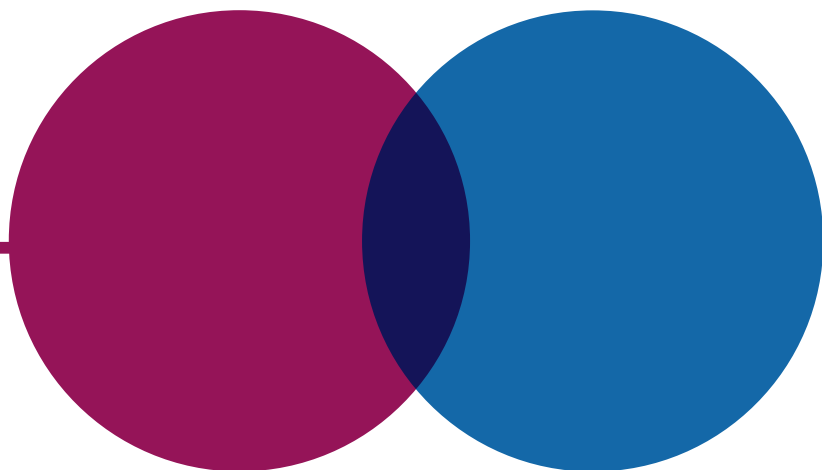




National Audit Office




REPORT

Costs of clinical negligence

Department of Health & Social Care

SESSION 2024–2026
17 OCTOBER 2025
HC 1335



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Costs of clinical negligence

Department of Health & Social Care

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 15 October 2025

This report has been prepared under Section 6 of the
National Audit Act 1983 for presentation to the House of
Commons in accordance with Section 9 of the Act

Gareth Davies
Comptroller and Auditor General
National Audit Office

9 October 2025

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CORRECTION SLIP

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Correction:

The correction changes the term ‘liability’ to ‘provision’ in paragraph 6 and paragraph 1.18.

Text currently reads:

Clinical negligence is the second largest liability on the government balance sheet after nuclear decommissioning.

Text should read:

Clinical negligence is the second largest provision on the government balance sheet after nuclear decommissioning.

Date of correction: 5 November 2025



Contents

Key facts 4

Summary

Introduction 5

Part One

Long-term changes in the government's liability for clinical negligence and the amounts needed to settle claims 13

Part Two

Drivers of claim volumes and costs 25

Part Three

The factors that will affect the cost of clinical negligence in the future 36

Appendix One

Our audit approach 45

Appendix Two

Clinical negligence data in other countries 49

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The National Audit Office study team consisted of:


Marianne O'Neill, Katie Sargeant and Freddie Wong with assistance from Muaaz Ahmed, Antonia Eckley, David Raraty and Morgan Sapsford, under the direction of Andy Morrison.

For further information about the National Audit Office please contact:

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

 020 7798 7400

 www.nao.org.uk

 @NAOorguk

Key facts

£3.6bn

estimated cost arising from clinical negligence claims settled in England in 2024-25

13,329

number of clinical negligence claims settled in 2024-25 (with and without damages)

£60bn

estimate of England's accumulated clinical negligence liabilities as at 31 March 2025

£1.1 billion total clinical negligence cost settled in England in 2006-07 (inflated to 2024-25 values)

5,625 the number of clinical negligence claims settled in England in 2006-07 (less than half the number settled in 2024-25)

£4.1 billion expected payments for clinical negligence in England in 2029-30 (compared with £3.1 billion in 2024-25)

£11.2 million the average compensation cost for obstetrics claims involving cerebral palsy or brain damage that were settled with damages in England in 2024-25

3.7:1 the ratio of legal costs to compensation for lower value claims (£25,000 or less) in 2024-25

Summary

Introduction

1 Clinical negligence is a breach of a legal duty of care which directly caused harm to the patient. If clinical negligence has occurred, a patient or their representative may claim for damages against the clinicians or their employers. NHS services are legally liable for any clinical negligence and must pay compensation to the claimant and cover their legal fees if the claim is proven. The vast majority of patient safety incidents are not associated with a clinical negligence claim.

2 NHS Resolution (NHSR) is responsible for administering seven clinical negligence indemnity schemes for general practice and secondary healthcare services in England. Members of NHSR's indemnity schemes include NHS trusts, foundation trusts and general practitioners. Private contractors, such as dental practitioners, are generally legally liable for their own clinical negligence claims. The Department of Health & Social Care (DHSC) oversees NHSR and develops policy to manage the costs of clinical negligence cases.

3 We last reported on the cost of clinical negligence in 2017, *Managing the costs of clinical negligence in trusts*.¹ We concluded that clinical negligence costs in trusts were significant and rising fast. While DHSC had proposed measures to reduce existing costs at the time, these were small and incremental compared with predicted rises in liabilities. In May 2025, the Committee of Public Accounts (PAC) concluded that it was unacceptable that DHSC had yet to develop a plan to deal with the cost of clinical negligence claims.²

4 With the cost of clinical negligence continuing to rise, and in response to PAC's concerns, this investigation sets out:

- long-term changes in the government's liability for clinical negligence and the amounts needed to settle claims (Part One);
- the drivers of claims volume and costs (Part Two); and
- the factors that could affect the future cost of clinical negligence, including systemic pressures (Part Three).

