for patients and healthcare staff, and saving costs.

14,428 ↑

new clinical negligence claims and reported incidents received.

14,431 ↑

clinical claims for compensation closed.

361

new primary care contracting appeal and dispute cases received.

278

primary care contracting appeal and dispute cases closed.

1,420

new and reopened requests for advice received from healthcare organisations with concerns about the practice of individual practitioners as well as services.

Share data and insights

Piloted a new strategic approach to regional member engagement events that emphasises joined-up working across our teams, enhancing stakeholder engagement and resource efficiency both internally and externally.

5

new Insights papers published plus other new resources that draw on our unique data and support organisations to learn from the insights we can provide.

885

delegates attended 60 educational workshops that shared learning and the embedding of good practice derived through our casework.

Collaborated with the Yorkshire and Humber Improvement Academy to facilitate a pilot Just Culture Workshop to support Board-level delegates in fostering just and learning cultures within their organisations.

Worked collaboratively with Loughborough University and HSSIB to embed our resources and unique perspective into patient safety syllabus curriculum materials.

Collaborate to improve maternity outcomes

126

cases received through our Early Notification (EN) scheme.

Piloted new ways of working collaboratively with families and lawyers to ensure we can get earlier support and compensation to families.

Launched enhanced family engagement process, which means that for babies born on or after 1 October 2023 we communicate directly with families at multiple points throughout the EN process.

Piloted an Interactive Board Reporting Workshop that helps to address the issue of Board reporting and governance outlined in recent national maternity inquiries and reports.

84%

of NHS hospital trusts delivering maternity care in England were fully compliant with all elements of the Maternity Incentive Scheme (MIS) (four results pending).

Progressed the evaluation of our EN scheme and the MIS to continue to assess their effectiveness against their objectives.

Invest in our people and systems to transform our business

Completed the migration of our Practitioner Performance Advice service, Healthcare Professional Alert Notices and Performers List Applicants to the new cloud-based CaseHub. The services provide an additional safeguard for employers during the pre-employment checking process for healthcare professionals and medical, dental, and ophthalmic practitioners.

Continued to leverage and expand our Claims Evolution Programme, our invest-to-save programme to build a target operating model which provides even greater value for money.

Began the integration of our systems with the forthcoming Single Perinatal Event Notification (SPEN) service, which will simplify the reporting of incidents across the NHS.

The year in review

Strategic priority one: Deliver fair resolution

We made good progress in tackling the issues we face earlier on in the claims process, retaining our commitment to fair resolution and using innovative approaches to resolving disputes. This was despite dealing with increased volumes and more complex cases.

We further reduced the volume of claims entering formal court proceedings, thereby providing earlier resolution for patients and healthcare staff, saving costs and reflecting our commitment to fair resolution while keeping patients and healthcare staff out of formal processes. In 2016/17, 66% of clinical claims were kept out of formal processes; in 2024/25, it is 83%. This means 11,110 clinical claims were resolved in 2024/25 without claimants needing to go through the distress of a court process.

We received 14,428 new clinical negligence claims and reported incidents, an increase of 5% on 2023/24. Looking at the increase in claims for CNST, our largest scheme, we appear to be seeing a trend similar to the one we were seeing before the impact of the Covid-19 pandemic and wider NHS pressures. We note the volume of new CNST claims has now surpassed the previous peak in 2019/20, prior to the pandemic.

We closed 14,431 clinical claims for compensation, an increase of 4% on 2023/24. We monitor the time it takes to move from a claim decision being reached to the agreement of damages as a key performance indicator but recognise it can be impacted by longer-term trends outside our control, including the availability of clinicians to provide the necessary expertise to progress claims and extended court deadlines. In 2024/25, this KPI was within tolerance.

We received 361 new primary care contracting appeal and dispute cases and closed 278 cases. This compares with 275 and 276 cases respectively in 2023/24, a 31% increase in new cases. However, in 2023/24, 132 appeals from two NHS community pharmacy companies were managed as two ‘group’ cases, so the increase on a case activity basis was significantly higher.

We received 1,420 new and reopened requests for advice from healthcare organisations with concerns about the practice of individual practitioners as well as services, a 24% increase on 2023/24. Our open caseload at the end of the financial year stood at 1,149, a 15% increase when compared with the end of 2023/24. Despite this increase, our Practitioner Performance Advice team still achieved its key performance metric of delivering 90% of interventions within a target timeframe.

For a full description of our performance against Strategic priority one, see page 31.

Strategic priority two: Share data and insights

This year saw us renew our commitment to effective collaboration and engagement that focuses on practical strategies to drive future improvements in safety. Our approach recognises the pressures faced by our system stakeholders.

We piloted a new strategic approach to regional member engagement events that emphasises joined-up working across our teams, enhancing stakeholder engagement and resource efficiency both internally and externally.

We published five new Insights papers and other new resources (as detailed in figure 17 on page 57) that draw on our unique data and support organisations to learn from the insights we can provide.

We delivered 60 educational workshops to 885 delegates, sharing learning and the embedding of good practice derived through our casework. We monitor feedback from our workshops as a KPI and met our aim that 90% of delegates rate the workshops not less than four out of five for overall quality.

We collaborated with the Yorkshire and Humber Improvement Academy to facilitate a pilot Just Culture Workshop. The workshop supported Board-level delegates to better understand their role in fostering just and learning cultures within their organisations, introduced tools to assess the actions required to foster such a culture and provided an opportunity to develop a peer network.

We continued to support the delivery of the patient safety syllabus by working collaboratively with Loughborough University and HSSIB to embed our resources and unique perspective into curriculum materials. The training has been rolled out to registered patient safety specialists working across the NHS in England.

For a full description of our performance against Strategic priority two, see page 54.

Strategic priority three: Collaborate to improve maternity outcomes

We have continued to draw on our unique position and to work with our system partners to support maternity and neonatal safety improvements via our EN scheme and the MIS.

We received 126 cases through our EN scheme, a similar number to the claims we received in 2023/24.

We piloted new ways of working collaboratively with families and lawyers to ensure we can get earlier support and compensation to families.

We launched an enhanced family engagement process, which means that for babies born on or after 1 October 2023 we communicate directly with families at multiple points throughout the EN process.

We piloted an Interactive Board Reporting Workshop that helps to address the issue of Board reporting and governance outlined in recent national maternity inquiries and reports.

All NHS hospital trusts delivering maternity care in England participated in year six of the MIS. At least 84% of trusts were found to be fully compliant with all elements of the scheme (with four results pending). This is an increase on the compliance rate for year five of the scheme, which was 77%.

We progressed the evaluation of our EN scheme and the MIS to continue to assess their effectiveness against their objectives.

For a full description of our performance against Strategic priority three, see page 59.

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

Work on our transformation programmes, designed to transform our business and continue to deliver best value for public funds, has progressed in a paced and pragmatic way. At the same time, 2024/25 has also seen us undertake work to support the Government's strategic shift from analogue to digital and reforms to drive efficiency and productivity.

We completed the migration of our Practitioner Performance Advice service, Healthcare Professional Alert Notices and Performers List Applicants to the new cloud-based CaseHub. The services provide an additional safeguard for employers during the pre-employment checking process for healthcare professionals and medical, dental, and ophthalmic practitioners.

We continued to leverage and expand our Claims Evolution Programme, our invest-to-save programme to build a target operating model.

We began the integration of our systems with the forthcoming Single Perinatal Event Notification (SPEN) service, which will simplify the reporting of incidents across the NHS.

For a full description of our performance against Strategic priority four, see page 67.

The year in numbers

Table 1: The finance year in numbers

Funding for clinical schemes				
Funding from DHSC (budget)	277.4	261.4	16.0	6.1% ^
Payments in respect of clinical schemes				
Claimant legal costs	620.9	545.3	75.6	13.9% ^
Income from members	61.1	60.5	0.6	1.0% ^
Damages payments to claimants	23.4	26.2	(2.8)	(10.7%) v
NHS legal costs	7.1	7.1	-	- -
NHS Resolution administration costs				
Non-clinical schemes administration	7.7	7.1	0.6	8.5% ^
Total administration expenditure	**71.7**	**58.9**	**12.8**	**21.7%** ^
• CNST cost of harm in the financial year[2]	4,585.7	4,777.4	(191.7)	(4.0%) v
• Other schemes cost of harm in the financial year	40.5	66.2	(25.7)	(38.9%) v

For a full insight into the finance year in numbers, see the Finance report on page 74.

1 The claims cost of harm above differs slightly to the Statement of Comprehensive Net Expenditure and Provisions (see Note 2.1 of the financial statements on page 154) due to payments made on incidents arising in the year, the difference is not material due to the time lags involved (Prior year comparatives have been adjusted accordingly).

2 Prior year CNST cost of harm has been restated to align with correct calculation shown in 2024/25.

Table 2: Claims – year in numbers

Notified claims for clinical schemes					
CNST					
CNSGP	2,575	2,382	193	8.1%	^
CNSC					
ELSGP	341	502	(161)	(32.1%)	v
DHSC Funded Schemes					
Notified claims for non-clinical schemes					
LTPS	3,068	3,299	(231)	(7.0%)	v
DHSC Liabilities	11	13	(2)	(15.4%)	v
PES	43	47	(4)	(8.5%)	v
Resolved claims for clinical schemes					
CNST					
CNSGP	2,262	2,089	173	8.3%	^
CNSC					
ELSGP	652	965	(313)	(32.4%)	v
DHSC Funded Schemes					
Resolved claims for non-clinical schemes					
LTPS	3,229	3,396	(167)	(4.9%)	v
DHSC Liabilities	16	18	(2)	(11.1%)	v
PES	39	38	1	2.6%	^
Closed claims for clinical schemes					
CNST	11,063	10,658	405	3.8%	^
CNSGP	2,229	1,994	235	11.8%	^
CNSC	17	14	3	21.4%	^
ELSGP	878	1,114	(236)	(21.2%)	v
DHSC Funded Schemes	244	53	191	360.4%	^
LTPS	3,394	3,768	(374)	(9.9%)	v
	20	19	1	5.3%	^
PES	45	49	(4)	(8.2%)	v
	3,459				

Performance analysis

The performance analysis reflects on our performance against the key performance indicators and deliverables set out in our Business plan 2024/25.[1]

1 See https://resolution.nhs.uk/wp-content/uploads/2024/07/NHSR_Business-Plan-24-25.pdf

Date of surgery
Patient/sample data
Age at surgery
Clinical outcome

Key performance indicators

Our key performance indicators (KPIs) cover all areas of our operations and provide an objective assessment of our performance against our strategy.

Our KPIs are agreed and set annually by our Board and DHSC, a process that helps us continuously develop our services and ensure we maintain focus on the areas that matter most. We track each KPI throughout the year, identifying trends, monitoring variations and making data-driven decisions, ultimately improving our strategic planning and risk management. Unless otherwise stated N/A indicates that the KPI was not in operation in that reporting year. Where a KPI was within tolerance, it means we were within 10% of the target figure and it has not impacted our ability to deliver against our strategic objectives.

Our KPIs provide high-level assurance to our Board and to DHSC that we are conducting our business as intended and for which we are funded. We will continue to monitor performance as we enter our new strategic cycle in 2025.

Deliver fair resolution

Annual KPI No	Annual KPI	Area	Target	2022/23 performance	2023/24 performance	2024/25 performance
1[1]	Time to resolution from claims decision to agreement of damages	Claims Management	Internal[2]	Not achieved	Achieved	Within tolerance
2[3]	Reduction in volume of cases that enter litigation before appropriate dispute resolution	Claims Management	Internal[4]	N/A[5]	Achieved	Achieved
3[6]	80% of pharmacy appeals where the decision maker agreed with the recommendation of the case manager	Primary Care Appeals	80%	Achieved	Achieved	Achieved
4[7]	90% of advice and other case interventions delivered within target timeframe[8]	Practitioner Performance Advice	90%	Achieved	Achieved	Achieved
5[9]	90% of all exclusions/ suspensions critically reviewed (where due)	Practitioner Performance Advice	90%	Within tolerance	Within tolerance	Within tolerance

Explanatory notes

KPI 1: this KPI is measured at the point at which claims are closed and can be impacted by longer-term trends outside our control. These include the availability of clinicians to provide the necessary expertise to progress claims and extended court deadlines.

KPI 5: the financial year 2024/25 ended on 82%, with 155 of 189 exclusions/suspensions reviewed within the required timescales. Where reviews did not take place within the required time this was predominantly due to the employing or contracting organisation not responding to the request for review discussions. In some instances, it is not practicable for a review to take place because of local factors that relate to the exclusion/suspension, for example where a practitioner is suspended from the register or if they are subject to court proceedings.

1 KPI 1 was KPI 2 in 2022/23 and 2023/24.
2 Target not reported externally due to commercial sensitivities.
3 KPI 2 was KPI 1 in 2022/23 and 2023/24.
4 Target not reported externally due to commercial sensitivities.
5 During 2022/23 we worked on establishing a baseline for this KPI and implementing processes to support data capture. Full measurement of this KPI was carried out from April 2023 onwards.
6 KPI 3 was KPI 11a in 2022/23 and 2023/24.
7 KPI 4 was KPI 10 in 2022/23 and 2023/24.
8 We have amended the measure from '90% of assessment and other intervention reports produced/issued within target timeframe'.
9 KPI 5 was KPI 9 in 2022/23 and 2023/24.

Share data and insights

Annual KPI No	Annual KPI	Area	Target	2022/23 performance	2023/24 performance	2024/25 performance
6	Demonstrate engagement with the system to share learning products/services; respond to feedback on these; and review evidence of uptake/implementation	Safety and Learning	90%	N/A	N/A	Achieved
7	90% of delegates rate the workshops not less than 4 out of 5 for overall quality	Practitioner Performance Advice	90%	N/A	N/A	Achieved
8a[1]	Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative information	Organisation wide	100%	Achieved	Achieved	Achieved
8b[2]	Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed)	Organisation wide	100%	Achieved	Achieved	Achieved
8c[3]	Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way	Organisation wide	100%	Within tolerance	N/A[4]	Achieved

1 KPI 8a was KPI 13a in 2022/23 and 2023/24.
2 KPI 8b was KPI 13b in 2022/23 and 2023/24.
3 KPI 8c was KPI 13c in 2022/23 and 2023/24.
4 Due to the low number of notifications (nine) that were raised through this framework during the reporting period, this has not been rated. The three cases that missed the 'timely' measure in 2023/24 each had different factors leading to the delay. We are using the lessons learned from these cases to inform future handling.

Collaborate to improve maternity outcomes

Annual KPI No	Annual KPI	Area	Target	2022/23 performance	2023/24 performance	2024/25 performance
9[1]	Reduction in the time from notification to a decision on entitlement to compensation on an Early Notification Scheme case compared to a similar cerebral palsy case received via the traditional claims route	Claims Management	Internal[2]	Achieved	Achieved	Achieved
10	EN clinical review within 30 days of acceptance within the Early Notification Scheme	Safety and Learning	100%	N/A	N/A	Achieved
11	Maternity Incentive Scheme reverification – 90% of reverification processes completed within their respective predefined timescales	Safety and Learning	90%	N/A	N/A	Achieved

1 KPI 9 was KPI 19 in 2022/23 and 2023/24.
2 Target not reported externally due to commercial sensitivities.

Invest in our people and systems to transform our business

Annual KPI No	Annual KPI	Area	Target	2022/23 performance	2023/24 performance	2024/25 performance
12	General Practice Indemnity schemes and Clinical Negligence Scheme for Trusts claims being managed on CaseHub by the end of the financial year	Digital, Data and Technology and Transformation	Internal[1]	N/A	N/A	Partially Achieved
13[2]	Management of budgets within net Departmental Expenditure Limits. Measured as income from members plus budget from DHSC vs expenditure[3]	Finance	No overspend, underspend within 5%[4]	Achieved	Achieved	Achieved
14	We continue to maintain the Investors in People 'We invest in People Gold' accreditation	Human Resources and Organisational Development	Investors in People annual review recommends NHS Resolution is on track to retain 'We invest in People Gold' accreditation	N/A	N/A	Achieved

Explanatory note

KPI 12: Claims management functionality on CaseHub is nearing completion but we intentionally paused migration until May 2025. While this means we did not achieve KPI 12 in the financial year 2024/25, it reflects our robust approach to transformation, which combines delivering vital change with agile planning and phasing that minimises the impact on business-as-usual activity.

1 Target not reported externally due to commercial sensitivities.
2 KPI 13 was KPI 32 in 2022/23 and 2023/24.
3 We have amended the measure from 'Management of budgets within net Departmental Expenditure Limits (between 95 and 100% of the in-year target for indemnity scheme spend)'.
4 We have amended the target from '95% – 100%'.

Strategic priority one: Deliver fair resolution

Our first strategic priority is to achieve fair and timely resolution, wherever possible keeping patients and healthcare staff out of formal processes, helping to minimise the distress they cause to harmed patients, families and healthcare staff while also preserving taxpayer funds.

In 2024/25 we have, once again, kept a record number of claims out of formal processes. The increase reflects our commitment to using non-adversarial dispute resolution approaches wherever possible and appropriate, as well as our collaborative approach to claims management.

This year's numbers demonstrate that we continue to operate in a landscape affected by, and recovering from, the Covid-19 pandemic and wider NHS pressures. Other external forces, including the change to the PIDR, have influenced legal market settlement behaviours.

As always, we have worked proactively internally and with our external legal partners to mitigate and manage these factors, helping to provide timely and fair resolution of every claim.

The claims journey

The time lag between a clinical incident occurring and a claim being reported to us means that we do not have a 'live' picture of the state of clinical negligence in the NHS, including the financial costs incurred. Instead, our claims portfolio identifies the patterns and trends relating to the types of clinical negligence incidents that have occurred in previous years. The portfolio does not reflect all clinical incidents that have occurred across the NHS, only those that result in a claim.

On average, there are three years between a clinical incident occurring and a claim being reported to us.

It can take some time for patients to decide whether they wish to pursue a claim and seek legal advice. During this time, the healthcare provider's focus will rightly be on understanding why the harm was caused and dealing with the immediate concerns of patients, including ongoing care.

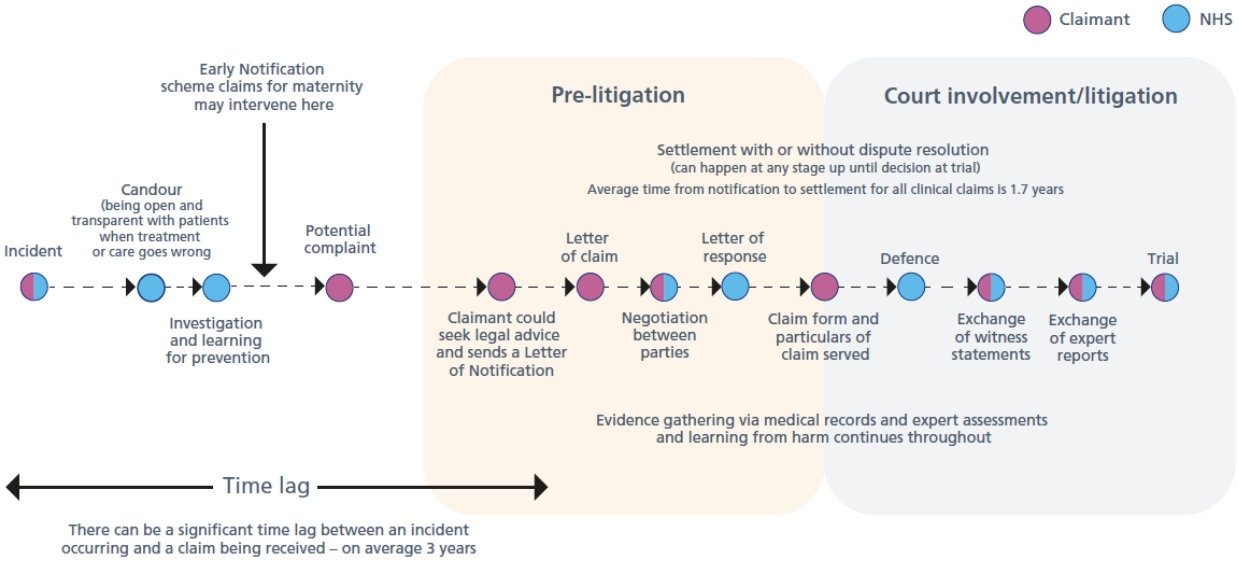
Once a patient or family member decides to make a claim there are several procedural and investigative stages to be undertaken before a decision can be made on liability.

Multiple factors have the potential to increase the time it takes to reach a resolution, including issues in the justice system and, in the healthcare system, the prioritisation of frontline care meaning the availability of clinicians to provide expert advice is constrained.

It may then also take some time to quantify and agree damages on a claim, particularly those high-value claims where brain damage has occurred at birth and where a full assessment cannot be undertaken until a child has reached developmental milestones. To ensure this time is kept to a minimum, we monitor the length of time between a claims decision being made and damages being agreed as our first key performance indicator.

The clinical claims journey is illustrated in figure 3.

Figure 3: Clinical claims journey[1]



What does liability mean?

Liability means legal responsibility. In clinical negligence, liability is established if treatment received falls below a reasonable standard of competence, resulting in an injury that is likely to have been avoided (or less severe) with appropriate care. We also use liability when managing our finances. In accounting terms, a liability is a present obligation as a result of past events, the settlement of which is expected to result in an outflow of resources (payment).

1 For more information on the EN scheme in the clinical claims journey, see page 44 of our Annual report and accounts 2023/24 (https://resolution.nhs.uk/wp-content/uploads/2024/07/NHS-Resolution-Annual-report-and-accounts_23-24_Access-1.pdf).

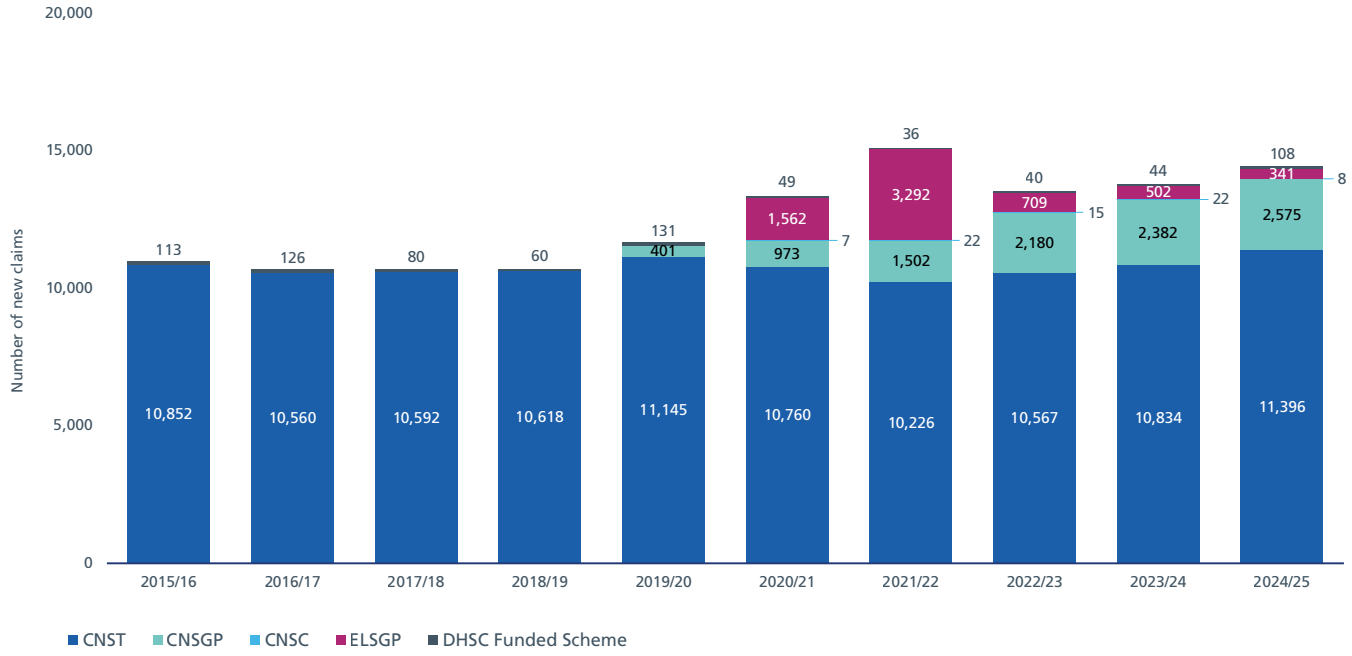
Reported claims and incidents

As figure 4 shows, we received 14,428 new clinical negligence claims and reported incidents in 2024/25, compared with 13,784 in 2023/24.

There were:

- 562 more CNST claims (11,396 in 2024/25 compared with 10,834 in 2023/24), an increase of 5% compared with 2023/24;
- 193 more CNSGP claims (2,575 in 2024/25 compared with 2,382 in 2023/24), an increase of 8% compared with 2023/24; and
- 161 fewer ELSGP claims (341 in 2024/25 compared with 502 in 2023/24), a decrease of 32% compared with 2023/24.

Figure 4: The total number of new clinical claims and incidents reported in each financial year from 2015/16 to 2024/25



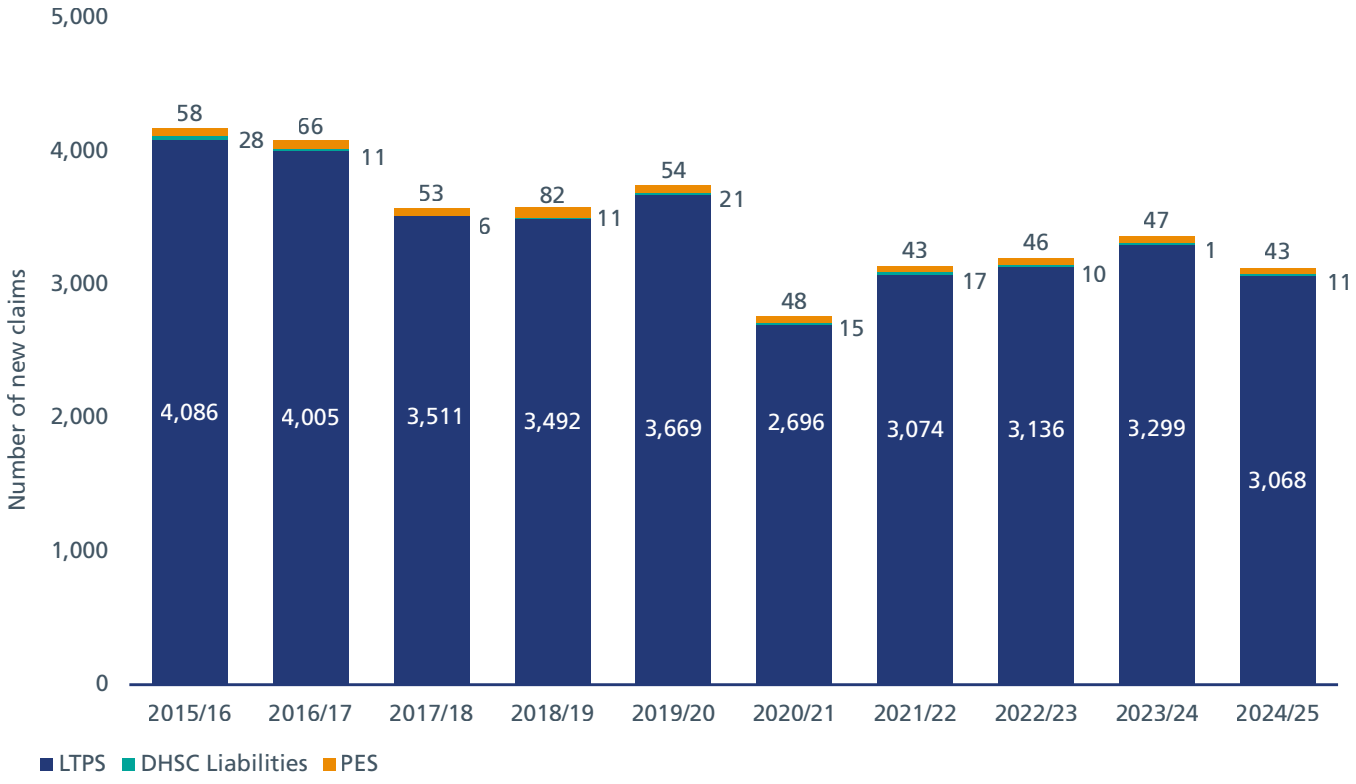
Looking at the increase in CNST claims, we appear to be seeing a trend similar to the one we were seeing before the impact of the Covid-19 pandemic and wider system pressures. We note the volume of new CNST claims has now surpassed the previous peak in 2019/20, prior to the pandemic.

The continued reduction in ELSGP claims is in line with what we would expect. The scheme provides indemnity cover in respect of liabilities incurred before 1 April 2019 and so we expect numbers to reduce over time as fewer new claims for incidents before that date are reported. Reported numbers in 2021/22 were particularly high due to the bulk migration of 2,005 claims from the Medical Protection Society.

In CNSGP claims, the 8% increase is broadly similar to the 9% increase we saw in 2023/24. This is in line with our expectations of a maturing scheme that covers clinical negligence liabilities in relation to incidents that occurred on or after 1 April 2019. The time lag between incident and reporting (as illustrated by figure 3: Clinical claims journey on page 32) and the possible impact of the pandemic means we are now more steadily receiving claims relating to incidents that occurred after the date the scheme began. We expect numbers to stabilise over time as the scheme reaches maturity.

In LTPS, which covers non-clinical claims such as public and employers' liability, we received 3,068 claims in 2024/25 compared with 3,299 in 2023/24, a decrease of 7%. The figures appear to show a return to the slow but steady decline in claim numbers we were seeing before the Covid-19 pandemic. These numbers, along with numbers from our other non-clinical schemes, are shown in figure 5.

Figure 5: The total number of new non-clinical claims and incidents reported in each financial year from 2015/16 to 2024/25



Closed claims

Business plan objective: Provide expertise in handling both clinical and non-clinical claims to members of our indemnity schemes.

KPI 1: Time to resolution from claims decision to agreement of damages.

In 2024/25 we closed 17,890 claims (compared with 17,669 in 2023/24), an increase of 1%. This included 14,431 clinical claims (compared with 13,833 in 2023/24), an increase of 4%.

We monitor the time it takes to move from a claim decision being reached to the agreement of damages as a key performance indicator. It is a KPI that can be impacted by longer-term trends outside our control, including the availability of clinicians to provide the necessary expertise to progress claims and extended court deadlines. In 2024/25, this KPI was within tolerance.

What are damages?

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

Closed clinical claims

In 2024/25, the percentage of clinical claims closed with damages was 54%. In 2023/24, it was 52%. The increase demonstrates our continued commitment to investigating claims robustly and fairly, and to making damages payments where the merits of the case warrant it.

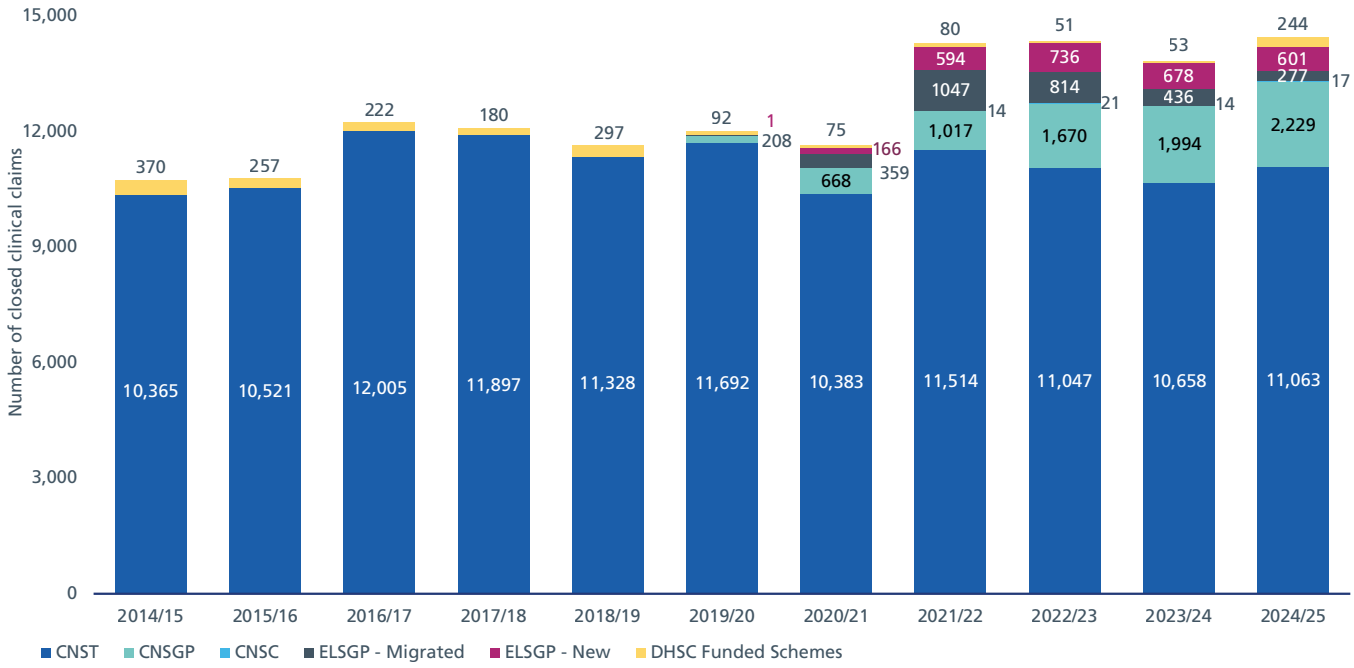
What is the difference between a resolved claim and a closed claim?

A claim is resolved when we have reached settlement about the payment or non-payment of damages. At this point, there may be claimant and NHS legal costs still to be agreed, so there will continue to be uncertainty over the total amount to be incurred on these claims. Also, in cases where a Periodical Payment Order (PPO) is involved, the claim is referred to as resolved for the duration of the claimant's lifetime. Costs for these cases will be uncertain due to inflation factors and life expectancy. We refer to resolved claims as settled claims in our internal systems. We have also referred to settled claims in previous annual reports and accounts. When all elements of a claim have been agreed and paid, or payments on a PPO have come to an end, the claim is closed.

We closed 6,625 clinical claims without damages in 2024/25, compared with 6,573 in 2023/24, an increase of 1% (52 claims). The estimated total value of claims we closed with no damages payment was £3.9 billion.[1]

We closed 7,806 clinical claims with damages in 2024/25, compared with 7,260 in 2023/24, an increase of 8% (546 claims).

Figure 6: The total number of clinical claims closed broken down by scheme in each financial year from 2015/16 to 2024/25[2]



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

2 CNSC refers to the Clinical Negligence Scheme for Coronavirus. Further information about the scheme can be found in Covid-19 related claims on page 41.

Closed non-clinical claims

In 2024/25, the percentage of non-clinical claims closed with damages was 49%. In 2023/24, it was 52%. This decrease again demonstrates our continued commitment to investigating claims robustly and fairly, and to making damages payments where the merits of the case warrant it.

Of our non-clinical claims, 1,756 claims were closed without damages in 2024/25, compared with 1,823 in 2023/24, a decrease of 4%.

We also closed 1,703 non-clinical claims with damages in 2024/25, compared with 2,013 in 2023/24, a decrease of 15%.[1]

1 The change in percentages in non-clinical claims can be more volatile than the changes in clinical claims because of the smaller volume of claims numbers involved.

Legal costs

We work hard to secure value for money alongside fair resolution.

As shown in figure 7, for clinical claims valued up to £25,000, the average claimant legal costs paid have increased from £26,095 to £27,380, an increase of 5%. This means average legal costs on claims valued up to £25,000 have again exceeded the highest damages paid in this cohort of claims.

For clinical claims valued between £25,001 and £100,000, the average claimant legal costs paid per claim were £55,767, a 1% increase from £54,978 in 2023/24.

Figure 7: Average claimant's legal costs for clinical claims closed in each financial year from 2015/16 to 2024/25

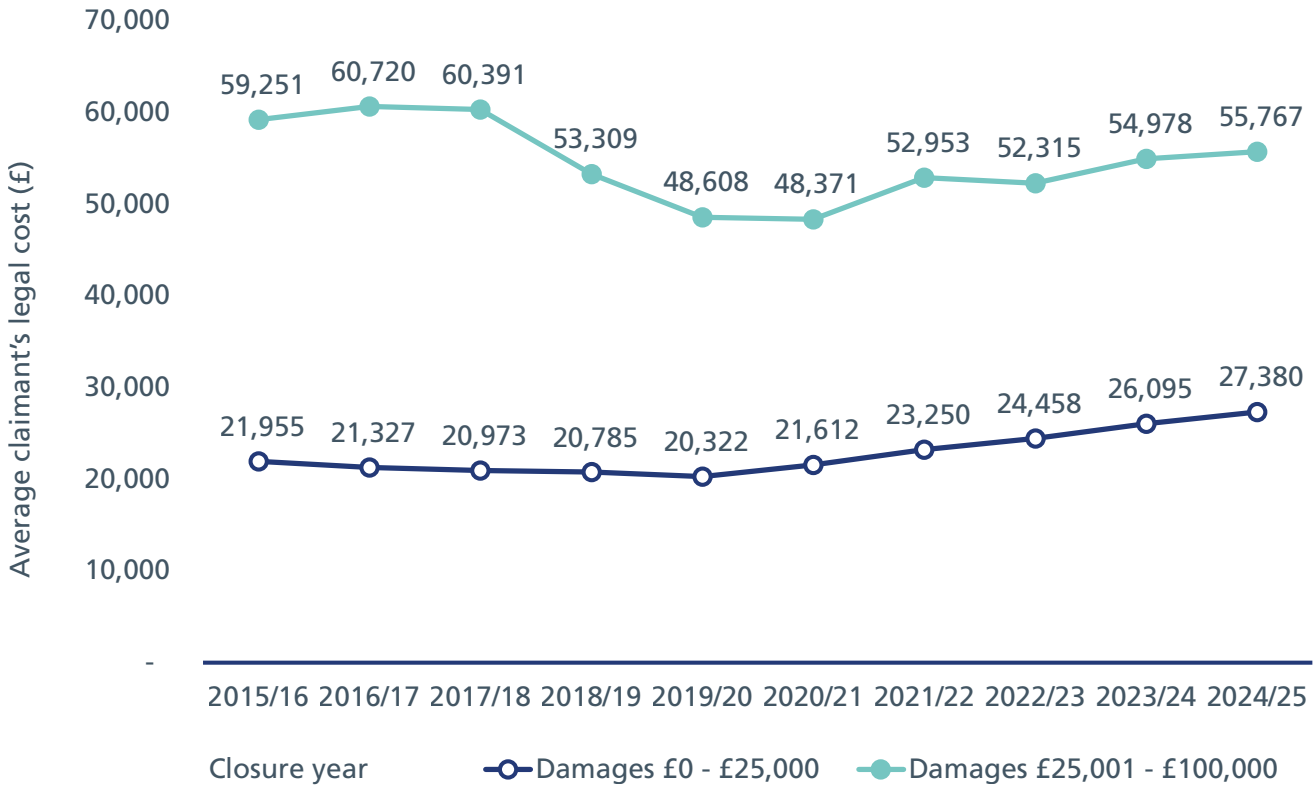
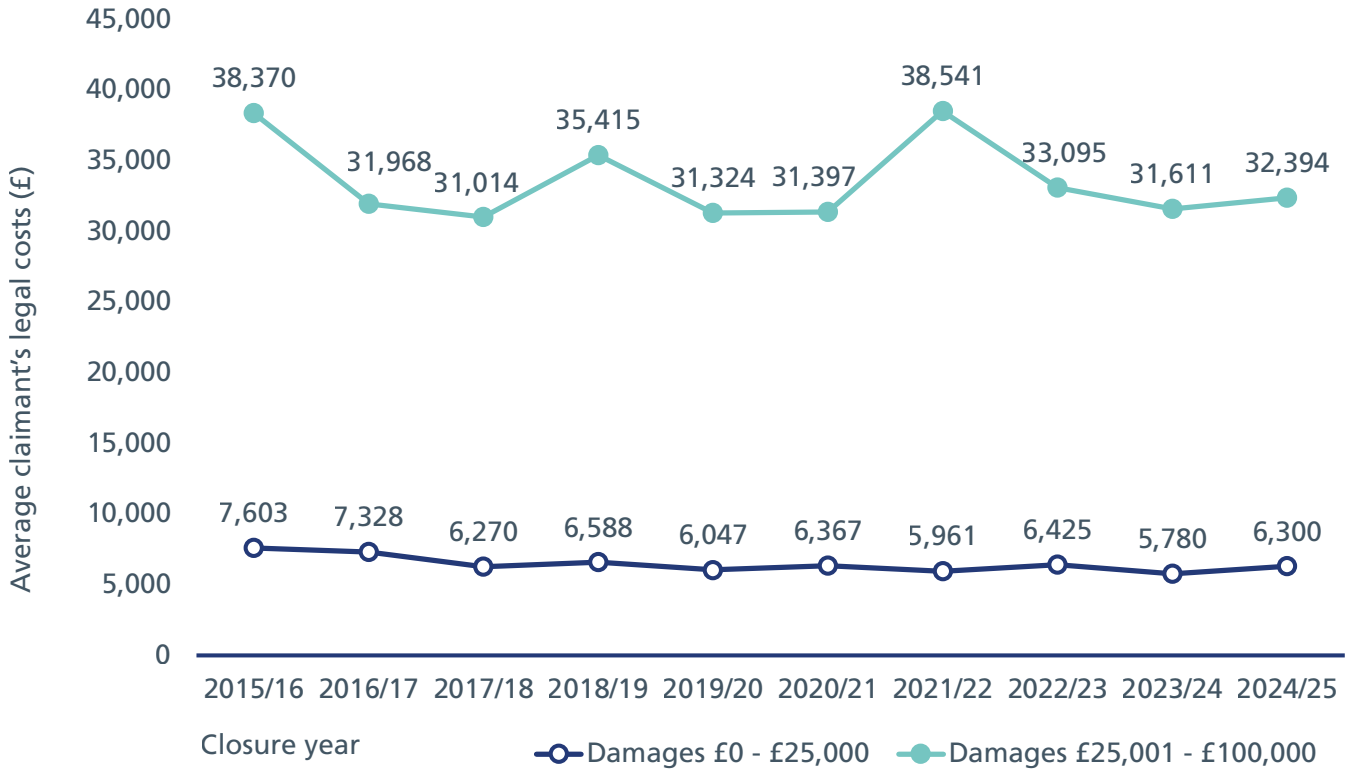


Figure 8: Average claimant's legal costs for non-clinical claims closed in each financial year from 2015/16 to 2024/25



Costs are fixed for non-clinical claims and in 2024/25, for non-clinical claims valued up to £25,000, the average claimant legal costs paid have increased from £5,780 to £6,300, an increase of 9%.