¹ Comptroller and Auditor General, *Managing the costs of clinical negligence in trusts*, Session 2017–2019, HC 305, National Audit Office, September 2017.

² Committee of Public Accounts, *DHSC Annual Report and Accounts 2023–24*, Twenty Fifth Report of Session 2024–25, HC 639, May 2025.

5 This report only considers the cost of clinical negligence in England. We have not set out to evaluate the performance of the public bodies involved, nor reviewed NHS patient safety, which is the subject of other inquiries and reviews. We consider only the compensation schemes administered by NHR, and not those administered separately, such as compensation for infected blood. The figures in this report are presented in 2024-25 values (referred to as real terms) unless otherwise stated.

Key findings

Long-term changes in the government's liability for clinical negligence and the amounts needed to resolve claims

6 At £60 billion, the government's liability for clinical negligence claims has quadrupled since 2006-07. The provision estimates the total amount that would be required to settle all NHS clinical negligence claims for incidents up to 31 March each financial year, including any claims not yet received. Clinical negligence is the second largest provision on the government balance sheet after nuclear decommissioning. Between 2006-07 and 2024-25, the total provision for clinical negligence increased by £45.6 billion in real terms, from £14.4 billion to £60.0 billion. This is due to more claims for clinical negligence and the rising costs of each settlement. Almost 40% (£23.9 billion) of the liability was estimated costs to the NHS from patient harm that had occurred before 31 March 2025, but a clinical negligence claim had yet to be made. The estimated value of the liability can fluctuate significantly between years due to the various assumptions needed (paragraphs 1.14, 1.18 to 1.20 and 2.5, and Figure 9).

7 The annual cost to settle claims has more than tripled over the last two decades. The settled cost of a clinical negligence claim represents the total cost of resolving the case, including any estimates of additional costs or payments due in future years. The financial cost to settle all claims in England has increased from £1.1 billion in 2006-07 (in real terms) to £3.6 billion in 2024-25. Most of the increase (£2.1 billion) relates to costs for damages. Claimant legal costs accounted for £0.4 billion of the increase, while NHS defence costs accounted for just £83 million (paragraphs 1.16, 1.17 and 2.5, and Figure 9).

8 Increases in costs are primarily due to a small number of very-high-value claims (£1 million and above). In 2024-25, damages for very-high-value claims accounted for 68% of total costs, but these claims represented only 2% of all claims by volume. The highest-value claims are typically those associated with brain injuries suffered in maternity care, which are often settled with a periodic payment schedule rather than a single lump sum. Between 2006-07 and 2024-25, the total cost for obstetrics claims involving cerebral palsy or brain damage increased by over £1 billion in real terms. In 2024-25, the average compensation for obstetrics claims involving cerebral palsy or brain damage was £11.2 million (for claims settled with damages). Damages can include compensation for suffering, care costs, future lost earnings, educational support, and adaptations for accommodation. Court rulings on the eligibility of innovative or novel treatment options can increase compensation for all claims (paragraphs 1.11 and 2.7 to 2.11, and Figure 10).

Changes in the type and cost of claims in recent years

9 Increases in the number of settlements in recent years are largely due to newly created schemes for general practice. Between 2006-07 and 2016-17, the number of settled clinical negligence cases more than doubled, from 5,625 to 11,397, including claims settled without damages. Most claims related to hospital activity, but volumes have been relatively stable since they peaked in 2016-17. Two new centralised schemes were introduced for general practice in 2019, and these are the main reason for recent increases in the number of claims NHSR has received and settled. Since their introduction, the number of settlements had increased to 13,329 by 2024-25. Most settlements, including settlements under the GP schemes, are low value (£25,000 or less). NHSR settled almost half of all claims (48%) in 2024-25 without damages, and a quarter of claims settled for £25,000 or less. Around 5% of settled claims were for more than £250,000 (paragraphs 1.9 and 1.12 to 1.15 and Figures 4 and 5).

10 Claim volumes have reduced across 11 medical specialties since 2016-17, and two specialties showed a notable reduction in costs. Since we last reported in 2017, settled claim volumes reduced for 11 of the 18 major specialties we reviewed. Since 2016-17, the most significant percentage reductions were in orthopaedic surgery (-33%) and general surgery (-31%), which also saw the most notable reductions in annual settled costs (£81 million and £71 million respectively, in real terms). The number of settled claims increased for six of the specialties reported, with mental health (73%) and radiology (30%) reporting the largest percentage increases. Obstetrics cases involving cerebral palsy or brain damage (£599 million) and paediatrics (£137 million) saw the largest increase in annual settled costs in real terms (paragraphs 2.2 to 2.4 and Figures 7 and 8).

On legal costs and wider costs

11 Claimant legal costs on successful claims have increased much more than NHS defence legal costs. Claimant legal costs increased from £148 million in 2006-07 (in real terms) to £538 million in 2024-25, representing 15% of the total cost of settled claims. NHS defence costs have also increased, from £76 million in 2006-07 (in real terms) to £159 million in 2024-25, but reduced from 7% to 4% of settled claim costs over the same period. The full cost of claimants' legal expenses is unknown because the figures do not include claimants' legal costs for unsuccessful claims and legal firms may charge additional amounts from compensation awards where claims are successful. Such arrangements have the potential to further inflate the damages claimants seek (paragraphs 2.12, 2.13 and 2.18).

12 Legal costs for low-value claims vastly exceed the damages payable to claimants. Around three-quarters of clinical negligence claims settle for £25,000 or less. The legal costs of these are almost four times the total damages awarded. In 2024-25, £143 million of the £183 million cost to settle low-value claims was for legal costs. Of this, £98 million was claimant legal costs and £45 million was NHS defence costs. Only £39 million (21%) was for damages, meaning the ratio of legal costs to damages was 3.7:1. Legal costs are also growing for medium-value claims (settlements between £25,001 and £250,000), and now account for more than half of the total cost to settle these claims in 2024-25 (paragraphs 2.16, 2.17 and Figure 11).

13 The government may be paying twice in some instances of clinical negligence: once through compensation and then again through providing treatment to the claimants. The law currently states that damages must be calculated on the presumption that care will be provided by the private sector and not the NHS. There is no estimate of the extent to which clinical negligence claimants go on to use publicly funded health or social care services for their conditions, and little is known about how damages are used by claimants. In 2022, the Health & Social Care Committee called the presumption of private treatment an "outdated assumption". The cost to health services of treating cases involving clinical negligence specifically or cases of avoidable harm to patients is also unknown. Although there is no official estimate, the Organisation for Economic Co-operation and Development estimates that treating cases where harm could have been prevented (but was not necessarily negligent) costs developed countries 8.7% of their health expenditure each year (paragraphs 2.19, 2.20, 3.32, and Figure 14).

Factors affecting the future costs of clinical negligence

14 Although forecasts remain uncertain, it is likely that the costs of clinical negligence will continue to grow substantially. The Government Actuary's Department (GAD) forecasts that annual payments for compensation and legal costs will increase from £3.0 billion in 2024-25 to £4.1 billion by 2029-30. Payments can be made for a single claim over multiple years, for example interim payments before settlement of damages or legal costs, payments upon settlement, and periodically in the years after settlement. Payments in a financial year are not necessarily related to claims settled in that year. The estimate produced by GAD is highly uncertain and influenced by a wide range of external factors such as estimates of life expectancy, developments in treatments and associated technology, and court case rulings. For example, the Supreme Court is currently considering whether claimants who are minors should be entitled to compensation for lost earnings beyond their life expectancy, which could increase damages (paragraphs 3.2, 3.3, and Figure 12).

15 The reported cost of clinical negligence to the taxpayer in England is higher than most other countries, in part because the UK offers universal healthcare, does not cap compensation, and has more comprehensive coverage of costs.

In England, the annual cost per capita for clinical negligence (£62.20) and annual number of claims per million people (227.5) appear high when compared with those of other countries operating similar legal systems. However, comparisons are skewed by the exclusion or capping of some types of costs, such as lost earnings, and partial coverage in other jurisdictions. England provides universal healthcare, and its centralised claims management approach provides a more comprehensive picture of clinical negligence claims. England's costs also reflect the full cost to government of compensation and legal costs. Many other countries cap compensation, particularly for loss of earnings, or provide equivalent services through state-funded support, such as social care, which are excluded from compensation figures (paragraphs 3.4 to 3.6 and Appendix Two).

16 Evidence suggests that improving the initial system response to harm could reduce the number of claims and the cost of clinical negligence. Stakeholders told us that, in many cases, patients are compelled to consider legal proceedings for the answers and reassurances they seek. Research commissioned by NHR in 2018 suggests that improving the NHS's initial response to harmful incidents could reduce the number of patients who pursue clinical negligence claims. Stakeholders raised concerns about how well individual health providers apply the duty of candour, which is the legal obligation for honesty and transparency when care goes wrong. NHR guidance advises apologising to patients as soon as possible after an incident occurs, as delayed or poor communication increases the likelihood a patient will seek answers in a different way. The 2025 Dash review of patient safety across health and care found that the current system for complaints and concerns is confusing, with issues often poorly handled and patients subject to delays and poor-quality responses (paragraphs 3.7 to 3.11).³

³ Department of Health & Social Care, *Review of patient safety across the health and care landscape (Dash review)*, July 2025.