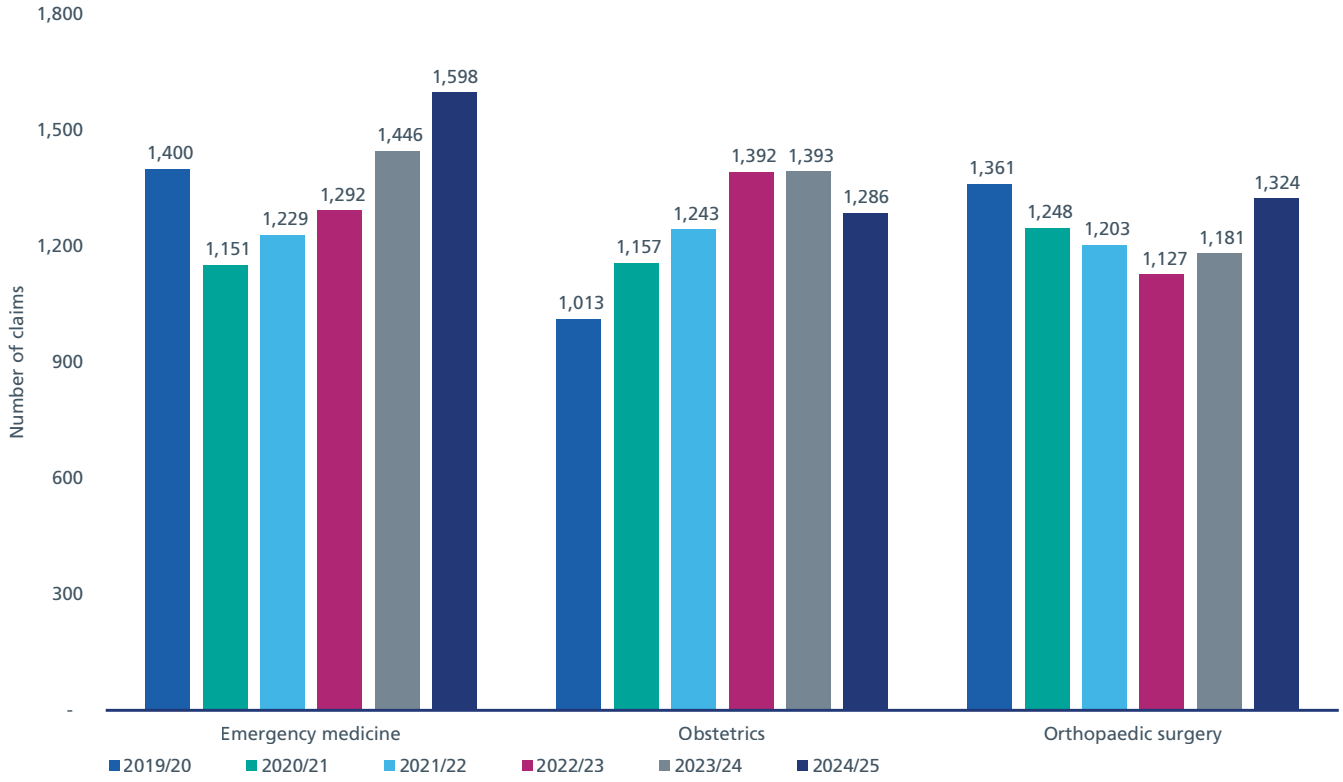
For non-clinical claims valued between £25,001 and £100,000, the average claimant legal costs paid have increased from £31,611 to £32,394, an increase of 2%.

Categories of clinical claim

Figure 9 shows the top three categories of newly-reported clinical claim numbers (excluding GPI) by specialty in 2024/25: emergency medicine, obstetrics and orthopaedic surgery. Emergency medicine remains the largest specialty by volume.

Since April 2017, when the EN scheme was first launched, we now receive notification of EN incidents earlier than would have been expected for such incidents prior to the scheme's launch. As expected, the volume of non-EN obstetric cerebral palsy/brain damage claims notified is lower now than prior to the launch of the EN scheme. For more information on EN claims in 2024/25, see Strategic priority three (page 59).

Figure 9: The top three categories of clinical negligence claims (excluding GPI) reported in each financial year between 2019/20 and 2024/25[1]



1 This data is based on clinical claims notified in each financial year.

Covid-19 related claims

In 2024/25 we received 159 clinical claims reported where there was a claim related to Covid-19 (excluding claims reported under CNSC, which is discussed below). This compares with 281 in 2023/24. As in previous financial years, most of these claims relate to indirect effects of the pandemic such as failures and/or delays in treatment or diagnosis. Because claims are time lagged (as explained in figure 3: Clinical claims journey on page 32), we can't speculate on any long-term trends or patterns at this stage.

Of the Covid-19 related clinical claims resolved in 2024/25, 57% were resolved without damages.

Under the non-clinical schemes, 218 claims were reported in 2024/25 compared with 36 in 2023/24. Of the non-clinical claims settled in 2024/25, 88% were resolved without damages.

The Clinical Negligence Scheme for Coronavirus (CNSC) was launched in April 2020 to meet clinical negligence liabilities arising from NHS services provided in response to the Covid-19 pandemic where no other indemnity or insurance arrangements were already in place to cover such liabilities.

We received eight CNSC claims in 2024/25. This compares with 22 claims in 2023/24, 15 claims in 2022/23 and 22 in 2021/22.

We have received no claims under the Coronavirus Temporary Indemnity Scheme (CTIS), which was set up to cover non-clinical liabilities under certain arrangements.

Vaginal mesh and sodium valproate claims

We offer simplified processes for vaginal mesh claims and sodium valproate claims to be reported to us by unrepresented claimants. We refer to these simplified processes as gateways.

The aim of the gateways is to manage the procedure for reporting and investigating claims without the need for litigation. Our assessment and investigation processes into any claims are not substantively different from any other negligence claim.

In 2024/25, we received 60 claims via the vaginal mesh gateway and six claims via the sodium valproate gateway. Claims in relation to vaginal mesh and sodium valproate have also been received and progressed through regular claims management arrangements during 2024/25.

We await the Government's response to The Hughes Report: Options for redress for those harmed by valproate and pelvic mesh,[1] and decisions regarding a redress scheme that could impact claims submitted via the gateways. At the same time, we will continue to progress the claims we receive to avoid the distress that would be caused to claimants by pausing their cases.

1 See https://www.patientsafetycommissioner.org.uk/wp-content/uploads/2024/02/14.385_DHSC_OPSSC-Redress-Report.pdf

Payments

As illustrated in figure 10, payments against all our clinical schemes in 2024/25 totalled £3,088.9 million. This includes:

- £2,286.7 million damages paid to claimants, an increase of 9% compared with 2023/24;
- £620.9 million claimant legal costs, an increase of 14% compared with 2023/24; and
- £181.3 million NHS legal costs, an increase of 7% compared with 2023/24.

There has been a 14% increase in claimant costs in 2024/25 compared with 2023/24. This increase will be contributed to by an increase in cases resolved between £250,000 and £4.8 million and a larger volume of cases settled under a PPO (161 in 2024/25 compared with 144 in 2023/24). There has been a 7% increase in NHS legal costs.

As figure 11 shows, payments against our non-clinical schemes in 2024/25 totalled £45.0 million. This includes:

- £23.4 million damages paid to claimants, a decrease of 11% compared with 2023/24;
- £14.5 million claimant legal costs, a decrease of 13% compared with 2023/24; and
- £7.1 million NHS legal costs, the same as in 2023/24.

Damages payments across our non-clinical schemes decreased by 11% in 2024/25 compared with 2023/24. Claimant legal costs decreased by 13% and NHS legal costs remained the same. The decrease in damages and costs will be contributed to by a 5% reduction in the volume of LTPS cases settled this year compared with 2023/24, particularly cases with damages over £500,000.

Across both clinical and non-clinical schemes, the split of spend between claimant legal costs, defence costs and damages has remained broadly similar between 2023/24 and 2024/25.

An overview of the financial performance across each scheme is described in the Finance report on page 74.

Figure 10: Clinical negligence payments made in 2023/24 compared with 2024/25

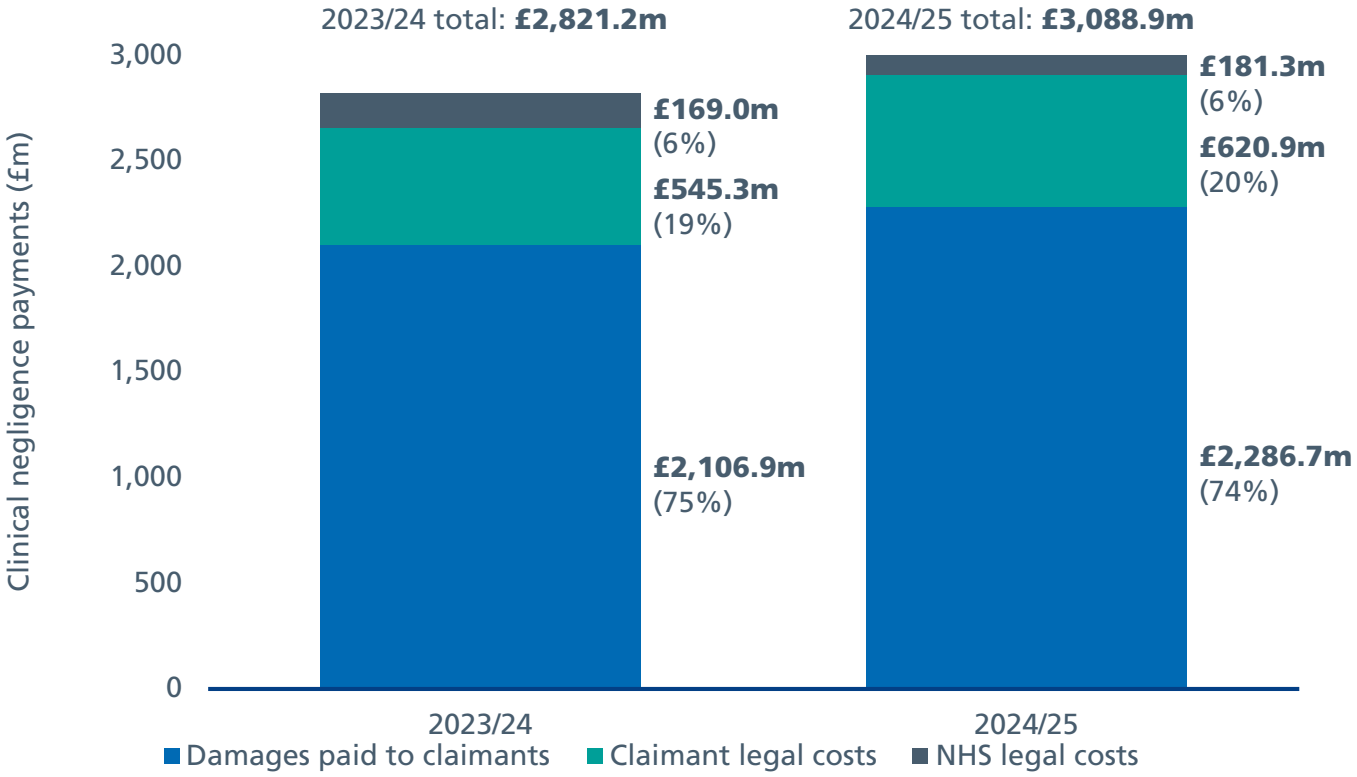
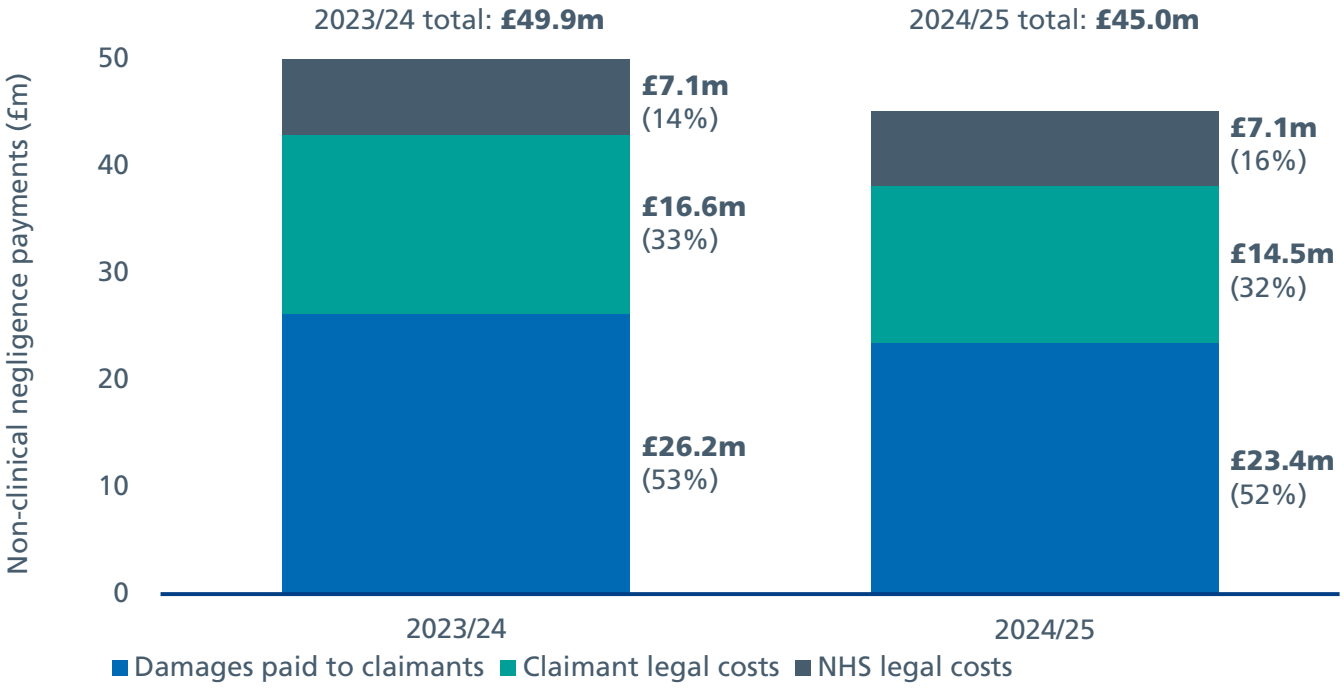


Figure 11: Non-clinical negligence payments made in 2023/24 compared with 2024/25



Our approach to dispute resolution

We are committed to a positive, less adversarial and more collaborative dispute resolution strategy for claims.

To achieve this, we offer a range of dispute resolution options, which are outlined on page 48. Resolving matters without the need for court proceedings can reduce costs[1] and the pressure on courts. It can also minimise the stress and distress of the claims process for claimants and healthcare staff, as well as being a valuable approach where claimants might be seeking an outcome which litigation might not be able to provide.

While working to ensure litigation is always by choice, we also recognise there will always be some claims where litigation is necessary, for example, where the court must approve a settlement in the best interests of a protected party.

It is also sometimes appropriate to take claims to trial or to the higher courts because they are in areas of law that require certainty or need to be challenged in the broader interests of the NHS. For example, during 2024/25 we took a case involving a child with negligently caused decreased life expectancy to the Supreme Court, to clarify the law on recoverability of earnings during the so-called 'lost years'. Judgement was outstanding on 31 March 2025. We also prepared for a Supreme Court hearing involving a claim against a mental health trust and other organisations brought on behalf of an individual who killed three people but was held by the jury in his criminal trial to be not guilty of murder by reason of insanity, this being a novel point of law.

We recognise that the circumstances of such cases can be truly tragic and do not seek to diminish the trauma of those involved. However, an outcome can provide an opportunity for others to claim under similar circumstances or deter claims without merit. It can also provide our members, the legal profession and healthcare staff with valuable insights to learn from.

We publish the findings of such cases as cases of note on our website.[2]

Litigation rate

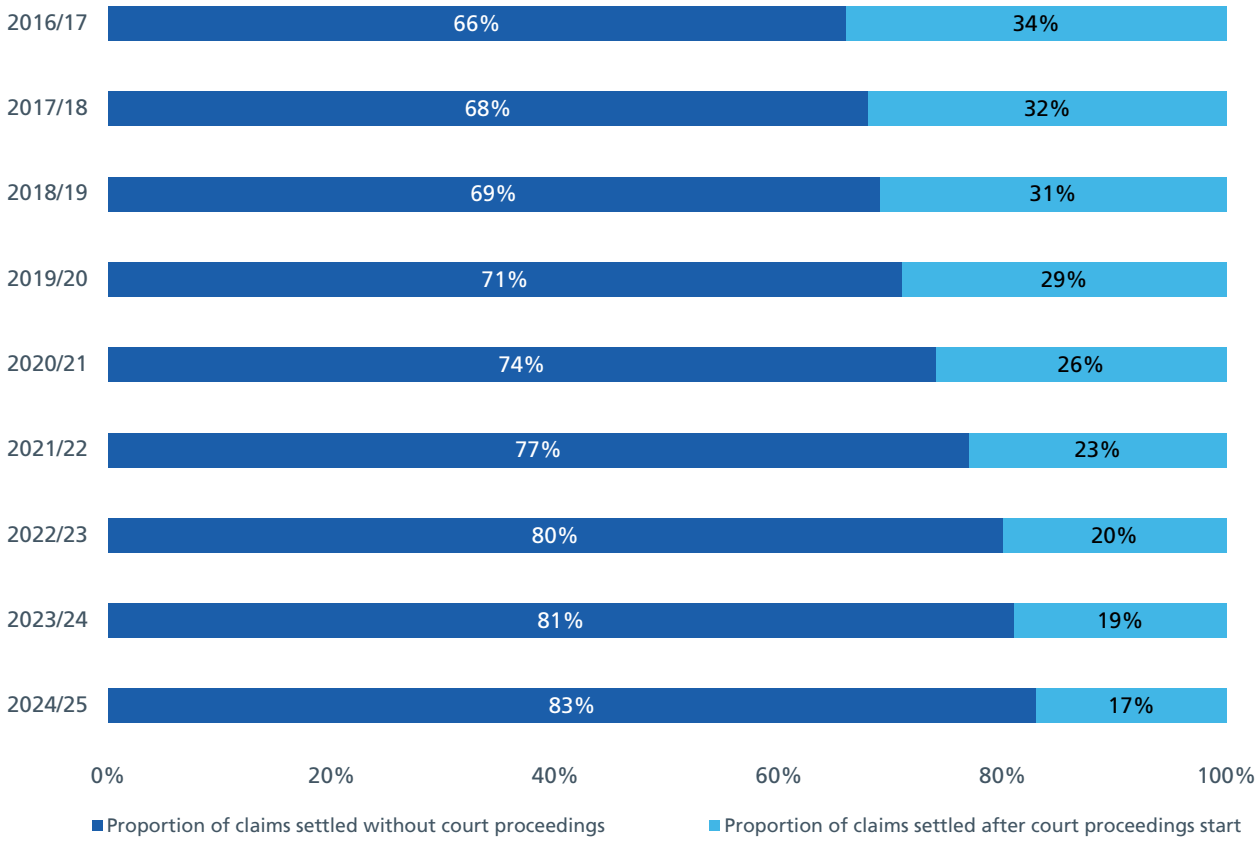
KPI 2: Reduction in volume of cases that enter litigation before appropriate dispute resolution.

As figure 12 illustrates, 83% of clinical claims were resolved without litigation (compared with 81% in 2023/24). This is the highest percentage we have ever achieved and a rise from the 80% of cases that were kept out of formal processes at the start of this strategy period.[3] It is a reflection of the success of our first strategic priority: commitment to fair resolution while keeping patients and healthcare staff out of formal processes.

We recognise this upward trend cannot continue indefinitely but, for the reasons outlined above, will always continue to promote dispute resolution over litigation. The decision to take a case to trial is often finely balanced, requiring careful assessment of all evidence.

1 See National Audit Office: Managing the costs of clinical negligence in trusts (https://www.nao.org.uk/reports/managing-the-costs-of-clinical-negligence-in-trusts/)
2 See https://resolution.nhs.uk/category/case-of-note/
3 See NHS Resolution: Annual report and accounts 2022/23 (https://resolution.nhs.uk/wp-content/uploads/2023/07/4405-NHSR-Annual-Report-and-Accounts_Rollout_A_Access2.pdf)

Figure 12: Litigation rate for clinical claims from 2016/17 to 2024/25[1]



In 2024/25, 45 clinical and non-clinical claims were litigated to trial. In 60% of these the court agreed with our assessment on the merits of the claim and awarded no damages (compared with 66% in 2023/24).

Within the total number of clinical and non-clinical claims litigated to trial, 24 were clinical claims:

- in 62.5% (15) of these the court agreed with our assessment on the merits of the claim and awarded no damages. This compares with 59% (17) in 2023/24
- in 37.5% (9) of these there was an award of damages. This compares with 41% (12) in 2023/24.

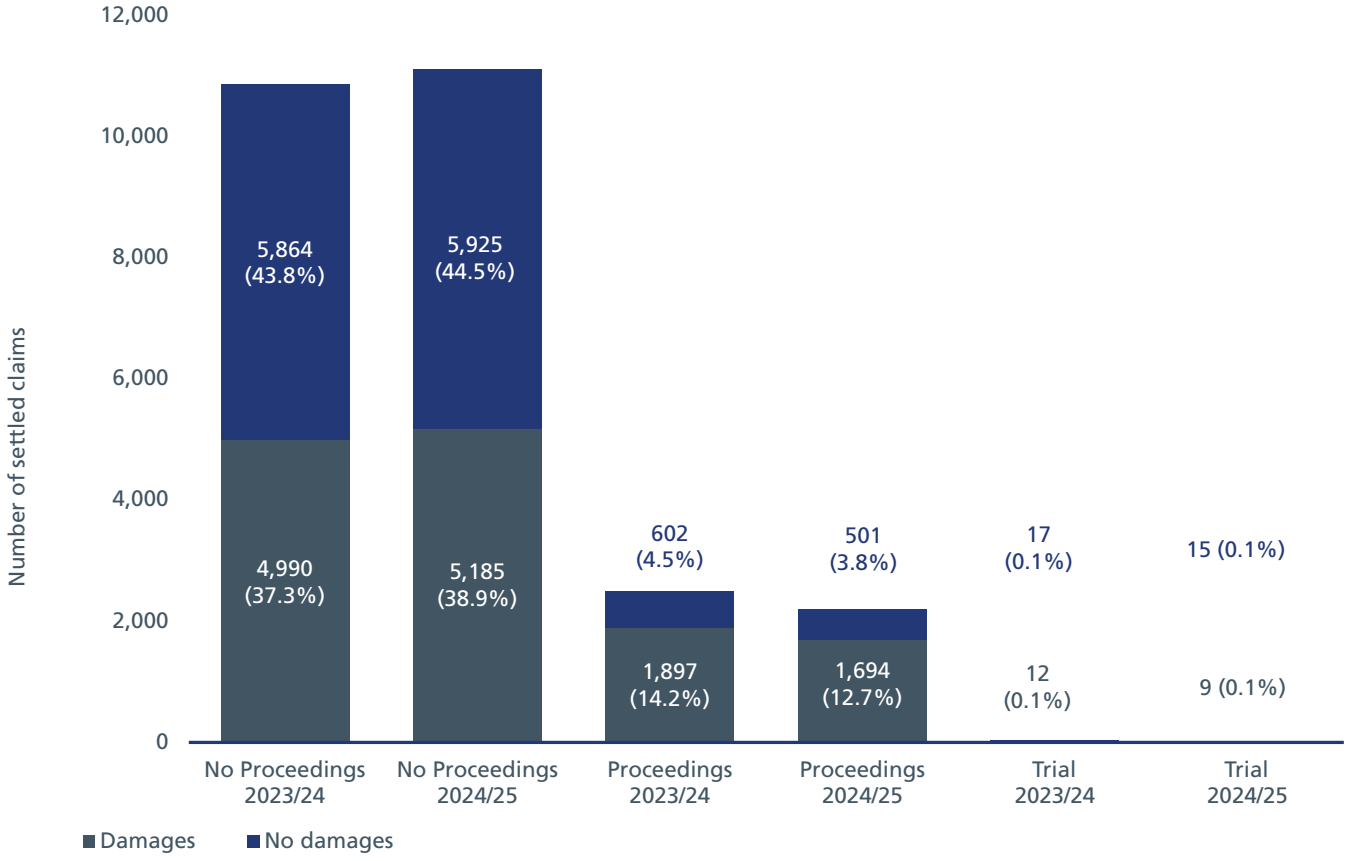
Within the total number of clinical and non-clinical claims litigated to trial, 21 were non-clinical claims:

- in 57% (12) of these the court agreed with our assessment on the merits of the claim and awarded no damages. This compares with 74% (17) in 2023/24
- in 43% (9) of these there was an award of damages. This compares with 26% (6) in 2023/24.

In all claims, seeking the input of the court was appropriate to ensure there was a fair outcome delivered for all parties.

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

Figure 13: The number of clinical claims resolved in 2023/24 compared with 2024/25, by settlement type, and with or without damages[1]

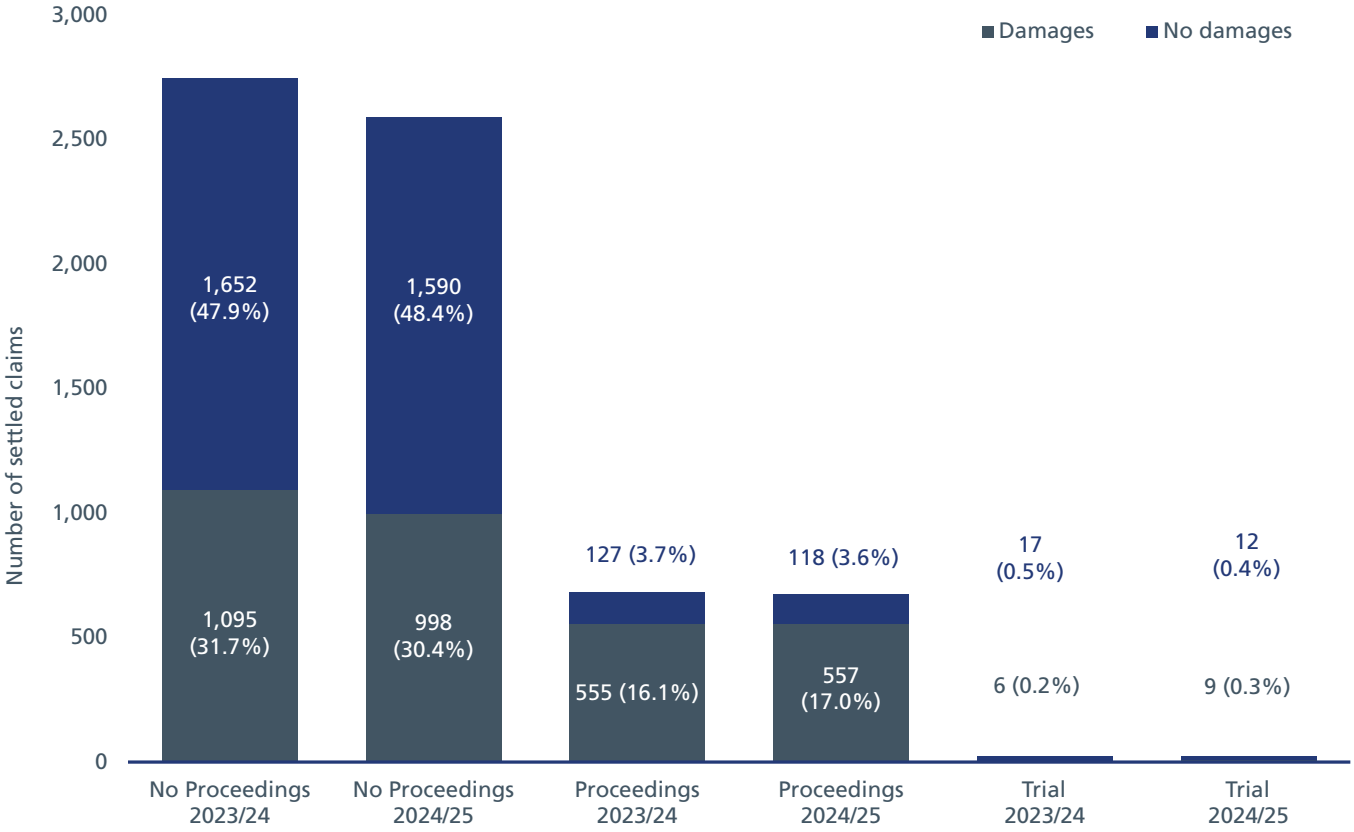


As figure 13 shows, the total number of clinical claims that resolved in 2024/25 decreased to 13,329 from 13,382 in 2023/24 (a decrease of 0.4%).

Of those, 52% resulted in a payment of damages, the same percentage as in 2023/24.

1 There has been a change in the resolved claims reported in 2023/24. Two claims that were reported as 'settled with proceedings' in 2023/24 have been updated to 'settled at trial'.

Figure 14: The number of non-clinical claims resolved in 2023/24 compared with 2024/25, by settlement type, and with or without damages



As figure 14 shows, the total number of non-clinical claims that resolved in 2024/25 decreased to 3,284 from 3,452 in 2023/24 (5%), as seen in figure 14.

Of those, 48% resulted in a payment of damages, the same as in 2023/24.

Dispute resolution options

Business plan objective: Enhance our approach to dispute resolution via resolution meetings, mediation, early neutral evaluation and stock takes.

In 2024/25, we continued to develop our use of these more empathetic methods of dispute resolution because they give us the opportunity to choose, in collaboration with the claimant, the most suitable course of action in each case, effectively addressing claimants' concerns and achieving satisfactory resolutions.

Resolution meetings

Resolution meetings allow the parties to explain their respective positions and are a useful way to discuss the strength and prospects of a claim. The process is particularly suited to claims where the merits of the case have been investigated and the issues in question are capable of being resolved between the parties with an open and constructive dialogue, often supported by a peer review.

In 2024/25, 162 claims with a damages reserve of under £150,000 were discussed in resolution meetings. Of those claims, 97 were resolved. Thirteen (8%) were resolved either on the day or within 28 days of the meeting and 84 (52%) went on to resolve after 28 days. The remaining 65 claims were not resolved. Of the claims that were discussed at a resolution meeting only eight (5%) went on to be litigated (as at 31 March 2025). In comparison, in 2023/24, 259 claims were discussed in resolution meetings with 105 being resolved (41%).

Mediation

Our mediation service provides access to an independent and accredited mediator and allows claimants, patients and their families to articulate concerns that would not ordinarily be addressed in other forms of dispute resolution. It also provides benefits to clinicians, allowing them to bring closure to historical concerns.

In 2024/25 a total of 138 claims proceeded to mediation with 73% of the claims settling on the mediation day or within 28 days of the mediation.

Stock takes

Stock take meetings allow us to work collaboratively, discuss the merits of claims with claimant firms and allow all parties to make better informed decisions about resolution.

In 2024/25 we held stock take meetings in relation to 40 claims. Of these claims, 39 went on to be resolved without the issue of formal proceedings and one was resolved after formal proceedings.

In comparison, in 2023/24 we held stock take meetings in relation to 45 claims. Of these claims, 39 went on to be resolved without the issue of formal proceedings and six were resolved after formal proceedings.

Early neutral evaluation

In April 2023, working in partnership with two claimant law firms, we launched a pilot to test the benefits and effectiveness of early neutral evaluation. This process involves the parties appointing an independent evaluator with specialist knowledge of the subject matter to give an assessment of the merits of their respective claims. The evaluation is non-binding and without prejudice, so no reference can be made in any proceedings to what happened in the early neutral evaluation process unless otherwise agreed by the parties. The final evaluations were completed in November 2024, and we hope to share the outcomes in a thematic review by the end of 2025.

Exaggerated or false claims

As the case study below shows, where there is evidence of a fabricated or exaggerated claim, we will always take steps to protect public funds and demonstrate to claimants the very serious consequences of submitting dishonest and exaggerated claims.

Case study: Lorry driver in dishonest NHS compensation case

Nigel Brown alleged he developed fibromyalgia because of a nine-year delay in diagnosing ankylosing spondylitis (AS). He claimed £2.3 million from Liverpool University Hospitals NHS Foundation Trust and Mersey and West Lancashire Teaching Hospitals NHS Trust to cover injuries, lost earnings, pension loss, care and assistance, accommodation, and other losses.

However, it became apparent that he was working for periods when he had claimed he was not. Brown was also convicted for drink-driving and suspended from driving in 2008. Despite being unable to work due to this conviction, he falsely claimed compensation for lost earnings during this period.

We presented evidence at trial revealing that Brown had provided false information about his employment history and earnings.

The Court found that Brown had been fundamentally dishonest about his claim and found in favour of the NHS trusts on all aspects of liability. The Court also awarded the trusts their legal costs of the action.

See further: NHS Resolution: Lorry driver in dishonest NHS compensation case[1]

Managing and enhancing our processes

- Business plan objective: Progress our claims mediation supplier tender.
- Business plan objective: Refresh our approach to the Covid-19 protocol.
- Business plan objective: Implement effective processes to manage any changes in the legal market.

We progressed the reprocurement of our mediation service, carrying out a competitive tendering process to ensure we obtained value-for-money services.

In August 2024, we implemented a new Clinical Negligence Claims Agreement for 2024. It built on the success of the Covid-19 Clinical Negligence Protocol and was developed in collaboration with key stakeholders, including Action against Medical Accidents (AvMA) and the Society of Clinical Injury Lawyers (SCIL).

The intention of the agreement is to encourage positive behaviours from claimant and defendant organisations and consistency of approach in practices across England, as well as support the resolution of more claims pre-action.

A new PIDR for England and Wales of +0.5% came into effect in January 2025.[2] We prepared thoroughly for any change to the rate and adjusted our claims management practices accordingly.

1 See https://resolution.nhs.uk/2024/10/03/lorry-driver-in-dishonest-nhs-compensation-case/
2 See GOV.UK: Personal Injury Discount Rate (https://www.gov.uk/guidance/personal-injury-discount-rate)

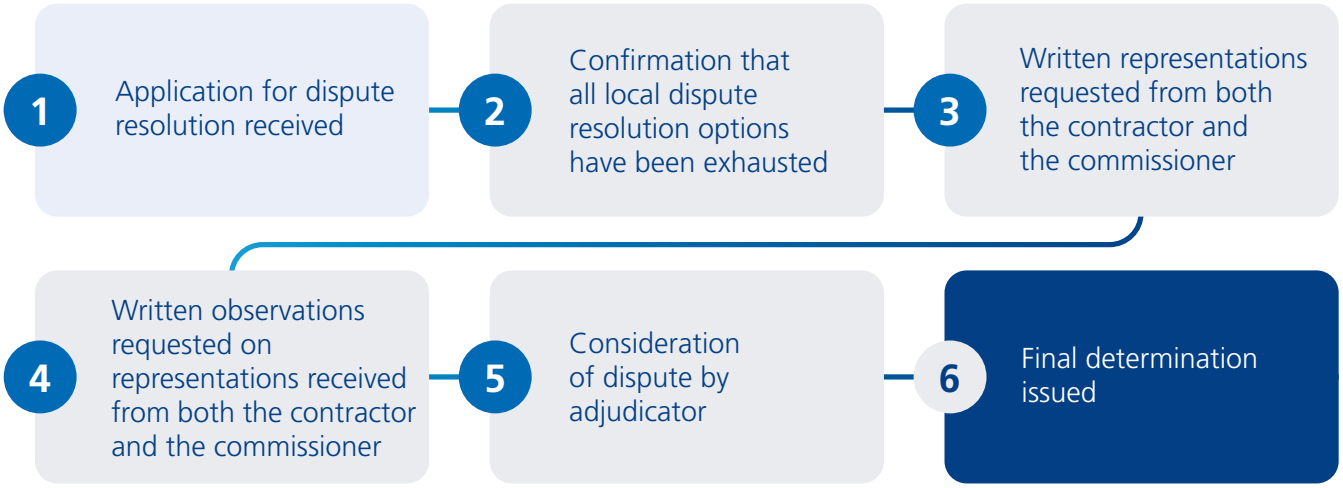
Resolving primary care contracting disputes

KPI 3: 80% of pharmacy appeals where the decision maker agreed with the recommendation of the case manager.

Our Primary Care Appeals service provides an impartial service for the resolution of appeals and disputes between primary care contractors or those wishing to provide primary care services and NHSE and/or ICBs. In 2024/25 the service has continued to deliver resolution in complex and contentious local circumstances, which have a direct bearing on the delivery of primary care services.

The Primary Care Appeals contracting disputes journey is summarised in figure 15.

Figure 15: Primary Care Appeals contracting disputes journey[1]



As seen in figure 16, in 2024/25, the service received 361 new appeals and dispute applications and closed 278 cases. This compares with 275 and 276 respectively in 2023/24, a 31% increase in new cases. However, in 2023/24, 132 appeals from two NHS community pharmacy companies were managed as two 'group' cases so the increase on a case activity basis was significantly higher.

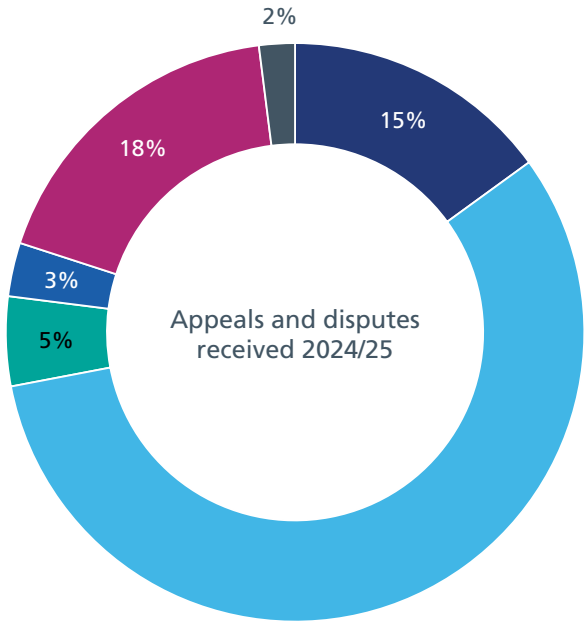
Increasing numbers of NHS community pharmacies are closing, but we are seeing more 'market entry' applications as companies seek to fill the gaps in provision. We have seen 131 cases in 2024/25 compared with 33 in 2023/24.

There has also been an increase in the number of pharmacy payment appeals where NHSE seeks to recover monies from contractors for services not provided, such as for medicines delivery, new medicines service and hypertension case finding. We received 63 cases in 2024/25 compared with 10 in 2023/24.

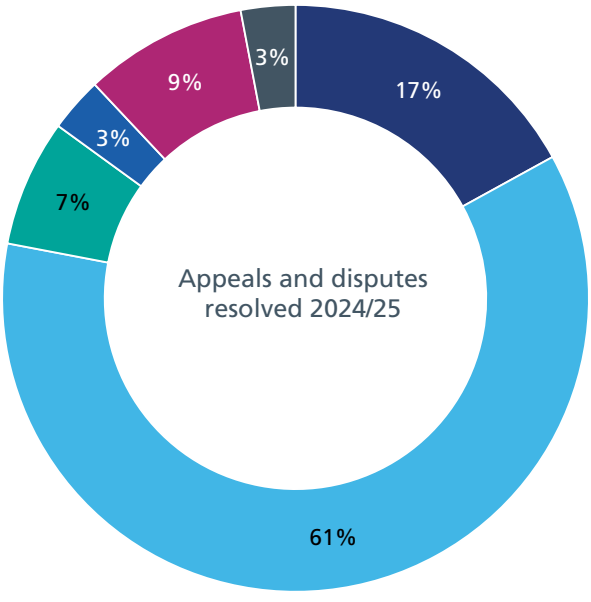
In December 2024, the Court of Appeal determined that Primary Care Appeals decisions affecting non-NHS contracts are open to judicial review.

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

Figure 16: Appeals and disputes received and resolved in 2024/25



- Pharmacy performance sanction appeals 55 (15%)
- Pharmacy market entry and change of listing appeals 207 (57%)
- Medical disputes 18 (5%)
- Dental disputes 11 (3%)
- Pharmacy overpayment appeals 63 (18%)
- PLR suspension payment appeals/consent to withdraw 7 (2%)



- Pharmacy performance sanction appeals 46 (17%)
- Pharmacy market entry and change of listing appeals 171 (61%)
- Medical disputes 20 (7%)
- Dental disputes 7 (3%)
- Pharmacy overpayment appeals 26 (9%)
- PLR suspension payment appeals/consent to withdraw 8 (3%)

Gaining feedback on our Primary Care Appeals service

Business plan objective: Gain feedback on our service to help inform service improvement and enhance user experience.

In 2024/25, to help inform service improvement and enhance user experience we conducted a stakeholder and service user survey on the effectiveness, efficiency and robustness of our Primary Care Appeals service.

We received an overall satisfaction rating of 86%. This is particularly noteworthy because, as an appellate function, our service decisions will always be adverse to one party and feedback has the potential to be influenced by those outcomes.

"Decisions are based on facts and evidence, they can objectively look at an appeal to see if the original decision was fair and followed due process, creating a level playing field for primary care."

Response to a stakeholder and service user survey on the effectiveness, efficiency and robustness of our Appeals service

Helping to resolve concerns relating to healthcare staff

- KPI 4: 90% of advice and other case interventions delivered within target timeframe.
- KPI 5: 90% of all exclusions/suspensions critically reviewed (where due).

Our Practitioner Performance Advice service provides impartial advice, assessment and intervention, training courses and other expert services to healthcare organisations to help them effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists.

We have continued to see increasingly high demand for case advice in 2024/25. We received 1,420 new and reopened requests for case advice, a 24% increase on 2023/24. Our open case load at the end of the financial year stood at 1,149, a 15% increase when compared with 2023/24. Despite the high demand, we continued to deliver a valued service to employers and contracting organisations, meeting KPI 4, which sets a timeframe for interventions. KPI 5, which sets a timeframe for reviewing exclusions/suspensions, was within tolerance. For more information on this, see Key Performance Indicators on page 26.

In 2023/24, requests for our assessment and remediation services, which help to clarify and understand the performance of individual practitioners and provide the healthcare organisation and practitioner with a sound basis upon which to bring the case towards a resolution, were at their highest for five years. In 2024/25 numbers have remained at a similarly high level, with 50 requests for professional support and remediation action plans, 44 requests for behavioural assessments, six requests for clinical performance assessments and four requests for team reviews.

Reviewing and developing our assessment and remediation services

- Business plan objective: Support the further development of our new IT system, CaseHub while developing organisational activity reports and Advice, Assessment and Remediation services.

In 2024/25 we undertook a comprehensive stakeholder analysis of our professional support and remediation service to evaluate users' experience and identify areas where processes could be improved. A working group was established to act on our findings and has already delivered a number of improvements.