17 NHSR has worked to resolve claims more quickly and without the need for litigation. Over the last 10 years, NHSR has introduced several new approaches to keep claims out of court and expedite cases where possible, such as the Early Notification Scheme for maternity, claims mediation and stocktake meetings. There are considerable benefits to these approaches, which have been well received by the legal sector. For example, for claims resolved with damages, average claimant legal costs were £96,000 higher for litigated claims than un-litigated ones between 2018-19 and 2023-24. The proportions of claims resolved without litigation have increased from 66% in 2006-07 to 83% in 2024-25. Faster resolution of cases also reduces the time commitment and emotional distress for the claimants and clinical staff involved with a claim. NHSR recognises it must balance speed with the likelihood that a claim will succeed. Some cases need to be resolved via legal proceedings, and it can take time to establish the full extent of claimant injuries in complex cases (paragraphs 3.12, 3.13, 3.22 and Figure 13).

18 Plans to control claimant legal costs by limiting the recoverable amount in lower-value damages cases have not been implemented following the change of government in 2024. Most clinical negligence claims fall outside the scope of the current fixed recoverable cost regime, which aims to provide more certainty and faster resolution for simple or lower value damages cases by fixing amounts of legal fees that can be recovered by successful parties. Stakeholders representing claimant lawyers have previously raised concerns that fixed recoverable costs will constrain access to justice for some claimants because there will be lower value but complex claims that become uneconomical to progress (paragraphs 3.20 to 3.21).

19 Changes in the legal industry and technology could dramatically alter the clinical negligence landscape, with both positive and negative consequences. Artificial intelligence (AI) brings opportunities and risks for the NHS to manage. It has the potential to greatly improve diagnosis and use of data but could also lead to errors as it is developed. NHSR and industry stakeholders told us of increasing financial interest in clinical negligence firms from venture capitalists. These private companies, which are typically faster adopters of new technology, are reportedly using AI to triage claims more efficiently and effectively (paragraph 3.28).

20 The 10-year health plan sets out the government's design for the future of the health system, including a review of the clinical negligence system.⁴ DHSC has accepted PAC's recommendation that it needs to manage the costs of clinical negligence more effectively, including a mechanism to control legal fees. It will advise ministers on the drivers of costs, how to manage spending on clinical negligence and the potential merits of reform options. DHSC has asked David Lock KC to advise on how to improve patients' experience of clinical negligence claims and manage rising legal costs. All stakeholders we spoke to saw opportunities to improve the clinical negligence system and how it operates, including how candidly the NHS responds to incidence of harm, and how quickly it can learn from its mistakes (paragraphs 1.5, 3.29 to 3.31 and Figure 14).

4 HM Government, *Fit for the Future: 10 Year Health Plan for England*, July 2025, white paper, CP1350.

Concluding remarks

21 We have reported several times over consecutive decades that the costs of clinical negligence are increasing but so far, no government has succeeded in controlling the cost. Even though recent claim numbers have plateaued in many areas the cost of claims has continued to increase, particularly for very high-value cases (£1 million or more). Although rising damages have been a key driver of cost increases, little is known about the extent to which the government may be paying twice by providing care for claimants who have already received compensation.

22 Over the last 10 years, NHSR has worked hard to reduce the financial and emotional cost of clinical negligence by resolving claims faster and without litigation wherever possible. Although these efforts have been well received by the legal sector, claimant legal costs continue to rise with legal costs for low value claims (£25,000 or less) greatly exceeding the level of damages. There is also a lack of transparency around claimant compensation being used to settle additional legal fees and how far this may inflate claim costs. While measures across these areas might reduce the rate at which costs increase, by far the most important issue is reducing the incidence of clinical negligence and the harm caused to patients.

Recommendations

23 We have identified several areas where DHSC, NHS England (NHSE) and NHSR should act to manage the rising costs of clinical negligence:

- a** In response to the increasing cost of higher-value claims, NHSR should:
- identify how much inflationary pressure is uncontrollable within the existing system to help inform policy decisions; and
 - build on its current work to use artificial intelligence to analyse damages awarded across its portfolio and identify any inconsistencies in claims for similar needs.
- b** Little is known about how much legal firms recoup in additional fees from claimant damages.
- NHSR should explore with the legal market whether there is the potential for greater voluntary transparency on fee arrangements agreed between claimants and their lawyers.
 - If greater transparency cannot be obtained, NHSR should work with government to consider alternative mechanisms for understanding the proportion of claimant damages legal firms recoup in fees, and the reasonableness of this to inform future policy development, for example: reviewing firms' published fee arrangements; or seeking anonymised or population level data on the scale and distribution of claimant legal costs settled through damages.

- c** In 2024-25, there was a 3.7:1 ratio of legal costs to damages payable for low-value claims (£25,000 or less). Legal costs also exceeded total damages for medium value claims (between £25,001 and £250,000). DHSC should consider whether the existing approach to legal costs remains proportionate for all claims, including whether alternative methods to compensate negligent treatment could provide better outcomes for patients, with less cost overall.
- d** On the specific risk that claimants receive funding for private treatment or social care then go on to use publicly funded NHS or social care services instead:

 - DHSC should assess whether the requirement to calculate damages based on privately funded care packages remains aligned with its vision of a modern NHS.
 - If so, DHSC should examine the feasibility of reviewing patient records to understand the extent claimants have used NHS and social care services for treatments covered under compensation packages and whether these costs merit further mitigation.
- e** Patients report finding the existing complaints process confusing and frustrating, and that the system does not always provide the answers or reassurance they are looking for. As part of the 10 Year Health Plan for England, the government has committed to improving the complaints process. In undertaking this work, DHSC and NHSE should:

 - incorporate performance against complaint standards into future inspection and oversight regimes for health bodies, including monitoring whether there is sufficient local capacity and capability to carry out high quality investigations on a timely basis; and
 - as part of the forthcoming review, ensure that NHS staff have the skills and capacity to deliver the duty of candour in practice.

Part One

Long-term changes in the government's liability for clinical negligence and the amounts needed to settle claims

1.1 This part of the report provides an overview of NHS patient safety, the clinical negligence system in England, and annual number and costs of settled claims. Unless otherwise indicated, financial information in this report is presented in 2024-25 real terms.⁵

Patient safety

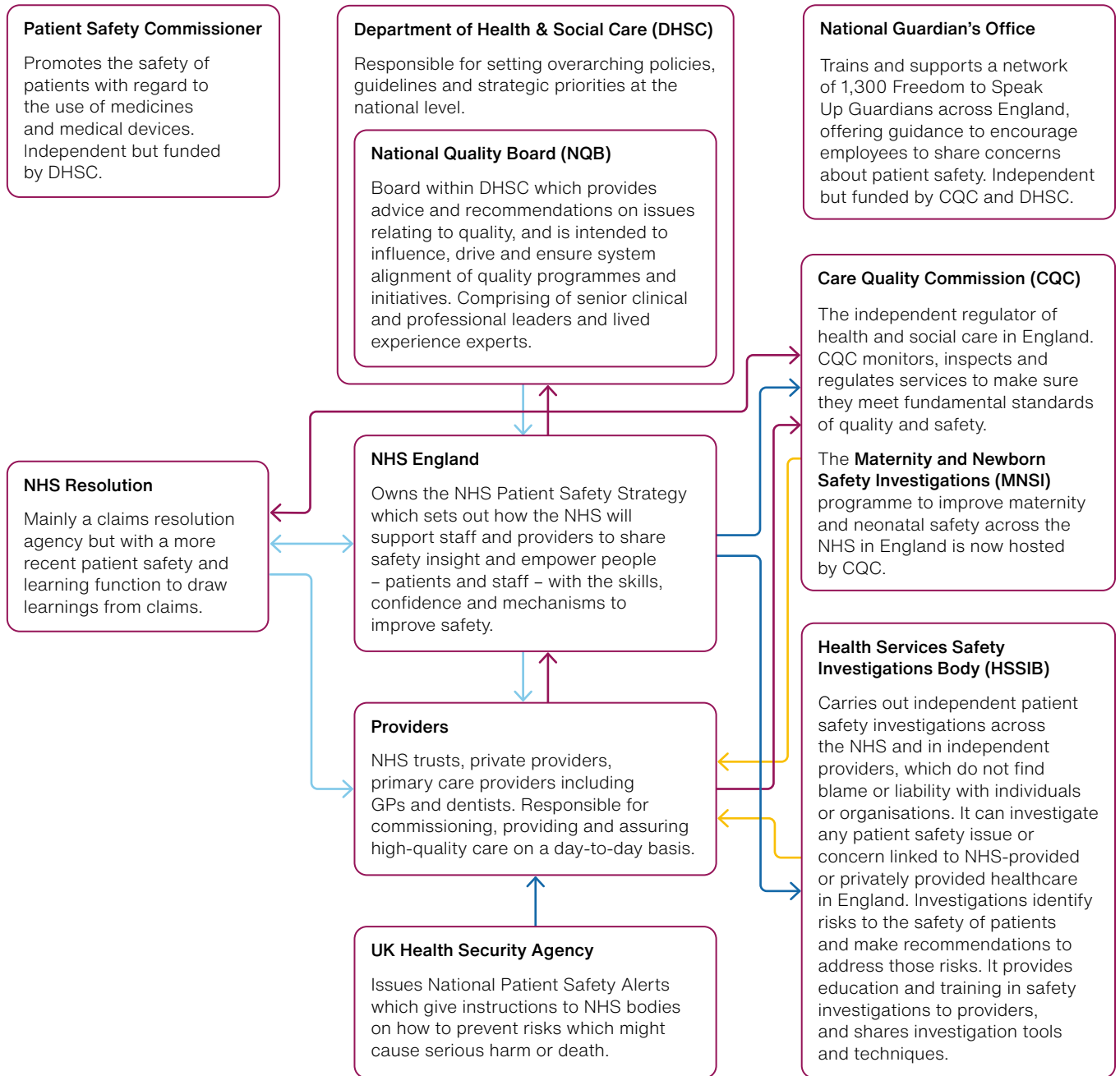
1.2 The vast majority of patient safety incidents are not associated with a clinical negligence claim. The NHS reports around 2.4 million patient safety incidents annually, most of which (70%) cause no harm to patients. Around 0.5% of patient safety incidents result in severe harm or death.