We also undertook a thorough thematic analysis of our team review service to identify key areas for development. We will engage stakeholders to agree next steps and aim to complete the work in 2025/26.

For commentary on our work to develop organisational activity reports, see Strategic priority two on page 54.

For commentary on our work to support the further development of CaseHub, see Strategic priority four on page 67.

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

Our second strategic priority recognises that our unique datasets reveal vital insights that can be used to improve service delivery. We use our data in two ways: to share insights that improve service delivery and to identify and advise on emerging patient safety risks.

Sharing claims insights that improve service delivery

- Business plan objective: Share our insights in a range of ways and with a wide range of stakeholders across the healthcare system.
- KPI 6: Demonstrate engagement with the system to share learning products/services; respond to feedback on these; and review evidence of uptake/implementation.

We share our insights in a range of ways and with a wide range of stakeholders across the healthcare system, and measure our engagement as KPI 6.

Our focus for our member engagement events in 2024/25 has been on piloting a new strategic approach that emphasises joined-up and collaborative working across our teams, enhancing stakeholder engagement and resource efficiency both internally and externally. The approach has been well received and will be rolled out in full in 2025/26.

In 2024/25 we delivered more than 900 engagements that provided an opportunity to use claims data as a catalyst for improvement. Following these:

- 90% of respondents reported that their knowledge of NHS Resolution increased because of the engagement
- 93% of respondents reported that their understanding of how claims data can be utilised to support learning had increased because of the engagement
- 91% of respondents reported that following the engagement, they intended to disseminate the points raised with the wider organisation.

Our publications continue to support organisations to learn from the insights we can provide and gain practical strategies to drive future improvements in safety.

For example, our Neonatal jaundice case story[1] incorporated an analysis of the themes within claims data by applying the Systems Engineering Initiative for Patient Safety model that is part of the Patient Safety Incident Response Framework. The approach communicates key themes succinctly to both clinicians working on the frontline and midwifery academia.

1 See https://resolution.nhs.uk/learning-resources/neonatal-jaundice-case-story/

Our Learning from workplace violence claims within the NHS: A thematic review[1] shared insights from claims brought by NHS staff who have experienced workplace violence exhibited by patients in their care. The content was further informed by engagement with key system stakeholders and identified six areas of future focus for NHS provider organisations to support the prevention of workplace violence while also highlighting the importance of responding compassionately when workplace violence does occur.

We supported the development and delivery of the national patient safety syllabus by embedding our resources and unique perspectives into curriculum materials. More widely, we continued to promote our learning resources and, in total, there were 59,327 active users of the Resources[2] section of our website in 2024/25. A selection of all the resources we provided in 2024/25 is in figure 17 on page 57.

Supporting organisations to manage concerns

In 2024/25, we continued to work to provide healthcare organisations with the knowledge and skills to identify and manage performance concerns locally. As part of this, we welcomed six Associate Advisers for Education to boost our capacity to deliver educational programmes aimed at building knowledge and capability in handling complex performance cases.

KPI 7: 90% of delegates rate the workshops not less than 4 out of 5 for overall quality.

We delivered 60 educational workshops to 885 delegates, sharing learning and the embedding of good practice derived through casework. We achieved KPI 7 in relation to this, which requires 90% of delegates to rate the workshops not less than 4 out of 5 for overall quality.

We trialled a Board Level Assurance for Resolving Performance Concerns workshop to support boards to seek their own assurance in reviewing their role in resolving performance concerns.

We collaborated with the Yorkshire and Humber Improvement Academy (YHIA) to facilitate a pilot Just Culture Workshop in February 2025, which was attended by 35 board members from 18 trusts in the Yorkshire and Humber region. The workshop supported delegates to better understand their role in fostering just and learning cultures within their organisations, introduced tools to assess the actions required to foster such a culture and provided an opportunity to develop a peer network. We will be working with our YHIA colleagues to evaluate the workshop, using the feedback to inform future activity including developing a shared definition of a just and learning culture and taking action to embed this across healthcare. The workshop builds on our *Being fair* work, which acts as a resource for organisations looking to adopt a just culture when managing incidents and supporting staff.

Similarly building on our *Being fair* work, we collaborated with NHSE's Professional Standards team to develop Fairness and Proportionality: Principles and framework for healthcare organisations managing performance concerns.[3] Initial feedback indicates the resources have been welcomed and adapted by provider organisations to their local circumstances.

"The British Islamic Medical Association supports this framework which we believe will foster better fairness and proportionality of case management at a local level. This framework empowers local trusts to ensure a quick resolution of cases which we know cause great distress to our workforce. 50% of all doctors are from an ethnic minority background and a significant proportion are IMGs. We can not afford to continue to discriminate and disadvantage them and further decrease the morale of the NHS. This framework is a welcomed tool to start our journey towards a fair process for all."

British Islamic Medical Association

1 See https://resolution.nhs.uk/resources/learning-from-workplace-violence-claims-within-the-nhs-a-thematic-review/
2 See https://resolution.nhs.uk/resources/
3 See https://resolution.nhs.uk/learning-resources/fairness-and-proportionality-principles-and-framework-for-healthcare-organisations-managing-performance-concerns/

We also strengthened our collaboration with NHSE's Professional Standards team to support the resolution of concerns for primary care practitioners.

We worked with a new cohort of organisations to develop Compassionate Conversations in relation to performance conversations to support kindness and compassion within the NHS.

We published five Insights papers, as well as our first 'expert view' Insight: Informal First – the value of informal resolution and how Advice can support you.[1] In each case, the aim has been to reflect on what our casework data tells us and offer practical strategies that enable organisations to take a data-led approach when managing and resolving performance concerns.

We continued to deliver our organisational activity reports (OARs), which allow organisations to analyse and reflect on trends over time and consider actions in relation to managing performance concerns and remediation.

We delivered OARs to 18 secondary care trusts in England, offering follow-up consultations with a Performance Practitioner Advice adviser to each of them. We finalised reports for primary care trusts, mental health trusts and trusts in Wales and Northern Ireland. These will be delivered in 2025/26.

1 See https://resolution.nhs.uk/2024/09/26/informal-first-resolution-how-advice-support/

Figure 17: A selection of the products developed in 2024/25 in order to share our insights

- Lifecycle of a clinical negligence claim in general practice: infographic and FAQs
- Virtual forums
  - Patient safety in primary care remote consultations
  - Dispelling the myth: towards safer practice
  - Taking action to improve patient safety in primary care
  - Digital Innovation in Healthcare
  - Complex Mental Health Presentations in Pregnancy: care, capacity and the role of the court
  - South Region Safety and Learning Networking Forum
  - Midlands and East Region Safety and Learning Networking Forum

Publications

- Collaboration for safer and sustainable maternity care in the South West region
- Case stories
  - Use of intermittent auscultation for intrapartum fetal surveillance
  - Fetal growth restriction
  - Communication and language challenges when English is not a mother's first language
  - Placental abruption
  - Consideration of meconium as a risk factor in labour
  - Neonatal jaundice
  - Suspected 'large for gestational age' baby
- Claims scorecards
  - Interactive claims scorecards for our CNST and LTPS schemes for each of our 217 member trusts

Managers

Virtual events

- Capsticks: Clinical Negligence Claims Agreement 2025: a collaborative approach
- Workshop
  - Case Manager Secondary Care

Publications

- Informal First – the value of informal resolution and how Advice can support you
- Fairness and Proportionality: Principles and framework for healthcare organisations managing performance concerns
- Insights
  - Practitioner and healthcare organisation experiences of Professional Support and Remediation action plans
  - Demographics, professions and concerns: Patterns in Practitioner Performance Advice cases with a focus on international medical graduates (IMGs)
  - Learning from workplace violence claims within the NHS: A thematic review
  - Learning from staff claims relating to exposure of substances hazardous to health
  - Trends from Practitioner Performance Advice's support of the management of exclusions in England

Families

Virtual resources

- The Early Notification scheme animation
- Support information for engagement with families for whom English is not their preferred language

Our 'recommendation to implementation' emergency medicine tool

- Business plan objective: Continue to progress our innovative 'recommendation to implementation' work.
- Business plan objective: Work closely with the DHSC, other Government departments and other arm's length bodies, contributing our data and expertise.

Our Recommendation to Implementation emergency medicine tool was designed to provide practical support to staff in aligning and prioritising safety recommendations from external bodies such as NHS Resolution alongside existing work. The tool was piloted with ten emergency care departments in 2023/24, and feedback demonstrated its value.

In September 2024, it was highlighted as a case study in R*ecommendations but no action: improving the effectiveness of quality and safety recommendations in healthcare*, which was published by HSSIB and ALB members of the Recommendations to Impact Collaboration Group. We are one of the ALB members and our Chair, Sally Cheshire, is the group's ALB Chair sponsor.

We have now concluded the pilot and are working as part of the cross-ALB group to feed in learning that may be relevant to the development of a broader recommendations platform.

Identifying and advising on emerging patient safety risks

- KPI 8a: Demonstrate that concerns raised through our Significant Concerns Group have included relevant qualitative information.
- KPI 8b: Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken (combination of appropriate steps and actions completed).
- KPI 8c: Demonstrate that concerns raised through our Significant Concerns Group have appropriate steps taken in a timely way.

The data we hold can sometimes suggest evidence of harm or potential harm (for example, unsafe clinical practice).

When this happens, our Significant Concerns Framework allows us to consider sharing information with relevant NHS bodies or regulators. The Framework is overseen by our Significant Concerns Group, and its activity is monitored as KPIs 8a, 8b and 8c. In 2024/25 there was a continued focus on the operationalisation of the Framework within business-as-usual activities across the organisation.

Strategic priority three: Collaborate to improve maternity outcomes

Our third strategic priority emphasises the importance of playing our part to improve maternity and neonatal outcomes and using our data to support the Government's maternity safety ambition to halve rates of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or shortly after birth, by 2025.[1]

Business plan objective: Continue to support the Government to deliver its maternity safety ambition and, where relevant to our work, the Women's Health Strategy.

We recognise that avoidable errors in maternity and neonatal services still occur and that incidents have devastating consequences for the child, mother and wider family, as well as the NHS staff involved.

We can never reverse the damage that has been caused but we can play our part to support those affected by these incidents and bring in measures to improve maternity and neonatal care in the future. We can also support the wider maternity and neonatal system through continuing our work to foster a just and learning culture, supporting cross-system action to address maternal and neonatal health inequalities, and evolving our processes to identify, share and escalate insights and concerns.

Our Early Notification (EN) scheme gives families more timely support, gets compensation to them more quickly and takes learning back into the system. Our Maternity Incentive Scheme (MIS) is a financial incentive programme designed to enhance maternity safety within NHS trusts. In 2024/25 we have continued to enhance these schemes. We have also begun the process of evaluating them to ensure they are delivering effectively on their aims.

Although secondary to the human impact, errors can also result in a significant financial cost to the NHS. As figures 18 and 19 highlight, obstetric claims accounted for 11% of clinical claims reported by volume (excluding GPI) but accounted for 53% of all clinical claims by value received in 2024/25 (excluding GPI), compared with 57% in 2023/24.. These include claims reported under our EN scheme on page 63. A breakdown of the financial value of obstetric claims is shown in figure 20.

1 See GOV.UK: Safer maternity care: progress and next steps (https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps)

Figure 18: Total number of clinical claims received in 2024/25 by specialty (excluding GPI)[1]

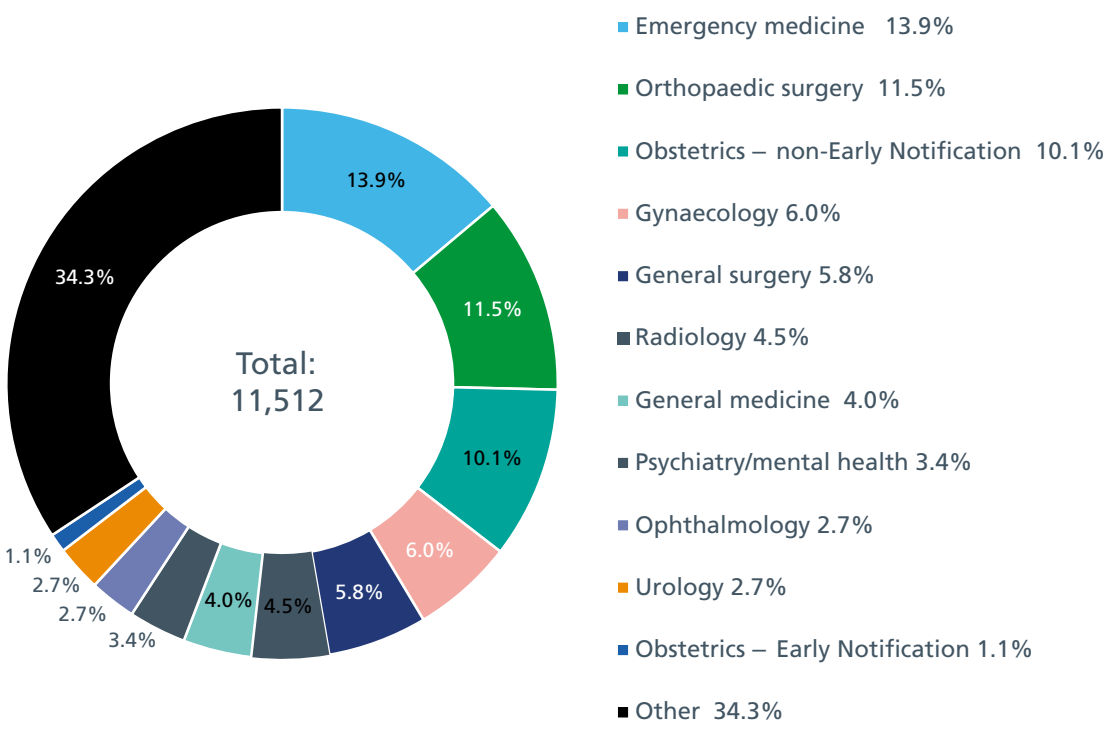
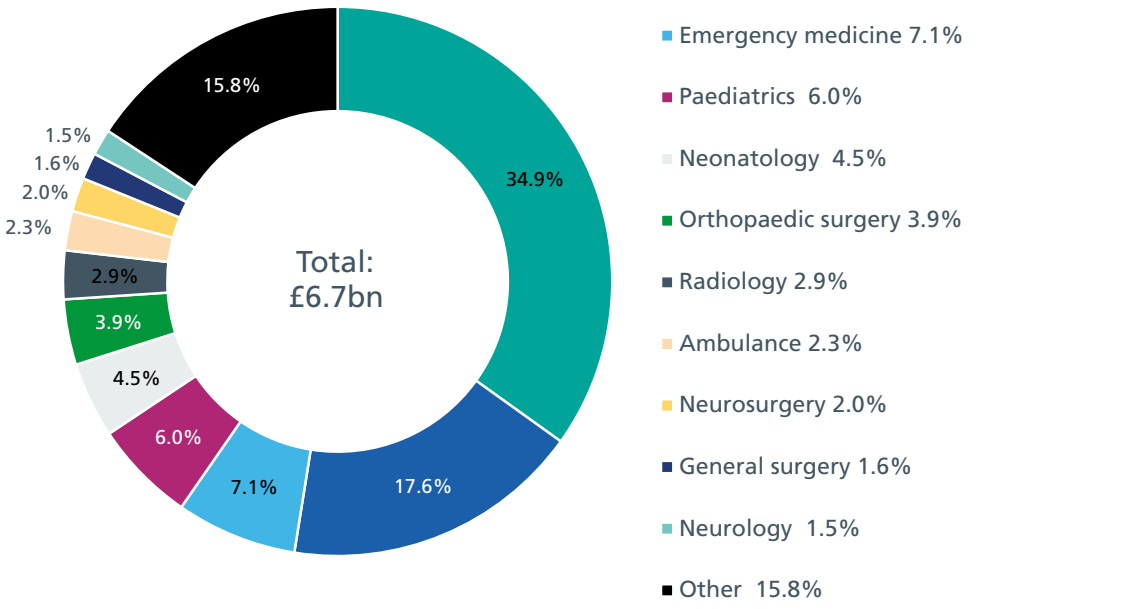


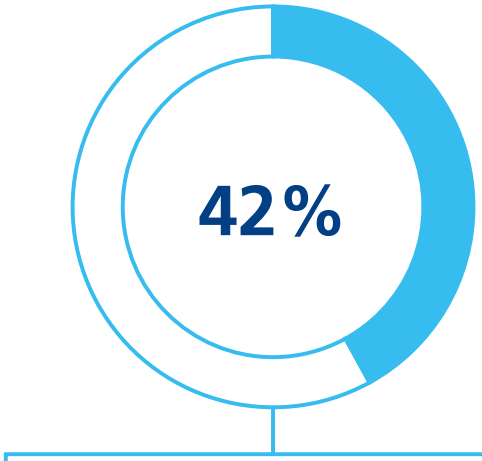
Figure 19: Total value of clinical claims received in 2024/25 by specialty (excluding GPI)[2]



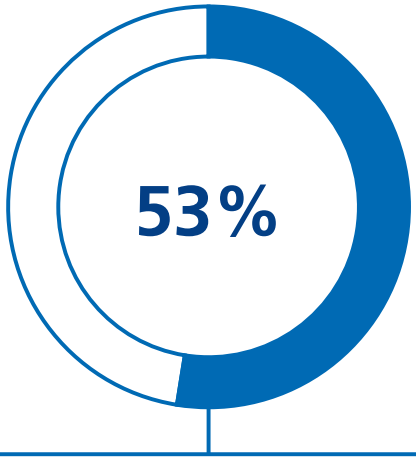
1 Figure 18 includes all claims received against our CNSC, CNST, DHSC clinical and ELS schemes. It does not include claims received against our GPI scheme. Obstetric care is defined as the care of women during pregnancy, childbirth and the period following delivery (typically 3–6 weeks).

2 Figure 19 includes all claims received against our CNSC, CNST, DHSC clinical and ELS schemes. It does not include claims received against our GPI scheme.

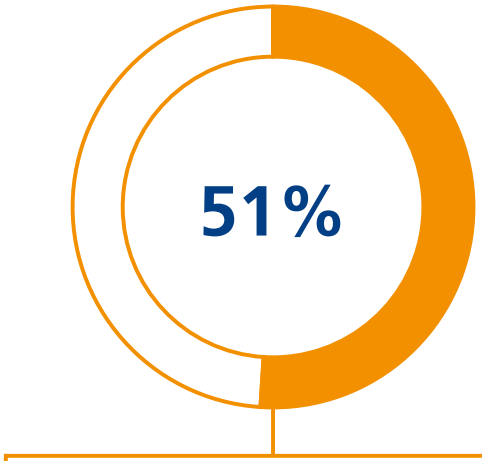
Figure 20: The financial value of obstetric claims as of 31 March 2025



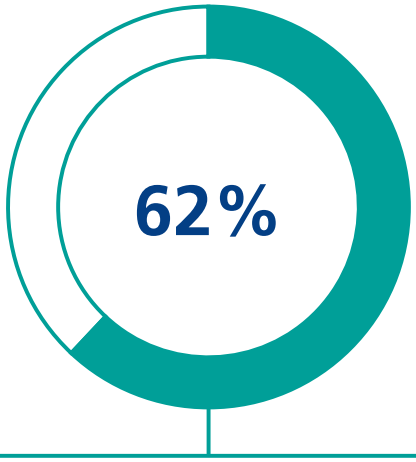
42% (£1.3bn) of the total clinical negligence payments (£3.1bn) in 2024/25 related to maternity. This is 1% higher than reported in 2023/24.



53% (£3.5bn) of notified claims by value, excluding GPI (£6.7bn) in 2024/25 related to maternity. This is a decrease from 57% reported in 2023/24.



51% (£2.5bn) of the total clinical negligence cost of harm (£4.9bn) relates to maternity. This is an increase from 49% in 2023/24.



62% (£37.5bn) of the total clinical negligence provision (£60.0bn) relates to maternity. This is the same percentage as reported in 2023/24.

Working to ensure families receive compensation more quickly

The Early Notification scheme

We launched the EN scheme in 2017 to proactively support the National Maternity Safety Ambition to halve maternal and neonatal deaths and reduce significant harm.

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

You can see where our EN scheme intervenes before notification in our claims in figure 3: Clinical claims journey on page 32.

Figures 21 and 22 provide an overview of the year-on-year movement in the volume and value[1] of cerebral palsy/brain damage claims over the last ten financial years. Since the introduction of the EN scheme in 2017/18, the number of non-EN scheme cerebral palsy/brain damage claims being notified is lower, as expected.

The total number of obstetric cerebral palsy/brain damage claims identified across our EN scheme and other clinical schemes, when combined, shows some fluctuation between the years (as shown in figure 21). This is due to changes in the criteria for entry into the EN scheme and the fact that incidents can occur across a range of different years. The reporting pattern is therefore as expected.

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

Figure 21: The total number of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2015/16 and 2024/25[1]

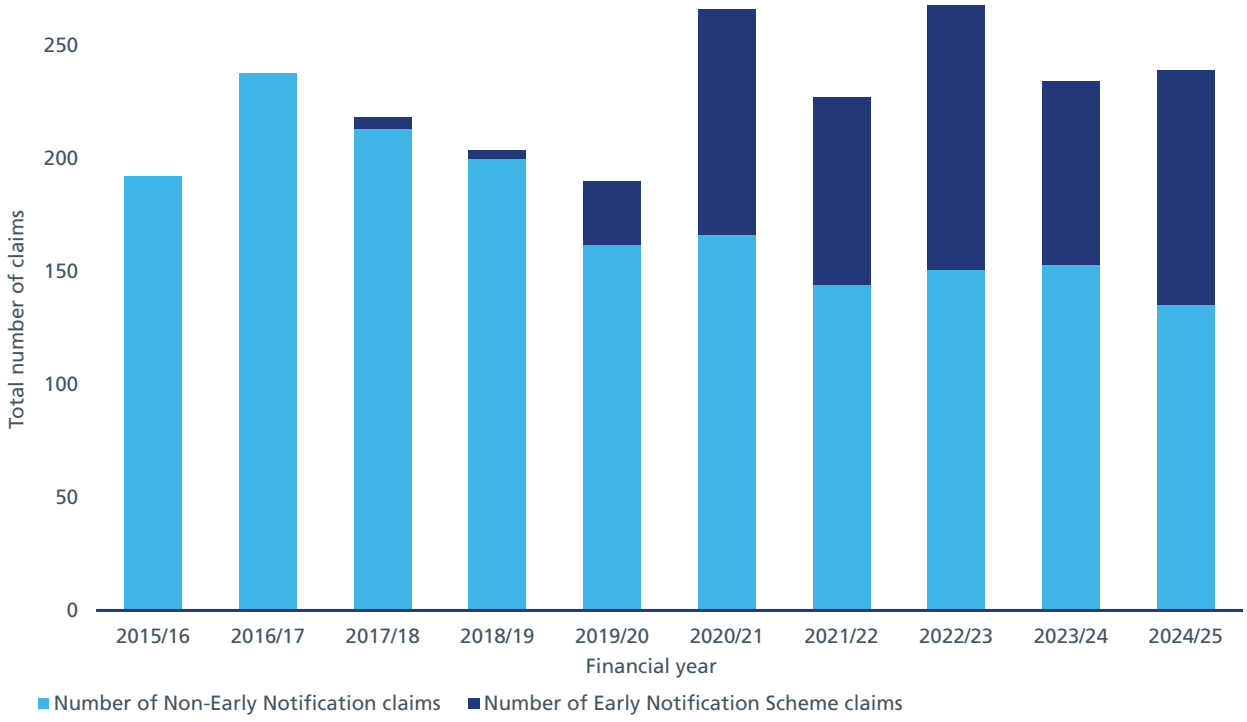
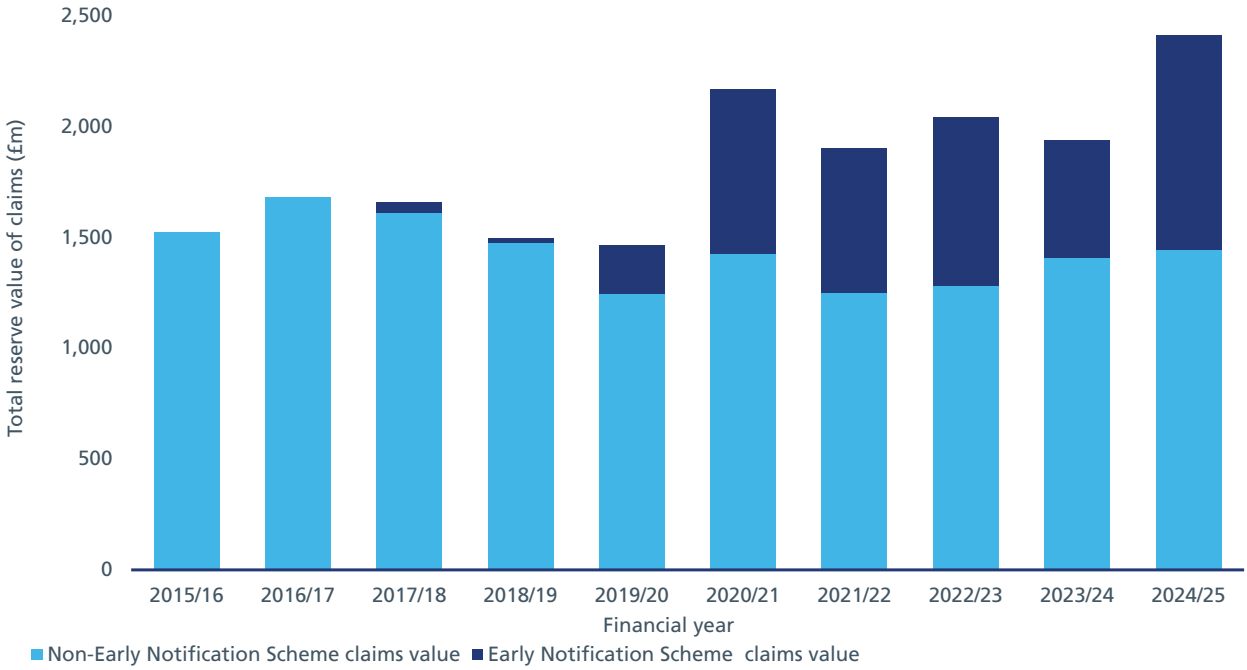


Figure 22: The total reserve value of obstetrics cerebral palsy/brain damage claims reported in each financial year across all clinical negligence schemes between 2015/16 and 2024/25[2]



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

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

Business plan objective: Continue to develop our processes to ensure families receive compensation more quickly.

KPI 9: Reduction in the time from notification to a decision on entitlement to compensation of an Early Notification Scheme case compared to a similar cerebral palsy case received via the traditional claims route.

KPI 10: Early Notification clinical review within 30 days of acceptance within the Early Notification Scheme.

In 2024/25, we achieved KPI 9, a reduction in the time from notification to a decision on entitlement to compensation of an EN scheme case compared to a similar cerebral palsy case received via the traditional claims route, and KPI 10, which requires 100% of eligible cases to receive an EN clinical review within 30 days of acceptance within the EN scheme.

We also piloted several new ways of working more collaboratively across NHS Resolution and with families and lawyers to ensure we can get earlier support and compensation to families.

For example, upon admission of liability, we offer the family an immediate interim payment to go towards needs such as counselling, aids and equipment. Court approval is retrospectively sought for this amount.

We offer to arrange an immediate needs assessment with a case manager. The assessment allows the family to tell us about their needs and, along with a review by a clinical paediatrician, enables us to make more substantive interim payments that allow families to pursue therapies or rehabilitations that will help them look after their child.

Engaging with families

Business plan objective: Continue to improve engagement with families.

We continue to develop the EN scheme too, by listening closely to feedback from families and NHS trusts to inform our approach and improve the quality of our engagement.

In April 2024 we launched an enhanced family engagement process, which means that for babies born on or after 1 October 2023, we communicate directly with families at multiple points throughout the EN process.

We offer an initial pathfinder meeting where we invite the family to a meeting with their representatives, NHS Resolution and trust staff. In many of the cases, such meetings provided an opportunity to foster better relations between the parties, leading to an improved experience for families.

We launched an animated introduction to the EN scheme. It was co-designed with our Early Notification Maternity Voices Advisory Group and a group of parents via Peeps, a UK charity dedicated to supporting those affected by hypoxic-ischaemic encephalopathy (a lack of oxygen to the brain that can cause injury). We procured a professional language service in June 2024, which allows us to engage with families in their preferred language. By 31 March 2025 we had translated resources into 11 languages, including an Easy Read translation.

Continuing to deliver the Maternity Incentive Scheme

The Maternity Incentive Scheme

The Maternity Safety Strategy set out DHSC's ambition to reward those who have taken action to improve maternity safety. We support this work through our Maternity Incentive Scheme (MIS).

The MIS is an incentive fund that charges trusts an additional 10% of their maternity contribution to the CNST indemnity scheme. Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services recover their 10% contribution and also receive a share of any unallocated funds. Trusts that do not meet all ten safety actions do not recover their contribution but may be eligible for a smaller discretionary payment to help them make progress against any actions they have not achieved. Trust submissions are checked against CQC findings in addition to a range of other external verification points.

The MIS's work is supported by our Collaborative Advisory Group (CAG), which brings together other arm's length bodies and the royal colleges. Members of the group include DHSC, NHSE, Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Neonatal Clinical Reference Group, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists, the Care Quality Commission and the Maternity and Newborn Safety Investigations (MNSI) programme.

Business plan objective: Continue to deliver the Maternity Incentive Scheme, aiming to improve the scheme to ensure it focuses on supporting harm reduction.

KPI 11: Maternity Incentive Scheme reverification – 90% of reverification processes completed within their respective predefined timescales.

In April 2024, we published full guidance for year six of the MIS. It included a voluntary audit and compliance tool to allow trusts to track progress with the actions, and record when supporting evidence has been approved and where it is saved.

All NHS hospital trusts delivering maternity care in England participated in year six of the MIS.

At least 84% of trusts were found to be fully compliant with all elements of the scheme (with four results pending). This is an increase on the compliance rate for year five of the scheme, which was 77%. For those trusts unable to achieve all ten safety actions this year, more safety improvement funding has been made available under the terms of the MIS to support them on their improvement journey.

The MIS includes an internal key performance indicator which measures the timeliness of reverification activity. This sets a standard for completing reverification processes within predefined timescales for 90% of all cases. Since its introduction, we have consistently met this standard, achieving completion within the required timeframe for a minimum of 95% of all reverification cases. We monitored this standard as KPI 11 in 2024/25.

In April 2024 we launched an NHS Resolution FutureNHS workspace. It includes information and a forum for queries about each action, as well as information and resources designed to support MIS compliance.

It is evident from our work that despite ongoing challenges, trusts are committed to improving the standards of quality and safety in their maternity and neonatal services, and we have observed a significant improvement in the quality of reporting over the life of the MIS.

However, recent national maternity inquiries and reports all highlight issues with Board reporting and governance. These themes are also often evident in trusts that fail MIS reverification.

To address these issues, we designed an Interactive Board Reporting Workshop. The focus is on defining 'what good looks like' by sharing knowledge and experiences, providing examples of (fictitious) Board reports for open discussion, and on guiding trust Boards towards an assurance rather than reassurance-based process.

Workshops have been held in Manchester and Devon. Feedback has been overwhelmingly positive, and we are receiving requests to deliver further workshops.

We continue to attend regional perinatal quality and safety committees and are core members of the National Perinatal Safety Group to share insight regarding trusts of concern and escalate any emerging concerns from our own data to support a collaborative and aligned approach.

Evaluating the EN scheme and the MIS

Business plan objective: Complete the evaluation of EN and the MIS.

In May 2024, we announced a collaboration with The Healthcare Improvement Studies Institute (THIS Institute) at the University of Cambridge to support the evaluation of the EN scheme and the MIS to assess their effectiveness against their objectives.

We originally intended to complete both evaluations and report on them in 2024/25. However, to allow enough time for incorporating in-depth stakeholder views in these sensitive areas (including ethical approvals where required) we will now report on the results in 2025/26.

In the meantime, as this section shows, we are continuing to evolve both schemes to support families and trusts in this vital area.

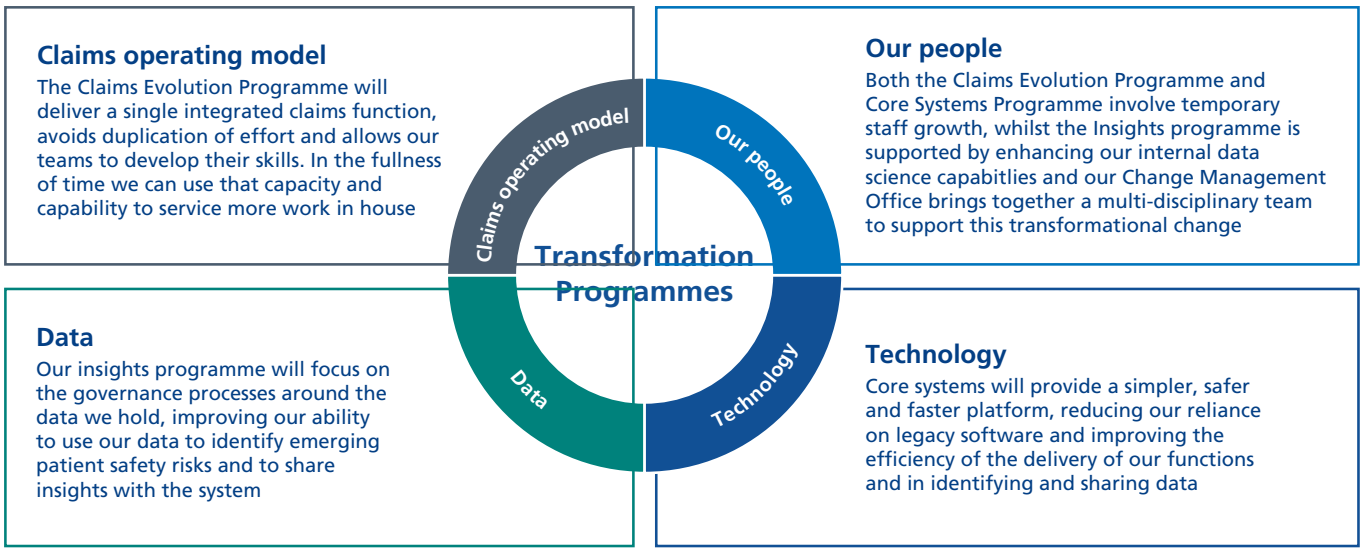
Strategic priority four: Invest in our people and systems to transform our business

Our fourth strategic priority focuses on developing our people, systems and services so that we can realise the ambitions of priorities one, two and three, and continue to deliver best value for public funds. As this priority reaches its conclusion and our transformation programmes complete, our focus will shift to embedding new ways of working into business as usual, while also identifying and implementing continuous improvement initiatives that will further enhance our efficiency and effectiveness to deliver best value to the wider NHS.

2024/25 has also seen us undertake work to support the Government's strategic shift from analogue to digital and reforms to drive efficiency and productivity as outlined in *Road to recovery: the government's 2025 mandate to NHS England.*

We have continued the process of moving to NHS.net Connect and will complete the transition in the next financial year. We are making the first steps towards being able to leverage the data centrally by NHS to support our data insights work through the NHS England Data Access Service (DARS).

Figure 23: Transformation programmes



The transition to CaseHub

- ✓ Business plan objective: Support the implementation and development of CaseHub.
- ✓ Business plan objective: Continue to progress all workstreams associated with the Claims Evolution Programme.
- ○ KPI 12: General Practice Indemnity Schemes and Clinical Negligence Scheme for Trusts claims being managed on CaseHub by the end of the financial year.

CaseHub is a cloud-based system that will replace our legacy case management systems. Over time, the new system will make it easier to interact with NHS Resolution and enable us to leverage new technology, including AI and digital tools that will drive further efficiencies in our work and improve how we analyse our data.

In 2024/25 we completed the migration of our Practitioner Performance Advice service to the new system. We have adopted a continuous improvement model to ensure we can continually enhance the service, implementing regular updates, fixes and optimisations based on user feedback that make the platform easier and quicker to use.

We migrated the administration of our Healthcare Professional Alert Notices to CaseHub in February 2025 and will migrate the administration of Performers List Applicants in April 2025. The services, which are being renamed NHS Resolution Performer and Healthcare Professional Check as part of the move, provide an additional safeguard for employers during the pre-employment checking process for healthcare professionals and medical, dental, and ophthalmic practitioners.

We have also begun the integration of our systems with the forthcoming Single Perinatal Event Notification (SPEN) service. This service will simplify the reporting of incidents across the NHS by providing a single platform for trusts to notify NHS Resolution's EN scheme, Maternity and Newborn Safety Investigations Special Health Authority (MNSI), MBRRACE-UK and trusts' own Child Death Overview Panel about specific instances in near-real time.

Work required to migrate our Claims Management service to the platform is now largely complete. However, recognising the transformation work also going on as part of the Claims Evolution Programme (CEP), we have intentionally paused the migration until early in 2025/26. While this means we did not achieve KPI 12, it reflects our robust approach to transformation which combines delivering vital change with agile planning and phasing that minimises the impact on business-as-usual activity.

We have already begun planning for the migration of our Primary Care Appeals service with the intention of this being complete by the end of 2025.

The development of CEP

Our CEP programme is building a target operating model that will help us reduce the money we spend on external legal suppliers.

CEP is reliant on the effective training and engagement of key stakeholders from across the claims landscape to ensure they are equipped with the knowledge and skills to navigate new ways of working.

In 2024/25 we have continued to leverage our regional model, running a series of regional engagement events that allow us to share and discuss regional insights from across our range of services.

We now have case managers in each region capable of running claims in-house across the end-to-end pre-litigation process, assessing eligibility for compensation and driving timely and fair resolution in line with our strategic priority to manage cases outside of the litigation process where appropriate.

The pre-litigation service will be expanded throughout 2025/26 as we increase the scope to other types of work. We will also continue to explore the potential to further reduce our use of external legal suppliers through direct sourcing.

Managing claims in-house would not be possible without our Claims Support Service (CSS), a centralised team that provides expert administrative support to free up our case managers to focus on technical claims management. In 2024/25, we have continued to embed the CSS model and CSS staff now provide support with key elements of the pre-litigation claims process.

Sustainability report

NHS Resolution reports on climate-related financial disclosures consistent with HMT's Task Force on Climate-related Financial Disclosures (TCFD)-aligned disclosure application guidance, which interprets and adapts the framework for the UK public sector. We have complied with the TCFD recommendations and recommended disclosures in a proportionate manner and in line with the implementation timetable. Where we have not disclosed information it is because data is not available to us or the disclosure requirement is not relevant to our activity.

We provide regular quarterly reporting to the Board on our carbon emissions via the Greening Government Commitments (GGC) template and annually, along with other sustainability metrics, via the Sustainability report in the Annual report and accounts. This Sustainability report has been reviewed and signed off by the NHS Resolution management team and Board.

In 2024/25, we developed a Sustainability strategy, setting out our commitment to continue to follow best practice on how to improve our environmental sustainability, working with our partners in central government and the NHS.

Through our risk management processes we considered potential impacts pertaining to climate change, this included our impact on the environment, direct or indirect impacts to us, as well as matters that are within our control to manage. At present, we have no principal risks relating to climate change and therefore no climate-related targets have been set. However, we recognise it is important to mitigate the effects of climate change on delivering our core business as well as our impact on the environment.

To help achieve NHS net zero and to ensure mitigations against the impact of climate change on our organisation and the work we do, our principles therefore are:

1. To reduce NHS Resolution's carbon footprint by:
    a. Engaging with our landlords to encourage reduction in environmental impact, including energy use, in our two shared office locations.
    b. Continuing to reduce our energy consumption through our ongoing cloud technology journey, adopting existing NHS mail services and closing our physical datacentres.
    c. Using energy efficient equipment such as computer monitors and reducing technology waste production through reduced numbers of mobile phones in service.
    d. Continuing to reduce business travel, making use of alternative meeting methods and encouraging most business travel to be completed using public transport.
    e. Continuing to work with all NHS Resolution teams to further reduce our paper, printer and toner usage.
    f. Engaging with staff on ways to reduce personal carbon impact via our Sustainability network.
    g. Encouraging staff who are commuting to move away from single occupancy journeys in fossil fuel powered cars towards more sustainable journeys, e.g. through the provision of cycling-related employee benefits.
2. To increase sustainability throughout our business practices and functions by:
    a. Procuring an environmentally responsible equipment disposal service, so that equipment is, where possible, re-used for alternative purposes, or recycled at the end of its life.

b. Developing a Sustainability Impact Assessment (SIA) procedure that requires NHS Resolution policy development, our suppliers, and procurement systems to consider the five Government Environmental Principles. Such changes will come into effect gradually as existing contracts expire and are renewed through competitive procurement processes.

3. To mitigate the effects of climate change on delivering our core business by:

   a. Considering sustainability risks and opportunities by building on our risk management framework.

   b. Enhancing our Business Impact Assessment processes to ensure our business resilience and response plans enable us to deliver our core business services where environmental events arise.

During the year we consolidated our progress to date to reduce our impact on the environment, focusing on areas where we as an organisation can have a direct impact on increasing our sustainability and reducing our emissions.

We will report to Board on a regular basis using the below metrics, providing an overview of what we have achieved against the sustainability strategy. The reports will be to note at Board meetings and have a dedicated discussion once a year. There will be a nominated member of Board responsible for this area of work.

Data published for the financial years 2021/22 to 2024/25[1]

Table 3: Greenhouse gas emissions in each financial year from 2021/22 to 2024/25[2]

Greenhouse gas emissions (tonnes CO_2)	2021/22	2022/23	2023/24[3]	2024/25
Gross emissions for scope 2 Gas	1.5	1.9	10.85	6.81
Gross emissions for scope 2 Electricity	116.4	117.3	95.86	122.1
Gross emissions for scope 3 Business Travel	5	20	26.11	32.58

We are a hybrid organisation, with both home-workers and office-based staff. We occupy shared office space in line with Government recommendations. Our main activities operate from two Government Hubs: 10 South Colonnade, London (Head Office) and 7&8 Wellington Place, Leeds.

Both offices are leased as serviced offices, with both landlords (the Government Property Agency and His Majesty's Revenue and Customs respectively) taking primary responsibility for providing gas, electricity, and water and waste services. Our occupancy represents a very small percentage of the total properties (part occupancy of floors representing around 4% and 1.88% respectively of the estates).

As such, we do not have scope 1 emissions. We have not set reduction targets because we have limited control over the majority of our carbon emissions, which relate to building energy consumption and waste, although we do monitor these on a regular basis. We have not yet set baseline years for data.