1.3 The Department of Health & Social Care (DHSC) is ultimately responsible for ensuring patient safety but devolves policy delivery to multiple other organisations (**Figure 1** overleaf). For example, NHS England (NHSE) owns the NHS patient safety strategy setting out programmes supporting continuous improvement, such as around data analysis of safety incidents, and how trusts respond to incidents when they occur. The next phase of the strategy will encourage a proactive approach to safety culture and better use of safety information.

⁵ Using Office of National Statistics GDP deflators published in June 2025.

Figure 1
Key organisations in the patient safety landscape, August 2025

There are many organisations responsible for monitoring and sharing information on patient safety across the NHS



→ Report safety issues → Share learning and insight → Share information → Inspections/Investigations

Note

1 As part of the restructure of the health sector and the NHS 10 Year Health Plan for England, in March 2025 the government announced the planned abolition of NHS England. In July 2025, it announced the planned abolition of the Health Services Safety Investigations Body.

1.4 The need to improve patient safety has been a key feature of two recent independent reviews by Lord Darzi and by Dr Penny Dash.^{6,7} Lord Darzi's 2024 report on the state of the NHS in England noted ongoing issues related to the safety of maternity care, including around workforce pressure, stress and morale, siloed working, and personal reactions dominating responses to incidents. The 2025 Dash review identified considerable overlap and duplication in the current patient safety landscape. Although DHSC had deployed substantial resources on patient safety over the last five to 10 years, the Dash review concluded there has been relatively little improvement. In 2024, the Health Services Safety Investigations Body reported that the broader health system was drowning in patient safety recommendations rather than taking affirmative actions to improve it. The NHS 10 Year Health Plan for England, published in July 2025, similarly noted an overwhelming amount of patient safety recommendations from the differing organisations within the system.⁸

1.5 DHSC recognises more needs to be done to improve patient safety across the NHS. The 10-year health plan sets out the government's design for the future of the health system. As part of this review, DHSC has asked David Lock KC to advise on how to improve patients' experience of clinical negligence claims and manage rising legal costs.

Clinical negligence

1.6 Clinical negligence is the breach of a legal duty of care directly causing harm to a patient. If clinical negligence is suspected to have happened, a patient or their representative may claim for damages. NHS service providers are legally liable for any clinical negligence by their employees and must pay compensation to the claimant, as well as their legal fees if the claim is successful. England uses a tort liability system where negligence must be proven for compensation to be paid. Tort law systems can be seen as adversarial, with claims negotiated between claimant and defendant solicitors and the potential for trial if no agreement can be reached.

1.7 NHS Resolution (NHSR) provides expertise to the NHS to resolve concerns and disputes fairly and shares learning that supports improvement.⁹ It administers a range of indemnity schemes covering the risks involved in delivering general practice and secondary healthcare services in England. Private contractors, such as dental practitioners, are generally legally liable for their own clinical negligence claims. DHSC oversees NHSR and develops policy to manage the costs of clinical negligence cases.

1.8 NHSR administers seven clinical and four non-clinical negligence indemnity schemes. Indemnity scheme members include NHS trusts, foundation trusts, general practitioners, private sector providers, integrated care boards and other arm's-length bodies of DHSC. NHSR is responsible for managing claims and covering any legal costs or damages on behalf of scheme members. In 2024-25, NHSR received 14,428 new claims for clinical negligence across its schemes (**Figure 2** on pages 16 and 17).

⁶ Lord Darzi, *Independent investigation of the National Health Service in England* (Darzi review), September 2024.

⁷ Department of Health & Social Care, *Review of patient safety across the health and care landscape* (Dash review), July 2025.

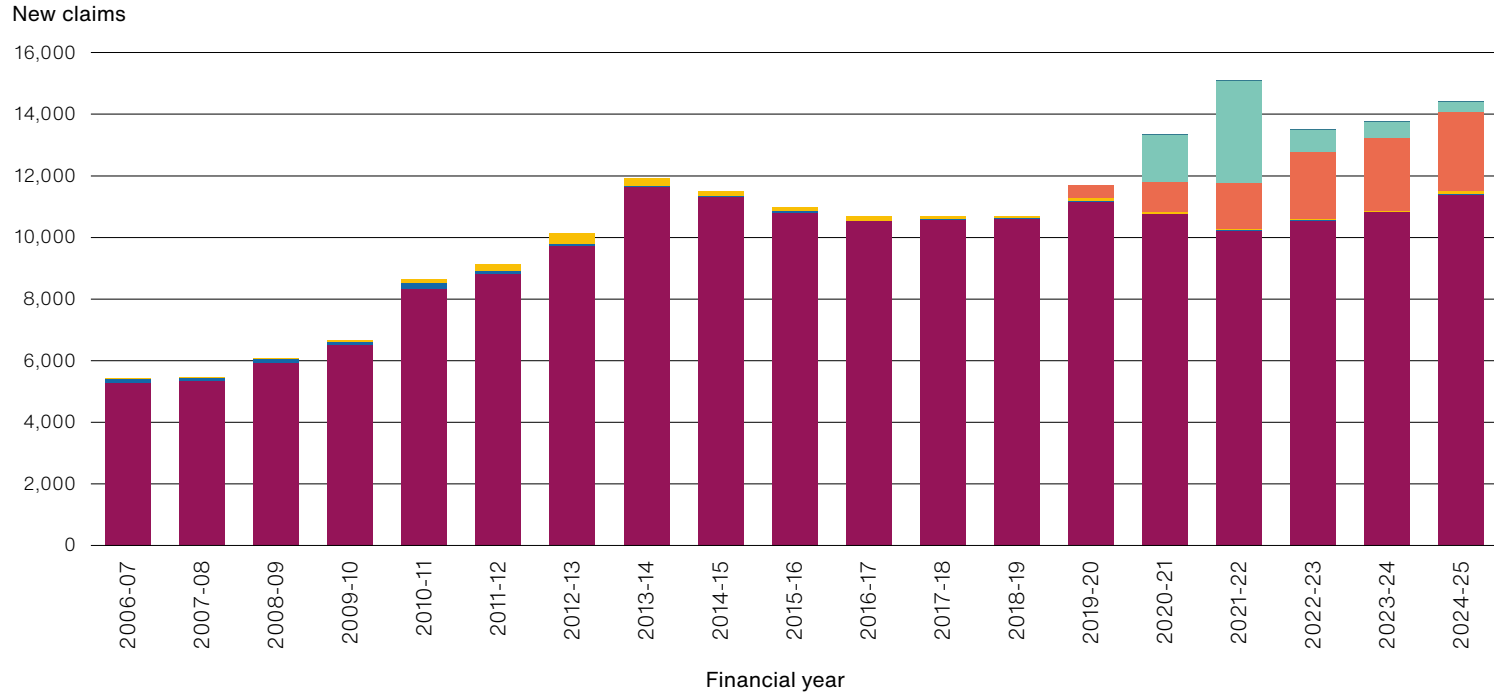
⁸ HM Government, *Fit for the Future: The 10 Year Health Plan for England*, July 2025, white paper, CP 1350.

⁹ NHS Resolution is the operating name of the NHS Litigation Authority.

Figure 2

New clinical negligence claims by scheme, 2006-07 to 2024-25

The number of claims notified to NHS Resolution more than doubled between 2006-07 and 2024-25, with recent increases since 2019 due to new schemes



	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
CNST	5,267	5,351	5,948	6,504	8,338	8,802	9,740	11,638	11,312	10,810	10,540	10,581	10,608	11,163	10,761	10,232	10,559	10,821	11,396
Ex-RHA	-	2	2	-	-	-	1	-	-	2	-	-	-	-	-	-	-	-	-
ELS	134	96	111	101	188	113	36	49	35	41	16	16	16	11	9	9	7	8	23
DH clinical claims	18	19	31	52	117	220	340	245	152	124	136	72	47	122	42	30	34	38	85
CNSGP	-	-	-	-	-	-	-	-	-	-	-	-	-	399	976	1,498	2,182	2,384	2,575
ELSGP	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1,558	3,321	720	503	341
CNSC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8	23	15	22	8

Figure 2 *continued*

New clinical negligence claims by scheme, 2006-07 to 2024-25

Notes

- 1 CNSC: Clinical negligence Scheme for Coronavirus, launched by NHS Resolution in April 2020.
- 2 ELSGP and CNSGP: Existing Liability Scheme for General Practice (for incidents before 1 April 2019) and Clinical Negligence Scheme for General Practice (for incidents on or after 1 April 2019). NHS Resolution became responsible for these schemes, both related to general practice, in 2019.
- 3 DH clinical claims cover the clinical liabilities of abolished relevant health bodies and are centrally funded by the Department of Health & Social Care.
- 4 ELS: Existing Liability Scheme, for incidents involving trusts before 1 April 1995.
- 5 Ex-RHA: Ex Regional Health Authority Scheme, for claims against Regional Health Authorities that were abolished in 1996.
- 6 CNST: Clinical Negligence Scheme for Trusts, for incidents on or after 1 April 1995.
- 7 Data includes 'nil claims' where no damages were paid.