However, we recognise that, although we are not directly responsible for the management of these services, our operational activities and use of resources have an impact on our landlords' own net-zero initiatives and GGC targets. We participate in regular meetings with our landlords where these are held. Our contribution to the GGC to reduce greenhouse gas and emissions continues to support the Estates and Operations strategy set by DHSC and the GPA's Net-Zero Estates Strategy.

The year-on-year reduction in gas emissions reflects the installation of air source heat pumps to replace gas-powered heating in Q4 at 10 South Colonnade. The year-on-year reduction in electricity emissions reflects upgrades to the mechanical plant and building systems at 10 South Colonnade which have increased the building's efficiency.

1 Sourced from GPA and external suppliers. All figures (including for prior years) have been stated in KWh (where applicable) to align with GGC reporting.
2 Data for 7&8 Wellington Place is included from 2023/24 onwards. The figures exclude data centre emissions.
3 Updated from our Annual report and accounts 2023/24 because incorrect figures were provided to us.

Table 4: 10 South Colonnade energy consumption in each financial year from 2021/22 to 2024/25

Building energy consumption		2021/22[1]	2022/23	2023/24[2]	2024/25
Electricity	Quantity (KWh)	293,261	360,814	365,232	483,376
	Cost (£)	49,308	49,075	92,267	121,991
Natural gas	Quantity (KWh)	8,266	10,413	11,759	5,239
	Cost (£)	1,260	449	551	587

Table 5: 7&8 Wellington Place energy consumption in financial years 2023/24 and 2024/25[3]

Building energy consumption		2021/22	2022/23	2023/24[4]	2024/25
Electricity	Quantity (KWh)	Not available	Not available	60,741	58,497
	Cost (£)	N/A	N/A	18,796	18,662
Natural gas	Quantity (KWh)	Not available	Not available	47,519	32,036
	Cost (£)	N/A	N/A	2,867	2,118

Electricity, gas and water consumption are all calculated per building tenant as a percentage of total consumption for both 10 South Colonnade and 7&8 Wellington Place.

In 2024/25 we have seen the results of GPA's action plan for 10 South Colonnade, which focuses on improving building energy efficiency and performance. As discussed above, new mechanical plant and building systems have contributed to a reduction in electricity use and natural gas usage has decreased following the installation of air source heat pumps in Q4.

Table 6: Data centre electrical energy consumption in each financial year from 2021/22 to 2024/25

Data centre energy consumption		2021/22	2022/23	2023/24	2024/25
Data centre 1	Quantity (KWh)	147,305	124,658	126,314	155,763

In previous years, we have reported on electrical energy consumption in a secondary data centre. In 2023/24 we completed a project to decommission this secondary data centre. Energy consumption in data centre 1 has increased this year because new equipment was installed to meet increased demand.

Table 7: Mileage and cost for road, air and rail travel in each financial year from 2021/22 to 2024/25

Travel		2021/22	2022/23	2023/24	2024/25
Road	Miles	8,080	15,792	21,449	15,520
	Cost (£)	4,976	8,843	12,519	9,645
Air	Miles	0	54,332	6,291	6,372
	Cost (£)	0	5,443	1,741	3,228
Rail	Miles	39,817	142,544	327,496	469,111
	Cost (£)	15,049	76,487	149,716	192,150
Total mileage		47,897	212,668	355,236	491,003

1 We moved into 10 South Colonnade part way through 2021 so figures are July 2021 onwards.
2 Figures from 7&8 Wellington Place are included from 2023/24 onwards.
3 Figures from 7&8 Wellington Place are included from 2023/24 onwards.
4 HMRC provided updated energy consumption figures and costs for 7&8 Wellington Place for 2023/24. Incorrect figures were reported in our Annual report and accounts 2023/24.

Road travel has reduced since 2023/24, which may be due to our commitment to holding meetings virtually rather than face-to-face where possible and promoting the use of sustainable travel options such as buses and trains where face-to-face meetings are necessary.

Table 8: Recycled waste quantity and cost in each financial year from 2021/22 to 2024/25

Waste	2021/22	2022/23	2023/24	2024/25
10 South Colonnade				
Quantity (tonnes)	6.0	6.5	4	2.15
Cost (£)	702	2,972	1,565	2,402
Energy from waste				2.20
Food waste				0.42
7&8 Wellington Place				
Quantity (tonnes)				0.84
Cost (£)[1]				
Energy from waste				0.95
Food waste				0.05

Our recycled waste quantities continue to reduce. For the first time, this year's figures also include food waste from 10 South Colonnade and all waste from 7&8 Wellington Place.

Table 9: Use of finite resources in terms of water consumption and paper in each financial year from 2021/22 to 2024/25

Use of finite resources		2021/22	2022/23	2023/24	2024/25
10 South Colonnade water consumption (m^3)	Usage	367	693	945	959
	Cost (£)	934	1,655	2,253	1,864
7&8 Wellington Place water consumption (m^3)	Usage	NA	N/A	162[2]	230
	Cost (£)	NA	N/A	556[3]	522
Paper (reams)	Usage	20	60	140	155
	Cost (£)	49	208	666	594

Paper consumption has increased since 2023/24. Our Operational Delivery Group is being asked to discuss the use of printers by remote workers.

1 Cost information for waste is provided annually by HMRC too late for inclusion in the Annual report and accounts.
2 7&8 Wellington Place water consumption for the financial year 2023/24 was recorded incorrectly in our Annual report and accounts 2023/24.
3 7&8 Wellington Place water costs for the financial year 2023/24 were recorded incorrectly in our Annual report and accounts 2023/24.

Finance report

KPI 13: Management of budgets within net Departmental Expenditure Limits. Measured as income from members plus budget from DHSC vs expenditure.

Headlines in numbers

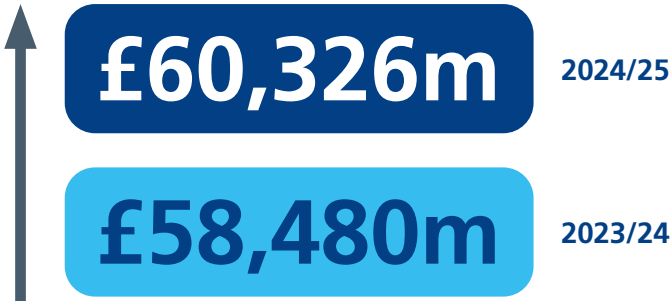
The two key aspects of our financial activities are the provision for liabilities arising from incidents that have already happened and in-year budgetary performance, which includes both scheme payments and our administration costs. Further information about our financial activity is provided in the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

- As at 31 March 2025, the provision for the liabilities arising from all schemes has increased by £1,846 million (3%) from £58,480 million at 31 March 2024 to £60,326 million.
- Prior to applying the Personal Injury Discount Rate (PIDR) and HMT discount rate updates, the provision for all schemes would have increased £4,847 million (8%) to £63,327 million.
- The total estimated cost of harm under CNST incurred as a result of incidents in 2024/25 was £4,586 million, down from £4,777 million the previous year. The change in the discount rates set by HMT has significantly affected this value. The expected value for CNST would have been £4,679 million if discount rates had stayed the same as in 2023/24.
- Payments made in relation to all schemes in 2024/25 increased by £263 million (9%), to £3,134 million.
- Administration costs for all our activities increased by £13 million (22%) to £72 million largely due to staff costs from increased headcount.
- Budget position:
  - Departmental Expenditure Limit (DEL): expenditure was £19 million (1%) under budgeted income and funding.
  - Annually Managed Expenditure (AME): £3,154 million (63%) under budget. Due to uncertainty around incurred but not reported (IBNR) assumptions, over £3 billion contingency was included in budget but this was not required due to the underlying spend being close to the central projection.

Year-end provisions

The provision is the value of liabilities arising from incidents that occurred before 31 March 2025, both in relation to claims received and our estimate of claims that we are likely to receive in the future but have yet to be reported as claims (incurred but not reported, IBNR). Figure 24 on page 77 shows how the provision for liabilities has changed over the last year for all incident years across all schemes.

The provision of liabilities arising from claims in 2024/25 compared to 2023/24



The provision has increased by £1,846 million (3%), from £58,480 million to £60,326 million. Aside from the PIDR change, 2024/25 movements have been broadly in line with expectations.

This increase in the provision has been driven by another year's worth of activity. Primarily due to natural growth of the provision (an additional year of exposure, as well as growth due to inflation), and compared to the assumptions we made last year the anticipated future claim numbers have risen. This is partially offset by changes in other assumptions that lower the provision, including:

- a further small reduction in the long-term claims inflation assumption for periodical payment orders (PPOs);
- an allowance for anticipated future reductions in NHS legal costs as a result of the Claims Evolution Programme (CEP); and
- the provision for Covid-19 continues to fall. The net impact of Covid-19 on total IBNR provisions across all NHS Resolution schemes is £0.6 billion for 2024/25, which is an overall decrease of £0.3 billion from the provision of £0.9 billion in 2023/24. Further detail on the approach adopted to quantify the impact of Covid-19 on the provisions is discussed in Note 7.2 and Note 7.3 to the financial statements on pages 164 and 168 respectively.

The PIDR is set by the Lord Chancellor and is used to determine lump sum settlement amounts, for both PPO and non-PPO claims, so alters the cost of settling claims. An update to the rate was announced in December 2024, effective from 11 January 2025. The rate increased from -0.25% to +0.50%, which has led to a £1.9 billion reduction in the value of the provision.

Updating the HMT discount rates has caused a reduction of £1.1 billion in the provision. The impact is smaller than seen in recent years, as changes in the HMT prescribed rates this year are much smaller than observed in previous years. A significant proportion of the provision relates to claims expected to be settled over the longer term. Consequently, the long-term and very long-term discount rates have a considerable impact on the value of the provision. However, this is an accounting estimate that does not change the underlying future payments that will be incurred in meeting the obligations arising from claims when they fall due in the short term. In other words, any change to the discount rates does not in any way reflect changes in the fundamental drivers of clinical negligence, such as the number of claims that result in damages being paid, the cost of paying these claims, the legal costs involved in handling them and the rate at which any payments might increase in the future.

What is the provision for claims?

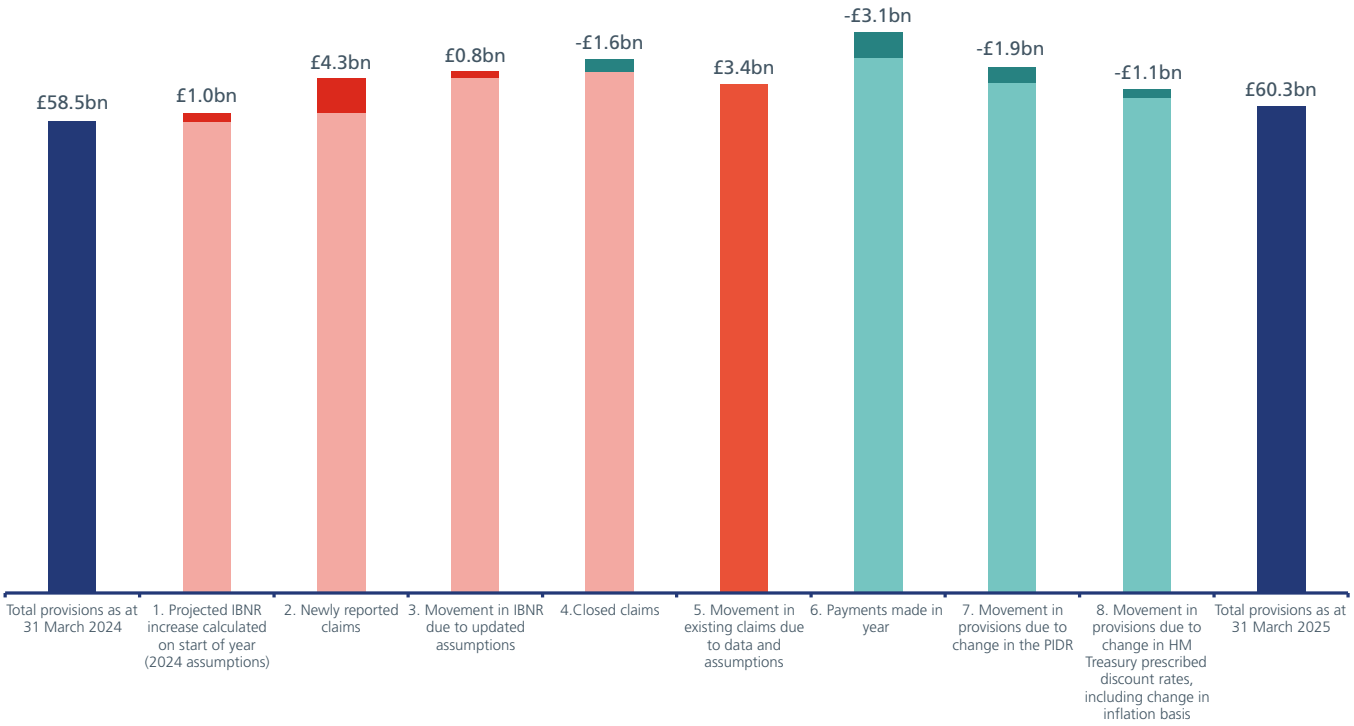
A provision is a liability of uncertain timing or amount. The provision in the NHS Resolution accounts is for claims arising from incidents up to and including the balance sheet date (31 March). This includes claims that we have already received, and those that we expect to receive in the future because of the length of time it can take for a claim to come forward after an incident. As it is expected that payments to settle the liabilities will be made for many years into the future, these are discounted to give a value for the provision at current prices. A helpful way to understand the provision is to think of it as the amount of money needed to settle all liabilities from claims arising from incidents up to the balance sheet date if they had to be settled on that date.

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

One of the key assumptions used in calculating the provisions are the discount rates, which are designed to recognise the value of money over time: generally speaking £1 in the future is worth less than £1 now, because of the interest that could be earned by investing £1 today. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings in today's terms. At a high level, it tells us how much it might cost to settle those obligations today or at the balance sheet date (31 March). In accordance with International Financial Reporting Standards (IFRSs), HMT has determined market rates which reflect the Government's cost of borrowing. NHS Resolution's provisions are particularly sensitive to the long-term and very long-term discount rates. This reflects the long-term nature of the liabilities, which is driven by the reporting and settlement delays as well as the fact that many high-value claims are settled as periodical payment orders (PPOs) with payments provided over the remaining lifetime of the claimant. Further information about HMT's discount rates can be found in Note 7 to the financial statements on page 158.

Change in provision for all schemes in 2024/25

Figure 24: The change in NHS Resolution's provisions for all schemes from 31 March 2024 to 31 March 2025



Note: figures may not sum due to rounding

Items 1 and 2: Liabilities from another year's worth of activity in 2024/25 for all schemes for all incident years are £5.3 billion.

Item 3: shows an increase of £0.8 billion due to changes in assumptions affecting the IBNR provision across all schemes. The main drivers of this increase are in the CNST IBNR, which is the most material component, including:

- An increase of £1.7 billion in respect of claim number projections. An increase in the volume of cancelled claims over the course of the year has driven a reduction in the projected ultimate number of PPO claims. However, this is more than offset by the reduction in the reported cohort of PPOs (which now excludes cancelled claims), leading to an increase in the assumed number of PPO IBNR claims and the IBNR provision.
- A decrease of £0.7 billion following an update to the long-term inflation assumptions. This reduction is particularly driven by a lowering of the long-term inflation assumption in respect of PPO damages, supported by recent trends in settled claim costs.
- An increase of £0.3 billion for average cost assumptions, particularly driven by a change in the profile of future claims weighted more towards maternity claims, which tend to be more expensive than non-maternity claims.
- A decrease of £0.3 billion in respect of Covid-19 related provisions. While the IBNR provision continues to allow for the possibility of further claims arising in the future, this reduction reflects run-off of the exposure measure for these risks and lower than expected actual experience of Covid-19 reported claims.

- A decrease of £0.3 billion following an update to the approach for provisioning for known incidents (incidents that have been notified to NHS Resolution, but which have not yet been formally recognised as reported claims).
- A decrease of £0.2 billion due to the inception of the Claims Evolution Programme (CEP), which is expected to reduce future NHS legal costs included in the provision.

Item 4: The liability has reduced by £1.6 billion in respect of claims closed during this financial year. This amount includes claims which had liabilities held at the last balance sheet date but have closed during this financial year with nil damages.

Item 5: The liability has increased by £3.4 billion in respect of changes in data (such as reserve values and other data held for individual claims) and assumptions affecting known claims. The known claims provision is impacted by the changes in inflation and Annual Survey of Hours and Earnings (ASHE) assumptions. It is also impacted by an uplift in the standard brain injury case reserves. Note, the impact of the change in PIDR is excluded here and shown separately within item 7.

Item 6: £3.1 billion was paid out during the financial year in relation to claims. This is lower than the amount we receive in claims from another year's worth of activity (items 1 and 2), partly because we generally settle high-value cases where ongoing care is a feature with a PPO. This gives a regular payment to the claimant over the rest of their life.

Five years ago (at the end of 2019/20 financial year), the number of PPOs in payment was 2,318 with £271 million paid out that year, and a whole-life value of £18.7 billion (22% of the total provision of £84 billion). At the end of this financial year (2024/25), the equivalent figures were 2,889, £490 million and £14.9 billion respectively (25%).

Item 7: There is a significant decrease in the provision due to changes in PIDR. This rate is used to calculate how much defendants must pay in lump sum damages to claimants in personal injury cases. The Lord Chancellor announced an increase in the rate from -0.25% to +0.50%, effective from 11 January 2025, which has driven a decrease in the provision of £1.9 billion.

Item 8: There is a decrease in the provision of £1.1 billion due to updates to the discount rates specified for use by HMT.

The changes discussed above highlight the uncertainty affecting the valuation of the provision. The sensitivity of the legal environment to our actions in managing the cost of claims, the degree of activity in the legal and health policy arena in response to the growth in costs, and NHS Resolution's view of the effect of these on key assumptions may change over time. Resulting small changes in assumptions as well as changes to discount rates reflecting the financial/market environment, as described above, can have significant impacts on the provision from one year to the next. Sensitivity of the valuation to changes in assumptions is discussed in more detail in Note 7.3 to the financial statements, on page 168.

Cost of harm

It is important to recognise the annual cost of clinical negligence across the NHS continues to be significant.

The cost of harm represents an estimation of the cost of claims arising from incidents within the most recent financial year, in this case 2024/25, compared to the total provision which is driven by older claims arising from many historic years of incidents. Monitoring the cost of harm is useful as it is not skewed by the Pay As You Go funding approach of annual expenditure, which is also driven by older claims arising from a range of activity across many years.

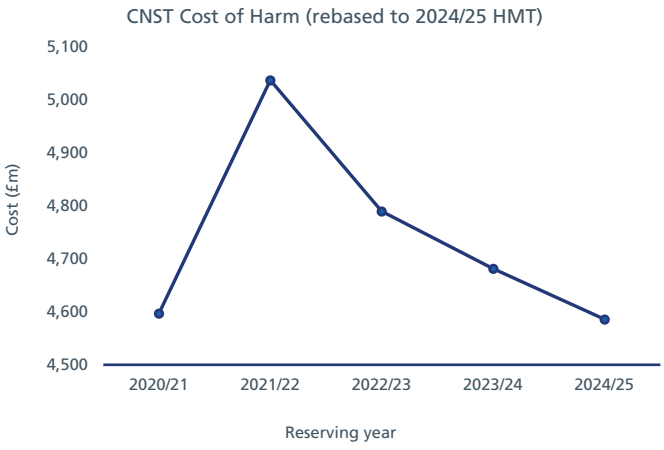
The cost of harm figure is higher than annual expenditure because it includes the capitalised cost of all structured settlement payments on PPO claims, compared to annual expenditure which only includes the structured settlement payment paid in a given year. Further to this, cost of harm relates to claims that may not settle for some time, so allows for future claims inflation compared to claims that are included in current annual expenditure.

Note that the cost of harm is calculated for claims arising from the most recent incident year, so is predominantly driven by the 'incurred but not reported' claims (IBNR) rather than claims that are known (both paid and unpaid). This is due to the time lags that exist between incidents occurring, reporting of a claim and claim settlement/payment.

The estimated cost of harm in 2024/25 covered by CNST was £4,586 million (see table 1 on page 22). This figure has decreased by £192 million compared to the previous year's figure of £4,777 million, which placed a slightly higher value on projected claims costs.

A significant part of this reduction is attributable to changes in HMT discount rates. If this year's HMT discount rate changes had not been applied, the equivalent cost of harm for CNST for 2024/25 would have been £4,679 million. Of the £192 million reduction in the cost of harm £99 million is due to the change in HMT discount rates. The remaining £93 million decrease is mainly due to the change in PIDR and a reduction in the long-term claims inflation assumption for PPO claims.

The cost of harm is sensitive to changes in discount rates due to the long-term nature of when payments are likely to be made. To isolate this effect, the following graph shows prior years cost of harm rebased to 2024/25 HMT discount rates.



This illustrates that in removing the impact of discounting, the cost of harm has reduced in recent years. The increase between 2020/21 and 2021/22 was driven by an assumption of increased clinical activity in 2021/22, following the pandemic-related reduction in the previous year.

Subsequent decreases are driven by updates to assumptions used in various provisioning exercises. These reflect trends in actual experience being more favourable than expected e.g. lower projected PPO claim numbers, lower long-term claims inflation for PPOs, lower average cost assumptions, as well as the increase in PIDR (affects 2024/25 only).

Although there have been decreases in our reported cost of harm in recent years it must be noted that due to the time lag in reporting this is an estimation of the cost of harm in a particular year and remains a significant cost.

The cost of harm is broadly equal to the provision for incidents in 2024/25 (see Note 2.1 to the financial statements on page 153 for further details) but also includes payments on claims with incident dates in 2024/25. Due to time lags in reporting the payments for 2024/25 incidents are minimal.

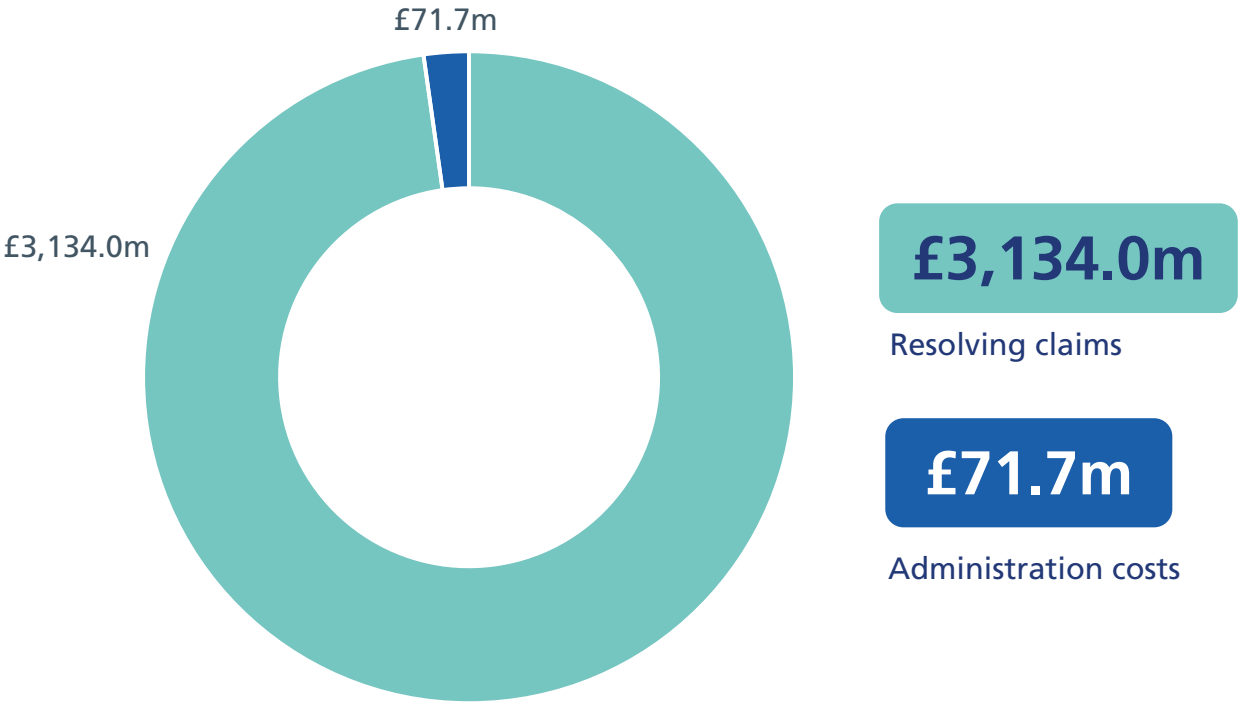
In-year financial performance

The settlement and administration of indemnity schemes is funded by a combination of contributions from members (NHS and independent sector providers of healthcare, integrated care boards and other DHSC arm's length bodies) and financing from DHSC. GPI costs are funded out of the budget held by NHSE for the NHS, via DHSC financing.

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

Despite a volatile year in claims expenditure as a result of the PIDR change and continued recovery from the pandemic, total expenditure against DEL budget was a 1% underspend compared to 2% underspend in the prior year.

A breakdown of NHS Resolution total expenditure budget for 2024/25



What is the Departmental Expenditure Limit (DEL)?

The DEL is a HMT budgetary control, which covers income and spending on general administration costs, e.g. salaries and goods and services, but also the settlement (utilisation) of the provisions in the financial year. HMT Consolidated Budgeting Guidance can be found at https://www.gov.uk/government/publications/consolidated-budgeting-guidance-2024-to-2025.

Indemnity schemes in-year financial position

Table 10: Clinical schemes financial performance

	2024/25				2023/24
Clinical schemes	Income/budget (£ million)	Expenditure[1] (£ million)	Under/ (over) spend (£ million)	Under/ (over) spend Percentage	Expenditure[1] (£ million)
Member funded – CNST	2,868	2,867	1	-	2,614
DHSC funded schemes	113	115	(2)	(2%)	101
GPI	162	161	1	1%	149
CNSC	2	1	1	53%	-
Total clinical schemes	**3,145**	**3,144**	**1**	**0%**	**2,864**

CNST is our largest scheme and was in line with budget expenditure. The change in the PIDR in January 2025 created some volatility in payment patterns during the year.

Payments on CNST claims and scheme administration increased year on year by £253 million (10%), following on from a £205 million (9%) increase in 2023/24. Expenditure was in line with income collected from members. Income from members increased by £204 million (8%) to £2,868 million in 2024/25 in the expectation of a continued trend in increasing claims costs.

£110 million of the year-on-year increase in CNST costs relates to damages payments. The increase was primarily due to lump sum payments on claims with a reserve value of £3.5 million or higher. In addition, annual payments on PPOs increased by £47 million (13%). These costs are expected to rise as we add around 150 newly settled claims of this nature every year.

CNST claimant legal costs increased by £75 million (15%), while NHS legal costs increased by £12 million (8%). Cost increases were generally spread across claims of all values.

For the EN scheme within CNST, while still at a relatively early stage of its development, spend on claims has increased compared to 2023/24 due to a small number of claims settling.

Expenditure on GPI schemes increased by £12 million to £161 million compared to the previous year. The growth is in the CNSGP scheme, which provides cover for incidents from April 2019 and is still maturing. The ELSGP scheme covers historic incidents prior to that date and it is expected that new claims and settlements will reduce over time, which has been seen in 2024/25. GPI schemes were less than £1 million (under 1%) underspent to budget. Given CNSGP is still maturing, and ELSGP has historic cases for which settlement dates can be uncertain, it can be difficult to establish firm information to support forecasting.

DHSC schemes were less than 1% underspent to budget. The largest increase compared to 2023/24 was in payments against claims with a value of over £3.5 million.

There were eight new claims received for CNSC during the year. £1.1 million has been spent on managing claims.

1 These expenditure figures include administrative costs which are not included in the payments figures in table 1 in the Performance report.

Table 11: Non-clinical schemes financial performance

	2024/25				2023/24
Non-clinical schemes	Income/budget (£ million)	Expenditure[1] (£ million)	Under/ (over) spend (£ million)	Under/ (over) spend Percentage	Expenditure[1] (£ million)
Member funded – LTPS	52	42	10	20%	46
Member funded – PES	9	6	3	38%	4
DHSC funded scheme	9	5	4	44%	7
CTIS	-	-	-	62%	0
Total non-clinical schemes	**70**	**53**	**17**	**24%**	**57**

As table 11 shows, expenditure on LTPS has decreased by £4 million (9%) compared to 2023/24, mainly due to payments against claim values in the range £250,000 to £1 million. LTPS scheme expenditure pattern is inconsistent and influenced by a small number of large value claims settlements. The actual number of high value settlements in 2024/25 was lower than projected when setting the income.

Expenditure on the Property Expenses Scheme (PES) is subject to fluctuation and it is difficult to predict due to the nature of claims received under this scheme. No claims have been received for the Coronavirus Temporary Indemnity Scheme (CTIS), and £59,000 has been spent on administration (primarily in relation to meeting financial reporting needs).

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

What is Annually Managed Expenditure (AME)?

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

As detailed in table 12, an expenditure budget of £5,000 million was set, based on updated HMT discount rates and PIDR, which were published in advance of the forecast being submitted to DHSC. It was therefore possible to provide an estimate of the impact they were likely to generate. A contingency for activity in the final few months of the year, and for adverse movements in key assumptions, was allowed for in the budget. This was because the work on updating the key assumptions had not commenced when the final forecast for the year was required for the Parliamentary Supply Estimate process. In the event, the contingency applied of £3,200 million was not required and this resulted in an AME underspend of £3,154 million (63%) against the agreed budget.

1 These expenditure figures include administrative costs which are not included in the payments figures in table 1 in the Performance report.

Table 12: Annually Managed Expenditure

Annually Managed Expenditure		£ million	£ million
Budget			5,000
Expenditure			
	Net cost of claims provision	6,034	
	Change in discount rates	(1,054)	
	Settlement of provisions	(3,134)	
Total expenditure		**1,846**	
Under / (overspend)			**3,154**

Administration costs in-year financial performance

Administration costs for all our activities (including the costs of administering member-funded schemes and GPI arrangements) have increased by £12.8 million (22%) to £71.7 million. This is 2% of our total DEL expenditure. The increase primarily relates to staffing costs, as average full-time equivalent staff numbers have increased by 113 (17%) to 766, including posts relating to the CEP. The costs of a further 12 full-time equivalent staff were charged to the capital budget for CaseHub, bringing our total average full-time equivalent to 778 staff members.

Activities delivered by our Practitioner Performance Advice service have generated £1.0 million (£0.9 million in 2023/24) of income. Services range from advice, assessments and intervention to training and other expert services provided to NHS organisations and other bodies.

The Claims Management service has continued to expand as the team continued the transformation work as part of the CEP. In addition, work to migrate our Claims Management service to the new CaseHub platform is largely complete. Both of these activities are discussed in Strategic priority four of the Performance report on page 67.

Capital

There was £4.0 million in capital additions in the year, an underspend of £0.2 million against the budget of £4.2 million. The majority of the capital expenditure was for ongoing development work on CaseHub, which is being set up to replace our claims management system.

Cash

The balance has increased by £56.5 million to £741.9 million by the end of the year due to the in-year underspend on our indemnity schemes and timing of claims payments. We aim to pay all administration vendors within 30 days from date of invoice in line with our prompt payment policy. Details of our prompt payment performance can be found on our website here Finance and corporate planning – NHS Resolution.[1]

While all cash balances are held in Government Banking Service accounts, we continue to discuss with DHSC the options for using cash surpluses in the context of limited opportunities for budgetary cover to enable reductions in contributions for members in future years. Funding for member-funded schemes is provided through the NHS finance regime, and any underspends incurred by NHS Resolution contribute to the management of the overall DHSC group financial position.

1 See https://resolution.nhs.uk/about/corporate-services/finance-and-corporate-planning/

Expected future performance

For the coming year, our focus will remain on ensuring fair and timely resolution, keeping patients and healthcare staff out of litigation and other formal processes to minimise distress and cost. In addition, we will continue to provide expert advice and support on the management of concerns about the performance of doctors, dentists and pharmacists, while also continuing to fairly and promptly resolve appeals and disputes between primary care contractors and commissioners.

In parallel, we will continue to work closely with the NAO to support its study[1] into the costs of clinical negligence claims. We will continue do everything we can within our remit to manage these costs and stand ready to work proactively to implement any recommendations that emerge from the findings of the study, which is scheduled for autumn 2025.

This year will see the conclusion of the evaluations of the MIS and the EN scheme. Their findings will support our continued efforts to contribute to improved maternity and neonatal care and we will continue to draw upon our unique position and work with our system partners to support maternity and neonatal safety improvements.

We will continue to embed our Claims Evolution Programme and deliver its benefits, using our expert workforce more effectively to ensure efficiency and effectiveness. We will also enter the final stages of implementing our new case management system, CaseHub, which will move us to a state-of-the-art technology platform for the future.

Underpinning our in-year work plan is a commitment to our people-centred activity, in addition to continuing to identify how we can use artificial intelligence (AI) and other digital tools that will help us be as effective and efficient as possible in delivering our core services.

I am satisfied this Performance report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2024/25.

Helen Vernon
Chief Executive and Accounting Officer

Date: Friday 11 July 2025

1 See National Audit Office: Clinical negligence costs (https://www.nao.org.uk/work-in-progress/clinical-negligence-costs/)

Accountability report

Corporate governance report

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

Directors' report

NHS Resolution's Board

This report primarily provides information about the composition of the Board of NHS Resolution. The Board had authority or responsibility for directing or controlling the major activities of the entity during the year and has responsibility for setting the strategic direction and risk appetite of the organisation. It is collectively accountable, through the Chair, to the Secretary of State for Health and Social Care for ensuring a sound system of internal control including implementing arrangements for securing assurance about the effectiveness of the organisation's governance. Details of the Board's activities are given in Board activities on page 92[1]

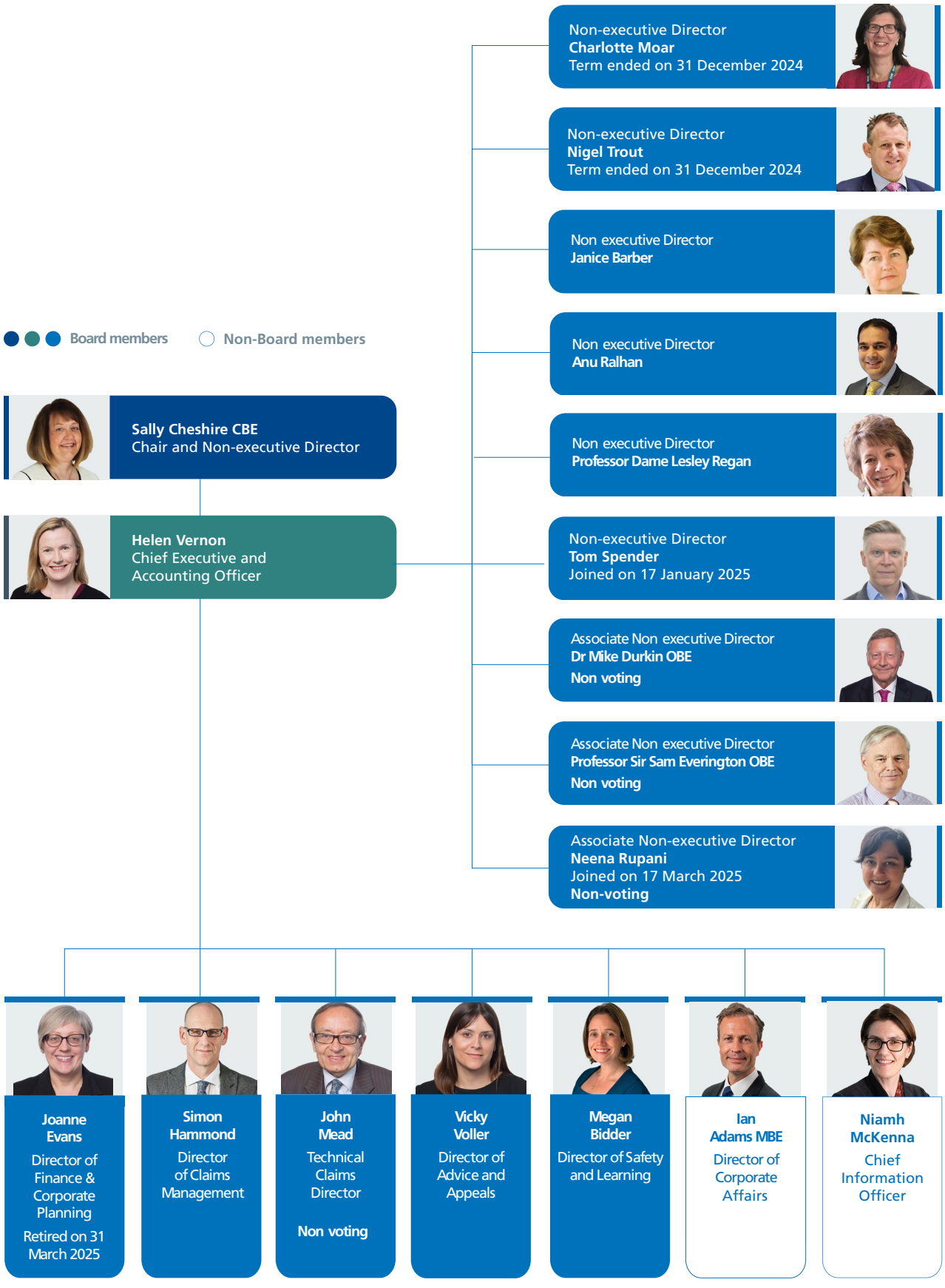
Board composition

As of 31 March 2025, the Board consisted of a non-executive chair, four non-executive members and five executive members. There are also three associate non-executive directors and one associate executive director. The Board can consist of the Chair, between three and five non-executive directors and between three and five executive directors.[2]

1 Further information about our Board and governance structures can be found on our website at https://resolution.nhs.uk/about/governance/governance-structures.

2 A register of interests of each of our Board members can be found on our website at https://resolution.nhs.uk/leadership.

Figure 25: NHS Resolution's Board in operation from 1 April 2024 to 31 March 2025



Statement of Accounting Officer's responsibilities

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

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

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

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

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

Helen Vernon
Chief Executive and Accounting Officer

Governance statement

Scope of responsibility

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

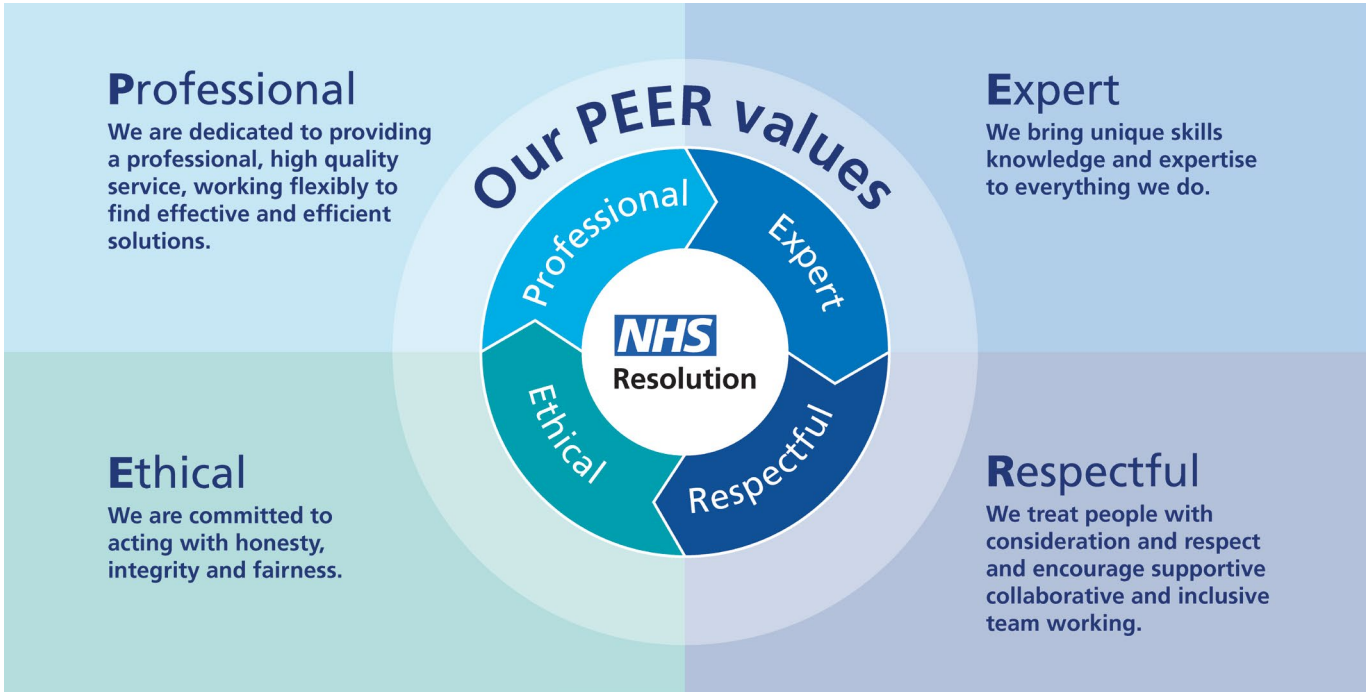
I have responsibility for the delivery of NHS Resolution's strategic aims and objectives within our legislative and regulatory parameters, as directed by DHSC and in conjunction with the Board through development of strategy and effective governance arrangements.

I am responsible for:

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

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

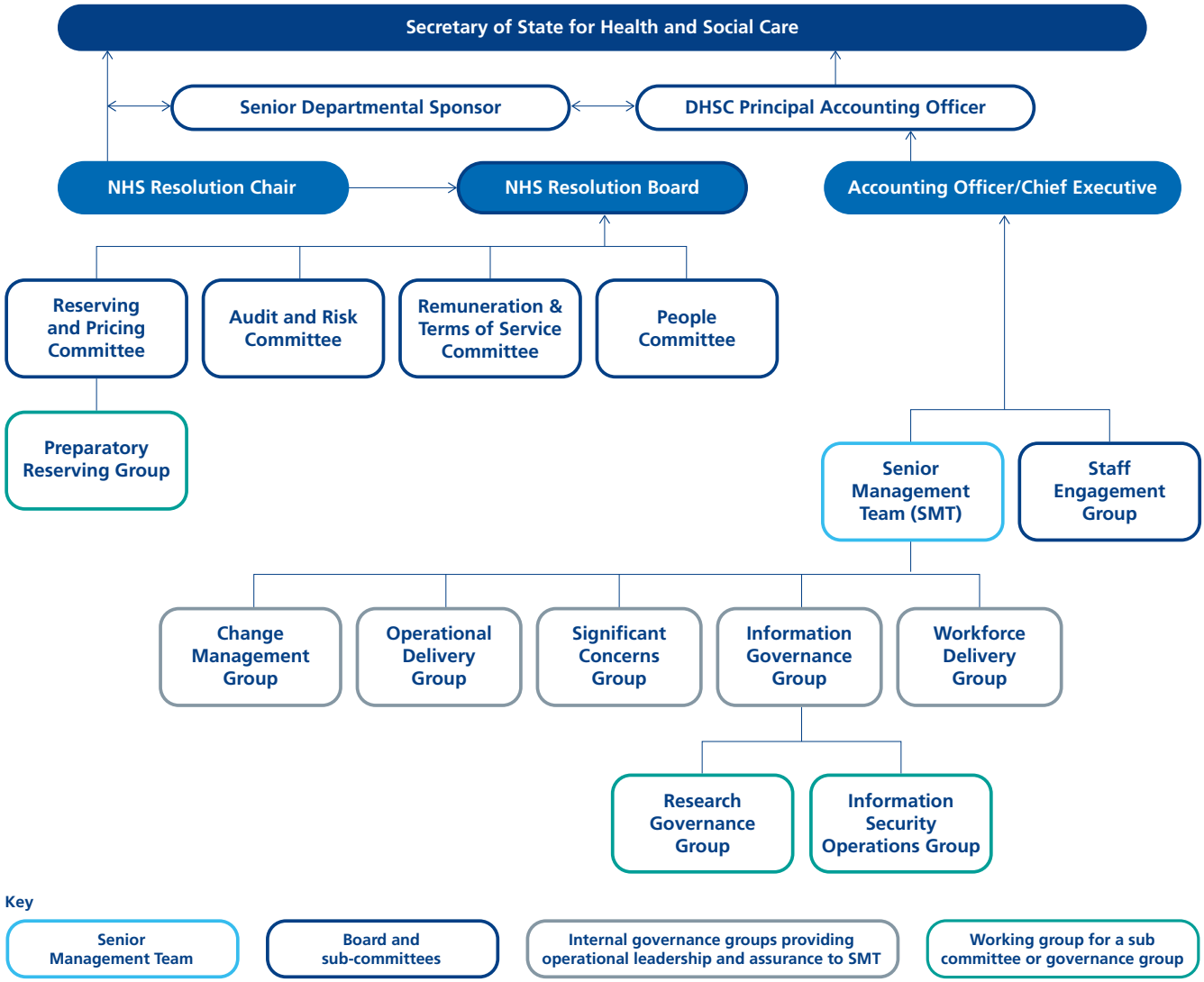
Figure 26: Our PEER values



The governance framework structures

Figure 27 outlines our governance and risk management structure, with the following sections describing the role of our Board and committees, the SMT and its sub-groups.

Figure 27: NHS Resolution governance structure in operation from 1 April 2024 to 31 March 2025



The NHS Resolution Board

Board activities

As NHS Resolution's Accounting Officer, I am supported by the SMT, internal audit and ARC to provide assurance to the Board on matters as they relate to effective governance. I provide reports on the organisation's performance to the Board and to DHSC on a regular basis in accordance with the Framework Agreement with DHSC.

The Board regularly considers these reports to ensure it remains satisfied regarding the quality of information, ensuring it is relevant and sufficient to inform the business of the Board. Consideration of the strategic objectives, business plan and associated risks is also given at the Board meetings.

During the period from 1 April 2024 to 31 March 2025 the Board met on six occasions. Table 13 provides further information on the attendance of the Board at these meetings and table 14 provides an overview of the key matters considered at these meetings.

Table 13: NHS Resolution Board meeting attendance from 1 April 2024 to 31 March 2025

Name	Post	Meetings attended
Sally Cheshire CBE	NHS Resolution Chair	6/6
Charlotte Moar *	Non-executive Director	3/4
Nigel Trout *	Non-executive Director	4/4
Professor Dame Lesley Regan	Non-executive Director	5/6
Janice Barber	Non-executive Director	6/6
Anu Ralhan	Non-executive Director	6/6
Tom Spender **	Non-executive Director	2/2
Helen Vernon	Chief Executive	6/6
Joanne Evans	Director of Finance and Corporate Planning	6/6
Megan Bidder	Director of Safety and Learning	6/6
Simon Hammond	Director of Claims Management	6/6
Vicky Voller	Director of Advice and Appeals	6/6
Dr Mike Durkin OBE	Associate Non-executive Director	5/6
Sir Sam Everington OBE	Associate Non-executive Director	6/6
Neena Rupani ***	Associate Non-executive Director	1/1
John Mead	Associate Board Member	6/6

* last meeting November 2024

** first meeting January 2025

*** first meeting March 2025

Table 14: Frequency of key matters discussed at Board meetings from 1 April 2024 to 31 March 2025

The Board considered reports from the Chief Executive that provided updates on key matters related to the work of NHS Resolution and its operating environment.	
Performance report: Considered the performance and activity across NHS Resolution in line with the NHS Resolution business plan and strategy.	
Risk and assurance: Regularly considered the risks related to performance, business plan, portfolio and key programme delivery and the strategy.	6/6
Annual report and accounts: Considered the drafting and endorsement of the Annual report and accounts for Accounting Officer signing.	
Business plan: Discussed the development of and approved the 2024/25 business plan.	3/6
Risk appetite statement: Considered and approved the risk appetite statement in line with the current internal and external risk environment.	2/6
Policies: Considered and approved polices as retained by the Board.	4/6

Compliance with the corporate governance code

As a public sector organisation we work to apply the principles of the Corporate Governance Code for central government departments.[1] The Board and its committees have due regard to the principles set out in the Code with effectiveness reviews of the Board and ARC also taking the Code into account. NHS Resolution is compliant with the principles relevant to us as an arm's length body.

Board and subcommittee effectiveness

A Board effectiveness self-assessment was carried out in 2024/25. The Board also considered the actions taken forward through the year and concluded improvements had been realised including:

- ✓ clear meeting agendas;
- ✓ the quality of papers presented;
- ✓ improved consideration of strategy versus operational matters;
- ✓ how we approach, debate and manage risk; and
- ✓ the conduct of meetings.

Committees of the Board

The Board is supported by four subcommittees, which have been established to enable the Board, and me as Accounting Officer, to discharge our responsibilities and to ensure effective financial stewardship and internal controls are in place.

Two non-executive directors' terms of office ended on 31 December 2024. Due to the length and rigour of Ministerial appointments processes, one non-executive and one associate non-executive Director were successfully appointed in the first quarter of 2025. The ARC Chair role remains vacant and interim co-chairing arrangements have been put in place to ensure Audit and Risk Committee continues to function whilst a new permanent ARC Chair is sought.

The People Committee have also had interim chairing arrangements in place to cover for six to nine months until one of the new non-executive directors is fully capable of taking on the role.

Both committees benefit from having independent, external members in place to support Board members on challenge and assurance.

Each of the committees has discharged its duties in line with its Terms of Reference and annual work plans.

There were no significant matters raised in relation to effectiveness highlighted from the committee reviews and discussions, with each agreeing potential actions to enhance its effectiveness.

1 See https://assets.publishing.service.gov.uk/media/5a747d24e5274a7f9902893d/PU2077_code_of_practice_2017.pdf

Audit and Risk Committee

The Audit and Risk Committee (ARC) supports the Board and me in our responsibilities for reviewing the comprehensiveness and reliability of our assurances on governance, risk management, the control environment and the integrity of financial statements as well as the Annual report and accounts. The ARC is supported by internal and external auditors.

As of March 2025, the ARC has an interim arrangement in place for the Committee to be co-chaired by a non-executive director and an independent member. This has ensured the Committee can continue to operate and provide assurance to the Board in line with its Terms of Reference.

During this reporting period the Committee met on four occasions, and the Chair of DHSC's ARC attended an ARC meeting held in May 2024. Table 15 provides further information on the attendance of ARC at these meetings.

Table 15: NHS Resolution ARC meeting attendance from 1 April 2024 to 31 March 2025

Name	Post	Meetings attended
Charlotte Moar *	Non-executive Director and Chair of ARC	3/3
Janice Barber **	Non-executive Director and Co-chair of ARC	2/2
Marcus Hine ***	Independent Member and Co-chair of ARC	4/4
Kafui Tay	Independent Member	4/4

*last meeting November 2024

**first meeting November 2024. Co-chair as of March 2025

***Co-chair as of March 2025

The Committee's key responsibilities are set out in its Terms of Reference[1] along with the standing items considered at its meetings. Other matters requiring assurance are also considered, such as independent reviews of the CaseHub core systems programme.

The Committee considered its effectiveness and concluded it is improving both the risk and assurance process on behalf of the Board and focusing on tightening up the controls in line with the three lines of defence processes. Internal Audit has been responsive where the ARC or the Accounting Officer have requested reviews of areas of emerging concern.

Areas for enhancing effectiveness were agreed including how the ARC and the Reserving and Pricing Committee are linked.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee and is chaired by the Chair of NHS Resolution. It considers risk and provides assurance to the Board on recruitment, appraisal and performance management of senior personnel, together with succession planning.

Further details on the work of the Committee can be found on page 108 of the Remuneration and staff report.

1 See https://resolution.nhs.uk/wp-content/uploads/2024/03/NHSR-Audit-and-Risk-Committee-ARC-ToR-V5-2024.pdf

People Committee

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

As of January 2025, the Committee has been chaired by the NHS Resolution Board Chair on an interim basis. This has ensured the Committee can continue to operate and provide assurance to the Board in line with its Terms of Reference.

During this reporting period the Committee met on three occasions.

Name	Post	Meetings attended
Nigel Trout*	Non-executive Director and Chair of People Committee	2/2
Sally Cheshire CBE **	NHS Resolution Board Chair and Interim Chair of People Committee	2/2
Lornette Pemberton	Independent Member and Advisor	3/3
Joanne Evans	Director of Finance and Corporate Planning	3/3
Simon Hammond	Director of Claims Management	3/3
Vicky Voller	Director of Advice and Appeals	3/3

*last meeting September 2024

**first meeting September 2024. Chair of Committee as of January 2025

As set out in the Terms of Reference,[1] the role of the Committee includes oversight and assurance of NHS Resolution's people and organisational development strategies and associated workstreams. It provides an appropriate dedicated forum to discuss people-related activities. The Committee provides support and oversight and recommends issues/matters which should be escalated to the Board for further discussion/agreement.

1 See https://resolution.nhs.uk/wp-content/uploads/2024/03/NHSR-People-Committee-ToR-V2-2024.pdf

Reserving and Pricing Committee

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

The Committee's key responsibilities are set out in its Terms of Reference[1] along with the standing items considered at its meetings.

The Committee's purpose is to:

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

The Committee met on eleven occasions through 2024/25:

Name	Post	Meetings attended
Helen Vernon	CEO and Chair of RPC	11/11
Janice Barber *	Non-executive Director	7/8
Anu Ralhan	Non-executive Director	11/11
Joanne Evans	Director of Finance and Corporate Planning	9/11
Simon Hammond	Director of Claims Management	9/11
Amerjit Grewal **	Independent Member	8/8

*last meeting November 2024

**first meeting August 2024

The RPC is supported by the Preparatory Reserving Group (PRG), a forum that brings the organisation and our actuaries together to consider emerging experiences that could influence and impact the reserving assumptions.

1 See https://resolution.nhs.uk/wp-content/uploads/2025/06/20250104-RPC-ToR-V6-Final.pdf

I, David Johnston, am an Actuarial Director at the Government Actuary Department (GAD) and a Fellow of the Institute and Faculty of Actuaries.

I have calculated the IBNR provisions to be £24,082 million for all schemes combined as at 31 March 2025 using the method and assumptions selected by NHS Resolution.

Bearing in mind the purpose of the calculation and taking into account discussions held with the working groups and NHS Resolution's Reserving and Pricing Committee:

- *in my opinion the actuarial assumptions that were selected by NHS Resolution's Reserving and Pricing Committee for both the IBNR and known claims provisions have been selected on a best estimate basis, with no explicit adjustment for risk and uncertainty;*
- *in my opinion the IBNR provisions for NHS Resolution as at 31 March 2025 that I have calculated, and are to be included in NHS Resolution's report and accounts, have been determined using an appropriate actuarial methodology and assumptions that are reasonable given the range of uncertainty; and*
- *in my opinion and based on my understanding of the approach taken by NHS Resolution's Finance team, the known claims and settled PPO provisions for NHS Resolution as at 31 March 2025 have been determined using an appropriate actuarial methodology and assumptions that are reasonable given the range of uncertainty.*

This opinion statement should be considered in the context of:

- *my advice to the Reserving and Pricing Committee; and*
- *GAD's role in determining the known claims provision – which is more limited in comparison to the IBNR.*

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

Senior management team

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

During 2024/25, the SMT worked closely with the Operational Delivery Group (ODG) to consider the delivery of our business plan and the associated resource requirements.

SMT governance sub-groups

We have established internal governance groups that provide operational leadership on matters related to business plan delivery. These groups, described in table 16, provide assurance to the SMT through regular reporting and the escalation of any risks or issues that could impact our business objectives.

Table 16: SMT sub-groups in operation from 1 April 2024 to 31 March 2025

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

The control environment

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

Capacity to handle risk

Effective risk management supports the delivery of our strategic priorities and business plan objectives. Through our risk management framework, we regularly considered the risks and issues that could have an impact on the achievement of our business objectives, our finances, people, reputation and environmental impacts including matters related to climate change. This included consideration of the controls we have in place to mitigate those risks and then, where required, developing plans to bring those risks within appetite. Risk reporting and escalation is set out in our Risk management policy and procedure.[1]

The Board actively considers the key strategic and operational risks facing NHS Resolution in carrying out its statutory and other functions. The Chair and Chief Executive ensure appropriate issues are discussed by the Board in a timely manner with a reporting process against key performance indicators (KPIs) to assure the Board of delivery against its strategy and business plan, together with associated risks and how they are being managed. The Board sets the organisation's risk appetite and ensures the framework of governance, risk management and control is in place to manage risk.

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

The SMT maintains and updates a strategic risk register which reflects those risks that could have an impact on the delivery of our strategy. The ODG is charged with the review and escalation of corporate operational risks that may impact the delivery of our business plan as well as business as usual matters.

Overall, we aim to ensure the risk registers are integrated and dynamic, and that all teams across the organisation support risk management and mitigation.

Regular reports are provided to the ARC, which considers the application of the risk management framework and as such the current controls and required treatment plans to mitigate risk. In relation to those risks which are outside the risk appetite of the organisation, the ARC recommends appropriate action to the Board.

Business resilience: business continuity

As an organisation we recognise the importance of linking business resilience to our risk profile and, as such, integrating plans to enable us to respond and recover from significant events into our risk management framework.

Through 2024/25 we tested our response plans through exercising scenarios where a number of current risks from our risk profile could materialise. The outcomes from the exercises have supported us with improvements to our business continuity plans. This ensures we can respond to and recover from major operating disruptions that would seriously impact our ability to conduct critical business operations for a significant period of time.

Risk appetite

The Board has developed a risk appetite statement, which is reviewed and updated annually.

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

1 See https://resolution.nhs.uk/governance-policies/risk-management/

Internal audit

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

Audit title	Audit opinion
Data Security Protection Toolkit	Substantial
Data Quality	Reasonable
Workforce Planning	Reasonable
Quality Assurance Framework	Reasonable
Key Financial Controls – CaseHub Counter Fraud	Advisory

Audit opinion key

Substantial Controls upon which the organisation relies to manage the risks are suitably designed, consistently applied and effective.	**Reasonable** Controls upon which the organisation relies to manage the risks are suitably designed, consistently applied and effective. Further actions have been identified to enhance the control framework.
Partial Action required to strengthen the control framework.	**Minimal** Urgent action required to strengthen the control framework.
Advisory Intended to add value and improve an organisation's governance, risk management and control processes. Advisory reviews do not include an internal audit assurance opinion but do provide a conclusion of the findings of the work undertaken. Advisory reviews are often delivered at the request of management and the audit committee.	

The Head of Internal Audit concluded NHS Resolution has **Adequate and Effective** systems of control, governance and risk management in place for the reporting year 2024/25.

Management assurance

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

Anti-fraud, bribery and corruption

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of NHS Resolution's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members. We have a cautious risk appetite in relation to fraud, bribery and corruption and, as such, work to have controls in place to ensure the risk of fraud and error is kept to a minimum.

Throughout 2024/25 and in line with the aims of our internal Counter Fraud strategy and annual work plan, we carried out Fraud Risk Assessments (FRA). This has enabled us to consider the fraud risks we potentially face and ensure focus on those that require enhancements to controls as well as actions to be considered for continuous improvement in line with the Government Counter Fraud Functional Standard GovS013 Continuous Improvement Framework.

We have also commissioned internal audits to provide assurance on our fraud controls, particularly in those areas where changes to processes have been made or are planned in line with our transformation programmes.

We continue to comply with the Government Counter Fraud Functional Standard GovS013.

Counter fraud services are provided by the Government Internal Audit Agency (GIAA).

We continue our membership of the Claims and Underwriting Exchange (CUE), a database of non-clinical claims reported to insurers. This enables us to share information with other indemnifiers, so as to identify potentially fraudulent claims. We are fully alive to the information governance risks entailed in such an initiative and ensure due legal process is adhered to.

Business critical models

All business critical models undergo an annual assurance review in line with the HM Treasury Aqua Book guidance.[1] The outputs of which are reported to the Reserving and Pricing Committee.

Data quality

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

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

Work is ongoing to document and enhance the assurance framework on data and model quality in relation to the inputs required for calculating the provision for claims liabilities.

Performance and financial controls

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

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

1 See https://assets.publishing.service.gov.uk/media/5a7f3bb8e5274a2e87db49be/aqua_book_final_web.pdf

Procurement and contracting

We ensure our procurement processes are compliant with regulation, Cabinet Office and DHSC requirements. We have pipeline plans in place to ensure that acquisitions for goods and services provide value for money and that we are transparent in our procurement approach.

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

Sustainability

We recognise the management of risks and opportunities is important to mitigate the effects of climate change on delivering our core business as well as our impact on the environment.

Through our risk management processes we have considered the risks pertaining to sustainability and at present have identified no principal risks.

We will as part of our 2025–28 Board-approved Sustainability Strategy and associated plans for 2025/26:

- continue to review and consider sustainability risks and opportunities by building on our risk management framework.
- enhance our Business Impact Assessment processes to ensure our business resilience and response plans enable us to deliver our core business services where environmental events arise.
- continue to embed sustainability throughout NHS Resolution decisions, activities, initiatives, and programmes including sustainability through procurement activities by utilising the Social Value requirements of the Procurement Policy Notice PPN06/20.

Information governance and security

NHS Resolution has maintained ISO 27001 Information Security certification, demonstrating we have an effective information security management system. The recertification audit in November 2024 reviewed a range of governance and technical security controls against the ISO standards. We also continue to maintain Cyber Essentials Plus certification, which is a UK Government scheme of good practice in information security.

Our incident policy and procedure includes a process for stepping up an incident oversight group. An incident oversight group is set up where a serious incident is reported with an impact score of three or above in line with our risk matrix, involves multiple teams and requires active team co-ordination to achieve quick resolution and learning.

During this reporting period there were two reports to the Information Commissioner's Office (ICO), which were directed through the Data Security Reporting Toolkit. While we continue to learn from any incidents and address potential gaps in our internal controls, the ICO concluded no further action was required on the reported incidents.

Complaints and feedback

During the year we significantly updated our complaints policy[1] process to align with the UK Central Government Complaint Standards,[2] which included moving to a two-stage approach. This ensures our handling of complaints is both effective and fair, as well as simplifying the complaints process for both complainants and staff.

Our complaints procedure is designed to address concerns about the quality of the service provided, rather than to review or overturn decisions made by service areas. We continue to ensure this distinction is clearly communicated, so expectations are managed appropriately and the complaints process remains focused on service improvement and learning.

There have been no complaints formally referred to the Parliamentary and Health Service Ombudsman (PHSO).

1 See https://resolution.nhs.uk/contact/complaints-about-nhs-resolution/#toc-item-2
2 See https://www.ombudsman.org.uk/sites/default/files/UK_Central_Government_Complaint_Standards_Oct.pdf

Health, safety and wellbeing

To ensure the health, safety and wellbeing of our staff we have in place policies and procedures, with staff required to participate in training to ensure they are aware of these. We have ensured all staff have completed display screen equipment assessments to make sure they are working safely both in the office and at home. To ensure all our staff are supported we provide an Employee Assistance Programme, various health and wellbeing tools, and the assistance staff who act as trained mental health first aiders. Further information about the support we provide can be found in Maximising employee health and wellbeing on page 128.

Freedom to speak up

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

- Regular meetings with the Human Resources/ Organisational Development (HR/OD) team to consider themes from issues raised and remedial actions that can be put in place, and to review corporate policies, taking account of examples of inconsistency or inequity.
- Promoting greater visibility and accessibility of the HR team as a valuable source of advice and support for managers and staff. Identifying training or policy and procedures knowledge gaps that may exist across the organisation.
- Regular meetings with teams to discuss concerns raised by their team members and providing intelligence to prompt earlier management intervention where possible.
- Participating in corporate induction sessions to promote the commitment to speaking up and how that facilitates change in the organisation.

Respect for human rights

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

People

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

Procurement and our supply chain

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

NHS Pension scheme regulations

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

Statutory functions

We maintain a register of the relevant directions and statutory functions for NHS Resolution, which ensures we are operating as we should be.

This gives me, as Accounting Officer, the assurance that we have a clear view of those functions and regulations we should be working to.

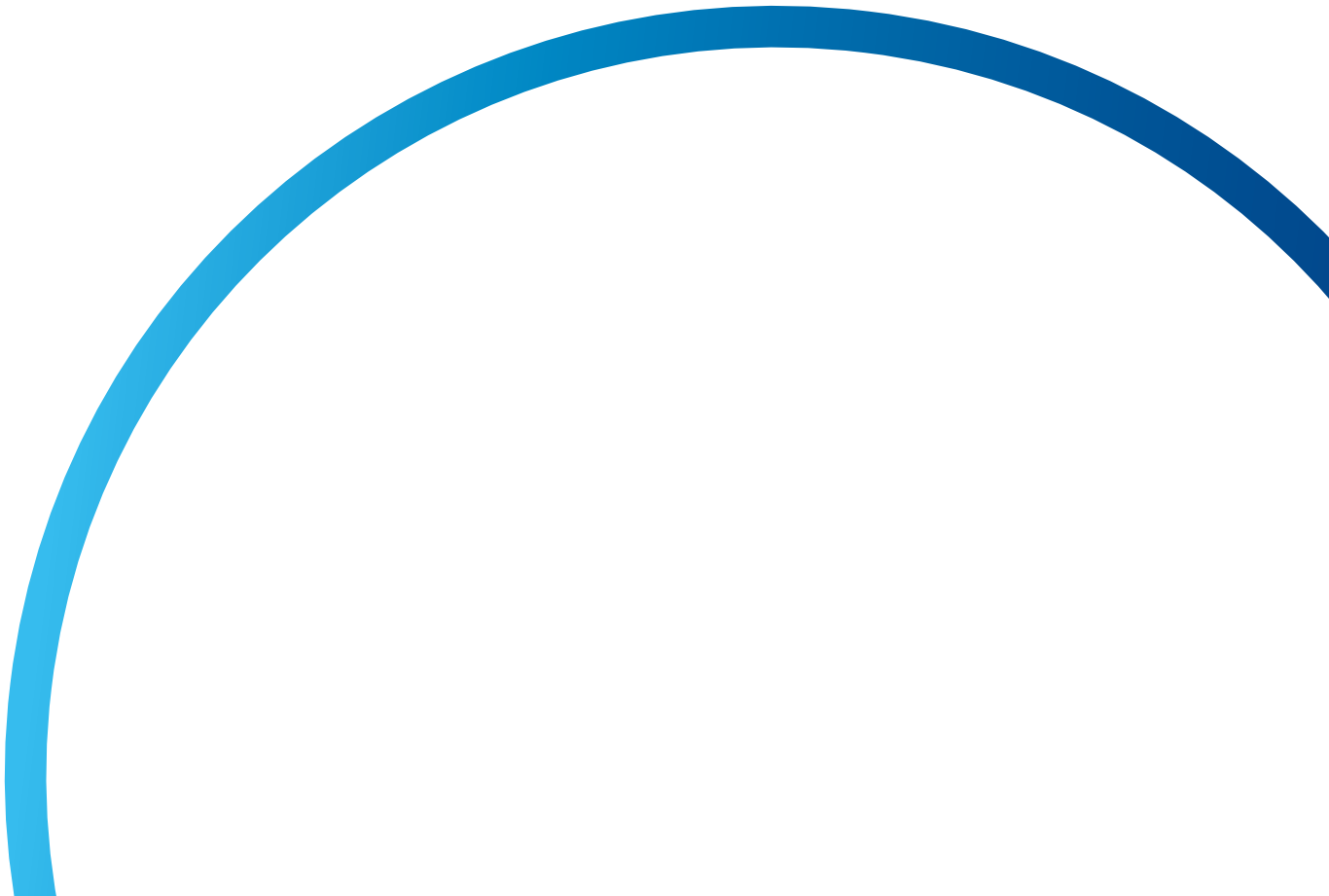
1 See https://www.gov.uk/government/publications/ppn-0223-tackling-modern-slavery-in-government-supply-chains/ppn-0223-tackling-modern-slavery-in-government-supply-chains-guidance-html

Accounting Officer's conclusion

The governance arrangements detailed in the statement aim to support NHS Resolution to maximise our understanding and use all of the available information about the quality and effectiveness of our systems, to help us improve services and satisfy assurance requirements about the effectiveness of our systems of internal control.

Based on my review, I am not aware of any significant control issues and I am content that appropriate arrangements are in place for the discharge of all statutory functions for which NHS Resolution is responsible.

In summary, I am satisfied that the framework of governance, risk management and system of internal controls are adequate and have been effectively maintained throughout 2024/25.



Remuneration and staff report

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a non-executive committee whose members have a role that includes the determination of the remuneration, benefits and terms of service of all posts covered by the Pay Framework for Executive and Senior Managers (ESMs). The Committee, established by NHS Resolution's Board, which also approves its Terms of Reference, met four times during the 2024/25 financial year. All meetings were quorate with the attendance of members shown in table 17.

Table 17: Remuneration and Terms of Service Committee meeting attendance from 1 April 2024 to 31 March 2025

Name	Post	Meetings attended
Sally Cheshire CBE	Chair	4/4
Charlotte Moar[1]	Non-executive Director	3/3
Nigel Trout[2]	Non-executive Director	2/3
Janice Barber	Non-executive Director	4/4
Professor Dame Lesley Regan	Non-executive Director	2/4
Anu Ralhan	Non-executive Director	4/4
Tom Spender[3]	Non-executive Director	1/1

In September 2024, following the retirement of the Director of Finance and Corporate Planning, the Committee approved the recruitment of a Chief Finance Officer. They considered an update on the appraisals discussions that had been held with each of the ESMs as presented by the CEO. This included the performance of each of the ESMs and the assigned performance ratings. The Committee also considered and approved the application of the 2024/25 pay awards, and the performance related payment for the 2023/24 performance year.

Subject to DHSC and, where necessary, Ministerial approval, the Committee approved the business cases for an extension to an existing Senior Maternity Clinical Adviser and the appointment of an additional Senior Medical Adviser on a fixed-term basis.

In March 2025 the Committee approved the extension of the two existing associate non-executive director positions and approved the appointment of a new associate non-executive director.

The Committee considered its performance in 2024/25 as satisfactory and concluded it had discharged its obligations as set out in the Terms of Reference. The Committee also considered that the Terms Of Reference remain appropriate and fit for their purpose.

1 Charlotte Moar's appointment as non-executive director ended on 31 December 2024.
2 Nigel Trout's appointment as non-executive director ended on 31 December 2024.
3 Tom Spender's appointment as non-executive director commenced on 17 January 2025.

Remuneration policy

NHS Resolution is bound by the NHS terms and conditions of service (known as Agenda for Change). With the exception of the directors who are paid in accordance with DHSC Pay Framework for Executive and Senior Managers in ALBs, all staff are paid in accordance with Agenda for Change. Where necessary, NHS Resolution also makes use of the national medical and dental pay, and terms and conditions of service for those positions for which it is deemed necessary to have a current licence to practise and/or professional membership with an appropriate body. We currently have three staff members employed under the medical and dental terms and conditions of service.

Full details on the Agenda for Change, including a copy of the current handbook, can be found on the NHS Employers website.[1] The provisions set out in this handbook are based on the need to ensure a fair system of pay for NHS employees that supports modernised working practices. Nationally, employer and trades union representatives have agreed to work in partnership to maintain an NHS pay system that supports NHS service modernisation and meets the reasonable aspirations of staff. Full detail on the medical and dental pay and terms and conditions of service can be found on the NHS Employers website.[2]

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

Remuneration for directors

The following tables provide the contractual salary and pension details of those executive and non-executive directors who had control over the major activities of NHS Resolution during 2024/25, except for the associate executive directors who have no voting rights on the Board. There were three changes in Board membership during 2024/25. Both Nigel Trout's and Charlotte Moar's appointments as non-executive directors ended on 31 December 2024. A new non-executive director, Tom Spender, started his term of office on 17 January 2025.

Tables 18, 19 and 20 that follow are subject to audit.

1 See https://www.nhsemployers.org/publications/tchandbook
2 See https://www.nhsemployers.org/articles/pay-and-conditions-circulars-medical-and-dental-staff

Table 18: Executive and non-executive director salaries and allowances[1] for 2024/25

Name and title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	All pension related benefits[2] total to nearest £1,000	Total (bands of £5,000) £000
Sally Cheshire CBE[3] (Chair)	60–65	7,100	0	N/A	**70–75**
Helen Vernon (Chief Executive)	165–170	0	5–10	33,000	**210–215**
Joanne Evans (Director of Finance and Corporate Planning)	135–140	7,800	0	42,000	**185–190**
Vicky Voller (Director of Advice and Appeals)	130–135	300	0	23,000	**150–155**
John Mead (Technical Claims Director)	110–115	4,700	0	28,000	**145–150**
Megan Bidder (Director of Safety and Learning)	100–105	0	0	26,000	**130–135**
Simon Hammond[4] (Director of Claims Management)	120–125	1,100	5–10	33,000	**160–165**
Charlotte Moar[5] (Non-executive Director)	5–10	2,000	N/A	N/A	**10–15**
Nigel Trout[6] (Non-executive Director)	5–10	100	N/A	N/A	**5–10**
Janice Barber (Non-executive Director)	5–10	0	N/A	N/A	**5–10**
Professor Dame Lesley Regan (Non-executive Director)	5–10	0	N/A	N/A	**5–10**
Anu Ralhan (Non-executive Director)	5–10	0	N/A	N/A	**5–10**
Tom Spender[7] (Non-executive Director)	0–5	0	N/A	N/A	**0–5**
Dr Mike Durkin OBE (Associate Non-executive Member)	5–10	0	N/A	N/A	**5–10**
Sir Sam Everington OBE (Associate Non-executive Member)	5–10	0	N/A	N/A	**5–10**
Neena Rupani[8] (Associate Non-executive Member)	0–5	0	N/A	N/A	**0–5**

1 The executive and non-executive directors do not receive any non-cash benefits other than travel costs for journeys to locations approved under NHS Resolution's travel expenses and reimbursement policy. The gross value of this benefit and any taxable expenses reimbursed are included in the expense payments column of this table.

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

3 Sally Cheshire was reappointed as Chair of NHS Resolution for three years from 18 September 2024.

4 Simon Hammond was appointed as executive director on 1 April 2024.

5 Charlotte Moar's non-executive director appointment and Chair of the ARC ended on 31 December 2024. The non-executive director full year equivalent salary is in the band of £10–£15k.

6 Nigel Trout's non-executive director appointment ended on 31 December 2024. The non-executive director full year equivalent salary is in the band £5–£10k.

7 Tom Spender's appointment as non-executive director commenced on 17 January 2025. The non-executive director full year equivalent salary is in the band of £5–10k.

8 Neena Rupani's appointment as associate non-executive member commenced on 17 March 2025. The associate non-executive member full year equivalent salary is in the band of £5–10k.

Table 19: Executive and non-executive director salaries and allowances for 2023/24

Name and title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000) £000	All pension related benefits[1] total to nearest £1,000	Total (bands of £5,000) £000
Sally Cheshire CBE (Chair)	60–65	8,200	N/A	N/A	**70–75**
Helen Vernon[2] (Chief Executive)	165–170	0	5–10	0	**175–180**
Joanne Evans (Director of Finance and Corporate Planning)	130–135	5,900	0	36,000	**175–180**
Vicky Voller[3] (Director of Advice and Appeals)	125–130	0	0	0	**125–130**
John Mead (Technical Claims Director)	105–110	5,900	0	0	**115–120**
Dr Denise Chaffer CBE (Director of Safety and Learning)	60–65	0	5–10	N/A	**65–70**
Megan Bidder[4] (Director of Safety and Learning)	45–50	0	0	13,000	**60–65**
Charlotte Moar[5] (Non-executive Member)	10–15	3,300	N/A	N/A	**15–20**
Nigel Trout (Non-executive Member)	5–10	100	N/A	N/A	**5–10**
Janice Barber (Non-executive Member)	5–10	0	N/A	N/A	**5–10**
Professor Dame Lesley Regan (Non-executive Member)	5–10	0	N/A	N/A	**5–10**
Anu Ralhan[6] (Non-executive Member)	0–5	0	N/A	N/A	**0–5**
Dr Mike Durkin OBE[7] (Associate Non-executive Member)	5–10	600	N/A	N/A	**5–10**
Sir Sam Everington OBE[8] (Associate Non-executive Member)	5–10	0	N/A	N/A	**5–10**

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

2 Helen Vernon is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

3 Vicky Voller is affected by the Public Service Pensions Remedy and her membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

4 Megan Bidder's appointment as Director of Safety and Learning commenced on 1 October 2023. The Director of Safety and Learning full year equivalent salary is in the band of £95–100k.

5 Charlotte Moar is also the Chair of the ARC.

6 Anu Ralhan's appointment as non-executive director commenced on 1 March 2024. The non-executive director full year equivalent salary is in the band of £5–10k.

7 Dr Mike Durkin OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2023.

8 Professor Sir Sam Everington OBE's appointment as associate non-executive director was extended for a further twelve months with effect from 1 July 2023.

Pension entitlements for executive directors

Table 20: Pension entitlements for executive directors

Name and title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)
	£000	£000	£000
Helen Vernon (Chief Executive)	2.5–5	0	55–60
Joanne Evans (Director of Finance and Corporate Planning)	2.5–5	0	25–30
Vicky Voller (Director of Advice and Appeals)	0–2.5	0	35–40
Megan Bidder (Director of Safety and Learning)	0–2.5	0	0–5
John Mead (Technical Claims Director)	0–2.5	0	40–45
Simon Hammond[1] (Director of Claims Management)	0–2.5	0	15–20

1 Simon Hammond was appointed as executive director on 1 April 2024.

	Cash equivalent transfer value at 31 March 2025	Cash equivalent transfer value at 31 March 2024	Real increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000
	1,239	1,112	34	0
0	444	366	38	0
	716	641	16	0
0	35	11	10	0
	0	0	0	0
0	212	163	23	0

Cash equivalent transfers

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025. HMT published updated guidance on 27 April 2023; this guidance has been used in the calculation of 2024/25 CETV figures.

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

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement that the individual has transferred to the NHS Pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement or for loss of office

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

Payments to past directors

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

Fair pay disclosures

The fair pay disclosures are subject to audit.

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

The banded remuneration of the highest-paid director/member in NHS Resolution in the financial year 2024/25 was £175,000–£180,000 (£175,000–£180,000 in 2023/24). The relationship to the remuneration of the organisation's workforce is disclosed in the following table.

		25th percentile	Median	75th percentile
2024/25	Total remuneration	£44,806	£54,320	£66,246
	Pay ratio – total remuneration	3.96:1	3.27:1	2.68:1
	Salary component of total remuneration	£44,806	£54,320	£66,246
2023/24	Total remuneration	£42,618	£53,741	£65,094
	Pay ratio – total remuneration	4.16:1	3.30:1	2.73:1
	Salary component of total remuneration	£42,618	£53,741	£65,094

The 25th percentile pay ratio has reduced significantly as opposed to smaller decreases in the case of median/75th percentile ratios because the average salary of 25th percentile staff has increased by more than 5%, whereas the remuneration of the highest-paid director remains unchanged from 2023/24. This is because average salaries of lower-banded staff increased more than higher-banded staff on average.

In 2024/25 no employee (2023/24 no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £26,530 to £177,760 (2023/24 £20,834 to £177,760). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The total banded remuneration of the highest-paid director is equal to the banding for 2023/24.

The basic pay of the highest-paid director in NHS Resolution in the financial year 2024/25 was £165,000–£170,000 (2023/24 £165,000–£170,000). The performance and bonus pay of the highest-paid director for 2024/25 was £5,000–£10,000 which was the same range as the prior year (£5,000–£10,000).

The average percentage change in total remuneration of employees taken as a whole (excluding the highest-paid director), was a 2.8% increase (2023/24 0.2% decrease), with the percentage change in basic pay being a 3.1% increase (2023/24 3.6% increase). In 2022/23 staff were paid a one-off non-consolidated pay award which was treated as a bonus. Therefore in 2023/24 the average total remuneration reduced from the prior year but then increased in 2024/25. As the non-consolidated pay award was excluded from basic pay, we've seen an increase year-on-year in the salary component between 2022/23 and 2024/25 in line with increases through the pay award.

The increase in pay and allowances that can be seen in the median and 75th percentiles is as a result of the NHS Agenda for Change pay award of 5.5%. In addition, the average workforce grew by 98 full-time equivalent at an average remuneration lying between the median and the upper quartile.

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

Staff report

During 2024/25 there has been an increase in average full-time equivalent (FTE) staff, up from 680 in 2023/24 to 778. The increase in budgeted establishment continues to reflect our requirements to successfully operate the CNSGP, CEP and CaseHub, including the corporate support required for the ongoing increase in remit and establishment.

While increasing our budgeted establishment and headcount in 2024/25, our annual staff turnover has remained at 8%. Our voluntary staff turnover rate for 2024/25 was 5%, down from 6% in 2023/24. Non-voluntary turnover includes the end of fixed-term contracts, cases of death in service and dismissals which includes compulsory redundancies. The organisation had no compulsory redundancies in 2024/25. The SMT receive regular reports on staffing levels by directorate, with attention drawn to where there may be risks from high vacancy rates.

During 2024/25 the People Committee, a subcommittee of the Board, met on three occasions. The role of the People Committee is to support the Board and the Accounting Officer by reviewing the comprehensiveness and reliability of assurances in relation to its people strategies, risks and activities. The Committee members provide advice on the adequacy of the organisation's people, plans and strategies. They provide support and recommend which issues/matters should be escalated to the Board for further discussion.

Throughout 2024/25 we have continued to support our workforce in a range of professional development opportunities both internally and externally. Our ongoing commitment to high standards of people management has been recognised by achieving and maintaining the Investors in People Gold accreditation.

Tables 21 and 22 set out staff costs and average staff numbers, which are subject to audit.

Table 21: Staff costs 1 April 2024 to 31 March 2025 compared to 1 April 2023 to 31 March 2024

Staff costs	Permanently employed staff £000	Other[1] £000	2024/25 Total £000	2023/24 Total £000
Salaries and wages	42,543	983	43,526	35,601
Social security costs	4,942	-	4,942	3,985
Employer contributions to NHS Pensions	8,794	-	8,794	6,035
NEST pension contributions	4	-	4	7
Apprenticeship levy	203	-	203	174
Total	**56,486**	**983**	**57,469**	**45,802**

Table 22: The average full-time equivalent staff employed broken down by related costs 1 April 2024 to 31 March 2025 compared to 1 April 2023 to 31 March 2024

Average number of persons employed/staff numbers and related costs	Permanently employed staff	Other[2]	2024/25 Total	2023/24 Total
Core department	754	12	766	653
Capital projects	12	0	12	27
Total	**766**	**12**	**778**	**680**

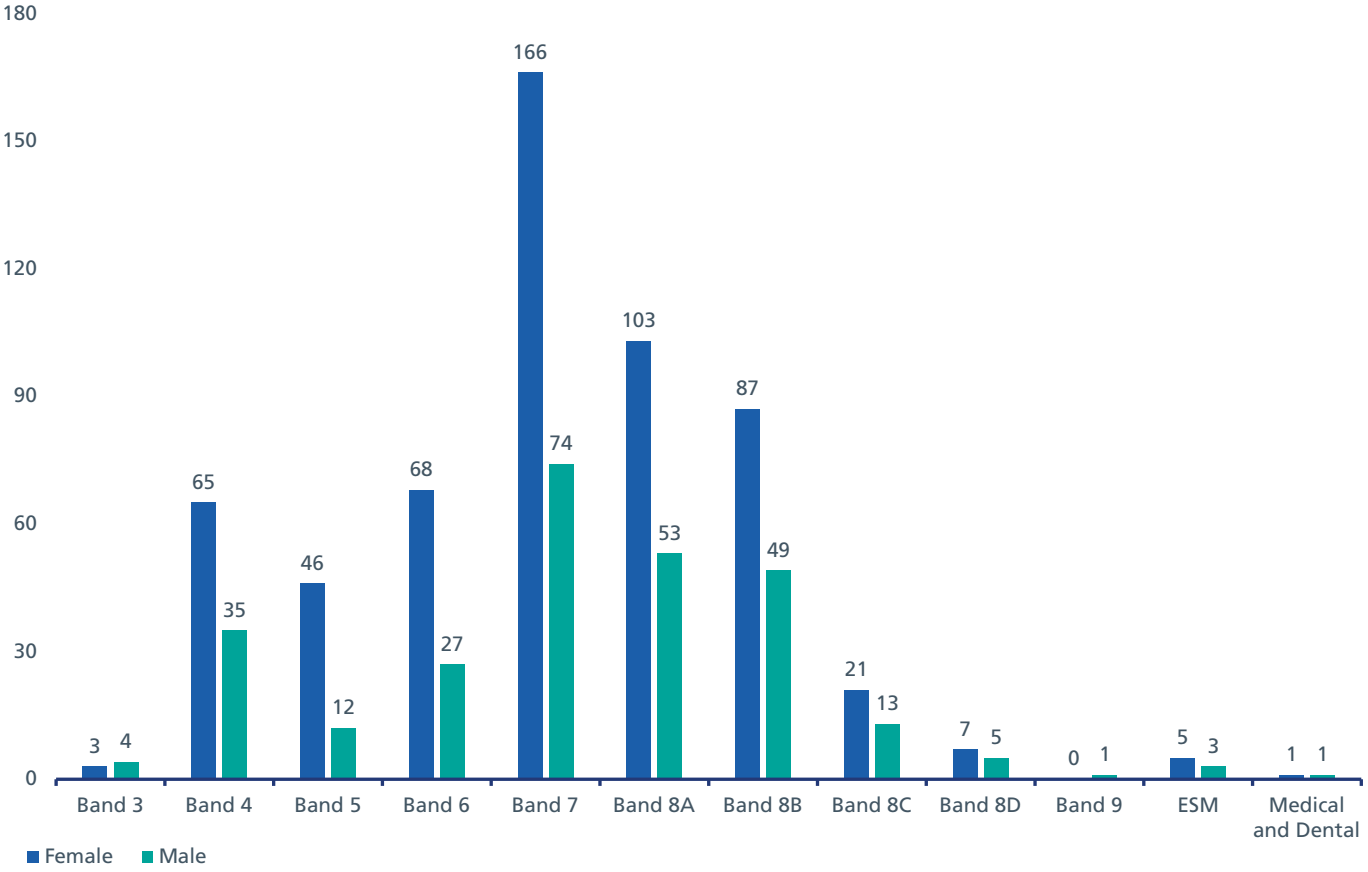
1 Other is seconded/agency staff.
2 Other is seconded/agency staff.

As at 31 March 2025, of the eight executive and senior managers, three were male (38%) and five were female (63%). The organisation's gender split ratio for all employees was 33% male and 67% female. This is broadly comparable to 2024 which was 34% male and 66% female.

Figures 28 to 34 detail how the organisation's workforce is made up in respect of the other monitored protected characteristics that are included under the Equality Act 2010. The overall proportions of staff against each of the monitored characteristics have remained broadly comparable to the proportions reported in 2023/24. There are some changes to the regional ethnicity profile information and ethnicity profiles across the pay bands shown in figures 32, 33 and 34.

Equality, diversity and inclusion (EDI) remains a core pillar of our People Plan. The graphs and narrative below set out our actions taken to date and intended future actions in tackling barriers to improving diversity in our workforce.

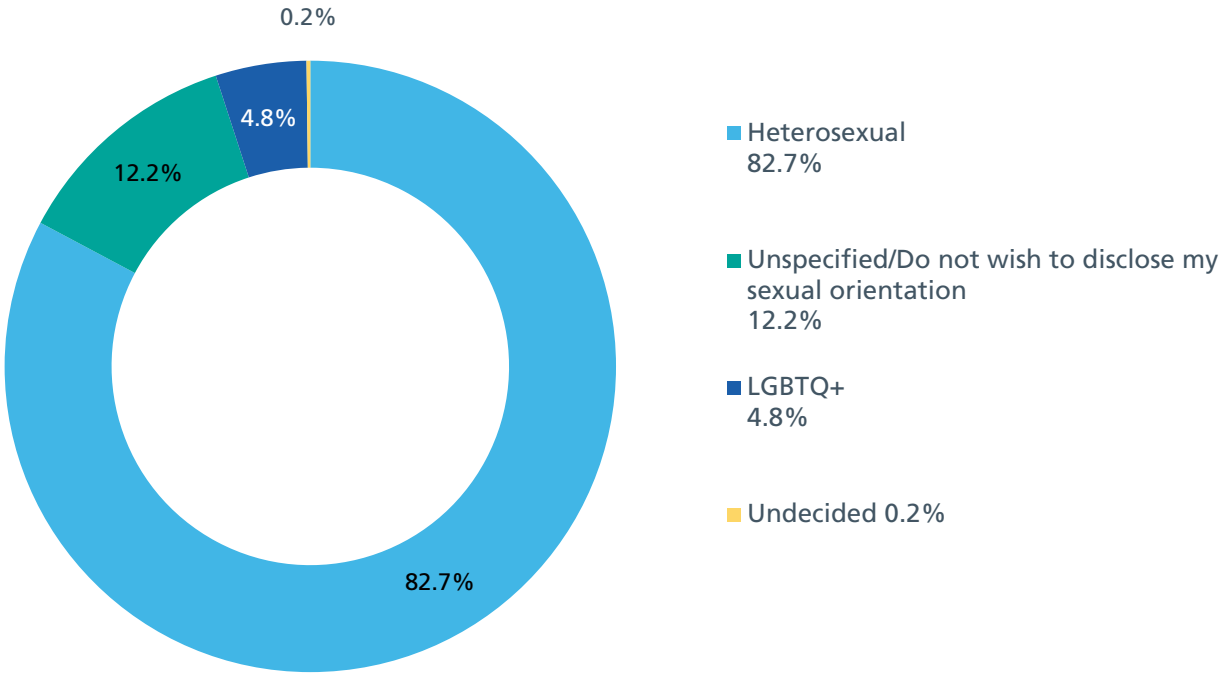
Figure 28: Staff headcount broken down by gender and banding from 1 April 2024 to 31 March 2025



Our gender pay gap (GPG) report for the twelve-month period ending 31 March 2024 noted we have seen a positive shift in the female profile in our senior pay bands (band 8a and above), which is likely a contributing factor to the decreased mean gender pay gap from 9.8% in 2023 to 8.2% this year. Further information about our 2024 GPG report can be found in Gender pay gap (GPG) reporting on page 127.

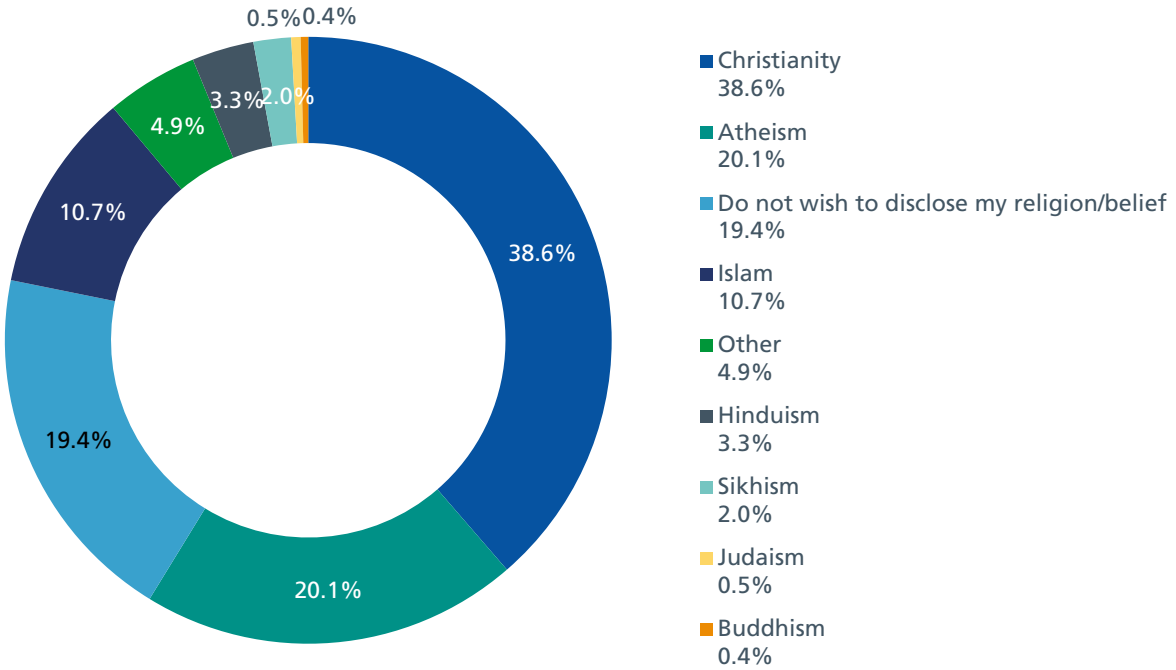
There has been an increase in the proportion of staff disclosing their sexual orientation when compared to 2023/24. The number of staff who do not wish to disclose their sexual orientation has reduced to 12.2% compared with 14% in 2023/24.

Figure 29: Sexual orientation of staff



*99.9% due to rounding

Figure 30: Religion and/or belief of staff



*99.9% due to rounding

Disability

We continue to demonstrate our commitment to our Disability Confident Leader award achieved in July 2023 by introducing inclusive practices that support neurodiverse staff in all our resourcing and learning interventions.

Our staff-led Disability Network has continued to meet throughout 2024/25. The purpose of this group is to:

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

Table 23 shows the percentage of applications shortlisted (from total applicants) and the percentage of appointments made (from total shortlisted candidates) from those who consider themselves as having a disability, those who do not consider themselves as having a disability and those who do not wish to disclose this information. It also provides a comparison to the previous year.

Table 23: A comparison of the proportion of job candidates shortlisted and appointed to roles at NHS Resolution in 2024/25 and 2023/24 with and without a disclosed disability

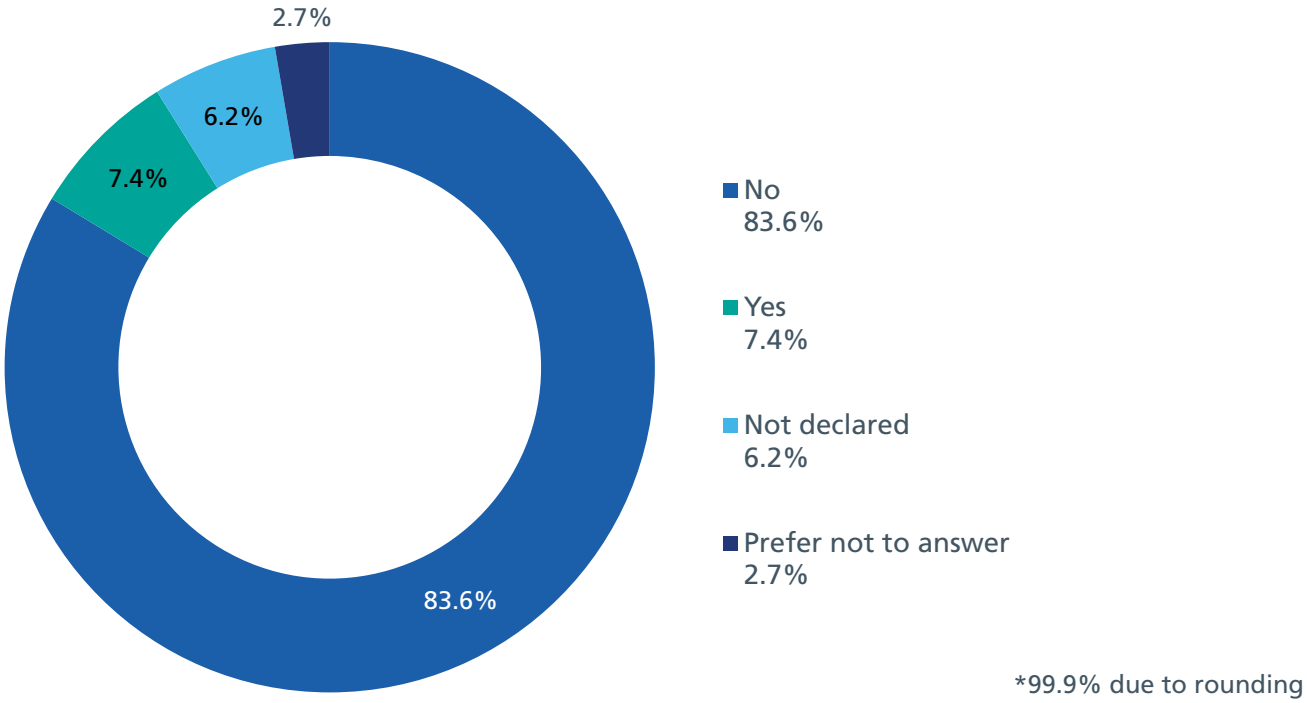
Application category	% Shortlisted 2024/25	% Shortlisted 2023/24	% Appointed from shortlisting 2024/25	% Appointed from shortlisting 2023/24
Disabled	22.6	28.5	21.5	25.7
Not disabled	22.3	15.4	25.3	39.1
Not disclosed	32.1	14.5	10.2	47.6

Note: The above figures exclude appointments made via agencies.

We appointed to 168 roles from the external market in 2024/25, approximately the same number as the previous year. Overall, we shortlisted a similar number of applicants compared to 2023/24, but the proportion of disabled candidates reduced for both applications to shortlist and shortlist to appointment. We will use our advertising and development of our ways of working pages to ensure an open and inclusive invitation for disabled and diverse candidates.

There has been an increase in the proportion of staff disclosing their disability status when compared to 2023/24. The number of staff who do not wish to disclose their disability status has reduced to 9% compared with 11% in 2023/24.

Figure 31: Proportion of staff declaring a disability



*99.9% due to rounding

Ethnicity

In 2024/25, the proportion of ethnic minority employees has increased to 34%, up from 33% in 2023/24. During this year we continued to grow our workforce in Leeds as well as seeing a number of staff moving to 100% home working. Figure 33 shows the current workforce profile compared to the regional profile information derived from the 2021 Census data for our two main office bases.

Figure 32: Ethnicity of staff (organisational profile)

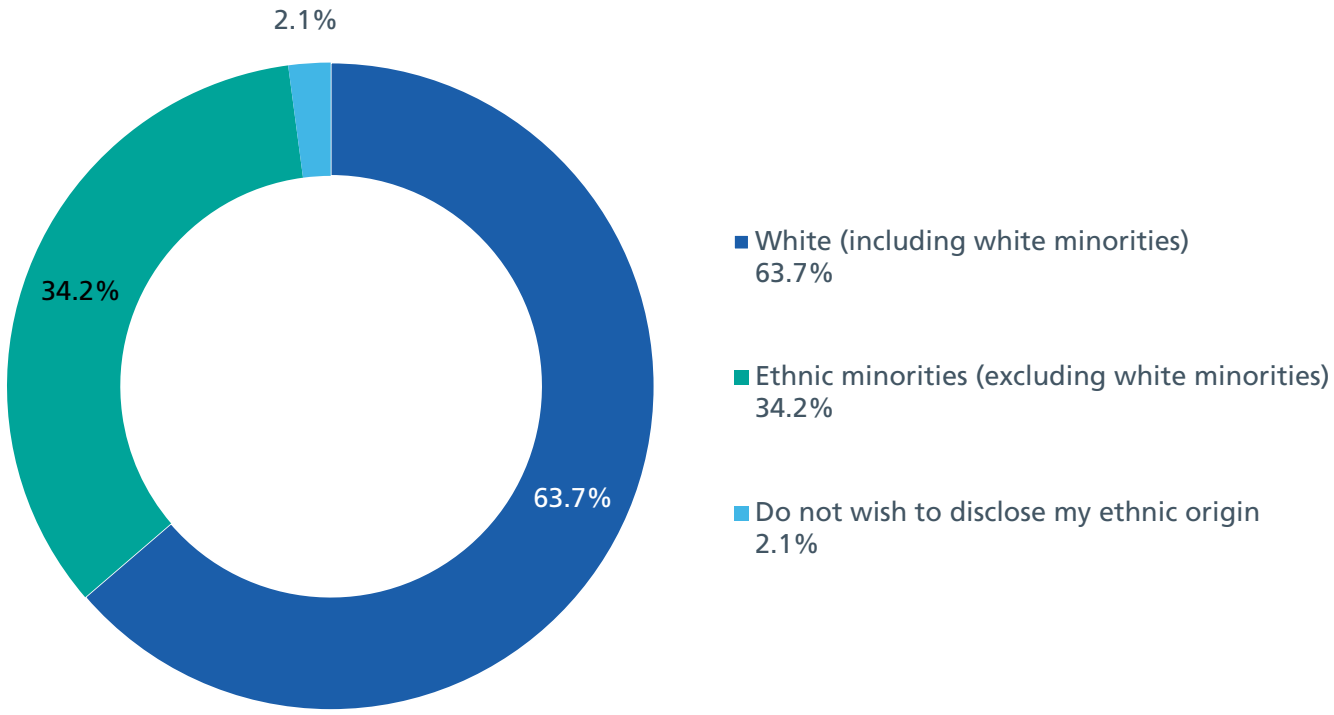
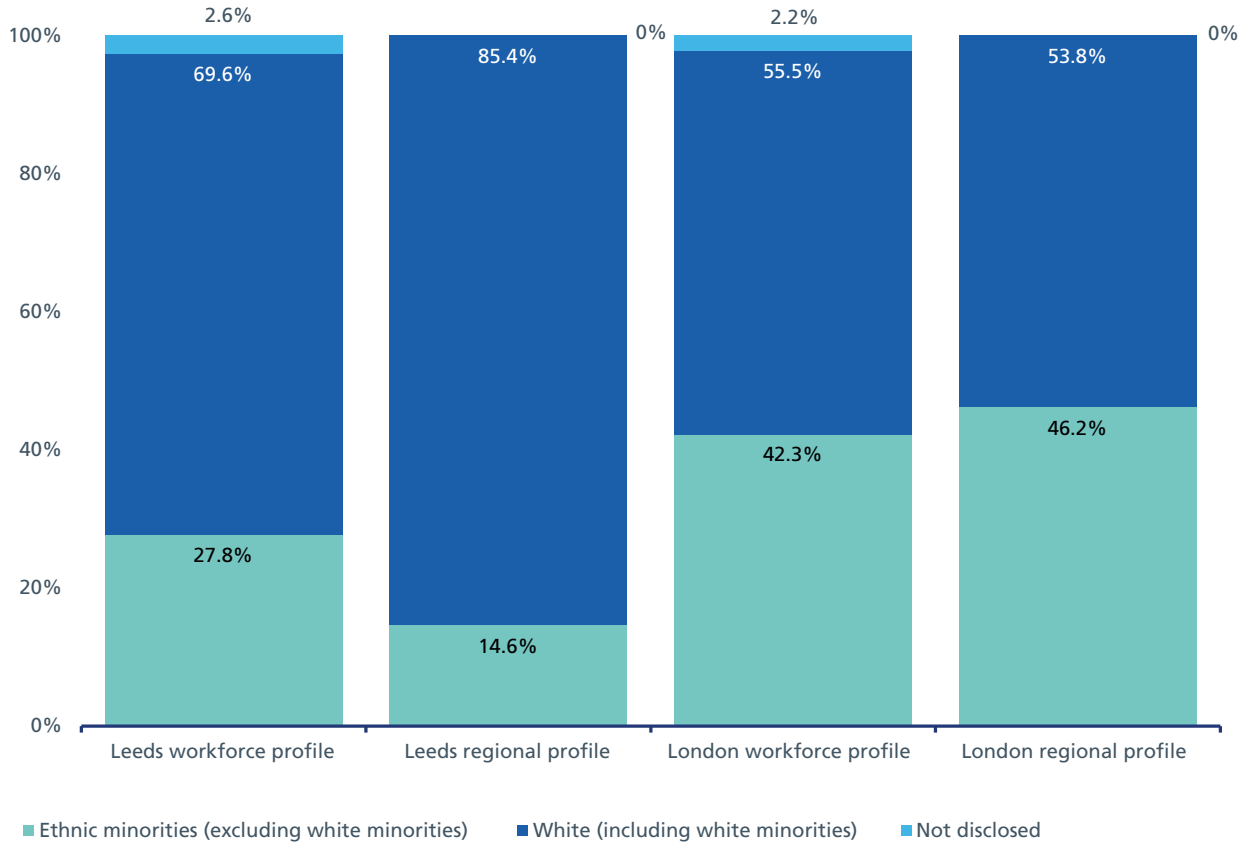


Figure 33: Ethnicity of staff based at NHS Resolution's London and Leeds offices compared to regional ethnicity data[1]



The number of London-based staff from an ethnic minority background (excluding white minorities) has increased to 42.3% compared with 40.6% in 2023/24. The regional profile for London has seen an increase in ethnic minority groups, up from 40% in the 2011 Census to 46.2% in 2021.

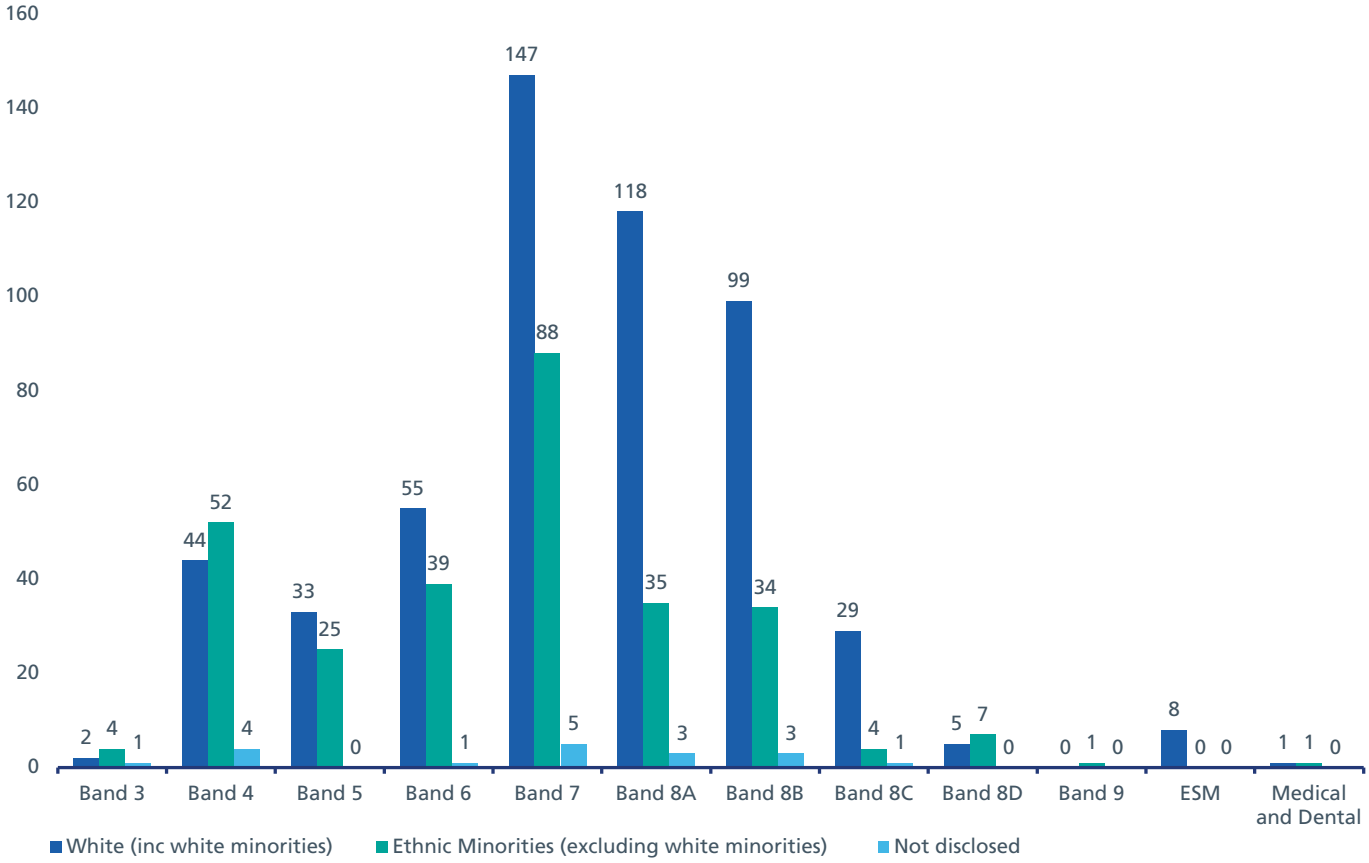
The number of Leeds-based staff who are from an ethnic minority background has increased to 27.8% compared with 21.2% in 2023/24.This is nearly double the regional workforce figure of 14.6%.

The regional profile for Leeds (Yorkshire and the Humber region) has also seen an increase in ethnic minority groups, up from 10.4% in the 2011 Census to 14.6% in 2021. The main category of ethnic minority staff in Leeds remains those from Asian groups, with an underrepresentation of staff from Black African/Caribbean/British backgrounds in comparison to the regional profile.

Figure 34 shows some areas of underrepresentation and overrepresentation across pay grades. While a number of the pay bands are closely aligned to the organisation's overall ethnicity ratio, there is an underrepresentation of ethnic minority staff at the ESM level and across pay bands 8a to 8c. This is consistent with the national data around the underrepresentation of ethnic minority staff at senior level within the NHS. The information also shows there is an overrepresentation of ethnic minority staff within the lower pay bands. As detailed in Equality, diversity and inclusion (EDI) on page 127, we continue to take steps to address these issues.

1 Leeds location reflects Yorkshire and the Humber. Regional ethnicity data is derived from the data published in the 2021 Census.

Figure 34: Headcount by ethnicity as at 31 March 2025



Sickness absence

The following figures are based on the 2024 calendar year. DHSC considers the resulting figures to be a reasonable proxy for financial year equivalents.

Figures converted by DHSC to best estimates of required data items			Statistics published by NHS Digital from ESR Data Warehouse	
Average FTE 2024	Adjusted FTE days lost to Cabinet Office definitions	Average sick days per FTE	FTE days available	FTE days lost to sickness absence
754	3,485	4.6	275,244	5,653

Table notes

Source: NHS Digital, Sickness Absence and Workforce Publications – based on data from the ESR Data Warehouse.

Period covered: January to December 2024.

Data items: ESR does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year. For the Annual report and accounts the following figures are used:

- The number of FTE days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
- The number of FTE days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
- The average number of sick days per FTE has been estimated by dividing the FTE days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

Off-payroll engagements

As of 31 March 2025, NHS Resolution has five off-payroll appointments costing more than £245 per day. None of these appointments is likely to last longer than six months and, at the time of reporting, all five appointments have existed for less than one year. The appropriate pre-placement checks were completed for these and for all off-payroll engagements, with the required assurances obtained to confirm these placements were assessed to ensure the appropriate tax and National Insurance arrangements were in place as they were not covered by IR35.[1]

Table 24: All off-payroll engagements as of 31 March 2025, for more than £245 per day

Off-payroll engagements as of 31 March 2025	
No. of existing engagements as of 31 March 2025	5
Of which:	
No. that have existed for less than one year at time of reporting	5
No. that have existed for between one and two years at time of reporting	-
No. that have existed for between two and three years at time of reporting	-
No. that have existed for between three and four years at time of reporting	-
No. that have existed for four or more years at time of reporting	-

Table 25: All off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day

Off-payroll engagements between 1 April 2024 and 31 March 2025	
No. of temporary workers engaged between 1 April 2024 and 31 March 2025	14
Of which:	
No. not subject to off-payroll legislation	-
No. subject to off-payroll legislation and determined as in scope of IR35	-
No. subject to off-payroll legislation and determined as out of scope of IR35	14
No. of engagements reassessed for compliance or assurance purposes during the year	-
No. of engagements that saw a change to IR35 status following the review	-

Table 26: Any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

No. of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off payroll that have been deemed 'Board members, and/or senior officials with significant financial responsibility' during the financial year	13

1 IR35 is tax legislation designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used.

Exit packages

Table 27: Exit packages

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies £000s	Number of other departures agreed	Cost of other departures agreed £000s	Total number of exit packages	Total cost of exit packages £000s	Number of departures where special payments have been made	Cost of special payment element included in exit packages £000s
Less than £10,000	-	-	3	15	3	15	-	-
£10,000–£25,000	-	-	2	28	2	28	-	-
£25,001–£50,000	-	-	-	-	-	-	-	-
£50,001–£100,000	-	-	-	-	-	-	-	-
£100,001–£150,000	-	-	-	-	-	-	-	-
£150,001–£200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Total			**5**	**43**	**5**	**43**		

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Table 28: Analysis of other departures

Type of other departures	Agreements number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	5	43
Exit payments following employment tribunals or court orders	-	-
Non-contractual payments requiring HMT approval	-	-
Total	**5**	**43**

As a single exit package can be made up of several components, each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in table 28, which will be the number of individuals.

Where appropriate, the Remuneration report includes disclosure of exit payments payable to individuals named in that report.

Trade Union Regulations

The Trade Union (Facilities Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. These regulations require relevant public sector organisations to report on the trade union facility time in their organisation. The following tables detail the number of union officials within NHS Resolution, the percentage of their time spent on facilities time, the percentage of pay bill spent on facilities time and the percentage of paid trade union activities. This covers the period 1 April 2024 to 31 March 2025.

Table 29: Relevant union officials from 1 April 2024 to 31 March 2025

Number of employees who were relevant union officials during 2024/25	Full-time equivalent employee number
1	1

Table 30: Percentage of time spent on facility time from 1 April 2024 to 31 March 2025

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

Table 31: Percentage of pay bill spent on facility time from 1 April 2024 to 31 March 2025

Percentage of pay bill	
Total cost of facility time	£4,818.55
Total pay bill[1]	£56,244,177
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	<0.01%

Table 32: Paid trade union activities from 1 April 2024 to 31 March 2025

Paid activities[2]	
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	34.05%

1 The total pay bill for this purpose is calculated against the total FTE headcount of all permanent and fixed term contract employed staff.

2 We note an increase in the paid trade union activities as a percentage of total paid facility time hours in 2024/25. This can be attributed to an increase of in-person UNISON meetings/conferences compared to previous years. Additionally, NHS Resolution has had one union official for the 2024/25 financial year and thus the increase could also be attributed to union officials reporting less time spent on union duties and increased time on union activities.

People

We recognise that when staff feel supported and listened to, they will continue to put every effort into helping to deliver value-for-money services and improve patient safety. Our approach to compassionate leadership is reflected in our *Being fair* charter and acknowledged by our Investors in People Gold accreditation awarded in 2023.

KPI 14: We continue to maintain the Investors in People 'We invest in People Gold' accreditation.

As illustrated in figure 35, our People Plan, which supported the implementation of our strategy to 2025, remained a focus for our workforce-related activities during 2024/25.

Figure 35: NHS Resolution's People Plan

Equality, diversity and inclusion

Our aim is to create an environment where staff respect and value each other's diversity. We have a set of intended actions which are captured in our equality, diversity and inclusion (EDI) people pillar. The key achievements for 2024/25 are set out below.

- The organisation has widened the Mandatory and Statutory Training (MAST) obligations including the introduction of sexual safety training in accordance with the Worker Protection Act 2023 (Amendment of the Equality Act 2010). In addition, recruitment and selection training is now a requirement for anyone involved in the recruitment of staff. This training ensures all staff are equipped with the relevant knowledge, skills and an understanding of the associated legislation, to recruit in a fair and consistent way.
- The organisation continues to ensure the EDI policy is clear, concise and reflects up-to-date procedures and ways of working.
- The organisation provides an offer of management development sessions which seek to educate new and existing managers to manage in line with our corporate values.
- The gender pay gap findings were signed off by the People Committee and published on both the GOV.UK website and the NHS Resolution external website in March 2025.

Gender pay gap reporting

In March 2025, in accordance with the requirements under the Equality Act 2010, we published our 2024 gender pay gap (GPG) report.

What are the key findings of the 2024 GPG report?

- ✓ Our 2024 mean GPG has decreased from 9.8% in 2023 to 8.2% in 2024.
- ✓ Our median GPG has decreased from 12.3% in 2023 to 10.9% in 2024.
- ✓ In 2024, female employees received a higher level of bonus pay compared to male employees.
- ✓ Our GPG remains lower than the 2024 UK GPG of 13.2%.
- ✓ In common with the wider NHS, our workforce is predominantly female; 67% of our workforce is female. While pay bands 6 to 8b and our ESM grade are generally reflective of the organisation's profile, there is a continued upwards trend in employing more female staff in bands 4 and 5. See figure 28: Staff headcount broken down by gender and banding as at 31 March 2025.
- ✓ Whilst we reported a higher turnover of female employees in senior pay bands (54%) compared to male employees (46%), with most leaving NHS Resolution due to promotion opportunities, this was less than the overall gender profile of the senior pay bands reported at 63% female and 37% male. Continued action is being taken to understand why females in senior roles are leaving the organisation by promoting the opportunity to undertake an exit interview. We are also encouraging managers to make effective use of the options available within our flexible working policy which may better support the retention of staff.

What are we going to do?

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

Workforce Race Equality Standard, Workforce Disability Equality Standard and ethnicity pay gap reporting

We continued to assess our workforce data in accordance with both the national Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. For the second year running we also considered our ethnicity pay gap (EPG) data, which was collated alongside our GPG data. All of this information was collated and presented as a combined staff inclusion report. The outputs from the staff inclusion report and subsequent required actions continue to be taken forward by the EDI working group.

Recruitment and retention

In support of our growth, we have continued to develop our internal resourcing expertise to ensure we are best placed to attract, recruit and retain staff. In collaboration with various parts of the organisation, we are evolving our attraction literature and approach, for example by using testimonials and videos of colleagues talking about their experiences at NHS Resolution to provide candidates with an insight into our ways of working. These are hosted within our LinkedIn careers pages and our new applicant tracking system. This approach will continue to evolve to support our recruitment activities in the attraction of high-calibre candidates.

With a focus on continuous service improvement, we are now using an end-to-end applicant tracking system (ATS), giving us a modern, reportable and easy-to-use system for candidates, hiring managers and the resourcing team. The new system replaces manual administrative tasks and therefore minimises the risk of errors occurring. It will provide a consistent and appropriate manner of communication in all our resourcing work. It will allow the team to use the system to on-board candidates online and link to our people software.

The ATS is in place to assist and support the organisation in attracting and recruiting the best and most diverse range of candidates while ensuring we keep up to date with technology changes and demands in workforce requirement and ensure a consistent experience for all users.

We have continued to use LinkedIn to advertise our roles, growing our professional networks and direct sourcing talent, resulting in a good number of difficult or hard-to-fill roles being filled as well as building our recruiting brand in the candidate market. As a result of our internal expertise and making the best use of our available routes to market, we have reduced our recruitment spend by approximately £350,000 (agency placement fee spend) and approximately £300,000 on advertising due to use of free-to-post advertising, direct advertising and candidate sourcing.

We remain committed to supporting the Government's Places for Growth agenda by continuing to increase our presence outside of London. We have continued to benefit from a nationwide approach to recruitment, and our current strategy is, wherever possible, to recruit to Leeds or home working arrangements by default.

Maximising employee health and wellbeing

Throughout the year, we continued to support staff health and wellbeing through a range of initiatives. In January 2025 we ran a 'Thrive in 2025' campaign, which explored the different dimensions of wellbeing and highlighted the wide range of support available across the organisation.

In 2024 we launched a new Employee Assistance Programme (EAP) to ensure the right level of wellbeing support was available to our staff at all times.

We have continued to evolve and update our health and wellbeing offer, which consists of tools to support mental, physical and financial wellbeing.

Talent management and succession planning

In line with our leadership and talent management strategy and following the director and deputy director talent conversations that took place throughout 2023/24, talent conversations have been taking place between deputy directors and their heads of service this year. Evaluation of these sessions will be used to inform a corporate rollout during 2025/26.

The Performance Appraisal Development Review (PADR) process cycle for all substantive staff runs from April to June each year. The organisation reported 93% compliance in 2024, down from 96% in 2023. For the 2025 PADR cycle we will be recording activity directly onto our Oracle Learning Management (OLM) system for those areas of the business who wish to utilise the digital functionality available.

We continue to use the apprenticeship levy to support a range of courses across the organisation. Apprenticeships are open to all staff at every level. The courses are funded through an apprenticeship levy at no cost to the learner. The organisation is currently supporting 27 members of staff through a range of apprenticeships.

Organisational change and transformation

HR and OD digitalisation

We have continued to make significant advances over the past 12 months in relation to our systems and digitalisation ambitions. In support of this we undertook an assessment of our Electronic Staff Record (ESR) which provided clear progress in all ten areas of the assessment and a clear focus for further improvement made in 2025.

In addition to the new ATS mentioned on page 128, we have continued to enhance our approach to capturing Mandatory and Statutory Training (MAST) data by moving away from manual recording to using ESR and OLM. The employee self-service portal provides a single point of access for MAST requirements and also allows line managers to view their team's compliance data at any given time. During the year we have also started to use OLM for other non-mandatory training packages. This not only enables staff to enrol on courses via their self-service portal but also allows the organisation to track and report on course attendance and compliance where appropriate.

During 2024/25 we extended our online leave management via ESR to cover all leave categories including special leave and sickness absence. This approach continues to provide staff and managers with quicker and easier management and oversight of leave allocation and allowances.

Our People Portal is a single point of contact for HR and OD related enquiries. Following a successful pilot, the portal was rolled out across the organisation in March 2024. Since its implementation, we have received 3,698 tickets and achieved a 99% resolution rate to these enquiries.

The ongoing improvements to our systems and tools aim to involve less resource-intensive processes, which allow our staff to spend their time on more value-adding activities.

Parliamentary accountability and audit report

The following disclosures are subject to audit except where specified.

Losses and special payments

We had losses of £62,707 and special payments of £352,602 in 2024/25. Of the special payments all individual payments were below the £300,000 threshold. In 2023/24 we had losses of £28,417 and no special payments. There were no special severance payments in the year (2023/24 none).

Fees and charges

Contribution levels for members of the indemnity schemes that NHS Resolution operates, i.e. the CNST, LTPS and PES schemes, are determined in order to meet members' liabilities as they fall due, in accordance with our accounting policy in Note 1.3 to the financial statements on page 149. The member contributions collected are set on the estimated full cost recovery basis. In addition to member contributions, NHS Resolution earns income from advice services which makes up our total operating income, (Note 3 to the financial statements on page 154). For 2024/25 total operating income was £2,930.0 million with related expenditure totalling £2,915.3 million.

Expenditure on consultancy

Expenditure incurred on consultancy in 2024/25 was nil. In 2023/24 the expenditure on consultancy was nil.

Gifts – notation of gifts made over the limits proscribed in Managing Public Money

We have not received or made any gifts where the value exceeded £300,000. Staff are required to declare gifts in line with NHS Resolution's Conflict of Interest Policy including hospitality and gifts (CG06), which states staff should not accept gifts that may affect, or be seen to affect, their professional judgement.

Regularity of expenditure

All expenditure is regular within the bounds of Parliament's intentions.

Indemnity scheme cover for NHS Resolution (not subject to audit)

For 2024/25, NHS Resolution was covered under both LTPS and PES.

Government Functional Standards (not subject to audit)

We continue to be compliant with the mandated requirements of the Government Functional Standards. We consider actions for continuous improvement in line with the Government Functional Standards Continuous Improvement Frameworks where relevant and proportionate to the work of NHS Resolution.

Remote contingent liabilities

The judgements and estimates taken to place a value on the provision and contingent liabilities (see Notes 7 and 8 to the Financial Statements on pages 158 and 182) arising from the indemnity schemes that NHS Resolution administers do not include an assessment for events that at this point in time, are too uncertain or remote to include. Therefore, there is no recognition of potential change in the value of the provision arising from policy developments, in particular around efforts to improve safety in the NHS (other than through experience reflected in current and past claims).

The Department of Health and Social Care previously proposed a scheme to apply Fixed Recoverable Costs (FRCs) to clinical negligence claims valued at between £1,501 and £25,000 coupled with a streamlined pre-action protocol with fixed timelines. The current Government has made no announcement on the future of the FRC scheme. The Civil Procedure Rule Committee (CPRC) will be responsible for enacting any necessary rule changes and we continue to monitor progress to ensure that NHS Resolution is in a position to respond if FRC proceeds.

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

I am satisfied that this Accountability report is a true and fair reflection of the work undertaken by NHS Resolution throughout 2024/25.

Helen Vernon
Chief Executive and Accounting Officer

Date: Friday 11 July 2025

The Certificate and Report of the Comptroller and Auditor General to the House of Commons

Opinion on financial statements

I certify that I have audited the financial statements of the NHS Litigation Authority (herein referred to as NHS Resolution) for the year ended 31 March 2025 under the National Health Service Act 2006.

The financial statements comprise NHS Resolution's:

- Statement of Financial Position as at 31 March 2025;
- Statement of Comprehensive Net Expenditure, Statement of Cash Flows and Statement of Changes in Taxpayers' Equity for the year then ended; and
- the related notes including the significant accounting policies.

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

In my opinion, the financial statements:

- give a true and fair view of the state of NHS Resolution's affairs as at 31 March 2025 and its net expenditure for the year then ended; and
- have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Opinion on regularity

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

Basis for opinions

I conducted my audit in accordance with International Standards on Auditing (UK) (ISAs UK), applicable law and Practice Note 10 Audit of Financial Statements and Regularity of Public Sector Bodies in the United Kingdom (2024). My responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of my certificate.

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

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

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

I draw attention to the disclosures made in Note 7 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in Note 7, given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by NHS Resolution. Significant changes to the liability could occur as a result of subsequent information and events that are different from the current assumptions adopted by NHS Resolution.

My opinion is not modified in respect of this matter.

Conclusions relating to going concern

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

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

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

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

Other information

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

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

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

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

I have nothing to report in this regard.

Opinion on other matters

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

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

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

Matters on which I report by exception

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

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

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

Responsibilities of the Accounting Officer for the financial statements

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

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

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

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

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

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

Audit response to identified risk

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

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

I communicated relevant identified laws and regulations and potential risks of fraud to all engagement team members including where relevant internal specialists and remained alert to any

indications of fraud or non-compliance with laws and regulations throughout the audit.

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

Other auditor's responsibilities

I am required to obtain sufficient appropriate audit evidence to give reasonable assurance that the expenditure and income recorded in the financial statements have, in all material respects, been applied to the purposes intended by Parliament and the financial transactions recorded in the financial statements conform to the authorities which govern them.

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

Report

I have no observations to make on these financial statements.

Gareth Davies

Comptroller and Auditor General

15 July 2025

National Audit Office
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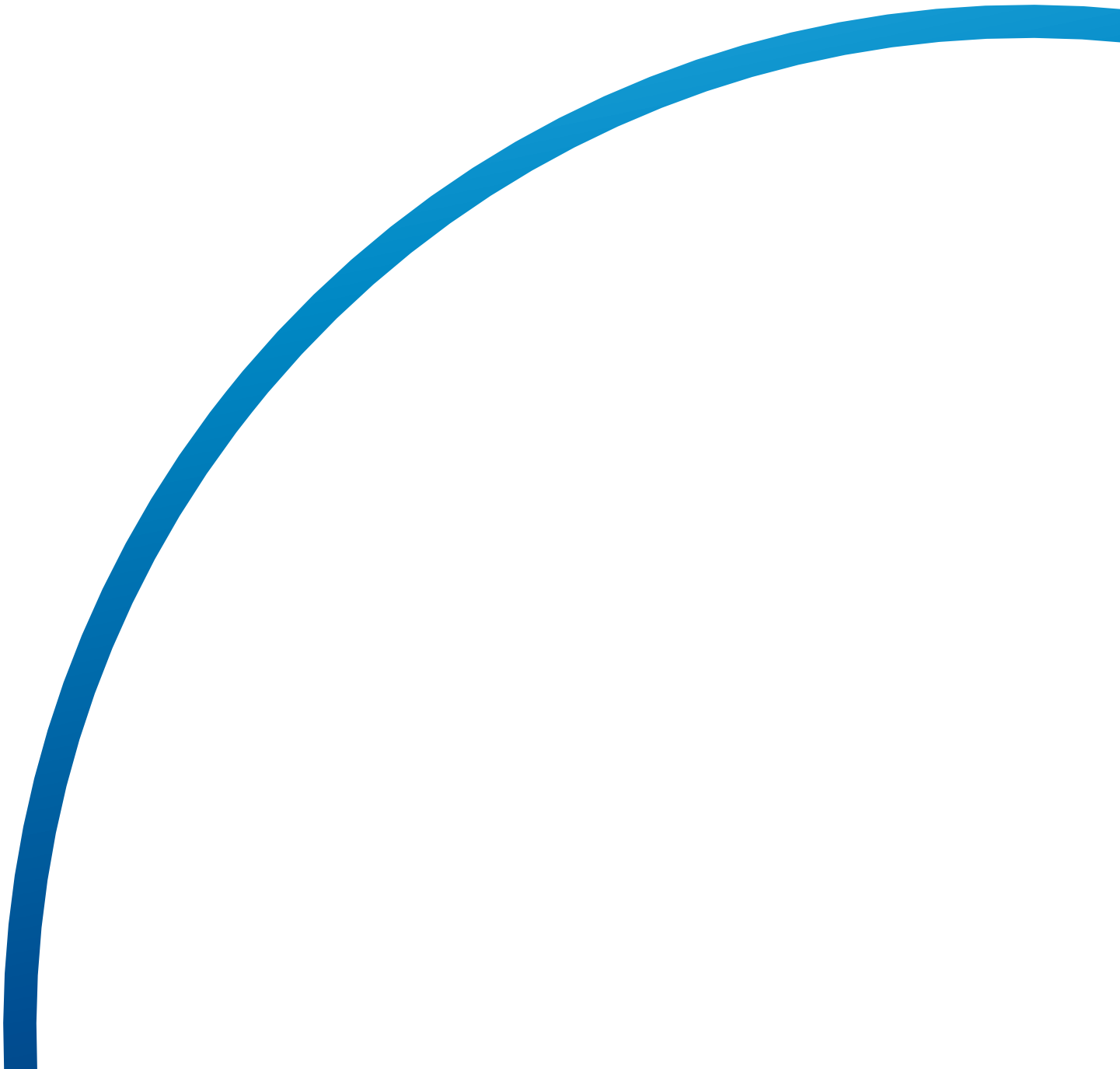
Victoria
London
SW1W 9SP



Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2025

Comprehensive net expenditure	Notes	31 March 2025 £000	31 March 2024 £000
Other operating income	3	**(2,929,613)**	(2,725,562)
Total operating income		**(2,929,613)**	**(2,725,562)**
Staff costs	2	**57,469**	45,802
Purchase of goods and services	2	**8,386**	7,691
Depreciation and impairment charges	2	**1,713**	1,878
Provision (release)/expense	7/7.1	**3,674,306**	(9,147,447)
Other operating expenditure	2	**4,006**	3,404
Total operating expenditure		**3,745,880**	**(9,088,672)**
Net operating expenditure		**816,267**	**(11,814,234)**
Finance costs – interest on lease liability	2/9	**78**	87
Finance costs – claims	7	**1,305,762**	884,985
Net expenditure for the year		**2,122,107**	**(10,929,162)**
Comprehensive net expenditure for the year		**2,122,107**	**(10,929,162)**

Statement of financial position as at 31 March 2025

Statement of financial position	Notes	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Property, plant and equipment		**544**	857
Intangible assets		**14,476**	10,829
Right of use assets		**7,362**	8,394
Total non-current assets		**22,382**	**20,080**
Current assets			
Trade and other receivables	4	**15,643**	26,666
Cash and cash equivalents	5	**739,241**	685,452
Total current assets		**754,884**	**712,118**
Total assets		**777,266**	**732,198**
Current liabilities			
Trade and other payables	6	**(88,058)**	(61,945)
Lease liability – short term	9	**(971)**	(948)
Provisions for liabilities and charges – known claims	7	**(3,668,755)**	(3,686,649)
Total current liabilities		**(3,757,784)**	**(3,749,542)**
Total assets less current liabilities		**(2,980,518)**	**(3,017,344)**
Non-current liabilities			
Lease liabilities	9	**(6,702)**	(7,673)
Provisions for liabilities and charges – known claims	7	**(32,575,315)**	(31,035,322)
Provisions for liabilities and charges – IBNR	7	**(24,082,000)**	(23,758,000)
Total non-current liabilities		**(56,664,017)**	**(54,800,995)**
Total assets less liabilities		**(59,644,535)**	**(57,818,339)**
Taxpayers' equity			
General Fund		**38,284**	36,291
Ex-RHA reserve		**(35,328)**	(35,328)
ELS reserve		**(672,660)**	(655,757)
CNST reserve		**(55,198,419)**	(53,529,293)
DHSC clinical reserve		**(1,701,224)**	(1,711,315)
ELSGP reserve		**(483,666)**	(576,000)
CNSGP reserve		**(1,352,902)**	(1,089,997)
CNSC reserve		**(7,212)**	(26,133)
CTIS reserve		**(4)**	(100)
DHSC non-clinical reserve		**(83,631)**	(83,325)
PES reserve		**8,429**	7,064
LTPS reserve		**(156,202)**	(154,446)
Total taxpayers' equity		**(59,644,535)**	**(57,818,339)**

The General Fund and individual scheme reserves are used to account for all financial resources. See figure 2: Our indemnity schemes on page 12 for a brief description of each scheme to which the reserves relate.

The Board approved a recommendation on 25 June 2025 that the financial statements from page 138 should be signed by the Accounting Officer and these were signed by Helen Vernon on 11 July 2025. The Notes on pages 146 to 187 form part of these financial statements.

Helen Vernon

Chief Executive and Accounting Officer

Date: Wednesday 11 July 2025

Statements of cash flows for the year ended 31 March 2025

Cash flows	Notes	31 March 2025 £000	31 March 2024 £000
Cash flows from operating activities			
Net income/(expenditure)		**(2,122,107)**	10,929,162
Net finance cost – IFRS 16		**78**	87
Other cash flow adjustments	2	**1,721**	1,878
Decrease/(Increase) in receivables	4	**11,023**	(6,997)
Increase/(Decrease) in payables	6	**26,113**	(4,498)
(Decrease)/increase in provisions	7	**1,846,099**	(11,133,542)
Net cash (outflow) from operating activities		**(237,073)**	**(213,910)**
Cash flows from investing activities			
Purchase of property, plant and equipment		**(7)**	(302)
Purchase of intangible assets		**(4,023)**	(3,153)
Net cash (outflow) from investing activities		**(4,030)**	**(3,455)**
Cash flows from financing activities			
Net Parliamentary funding		**295,911**	298,100
Repayment of lease liability – capital	9	**(941)**	(924)
Repayment of lease liability – interest	9	**(78)**	(87)
Net financing		**294,892**	**297,089**
Net increase in cash and cash equivalents		**53,789**	79,724
Cash and cash equivalents at the beginning of the period		**685,452**	605,728
Cash and cash equivalents at the end of the period	**5**	**739,241**	**685,452**

Statement of changes in taxpayers' equity for the year ended 31 March 2025

Changes in taxpayers' equity	General Fund £000	Ex-RHA Reserve £000	ELS Reserve £000	CNST Reserve £000	DHSC Clinical Reserve £000
Balance at 31 March 2023	33,593	(43,701)	(833,763)	(64,030,917)	(2,213,692)
Total recognised income and expense as at 2023/24	(6,807)	6,857	155,150	10,501,624	420,387
Net Parliamentary funding	9,505	1,516	22,856	-	81,990
Balance at 31 March 2024	**36,291**	**(35,328)**	**(655,757)**	**(53,529,293)**	**(1,711,315)**
Changes in taxpayers' equity for 2024/25					
Expenditure					
Authority and claims administration	(8,250)	-	(32)	(40,965)	(281)
(Increase)/decrease in provision for known claims	-	(1,608)	(41,724)	(4,215,658)	(65,651)
(Increase)/decrease in the provision for IBNR	-	-	-	(280,000)	(10,000)
	(8,250)	**(1,608)**	**(41,756)**	**(4,536,623)**	**(75,932)**
Scheme and other income	979	-	-	2,867,497	-
Total recognised income and expense for 2024/25	**(7,271)**	**(1,608)**	**(41,756)**	**(1,669,126)**	**(75,932)**
Net Parliamentary funding	9,264	1,608	24,853	-	86,023
Balance at 31 March 2025	**38,284**	**(35,328)**	**(672,660)**	**(55,198,419)**	**(1,701,224)**

	CNSGP Reserve £000	CNSC Reserve £000	CTIS Reserve £000	DHSC Non-Clinical Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
(731,589)	(912,927)	(36,414)	(2,240)	(97,075)	3,835	(180,711)	**(69,045,601)**
	(206,279)	9,592	1,985	7,550	3,229	26,265	**10,929,162**
145,980	29,209	689	155	6,200	-	-	**298,100**
	(1,089,997)	**(26,133)**	**(100)**	**(83,325)**	**7,064**	**(154,446)**	**(57,818,339)**
(8,898)	(5,325)	(178)	(59)	(189)	(149)	(7,326)	**(71,652)**
	(186,740)	(1,347)	-	(5,233)	(7,486)	(78,567)	**(4,656,068)**
48,000	(128,000)	18,000	-	(4,000)	-	32,000	**(324,000)**
	(320,065)	**16,475**	**(59)**	**(9,422)**	**(7,635)**	**(53,893)**	**(5,051,720)**
	-	-	-	-	9,000	52,137	**2,929,613**
	(320,065)	**16,475**	**(59)**	**(9,422)**	**1,365**	**(1,756)**	**(2,122,107)**
	57,160	2,446	155	9,116	-	-	**295,911**
	(1,352,902)	**(7,212)**	**(4)**	**(83,631)**	**8,429**	**(156,202)**	**(59,644,535)**

Notes to the financial statements

1. Accounting policies

The financial statements have been prepared in accordance with the 2024/25 Government Financial Reporting Manual (FReM) issued by HM Treasury (HMT). The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRSs) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy that is judged most appropriate to the particular circumstances of NHS Resolution for giving a true and fair view has been selected. The particular policies adopted by NHS Resolution are described in the following text. They have been applied consistently in dealing with items considered material to the accounts.

The accounts are presented in pounds sterling and all values are rounded to the nearest thousand pounds, with the exception of IBNR provisions which are rounded to the nearest million pounds. The functional currency of NHS Resolution is pounds sterling.

1.1 Accounting conventions

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

1.2 New adoption of standards, amendments and interpretations

New standards or amendments effective and adopted in these accounts

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

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

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

The following have not been adopted early in these accounts:

IFRS 17 Insurance Contracts

The effective date for the adoption of IFRS 17 was for accounting periods beginning on or after 1 January 2023, but this standard was adopted by the FReM from 1 April 2025.

NHS Resolution has conducted several thorough assessments of IFRS 17 and have determined that the schemes we administer on behalf of the Secretary of State for Health and Social Care are outside the scope of IFRS 17.

The basis for this significant judgement is the FReM's interpretation and adaptation of IFRS 17 for public sector. FReM chapter 8 (section 8.2) states that:

"For the purpose of applying IFRS 17 in central government, legislation and regulations, in isolation, are not equivalent to insurance contracts. Legislation and regulations can include binding rights or obligations, can facilitate the creation of arrangements that fall within the definition of a contract and can form part of the implied terms of a contract, but in themselves are not agreements between parties. (IFRS 17 para 2)."

Therefore, a judgement can be made that:

- if the scheme is established under legislation and the terms of the rules supporting the scheme do not add or amend the requirements set out in legislation; and
- the rules do not create additional financial rights or obligations beyond those that were already established within the relevant legislation.

Then the scheme is deemed to be outside of the scope of IFRS 17.

In considering the legislation we note that NHS Resolution (known formally as NHS Litigation Authority) was established under the National Health Service Litigation Authority (Establishment and Constitution) Order 1995 which came into force on 20 November 1995. This legislation gives NHS Resolution the authority to act on behalf of the Secretary of State for Health and Social Care to establish and administer the schemes under the National Health Service and Community Care Act 1990 (scheme for meeting liabilities of health service bodies).

The most significant of our schemes is the Clinical Negligence Scheme for Trusts (CNST), which represents 92% of the total provision as at 31 March 2025 of the indemnity schemes administered by NHS Resolution.

The basis of the CNST Scheme is established by and set out in primary and secondary legislation. The National Health Service Act 2006 is the primary legislation which enables the scheme to be established and the current regulations for the CNST are the National Health Service (Clinical Negligence Scheme) Regulations 2015 (SI 2015/559). They were made under the power set out under Section 71 of the 2006 Act as a statutory instrument.

A full review was performed of the clauses within the Scheme Rules to confirm that no additional financial rights or obligations were created beyond those that were already established within the relevant legislation.

NHS Resolution has concluded from the work performed that the Scheme Rules do not create additional financial rights or obligations beyond those established in legislation whilst the member remains within the scheme, and therefore the CNST is outside the scope of IFRS 17. This applies similarly to all other schemes NHS Resolution administers on behalf of the Secretary of State for Health and Social Care.

IFRS 14 Regulatory Deferral Accounts

The effective date for first time adopters of IFRS 14 was for accounting periods beginning on or after 1 January 2016. However, this standard has not been endorsed by the UK and has not been adopted within FReM. NHS Resolution's assessment is that this standard would not be applicable to our business and therefore is not anticipated to have any impact on the accounts.

IFRS 18 Presentation and Disclosure in Financial Statements

IFRS 18 was published in April 2024. The effective date for first time adopters of IFRS 18 is for accounting periods beginning on or after 1 January 2027. However, this standard has not yet been adopted within FReM. NHS Resolution's initial assessment is that this standard will not materially impact the accounts but may require consideration of some additional disclosures.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

IFRS 19 was published in May 2024. The effective date for first time adopters of IFRS 19 is for accounting periods beginning on or after 1 January 2027. However, this standard has not yet been adopted within FReM. NHS Resolution's assessment is that this standard would not be applicable to our business and therefore is not anticipated to have any impact on the accounts.

IAS 8 Accounting Policies, Changes in Accounting Estimates and Errors

In December 2023 HM Treasury released an exposure draft on potential changes to make to valuing and accounting for non-investment assets (e.g. PPE, intangible assets). The following changes to the valuation and accounting of non-investment assets is to be included in the 2025-26 FReM for mandatory implementation.

References to assets being held for their "service potential" and the terms "specialised / non-specialised" assets are being removed from the FReM. Non-investment assets are instead described as assets held for their "operational capacity". This change has no impact on the valuation basis of non-investment assets which remains Existing Use Value (EUV) or Net Book Value (NBV).

An adaptation to IAS 16 will be introduced to withdraw the requirement to revalue an asset where its fair value materially differs from its carrying value. Assets are now valued using one of the following processes:

- A quinquennial revaluation supplemented by annual indexation.
- A rolling programme of valuations over a five year cycle, with annual indexation applied to assets during the four intervening years.
- For non-property assets only appropriate indices.
- In rare circumstances where an index is not available, a quinquennial revaluation supplemented by a desktop revaluation in year three.

The option to measure intangible assets using the revaluation model is withdrawn. The carrying values of intangible assets at 31 March 2025 will be considered the historical cost at 1 April 2025.

NHS Resolution's assessment is that this standard would not materially impact the accounts as our non-investment assets are immaterial and therefore, we will continue to account for PPE and intangible assets under historical cost less depreciation and right of use assets as per IFRS 16 requirements.

IAS 21 The Effects in Foreign Exchange Rates

The revisions to IAS 21 were published in August 2023 and the effective date for adoption is for accounting periods beginning on or after 1 January 2025. The revisions relate to the rate of exchangeability on foreign currency when one currency cannot be exchanged into another. It is our assessment that as NHS Resolution has minimal foreign currency transactions and that all such transactions have always been in known currencies such as US Dollar, Euro and NZ Dollars, we do not consider that this update is applicable and therefore we do not have a policy on it.

Annual improvements process

The International Accounting Standards Board (IASB) makes minor amendments to improve the clarity and internal consistency with IFRS Accounting Standards. Only those applicable to NHS Resolution are listed below.

IFRS 9 Financial instruments

The amendments to IFRS 9 will become effective for accounting periods beginning on or after 1 January 2026. The key amendments to IFRS 9 are:

- Amendment on trade receivables – IFRS 9 has been amended to require companies to initially measure a trade receivable without a significant financing component at the amount determined by applying IFRS 15.
- Derecognising lease liabilities – if a lease liability is derecognised, then its derecognition is accounted for under IFRS 9. However, when a lease liability is modified, the modification is accounted for under IFRS 16 Leases. The amendment states that when lease liabilities are derecognised under IFRS 9, the difference between the carrying amount and the consideration paid is recognised in profit or loss.

It is anticipated that the above amendment to trade receivables will have minimal impact on NHS Resolution's accounts as we already report under IFRS 15 for trade receivables. With regards to the amendment in respect of IFRS 16 Leases we currently anticipate no impact as we have no foreseeable need to derecognise lease liabilities early and the application of IFRS 16 will run its course for the remainder of the initial 10 year lease period on which it was calculated for London and Leeds office leases.

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

1.3 Income

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

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

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

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

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

Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within the same financial year that NHS Resolution receives the returned funds.

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

Annual compliance with the ten safety actions was assessed in 2024/25. The contributions to the MIS were collected and distributed against achievement of the actions in the 2024/25 financial year.

1.4 Taxation

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

1.5 Pensions

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

NHS Pension scheme

Past and present employees are covered by the provisions of the NHS pension schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website.[1] Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025 is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 HMT have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

NEST

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

1 See https://www.nhsbsa.nhs.uk/nhs-pensions

NEST is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. The minimum contributions remain set at 8%. Contributions are taken from qualifying earnings, which for the tax year 2024/25 were earnings between £6,240 and £50,270. Employee contributions are set at 5% although most employees will only pay around 4% of their take-home pay as they will get tax relief from the government every time they contribute. Employer contributions are set at 3%. More details on NEST can be found on the NEST website[1].

1.6 Short-term employee benefits

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

1.7 Provisions and contingent liabilities

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

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

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

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

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

1.8 Financial assets

The simplified approach to impairment, in accordance with IFRS 9, measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses (stage 1). For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2).

DHSC provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and as such NHS Resolution does not recognise stage 1 or stage 2 losses against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), NHS Resolution measures expected credit losses at the reporting date as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss. In the current year, following review of NHS Resolution debts, we have not recognised any expected credit loss (nil in 2023/24).

1.9 Financial liabilities

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

1 See https://www.nestpensions.org.uk/schemeweb/nest/my-nest-pension/contributions-and-fees

1.10 Critical judgements and key sources of estimation uncertainty

In the application of NHS Resolution's accounting policies, which are described elsewhere in Note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities. The key accounting estimates relate to the calculation of the provision for known claims and for IBNR as disclosed in Note 7.

NHS Resolution's assessment of IFRS 17 has concluded that NHS Resolution is out of scope and therefore, from adoption of the standard by the FReM from accounting periods after 1 April 2025, we will continue to account for provisions in accordance with IAS 37 as detailed in Note 1.7 above.

There have been no other critical accounting judgements relevant to the accounts.

1.11 IFRS 8 – operating segments

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

1.12 IFRS 16 – leases

The transition to IFRS 16 was completed in accordance with paragraph C5 (b) of the Standard, applying IFRS 16 requirements retrospectively recognising the cumulative effects at the date of initial application.

The London lease is for ten years, and the Leeds lease is for twenty years with five-year break clauses. Management recognised both leases for a ten-year period based on reasonable certainty that this would be the expected life of both property leases. Management will review again when appropriate.

NHS Resolution measured the right of use assets for leases previously classified as operating leases, at an amount equal to the lease liability adjusted for accrued or prepaid lease payments.

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

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

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

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

Short-term leases of low-value assets

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

2. Expenditure

Expenditure	Notes	2024/25 £000	2023/24 £000
Non-executive members' remuneration[1]		**153**	127
Other salaries and wages[2]			
Salaries and wages		**43,526**	35,601
Social security costs		**4,942**	3,985
Pension costs		**8,798**	6,042
Apprenticeship levy		**203**	174
Education, training and conferences		**190**	196
Establishment expenses		**694**	902
Low-value and short-term leases			
Land and buildings		**73**	63
Lease cars		**4**	5
Photocopiers and franking machine		**-**	(7)
Insurance		**139**	135
Transport (business travel)		**225**	187
Premises and fixed plant		**6,341**	5,482
External contractors			
Actuary's advice		**1,886**	1,771
Appeals advisory expenditure		**150**	46
External corporate legal fees[3]		**319**	365
Practitioner Performance Advice assessment expenditure		**292**	277
Other[4]		**1,504**	1,172
Auditor's remuneration: audit fees[5]		**310**	295
Internal audit fees		**91**	68
Bank charges and interest		**13**	11
Disposal of assets		**8**	-
		69,861	**56,897**
Depreciation		**312**	379
Depreciation – right of use assets		**1,025**	1,034
Amortisation		**376**	465
Total depreciation and amortisation		**1,713**	**1,878**
Total expenditure before provisions and finance costs[6]		**71,574**	**58,775**
Finance costs – unwinding of discount	7	**1,305,762**	884,985
Increase in provision for known claims (excl. unwinding of discounts and change in the discount rates)	7	**3,898,060**	4,452,329
Change in the discount rates[7]	7	**(1,053,754)**	(14,552,776)
Increase in the provision for IBNR	7	**830,000**	953,000
Total provision (release)/expense	**2.1/7.1**	**4,980,068**	**(8,262,462)**
Finance costs – interest on lease liability		**78**	87
Total provision (release)/expense and finance costs		**4,980,146**	**(8,262,375)**
Total (income)/expenditure		**5,051,720**	**(8,203,600)**

1 Additional explanations can be found in the Remuneration and staff report in the Accountability report section.
2 Additional explanations can be found in the Remuneration and staff report in the Accountability report section.
3 External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included in Note 7: Provisions.
4 Other external contractor costs have increased primarily due to additional spend in professional services on Core Systems Projects.
5 NHS Resolution did not make any payments to its auditors for non-audit work.
6 Of the £71.7 million total expenditure for 2024/25, £6.1 million is shown as administration expenditure in DHSC consolidated group accounts.
7 The discount rates used are mandated by HMT and are set out in Note 7.3 to the financial statements.

2.1 Analysis of the provision expense

2024/25	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000
2024/25 incidents				
Known claims	-	-	28,464	-
IBNR	-	-	4,556,978	-
Total 2024/25			**4,585,442**	
Prior year incidents				
Known claims	1,608	41,724	4,187,193	65,652
IBNR	-	-	(4,276,977)	9,999
Total prior years	**1,608**	**41,724**	**(89,784)**	**75,651**
Total	**1,608**	**41,724**	**4,495,658**	**75,651**

2023/24	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000
2023/24 incidents				
Known claims	-	-	20,685	-
IBNR	-	-	4,757,121	-
Total 2023/24			**4,777,806**	
Prior year incidents				
Known claims	(6,861)	(143,196)	(3,207,662)	(330,694)
IBNR	-	(12,000)	(9,440,121)	(90,000)
Total prior years	**(6,861)**	**(155,196)**	**(12,647,783)**	**(420,694)**
Total	**(6,861)**	**(155,196)**	**(7,869,977)**	**(420,694)**

3. Operating income

Operating income	2024/25 £000	2023/24 £000
CNST contributions	**2,867,497**	2,664,151
LTPS contributions	**52,137**	52,523
PES contributions	**9,000**	8,000
Practitioner Performance Advice	**979**	888
Total	**2,929,613**	**2,725,562**

	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
	2,759	-	-	0	3,563	7,384	**42,170**
-	290,264	-	-	78	2,545	26,823	**4,876,688**
	293,023			**78**	**6,108**	**34,207**	**4,918,858**
	183,981	1,347	-	5,233	3,923	71,182	**4,613,897**
(48,000)	(162,264)	(18,000)	-	3,922	(2,545)	(58,822)	**(4,552,687)**
	21,717	**(16,653)**		**9,155**	**1,378**	**12,360**	**61,210**
	314,740	**(16,653)**		**9,233**	**7,486**	**46,567**	**4,980,068**

	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
	1,282	-	-	-	4,866	8,017	**34,850**
-	271,866	-	-	114	2,309	50,983	**5,082,393**
	273,148			**114**	**7,175**	**59,000**	**5,117,243**
	125,485	3,363	-	7,329	772	31,385	**(3,516,312)**
(20,000)	(196,866)	(13,000)	(2,000)	(15,114)	(3,309)	(70,983)	**(9,863,393)**
	(71,381)	**(9,637)**	**(2,000)**	**(7,785)**	**(2,537)**	**(39,598)**	**(13,379,705)**
	201,767	**(9,637)**	**(2,000)**	**(7,671)**	**4,638**	**19,402**	**(8,262,462)**

4. Receivables

Receivables	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000
NHS receivables – revenue	-	-	4	-	-	-
Accrued income	-	-	580	-	-	-
Prepayments	52	498	761	1,840	-	-
VAT	-	11	4,759	63	141	250
Other receivables	-	94	3,121	47	-	-
At 31 March 2025	**52**	**603**	**9,225**	**1,950**	**141**	**250**

5. Cash and cash equivalents

Cash and cash equivalents	Ex-RHA £000	ELS £000	CNST £000	ELSGP £000	CNSGP £000
At 1 April 2024	1,167	69,833	373,983	121,034	1,511
Change during the year	(744)	(8,598)	142,124	(96,785)	(695)
At 31 March 2025[1]	**423**	**61,235**	**516,107**	**24,249**	**816**

6. Trade payables and other current liabilities

Trade payables	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000	CNSGP £000
NHS payables – revenue	-	-	9	-	-	-
Prepaid income	-	-	18,175	915	-	-
Accruals	-	278	10,125	126	264	444
Other payables	-	-	45,175	253	6,942	138
At 31 March 2025		**278**	**73,484**	**1,294**	**7,206**	**582**

1 Cash and cash equivalents is made up of cash only. All cash balances are held in Government Banking Service accounts.

	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Administration £000	Total 31 March 2025 £000	Total 31 March 2024 £000
-	-	-	19	736	30	**789**	1,353
	-	-	-	-	185	**765**	2,050
-	-	31	-	-	1,746	**4,928**	5,787
	-	16	10	187	316	**5,755**	8,439
-	-	-	-	2	142	**3,406**	9,037
		47	**29**	**925**	**2,419**	**15,643**	**26,666**

				LTPS £000	Administration £000	Total 31 March 2025 £000	Total 31 March 2024 £000
			20,016	92,183	5,725	**685,452**	605,728
				(2,231)	17,554	**53,789**	79,724
				89,952	**23,279**	**739,241**	**685,452**

	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Administration £000	Total 31 March 2025 £000	Total 31 March 2024 £000
-	-	-	-	2	-	**11**	127
	-	-	-	-	50	**19,140**	13,250
5	-	58	47	298	2,460	**14,105**	20,709
	-	-	-	52	2,242	**54,802**	27,859
		58	**47**	**352**	**4,752**	**88,058**	**61,945**

7. Provisions for liabilities and charges

Opening provision for known claims	34,914	635,774	31,555,133	1,679,543
	-			
Provided in the year	657	36,430	6,861,206	64,780
Unwinding of discount	1,578	28,077	1,174,605	72,656
Provisions utilised in the year	(1,559)	(28,964)	(2,826,027)	(84,619)
Movement in IBNR				
	-			
Increase/(decrease) in provision for IBNR	-	1,000	780,000	13,000
Closing provision for known claims	34,963	648,534	32,944,764	1,660,575
	-			
Not later than one year[2]	1,566	26,745	3,314,574	97,035
Later than five years	27,428	571,604	41,393,247	1,350,333

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

2 The one-year projected cash flow figures shown above reflect an updated view of 2025/26 cash flow based on the latest provisioning exercise. As well as using the most up-to-date data and assumptions, the provisioning exercise more generally focuses on long-term (rather than short-term) view. This leads to differences in projected cash flows from those budgeted for 2025/26 as part of the 2025/26 cash flow projection exercise that was performed during the summer of 2024, where the emphasis was on short-term cash flows and assumptions that materially impact the short-term view. Both results are considered equally valid for their respective purposes.

	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
429,418	254,034	3,904	-	13,329	12,067	103,855	**34,721,971**
	821,000	23,000	-	76,000	3,000	105,000	**23,758,000**
	1,075,034	**26,904**		**89,329**	**15,067**	**208,855**	**58,479,971**
128,949	250,170	1,837	-	8,290	9,437	105,651	**7,467,407**
	(72,501)	(651)	-	(3,410)	(2,349)	(30,991)	**(3,569,347)**
14,736	9,438	148	-	333	365	3,826	**1,305,762**
	(367)	13	-	20	33	81	**(547,754)**
(92,519)	(54,278)	(960)	-	(5,124)	(5,398)	(34,521)	**(3,133,969)**
	132,462	**387**		**109**	**2,088**	**44,046**	**1,522,099**
	(1,000)	-	-	-	-	-	**(506,000)**
(47,000)	129,000	(18,000)	-	4,000	-	(32,000)	**830,000**
	128,000	**(18,000)**		**4,000**		**(32,000)**	**324,000**
388,953	386,496	4,291	-	13,438	14,155	147,901	**36,244,070**
	949,000	5,000	-	80,000	3,000	73,000	**24,082,000**
	1,335,496	**9,291**		**93,438**	**17,155**	**220,901**	**60,326,070**
86,402	78,481	1,348	-	11,313	8,902	42,389	**3,668,755**
	520,034	3,167	-	23,527	8,190	125,446	**12,206,171**
255,048	736,981	4,776	-	58,598	63	53,066	**44,451,144**
	1,335,496	**9,291**		**93,438**	**17,155**	**220,901**	**60,326,070**

Provisions for liabilities and charges (prior year)

Provisions	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000
Opening provision for known claims	43,262	801,869	37,323,913	2,087,050
Opening provisions for IBNR	-	67,000	27,081,000	196,000
Total provisions as at 1 April 2023	**43,262**	**868,869**	**64,404,913**	**2,283,050**
Movement in known claims				
Provided in the year	1,149	37,529	7,857,403	96,497
Provision not required written back	(141)	(29,099)	(3,675,786)	(75,760)
Unwinding of discount	1,427	25,627	775,602	63,986
Change in discount rates	(9,296)	(177,253)	(8,144,196)	(415,417)
Provisions utilised in the year	(1,487)	(22,899)	(2,581,803)	(76,813)
Movement in known claims	**(8,348)**	**(166,095)**	**(5,768,780)**	**(407,507)**
Movement in IBNR				
Change in discount rates	-	(15,000)	(5,606,000)	(41,000)
Increase/(decrease in provision for IBNR	-	3,000	923,000	(49,000)
Movement in IBNR		**(12,000)**	**(4,683,000)**	**(90,000)**
Closing provision for known claims	34,914	635,774	31,555,133	1,679,543
Closing provisions for IBNR	-	55,000	22,398,000	106,000
Total provision as at 31 March 2024	**34,914**	**690,774**	**53,953,133**	**1,785,543**
Analysis of expected timing of discounted cash flows[1]				
Not later than one year[2]	1,502	25,974	3,352,753	101,442
Later than one year and not later than five years	7,079	120,623	11,195,088	360,785
Later than five years	26,333	544,177	39,405,292	1,323,316
Total provision as at 31 March 2024	**34,914**	**690,774**	**53,953,133**	**1,785,543**

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

2 The one-year projected cash flow figures shown above reflect an updated view of 2024/25 cash flow based on the latest provisioning exercise. As well as using the most up-to-date data and assumptions, the provisioning exercise more generally focuses on long-term (rather than short-term) view. This leads to differences in projected cash flows from those budgeted for 2024/25 as part of the 2024/25 cash flow projection exercise that was performed during the summer of 2023, where the emphasis was on short-term cash flows and assumptions that materially impact the short-term view. Both results are considered equally valid for their respective purposes.

	CNSGP £000	CNSC £000	CTIS £000	DHSC non-clinical £000	PES £000	LTPS £000	Total £000
541,042	149,869	713	-	13,067	10,335	103,393	**41,074,513**
	746,000	36,000	2,000	91,000	4,000	125,000	**28,539,000**
	895,869	**36,713**	**2,000**	**104,067**	**14,335**	**228,393**	**69,613,513**
169,627	174,679	3,808	-	10,691	8,127	73,947	**8,433,457**
	(35,156)	(358)	-	(3,292)	(2,592)	(35,469)	**(3,981,128)**
11,011	3,873	21	-	90	252	3,096	**884,985**
	(16,629)	(108)	-	(160)	(149)	(2,172)	**(8,818,776)**
(115,391)	(22,602)	(172)	-	(7,067)	(3,906)	(38,940)	**(2,871,080)**
	104,165	**3,191**		**262**	**1,732**	**462**	**(6,352,542)**
	(40,000)	(5,000)	-	(9,000)	-	(4,000)	**(5,734,000)**
(6,000)	115,000	(8,000)	(2,000)	(6,000)	(1,000)	(16,000)	**953,000**
	75,000	**(13,000)**	**(2,000)**	**(15,000)**	**(1,000)**	**(20,000)**	**(4,781,000)**
429,418	254,034	3,904	-	13,329	12,067	103,855	**34,721,971**
	821,000	23,000	-	76,000	3,000	105,000	**23,758,000**
	1,075,034	**26,904**		**89,329**	**15,067**	**208,855**	**58,479,971**
99,174	45,836	1,027	-	14,414	7,238	37,289	**3,686,649**
	386,628	5,855	-	21,523	7,119	118,163	**12,436,934**
287,173	642,570	20,022	-	53,392	710	53,403	**42,356,388**
	1,075,034	**26,904**		**89,329**	**15,067**	**208,855**	**58,479,971**

7.1 Reconciliation of Note 7 to Statement of comprehensive net expenditure

Reconciliation of Note 7 to Statement of comprehensive net expenditure	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000	ELSGP £000
Unwinding of discount/finance charge	**1,578**	**28,077**	**1,174,605**	**72,656**	**14,736**
Increase in known claims provision	657	36,430	6,861,206	64,780	128,949
Provision not required written back	(79)	(11,978)	(3,311,143)	(47,470)	(88,775)
Change in discount rates (known claims and IBNR)	(548)	(11,805)	(1,009,010)	(27,315)	(3,856)
Increase/(decrease) in provision for IBNR	-	1,000	780,000	13,000	(47,000)
Provision expense charged to Statement of comprehensive net expenditure	**30**	**13,647**	**3,321,053**	**2,995**	**(10,682)**
Total charge to Statement of comprehensive net expenditure	**1,608**	**41,724**	**4,495,658**	**75,651**	**4,054**

						Total 2024/25 £000	Total 2023/24 £000
						1,305,762	**884,985**
	1,837	-	8,290	9,437	105,651	**7,467,407**	8,433,457
(72,501)	(651)	-	(3,410)	(2,349)	(30,991)	**(3,569,347)**	(3,981,128)
	13	-	20	33	81	**(1,053,754)**	(14,552,776)
129,000	(18,000)	-	4,000	-	(32,000)	**830,000**	953,000
						3,674,306	
	(16,653)		**9,233**	**7,486**	**46,567**	**4,980,068**	**(8,262,462)**

7.2 Explanatory notes

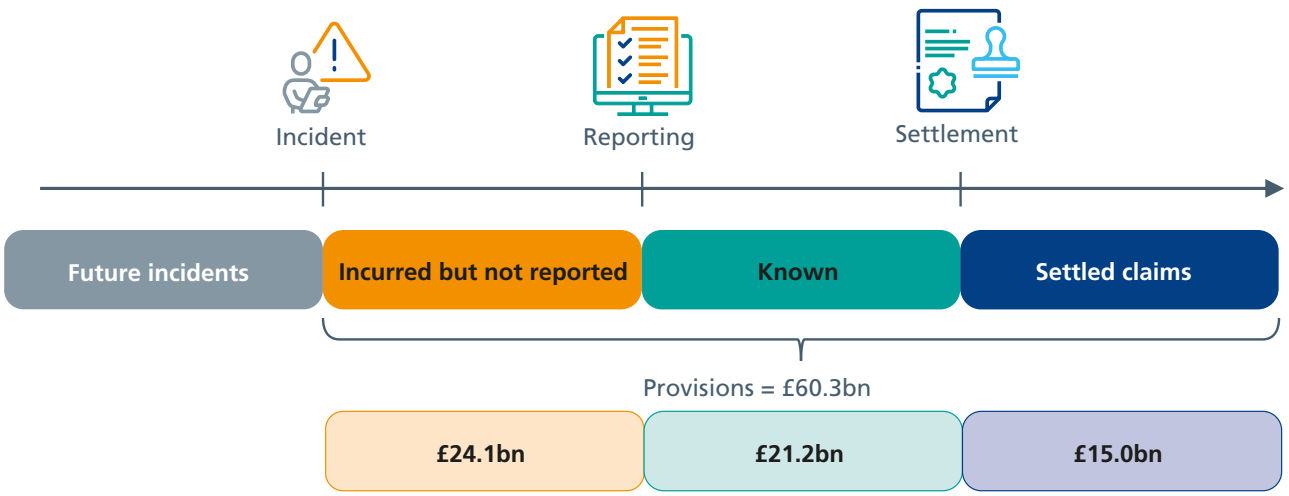
Nature and scope of the obligation

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

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

The different parts of the provision and their link to the claims journey is shown in figure 36.

Figure 36: Provision and the claims journey



The schemes we administer are shown in Who we are and what we do on page 10.

Developments over the year affecting the provisions

2024/25 has been a relatively uneventful year in regard to the provision, with movements broadly in line with expectations. NHS Resolution's Reserving and Pricing Committee (RPC) is responsible for making decisions on the key judgements and estimates. Key developments over the year, including considerations in respect of the key judgements, are outlined in more detail below. This includes:

- Assumptions that are prescribed and are not within the control of NHS Resolution e.g. the Personal Injury Discount Rate (PIDR) and HMT discount rates.
- Assumptions and methodologies that are not prescribed, where judgement is required e.g. assumptions for long-term inflation and ultimate claim numbers and the approach in respect of Covid-19 provisioning and CEP.

Personal Injury Discount Rate (PIDR) – prescribed

The Personal Injury Discount Rate (PIDR) is a key determinant of lump sum settlement amounts, for both PPO and non-PPO claims, and so alters the cost of settling claims. The PIDR is set by the Lord Chancellor and a statutory review of the rate (applicable in England and Wales) was held during 2024/25. An update to the rate was announced in December 2024, effective from 11 January 2025. The rate increased from -0.25% to +0.50%, which has led to a £1.9 billion reduction in the value of the provision.

Discount rates – prescribed

A key assumption used in calculating the provisions are the discount rates used to place a present value on projected future cash flows. These rates are prescribed by HMT.

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

This year, there have been relatively minor changes to the discount rates prescribed by HMT, with small increases seen for the medium-, long- and very long-term durations. These rates are used to convert future payments into a present value. This update has decreased the provision by £1.1 billion (2%). Although the change in discount rates prescribed by HMT affects the value of the provision, it does not alter the cost of settling claims, which is driven by the frequency and severity of claims and the legal environment in which the claims are settled (e.g. the PIDR). As such, the £1.1 billion decrease in the provisions reflects a change in the way the liabilities are valued, rather than a change in the underlying liabilities.

Short term inflation

In determining the value of the provisions, we consider expectations of inflation in the short-term. For the provision as at 31 March 2025, we have allowed for slightly higher inflation expectations in the next two years, assuming that a higher cost of living in the general economic environment would lead to higher claim settlement costs. While cost of living pressures in the general economic environment have eased, the general expectations are that Consumer Price Index (CPI) inflation will continue to exceed the Bank of England's 2% for longer than was assumed last year. This year's provisions include updated forecasts for short-term inflation expectations, which assume that claims inflation will be slightly higher than the long-term assumptions in the next two years, before returning to the long-term view thereafter. The impact on the CNST IBNR provision is shown in table 33: Key assumptions in the CNST IBNR provision on page 172.

Long term claims inflation trends

For PPO damages, recent trends in settled claim costs have continued and support a slight reduction in the long-term view of inflation. Otherwise, average settlement costs have generally grown at rates previously assumed. See table 33: Key assumptions in the CNST IBNR provision on page 172 for details of the impact of the changes to the claims inflation assumption on CNST IBNR.

Early notification

The majority of the CNST provision is as a result of claims arising from maternity activities, such as babies brain damaged at birth following negligent care.

A baby born with serious brain injury which meets the criteria for a Maternity and Newborn Safety Investigations (MNSI) investigation will be reported to MNSI by the trust. If MNSI accept the case and an investigation is commenced, the trust must also report the incident to NHS Resolution. After the MNSI investigation is complete the trust will share the final MNSI report with NHS Resolution. NHS Resolution's Early Notification (EN) team will triage the matter based on our internal clinical definition and where there are potential concerns about the care provided that may have caused injury, NHS Resolution will proceed to a full liability investigation. For babies born after 1 October 2023, NHS Resolution will seek the family's permission before proceeding.

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

Within the IBNR provision, we continue to separately model claims reported under the EN scheme and those expected to be reported outside of EN, but still within CNST. In arriving at our assumed number of claims, we have considered the rate at which EN cases have been opened to date while assuming the overall level of risk in relation to brain damage at birth is broadly similar to the period before EN. Hence, we assume the overall number of successful high-value claims after the introduction of EN will be similar to the period before, reflecting that EN only alters the reporting and claim settlement process, rather than the exposure to risk. Since only a very small number of high-value EN claims have been settled so far, other assumptions in respect of claim costs and settlement lags are set with reference to standard maternity claims.

Claim number projections

This year has seen an increase in the IBNR in respect of claim number projections, driven by a higher volume of cancelled claims over the year (originating from EN incidents). Cancelled claims refer to cases that were initially identified as a claim but later closed as nil, as they should never have been opened. Excluding these cancelled claims increases the assumed number of IBNR claims, leading to a higher IBNR provision.

Indemnity arrangements for Covid-19

The Covid-19 pandemic has had a significant impact on the NHS over the last five years, which has the potential to affect the value of the liabilities covered by NHS Resolution. In addition to the two new schemes established for 2021/22 (CNSC and CTIS), the liabilities covered under the arrangements already in place (i.e. through CNST, CNSGP and LTPS) have also been affected owing to changes in healthcare provision.

As was the case last year, the estimated effect on the NHS Resolution provision is fairly limited (£0.6 billion on the IBNR and £0.1 billion on the known claims). This is because a large proportion (62% for 2024/25 compared to 62% in 2023/24) of the total provision (across all clinical schemes) is as a result of claims arising from maternity activity. Although there were some changes to maternity activities during the pandemic, activities generally continued and we assume there will be a similar level of claims as in previous years.

Our approach to determining the impact of Covid-19 on the provisions is similar to that adopted in previous years, where we have separately considered the direct impacts that might arise from new activities related to responding to the pandemic, as well as indirect impacts that might influence claims and costs. Although we continue to allow for the possibility of new risks and potential claims arising from Covid-19, these have been towards the lower end of the ranges that we have previously considered.

Note that since being established in 2020/21, the CTIS has not received a single claim, so we continue to assume a nil IBNR provision for this scheme.

Claims Evolution Programme (CEP)

The implementation of the CEP (described in more detail on page 69) is expected to lead to a reduction in NHS legal costs in future years. Anticipated future reductions in NHS legal costs have therefore been allowed for within the provisioning calculation this year.

Risk and uncertainty

The provision is subject to uncertainty arising from both model assumptions and inherent variability in future outcomes. To illustrate this, two uncertainty ranges are presented: the first reflects plausible alternative assumptions that could reasonably have been selected based on the same analysis of past data, focusing on the most material and subjective inputs; the second captures a broader range of plausible assumptions informed by wider historical variation and potential future developments. Together, these ranges provide insight into both model risk and inherent uncertainty in the provision estimate. Further detail is provided in Note 7.3.

Assumption of liabilities upon cessation

The NHS Act 2006 Section 70 requires the Secretary of State for Health and Social Care to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This includes the liabilities assumed by NHS Resolution in respect of all schemes.

Process and methodology for setting the provision

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

NHS Resolution's Reserving and Pricing Committee (RPC) is responsible for making decisions on the key judgements and estimates. The RPC chooses 'best estimate' assumptions, which are set on the basis that they are not judged to have a consistent under- or over-estimation in the value expected. The work of the RPC is supported by the advice of the actuaries alongside the Reserving, Cashflows and Pricing Working Group, which reports into the RPC and brings together colleagues from across the organisation to scrutinise the analysis.

Although assumptions, in general, are set in line with past experience, the RPC has considered whether it would be appropriate for any individual assumptions to differ from past experience, for example due to changes in NHS Resolution's policies or processes, or changes in the external environment.

In addition to the PIDR and HMT prescribed discount rates, there are other factors that influence the provision that are outside NHS Resolution's control; for example, patients (and their legal representatives) have an element of control over the timing of the reporting of claims.

The RPC keeps all the factors affecting the calculation of provisions under review to ensure the final provisions reflect the experience of the organisation and are adjusted in a timely manner.

Methodologies

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

- **Known claims** – The provision is based on the case estimates of individual reported claims received by NHS Resolution. The case estimates are adjusted for:
  - the case handlers' estimated probability of each claim being successful;
  - expected future claims inflation to settlement, based on an actuarial view of the expected timing of settlement of the provision;
  - the likelihood that they will go on to settle under a periodical payment regime, with part of the claim paid over the life of the claimant as a regular stream of compensation income rather than purely as a lump sum; and
  - the difference in cost if the case were to settle as a PPO.

The resulting adjusted claim values are then discounted for the time value of money (at HMT-prescribed rates) to give a present value at the accounting date.

- **Settled PPOs** – The provision is determined on an individual claim-by-claim basis and then aggregated across all settled PPOs. Each claim's schedule of future payments is projected into the future on each of their due dates, allowing for applicable increases (e.g. inflation). A probability of survival is then applied to each projected payment, based on the individual's life expectancy and the relevant mortality tables. This provides a weighting that allows for the relative probability of each payment being made. This forms the cash flows which are then discounted using HMT-prescribed discount rates to calculate a present value of the liability.
- **IBNR** – To estimate the IBNR provision at the accounting date, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a present value (at HMT-prescribed discount rates). The steps to arrive at an estimate are:

- A characteristic pattern of claims reporting from claim incident year is identified to determine the ultimate number of claims expected to arise from incidents that have occurred in each past year up to the accounting date. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year. Further assumptions are made in respect of how many claims will result in payment of damages.
- Assumptions are then made about the average claim cost for different types of claims. Adjustments are made to these assumed claim costs to allow for expected future claims inflation.
- By combining the average claim sizes with the claim numbers and patterns for the reporting to payment time lag appropriately, a projection is made for the total value of claim payments for IBNR claims in each future year.
- For claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows, based on mortality assumptions derived from the settled PPO claims. Lump sum settlements are assumed to be paid out in full around settlement time.
- The final step in the process is to calculate the present value of the projected future cash flows (using the HMT-prescribed discount rates), and this gives the estimated IBNR provision at the accounting date.

These steps are applied across all schemes, noting the following differences:

- For CNST, ELS and DHSC clinical liabilities, calculations are carried out separately for damages, NHS legal costs and claimant costs, and for PPO and non-PPO type claims. We continue to set separate assumptions for the maternity claims reported under the EN scheme within the IBNR provision.
- For ELSGP, the reserving assumptions are based upon the combined historical claims experience from periods where claims were handled by the Medical and Dental Defence Union of Scotland (MDDUS) and/or the Medical Protection Society (MPS), and also more recently where claims have been handled by NHS Resolution.
- For CNSGP, the assumptions used to determine the provisions are based mainly on CNSGP experience, supplemented by ELSGP experience where appropriate.
- For CNSC and other coronavirus liabilities, approximate methods have been used based on levels of activity and assumed claim frequency and severity based on similar clinical risks.

Note that the IBNR includes a provision of £1.5 billion (£1.8 billion in 2023/24) in respect of known incidents. For financial reporting purposes, these matters are (and have always been) regarded as IBNR, as they are not yet formally recognised as reported claims, so the provision for these incidents is included within the IBNR figures presented throughout this report. However, the approach to provisioning for these matters has been reviewed during 2024/25 to make use of case level information (including case reserves and assigned probabilities).

7.3 Key assumptions and areas of uncertainty

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

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

The IBNR provisions are subject to considerable uncertainty. At a high level, the method used to calculate the provisions assumes future experience will be in line with past experience, making adjustments for emerging risks and changes where relevant. In particular, the provisions are calculated on the basis of the current legal and claims environment, including the recently updated Personal Injury Discount Rate (PIDR). There is also uncertainty in the IBNR for the CNST scheme in relation to the impact of the EN scheme given the innovative nature of the scheme.

Key areas of uncertainty in the estimation of the claims provision

- **The number of clinical claims reported to NHS Resolution and lag patterns:** The number of claims reported to NHS Resolution's long-established schemes has generally reduced over the last couple of years, excluding claims reported under the EN scheme. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims and healthcare environment and resulting instability in past claim trends. The year 2020/21 saw a reduction in the number of claims received due to Covid-19; however, the clinical activity has recovered since, resulting in the number of claims received stabilising to the pre-pandemic levels.

  Estimating the ultimate number of claims is complicated by the fact that clinical negligence claims can take a number of years to be reported following the incident that gives rise to the claim. The IBNR provision depends on an assumed time-lag pattern for how claims are reported to NHS Resolution following the incident. If the true pattern of reporting is faster than that assumed, this may mean that the number of IBNR claims has been overestimated, and vice versa. Changing trends in this pattern over time, for example as a result of changes to the legal environment, the introduction of the EN scheme (leading to earlier reporting of incidents and claims), increased awareness of the availability of compensation, potential disruptions owing to Covid-19 and the growth in waiting lists, increase the uncertainty in this assumption.

- **Claims settling as PPOs:** PPOs remain a key area of uncertainty, given the high value of PPO settlements and the relatively small number of claims that settle on this basis. PPO claim settlements are paid over the lifetime of the claimant, and consequently there are additional inflation and longevity uncertainties, compared to equivalent lump sum settlements.

- **Claims inflation:** Because of the long-term nature of the liabilities, even small changes to the assumed rate of future claim value inflation can have a significant impact on the estimated provisions. Claim value inflation has historically been much higher than price inflation. For clinical negligence claims, inflation is affected by a number of external factors such as the PIDR, changes in legal precedent (e.g. rules relating to accommodation costs determined by Swift v. Carpenter in 2020) and changes in legal costs. The variety of potential external influences on future claims inflation means this assumption is subject to significant uncertainty.

  The HMT Public Expenditure System (PES) discount rate note from December 2024 (which specifies the financial assumptions to be used for valuing provisions at March 2025) states all cash flows should be assumed to increase in line with the Office for Budget Responsibility (OBR) CPI forecasts unless certain conditions are met for this assumption to be rebutted. These conditions are set out in Paragraph 41 of Annex B of the HMT PES note PES (2024) 09.

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

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

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

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

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

- first, looking at nominal increases in average claim costs over past years by reserving segment; and
- then adjusting this to reflect any significant differences in expected future inflation in the economy compared to observed historical inflation over the recent past.

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

- **Life expectancy:** The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Each claimant's life expectancy is estimated at settlement by medical experts. The actual future lifetime of an individual claimant may differ significantly from this estimate. Furthermore, it is difficult to determine whether the life expectancies estimated by medical experts, in aggregate, will prove to be too long or too short on average across all claimants. The average life expectancy of claimants could also be influenced by future advances in medical care or other events (e.g. epidemics).
- **Covid-19:** As with last year's provisions, there are additional assumptions made, and hence uncertainties in the provision, as a result of the impact of Covid-19. Among other risks, the provision continues to allow for clinical negligence claims resulting from the treatment of Covid-19.
- **Legal environment:** The provisions have been valued using the latest PIDR of +0.50%. The Civil Liability Act 2018 introduced a process for periodical reviews of the PIDR, requiring the Government to review the rate in England and Wales at least every five years. There is no certainty on the outcomes of future reviews, so no adjustments have been made to the IBNR or known claims provisions for the potential effects of such changes.
- **Scheme developments:** There is additionally some uncertainty in relation to the impact of the EN scheme, which impacts some maternity incidents that occurred on or after 1 April 2017, on claims costs and reporting trends. We continue to set separate assumptions for claims reported under the EN scheme and those reported outside of the scheme. Assumptions have been set based on EN experience to date and we have assumed that the overall level of risk of brain damage to babies at birth is similar to that seen in previous years, but that EN brings forward the reporting of those claims. It will take several more years to ascertain fully what the impact of EN may be.

Key assumptions

Table 33 shows a summary of the key assumptions used to determine the CNST IBNR provision. The CNST IBNR provision is the largest single element of the total provision, and therefore where uncertainty has the greatest effect. For each assumption, the degree of uncertainty in the assumption and the impact of the assumption on the level of provisions has been categorised as 'high', 'medium' or 'low'. These categories are colour coded in the table, with red shading to highlight the areas of greatest uncertainty and sensitivity, and green shading to highlight the areas where uncertainty and sensitivity is relatively low. Where appropriate the same assumptions are used for the CNST settled PPOs and known claims provisions.

The impacts of the various assumptions can be found detailed in CNST sensitivities as at 31 March 2025 (page 179).

Table 33: Key assumptions in the CNST IBNR provision

Assumption	Approach	Degree of uncertainty	Sensitivity to changes[1]
Nominal discount rates	HMT prescribed	Prescribed	High
Personal Injury Discount Rate (PIDR)	Prescribed by Lord Chancellor	Prescribed	Medium
Ultimate number of claims and propensity to settle as PPO	Derived from past claim numbers and development patterns and assumptions that the level of risk will be similar to previous years, adjusted for levels of activity	Medium	High
	Value threshold derived from recent years' settled claims data	Medium	Medium
Average cost per claim	Derived from past settled claims – set separately for damages, NHS legal costs and claimant costs	High	High
Claims inflation	Long-term claims inflation: derived from past settled claims Short-term claims inflation: derived from short-term HMT prescribed CPI forecasts	High	High
Probability of paying damages	Derived from past settled claims, adjusted for incomplete development	Medium	Medium
Creation to payment lags	Derived from past settled claims	Low	Medium (for PPOs)
Life expectancy for PPO payments	Based on analysis of past settled PPO claims	Medium	Low
ASHE 6115 (80th percentile)	Based on earnings increases relative to CPI over the longer term	Medium	High
Covid-19	Scenario-based approach	Medium	Low
Methodology updates	Claims Evolution Programme (CEP)	Medium	Low
	Provision for known incidents	Medium	Low

1 Sensitivity to changes selected with regard to the overall level of sensitivity, rather than the movement that has been observed in the year.

All discount rates have been updated. The short-term rate has decreased by 0.23 percentage points. The medium-term, long-term and very long-term rates have increased by 0.04 percentage points, 0.09 percentage points and 0.15 percentage points respectively.	-£0.5 billion
The PIDR has increased from -0.25% to +0.50%. This decreases the present value of lump sum damages payments, in respect of both PPO and non-PPO claims.	
The EN scheme has accelerated the reporting of potential PPO claims. We allow for this by specifying separate assumptions for claims that are expected to be reported under the EN scheme. There has been a marked increase in the volume of cancelled claims over the course of the year, mainly a result of trusts' misreporting of incidents in respect of EN. Including these claims in the reported claim cohort distorts the reporting and settlement patterns, and could potentially lead to an understatement of the provision. Therefore, they have been removed from the claim number projections. Although this has driven a reduction in the projected ultimate number of PPO claims, this is more than offset by the reduction in the reported cohort of PPOs, which leads to an increase in the assumed number of IBNR claims and the IBNR provision. The expected number of future non-PPO claims is similar to last year.	+£1.7 billion
A value-based threshold has been used to identify potential PPO claims. The selected value of the threshold has increased from £4.75 million to £5.00 million (on the -0.25% PIDR basis, with subsequent reduction to £4.25 million, following the PIDR update).	
The average cost per claim assumptions have increased broadly in line with the rates previously assumed. However, an adjustment is applied to the average costs, which allows for the speciality mix of future PPOs being different to that seen in the past. Projected claim numbers indicate that future PPOs will be more heavily weighted towards obstetrics claims, which have a higher average cost.	
The long-term inflation assumption for PPO damages has decreased by 0.25 percentage points per annum from the previous year.	-£0.8 billion
We are assuming that the higher short-term inflationary environment will feed through to higher short-term claims inflation and persist for longer than was assumed last year.	+£0.1 billion
This year the probability of paying damages for non-EN PPOs has increased for the 2017/18 and 2018/19 incident years, bringing the assumption for these years into line with the assumption for all other incident years. For EN PPOs and non-PPO claims the assumptions are unchanged from last year.	
Lag range from 2.9 to 7.4 years, increasing marginally (by 0.1 years) at both ends of the range.	<+£0.1 billion
The mortality assumptions have been updated based on the latest available data from the Office for National Statistics. Separate life expectancy assumptions are specified for EN claims (43 years) and non-EN claims (39 years).	
The ASHE assumption is unchanged at CPI+1.75%.	-
The provision in respect of Covid-19 has reduced due to the run-off of the exposure measure for these risks and in light of lower than expected actual experience on Covid-19 reported claims.	
The Claims Evolution Programme (CEP) is expected to lead to savings in NHS legal costs in future years. Anticipated future reductions in NHS legal costs have therefore been allowed for within the provisioning calculation.	-£0.2 billion
The approach to provisioning for known incidents has been updated and is now broadly aligned with the approach used for known claims.	-£0.3 billion

Sensitivities as at 31 March 2025

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

- Sensitivity of the total provisions (known claims, settled PPOs and IBNR) to changes in the following key assumptions:
  - HMT discount rates;
  - ASHE assumption;
  - claims inflation;
  - life expectancy; and
  - payment pattern.
- For CNST, which represents the largest scheme and the single most uncertain element of the total provision, sensitivity of the total provisions to other assumptions and uncertainty ranges.

The sensitivity levels were selected to reflect an equivalent likelihood of occurrence across assumptions. For example, a 1% change in discount rates is considered as likely as a 1.5% change in claims inflation. This methodology was recommended by the RPC. While this equivalence is inherently subjective, it is supported by historical trends – particularly the observation that base inflation (e.g. PPO inflation) has typically been higher and more volatile than discount rates. As such, a higher sensitivity is applied to inflation. For life expectancy, a 30% sensitivity was adopted to reflect a stressed scenario.

Sensitivity of provision to key assumptions

The following tables show the effect on the valuation of the total provisions if different rates and assumptions were applied for HMT discount rates, the differential between CPI and ASHE, claims inflation, life expectancy and payment patterns. The ranges of the sensitivity tests that follow are based on potential levels of variability for each assumption, including observations in past data. They do not represent the maxima or minima of past observed values, nor the range of possible outcomes, but they do capture future values that could occur. Each change is shown separately, but in practice combinations are possible, as different assumptions can be correlated.

The tables show the separate impact on:

- The **known claims** provision. This represents 35% of total provisions.
- The **settled PPO** provision. This represents 25% of total provisions. They are typically high-value claims, and their long-term nature means they are highly sensitive to changes in key assumptions.
- The **IBNR** provision. This represents 40% of total provisions.

Note that the tables that follow show the sensitivity of the total provision across all schemes. However, the provision, and sensitivity of the provision, is dominated by CNST, which accounts for 92% of the total provisions.

Historically, the IBNR provision represented over 50% of the total provision, exceeding the provision for known claims and settled PPOs. However, from the 2022/23 financial year, this is no longer the case because:

- much of the known claims provision is driven by a growing book of settled PPOs that are particularly exposed to claims inflation due to the long-term nature of structured settlement payments;
- the EN scheme has accelerated the movement of claims from IBNR into the known claims; and
- due to potentially lengthy delays between claim incident, reporting and settlement, the IBNR is heavily discounted and sensitive to the discount rate. This reduces the IBNR provision, particularly when the discount rates are relatively high.

Sensitivity to HMT tiered nominal discount rates

Since 2018/19, HMT specifies discount rates in nominal terms. These rates have increased this year for durations in excess of five years, which has led to decreases in the provision for the majority of schemes.

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

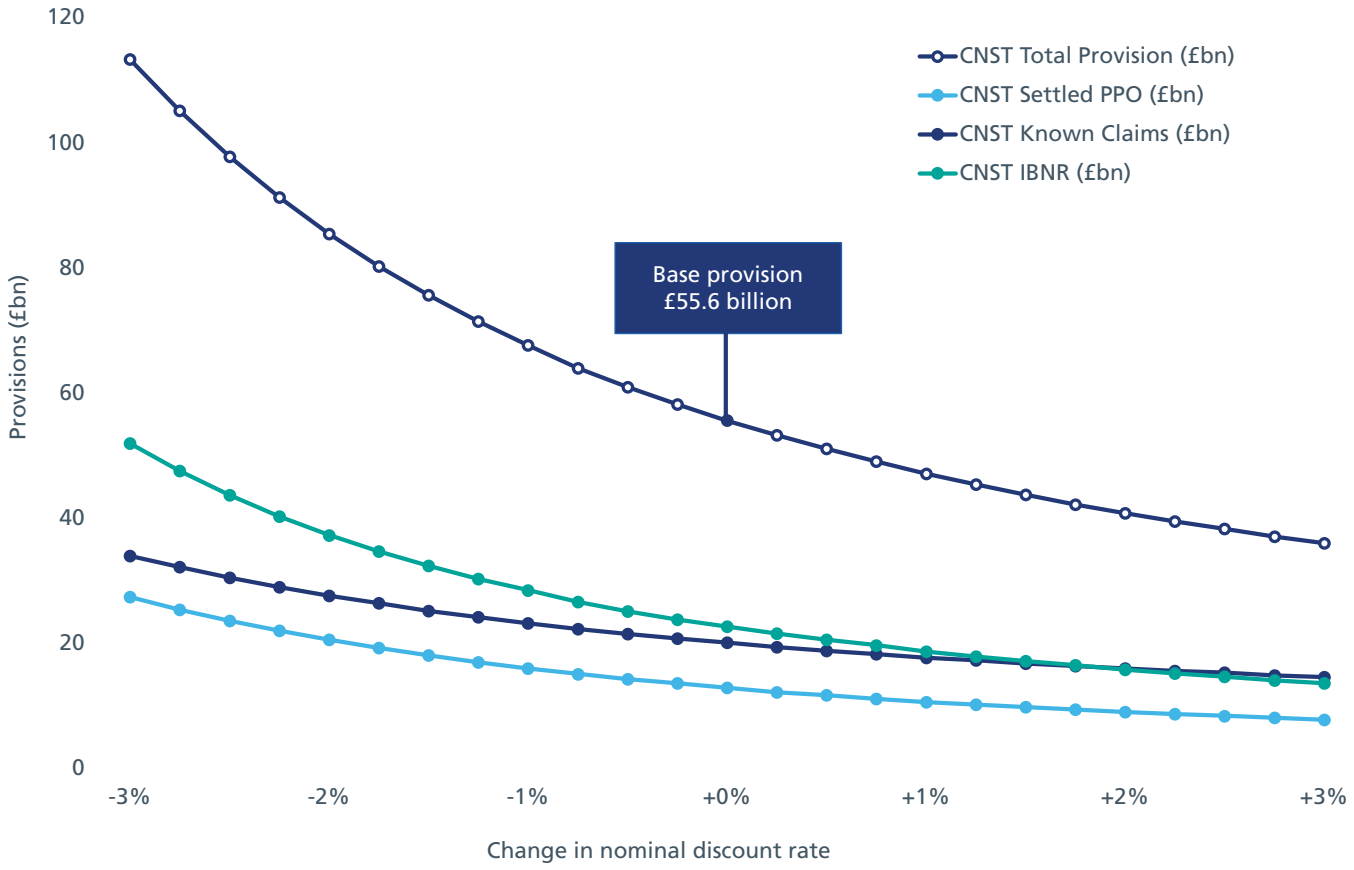
Discount rates term	31 March 2024 nominal rates (%pa)	31 March 2025 nominal rates (%pa)	Change
Short-term (<5 years)	4.26%	4.03%	-0.23%
Medium-term (5–10 years)	4.03%	4.07%	+0.04%
Long-term (10–40 years)	4.72%	4.81%	+0.09%
Very long-term (over 40 years)	4.40%	4.55%	+0.15%

As shown in the following material, the relationship between the value of the total provision and the effect of changes in the discount rates is not a symmetrical one, due to the impacts of compound discounting. The table below is based on adjusting the nominal discount rates by +1% and -1%. A reduction of 1% in the discount rates will increase the total provision by 21%, but a 1% increase will reduce the provision by 15%.

Sensitivity of total provisions to HMT discount rates (£m)					
Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1.0% pa	%		1.0% pa	%
Known claims	24,535	+15%	21,259	18,845	-11%
Settled PPOs	18,535	+24%	14,985	12,443	-17%
IBNR	29,989	+25%	24,082	20,039	-17%
Total provisions	**73,059**	**+21%**	**60,326**	**51,327**	**-15%**

Figure 37 is based on adjusting the nominal discount rate by the increments shown for the CNST scheme only (as it is the most significant scheme) to show the non-linear effect of changes in this factor on the value of the provision. A change in the nominal discount rate of +1% would represent short-, medium-, long-term and very long-term nominal discount rates of 5.03%, 5.07%, 5.81% and 5.55% respectively.

Figure 37: Sensitivity to changes in the nominal discount rate



Sensitivity to differential between ASHE and CPI

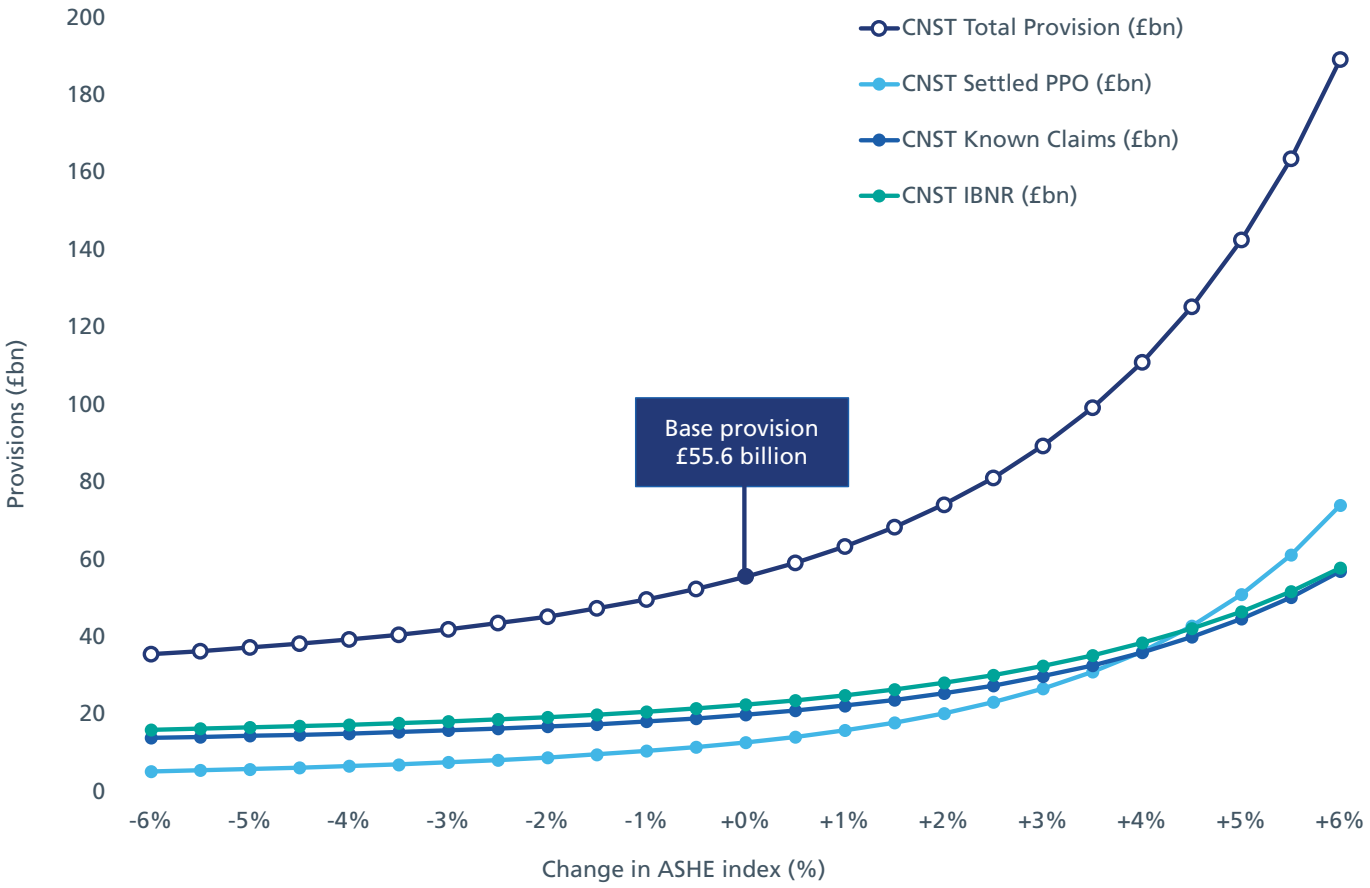
The ASHE index, used in the calculation of damages in PPO claims where care costs are a component, measures the rate of change in the wages of carers. The current assumption is that the rate of inflation in carers' wages is 1.75% higher than CPI price inflation each year.

The table that follows shows the effect on the value of the provision where this differential is varied. An additional +/- 1.0% difference between ASHE and CPI will either increase the provision by 14% or decrease it by 10% respectively.

Sensitivity of total provisions to ASHE assumptions (£m)					
Provisions	All rates reduced by		Base assumptions	All rates increased by	
	1.0% pa	%		1.0% pa	%
Known claims	19,455	-9%	21,259	23,683	+11%
Settled PPOs	12,498	-17%	14,985	18,419	+23%
IBNR	22,232	-8%	24,082	26,521	+10%
Total provisions	**54,185**	**-10%**	**60,326**	**68,623**	**+14%**

Figure 38 shows the non-linear relationship between this assumption and the value of the CNST provision (as the most significant scheme). The impact is also more pronounced for the book of settled PPOs as this provision relates to structured settlement payments only (which are fully exposed to changes in ASHE).

Figure 38: Sensitivity to differential between ASHE and CPI



Claims inflation

The following table shows the effect on the value of the provisions of a +/- 1.5% change to the claims inflation assumptions. An addition of +/- 1.5% to the claims inflation assumptions will increase the provision by 8% or reduce it by 7% respectively. The effect of changes in the rate of claims inflation is not a symmetrical one, due to the impacts of compound inflation and discounting.

Sensitivity of provisions to claims inflation (£m)					
Provisions	**All rates reduced by**		**Base assumptions**	**All rates increased by**	
	1.5% pa	**%**		**1.5% pa**	**%**
Known claims	20,169	-5%	21,259	22,446	+6%
Settled PPOs	14,985	0%	14,985	14,985	0%
IBNR	20,866	-13%	24,082	27,945	+16%
Total provisions	**56,020**	**-7%**	**60,326**	**65,376**	**+8%**

Life expectancy

The provisions in respect of PPOs are sensitive to the assumed life expectancy of claimants. The following table shows the effect on the value of the provisions of a 30% adjustment to the assumed life expectancy of claimants. Reducing life expectancy by 30% reduces the provision by 17%, while increasing life expectancy by 30% increases the provision by 15%.

Sensitivity of total provisions to life expectancy (£m)					
Provisions	All life expectancies reduced by		Base assumptions	All life expectancies increased by	
	30%	%		30%	%
Known claims	18,728	-12%	21,259	23,642	+11%
Settled PPOs	10,219	-32%	14,985	19,312	+29%
IBNR	21,285	-12%	24,082	26,612	+11%
Total provisions	**50,232**	**-17%**	**60,326**	**69,566**	**+15%**

Payment pattern

Payment patterns are used to express the timing of when a claim is expected to be paid, defining the lag between the claim being reported and the claim paying out. The following table shows the effect on the value of the provisions of a +/- 1 year adjustment to the claims payment pattern. Lengthening the assumed payment dates by 1 year will increase the provision by 1%, while shortening the payment pattern by 1 year reduces the provision by 1%.

Sensitivity of total provisions to payment pattern (£m)					
Provisions	Creation to payment lag reduced by		Base assumptions	Creation to payment lag increased by	
	1 year	%		1 year	%
Known claims	21,166	0%	21,259	21,381	+1%
Settled PPOs	14,984	0%	14,985	14,984	0%
IBNR	23,838	-1%	24,082	24,325	+1%
Total provisions	**59,988**	**-1%**	**60,326**	**60,690**	**+1%**

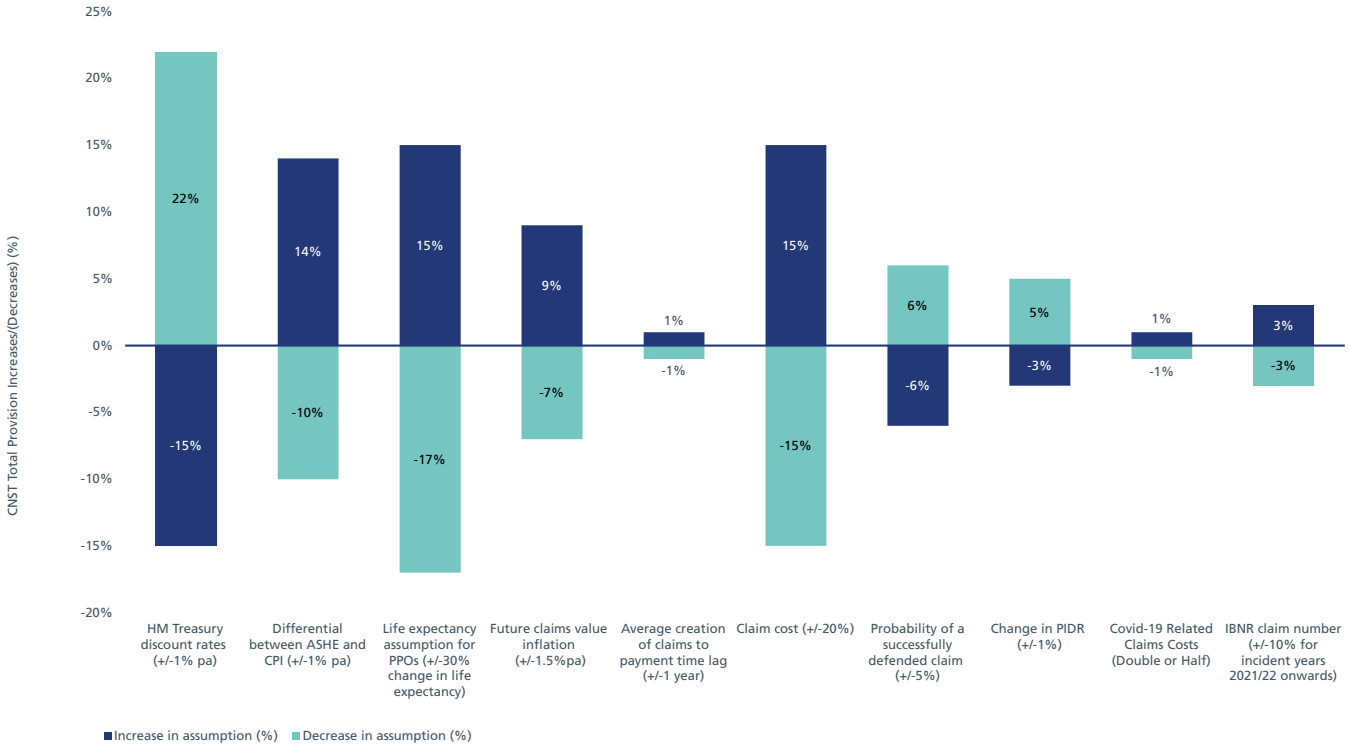
CNST: sensitivity of provision to other assumptions

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

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

CNST sensitivities as at 31 March 2025

Figure 39: The value and percentage impact of variations in the key assumptions within the CNST estimate



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

CNST: uncertainty range

The CNST provision is the single largest element within the total provision. Changes to the assumptions underpinning this element have the greatest potential to affect the estimate of the total provision.

The CNST IBNR and known claims provisions in the accounts are based on a set of chosen assumptions. It is possible to have a range of different results if a different set of assumptions had been chosen. To illustrate this, an uncertainty range (formerly referred to as 'reasonable range') is set out below to demonstrate how different judgements on the main assumptions, given the current environment and the same overall approach, could result in different values for the provision.

Two separate ranges are considered:

- **Range 1 (plausible alternative assumptions)** – this illustrates the range of outcomes for the provision using plausible alternative assumptions. These assumptions reflect the range of values that could reasonably have been selected based on the same analysis of past data, focusing on the assumptions that are the most material and subjective.
- **Range 2 (broader plausible alternative assumptions)** – this illustrates the range of outcomes for the provision using alternative assumptions that represent a broader range of possible values that reflect the wider variation in the observed historical and/or potential future experience.

It should be noted that neither uncertainty range include variations in the PES discount rate or PIDR as these are both prescribed (by HMT and the Lord Chancellor, respectively). As the HMT discount rate is prescribed and therefore not under NHS Resolution control, we do not consider this as a plausible option but instead show HMT discount rate sensitivities separately.

It should also be noted that the presentation of the uncertainty ranges does not in itself reflect the potential uncertainty in the assumptions underpinning the provision as future experience may differ to the past, changes may occur in the claims and legal environment, and the modelling approach may not be a perfect representation of real life. Therefore, the ranges reported do not cover all possible outcomes. The ranges 1 and 2 meant to show the impact of plausible alternative options had NHS Resolution selected other plausible options for assumptions such as claim numbers and average costs for IBNR. We typically select plausible alternatives based on what options were considered during assumptions setting and those that are under NHS Resolution control only.

The uncertainty ranges have been derived by varying the assumptions for both the IBNR and known claims (excluding settled PPOs). For the assessment, a number of assumptions are varied together.

CNST uncertainty range		Baseline provision £m	Upper range £m	Difference to accounts estimate	Lower range £m	Difference to accounts estimate
Range 1: plausible alternative assumptions	IBNR	22,678	24,589	+8%	21,381	-6%
	Known claims	20,068	21,560	+7%	18,791	-6%
	Settled PPOs	12,876	12,876	0%	12,876	0%
	Total	**55,622**	**59,025**	**+6%**	**53,048**	**-5%**
Range 2: range of possible outcomes	IBNR	22,678	29,081	28%	18,232	-20%
	Known claims	20,068	22,974	+14%	17,428	-13%
	Settled PPOs	12,876	12,876	0%	12,876	0%
	Total	**55,622**	**64,931**	**+17%**	**48,536**	**-13%**

The plausible alternative assumptions range (Range 1) was derived by varying the following assumptions, all of which could have reasonably been applied:

- For IBNR claims (excluding known incidents):
  - the estimate for numbers of PPO damages claims for the incident years 2017/18 onwards;
  - the average cost for PPO damages; and
  - PPO damages claims inflation.
- For known incidents and known claims (excluding settled PPOs):
  - case estimates in respect of each known incident/claim;
  - the probability of a claim being successful; and
  - PPO damages claims inflation.

The assumptions listed above were also varied (but to a greater extent) for the range of possible outcomes (Range 2). In addition, the following assumptions were also varied:

- For IBNR claims (excluding known incidents):
  - the probability of defence for PPO-type claims;
  - the creation to settlement lag for PPO claims; and
  - the Covid-19 related claims costs.
- For known incidents and known claims (excluding settled PPOs):
  - the creation to settlement lag for PPO claims.

In summary, the provision in the accounts for CNST could have been set at a value between £53.0 billion and £59.0 billion, if the same data, method and approach were used, but different reasonable assumptions were selected on the basis of the past data. This is compared to the £55.6 billion provision in the accounts.

This uncertainty range of £6.0 billion demonstrates the sensitivity of the provision to relatively small changes in the assumptions, as summarised in figure 39. The range is mainly driven by the IBNR (£3.2 billion), which is the most uncertain element of the provision as these claims are yet to be reported. The change in the estimate for the numbers of PPO damages claims and the alternative view of PPO damages inflation have the largest impact on the IBNR uncertainty range calculation. This is further compounded by the sensitivity of the other factors. The remainder of Range 1 (£2.8 billion) is driven by the known claims provision, where claims have been reported and there are fewer uncertainties, but judgement is still required as to the timing and cost of settlement.

Range 2 shows a variation of between £48.5 billion and £64.9 billion and reflects the range of possible outcomes if the assumptions chosen reflect variation in the observed historical and/or potential future experience.

This range of £16.4 billion is quite wide, illustrating the sensitivity of the provision to relatively small changes in the assumptions, the uncertainty of the assumptions underlying the provisioning estimate and the range of possible outcomes if experience deviates from current expectations.

Note that last year's accounts disclosed uncertainty ranges of -4% to +5% and -13% to +14% for Ranges 1 and 2 respectively. This is broadly comparable to the uncertainty ranges shown above.

8. Contingent liabilities

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

The contingent liability represents an estimation of the additional provision NHS Resolution would recognise in its accounts if damage payments were awarded on all claims, rather than taking into account the probability of damages being paid (i.e. reflecting that typically many claims settle at nil). The known claims provision is calculated as the sum of outstanding reserve values (i.e. total claim value less payments) multiplied by the probability of damages being paid, inflated and discounted to provide a present value of the claim based on the expected settlement dates. The IBNR provisions calculation also includes probabilities of a claim being paid for each of the schemes. The contingent liability is then the difference between the total valuation of IBNR and known claims (including estimations on claims which are ultimately expected to settle at nil) and the main valuation of known claims and IBNR (which excludes claims expected to settle at nil). This does not include the full range of possible outcomes and there remains uncertainty in the amounts calculated due to the uncertainty in the number and type of claim and the costs of the claims (as described in Note 7).

As a result of the dissolution of NHS primary care trusts and strategic health authorities (on 1 April 2013), NHS Resolution has taken on responsibility for any outstanding criminal liabilities, on behalf of the Secretary of State for Health and Social Care. While no claim of this nature is currently provided for, any valid claims arising from the activities of those organisations will be dealt with by NHS Resolution and funded in full by DHSC.

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

Contingent liabilities	Ex-RHA £000	ELS £000	CNST £000	DHSC clinical £000
Contingent liability as at 31 March 2025	**-**	**100,054**	**23,794,828**	**209,239**
Contingent liability as at 31 March 2024	-	95,648	23,394,831	185,337

	CNSGP £000	CNSC £000	CTIS £000	DHSC non clinical £000	PES £000	LTPS £000	Total £000
207,140	**706,602**	**5,217**	**-**	**59,935**	**9,859**	**149,383**	**25,242,257**
	592,842	16,460	-	57,862	9,732	159,336	24,780,779

9. Lease liabilities

The total future minimum lease payments under lease liabilities payable in each of the following periods are as below.

Maturity analysis – contractual undiscounted cash flows lease liabilities	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2024/25 £000	2023/24 £000
Within 1 year	185	855	-	**1,040**	1,026
Between 1 and 5 years	778	3,596	-	**4,374**	4,288
After 5 years	386	2,153	-	**2,539**	3,666
Total undiscounted lease liabilities at 31 March	**1,349**	**6,604**		**7,953**	**8,980**

Lease liabilities included in the statement of financial position at 31 March	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2024/25 £000	2023/24 £000
Current	173	798	-	**971**	948
Non-current	1,130	5,572	-	**6,702**	7,673
	1,303	**6,370**		**7,673**	**8,621**

Amounts recognised in profit and loss	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2024/25 £000	2023/24 £000
Interest on lease liabilities	13	65	-	**78**	87
Expenses related to low-value assets	-	-	77	**77**	61

Amounts recognised in the statement of cash flows	Leased from DHSC	Leased from other government bodies	Leased from bodies external to government	2024/25 £000	2023/24 £000
Repayment of lease liability – capital	168	773	-	**941**	924
Repayment of lease liability – interest	13	65	-	**78**	87
	181	**838**		**1,019**	**1,011**

10. Related parties

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

All commissioning support units
All English NHS foundation trusts
All English NHS trusts
All integrated care boards
Care Quality Commission
NHS Digital
Health Education England
Health Research Authority
NHS Blood and Transplant
NHS Business Services Authority
NHS England
NHS Property Services Limited
NHS Trust Development Authority
NHS Counter Fraud Authority

NHS Resolution directors and transactions with other organisations

The following individuals hold director positions within NHS Resolution and during the year NHS Resolution has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out in the following material. The remuneration for executive and non-executive directors for the roles they perform for NHS Resolution is disclosed in the Remuneration and staff report on page 106.

The transactions between NHS Resolution and the related parties are all arm's length and concern solely those arising in the ordinary course of NHS Resolution indemnity schemes services and not the individuals referred to in the following table.

NHS Resolution directors and transactions with other organisations

Dr Mike Durkin OBE Associate Non-executive Director	Health Services Safety Investigations (HSSIB)	Non-executive Director	-	4	-	-
					-	-
Niamh McKenna Chief Information Officer	NHS BT Audit and Risk Committee	Independent Member	4	704	-	20
					-	-
DHSC[1]	NHS Confederation	Related party to DHSC	4	-	-	-

1 DHSC have provided us with a list of individuals and entities which are deemed to be related parties of theirs for this financial year. These entities are deemed to be related parties of NHS Resolution for the purposes of IAS 24 Related Party Disclosures.

11. Financial instruments

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

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

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

12. Events after reporting period

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

Glossary

An online glossary[1] is available to support this document.

1 See https://resolution.nhs.uk/glossary/

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