Source: National Audit Office analysis of NHS Resolution data

1.9 Most claims relate to hospital activity under the largest indemnity scheme administered by NHR – the Clinical Negligence Scheme for Trusts (CNST). The scheme is voluntary, but all NHS trusts in England are currently members. Members contribute to CNST using annual pay-as-you-go arrangements based on each trust's claims experience and its exposure to future claims. To avoid large fluctuations in contributions, NHR also imposes a maximum and minimum percentage change from year to year.

Claim journey

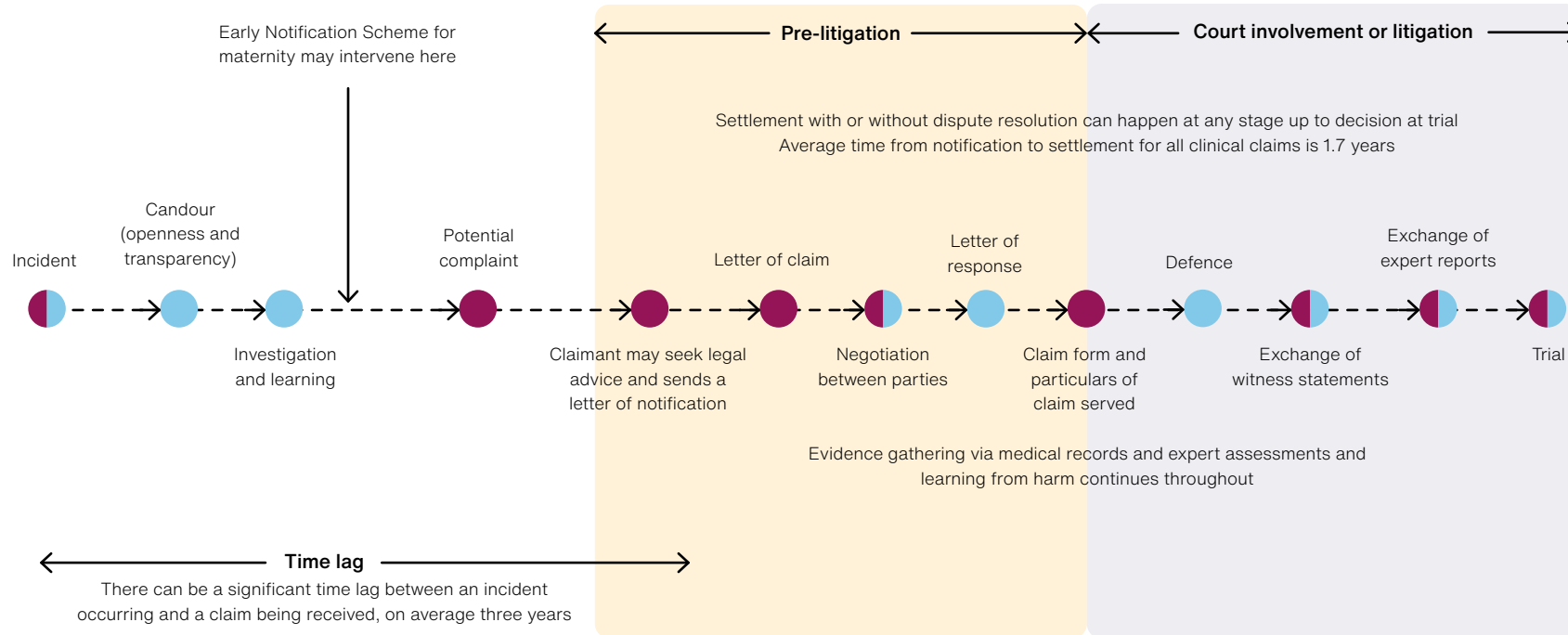
1.10 For many reasons, the journey of a claim can be lengthy and complex. On average it takes three years from an incident to when a claim is made and a further 1.7 years before it is resolved (**Figure 3** overleaf). Patients or families may need time to decide whether they want to pursue a claim, and then it may also take many months to quantify and agree damages, particularly for higher value claims or those involving younger claimants (paragraph 3.22). NHR's objective is to achieve fair and timely resolution in all cases, and it routinely monitors the time between a claim decision and agreeing damages.

1.11 Damages can include compensation for pain and suffering, care costs, future lost earnings, educational support and accommodation adaptations. Damages are calculated based on a claimant's specific circumstances and to reflect differing needs throughout their remaining life. For example, if a baby is injured at birth, future educational support may be payable until the age of 18, with loss of future earnings payable from 18 until expected retirement age.

Figure 3

The process for resolving clinical negligence claims in the NHS, August 2025

The average time between an incident occurring and a claim being settled is almost five years



- Claimant
- NHS
- Claim progression

Notes

- 1 Since 2014, a statutory duty of candour has required all NHS providers to be open and transparent with patients and their families when harm occurs.
- 2 NHS Resolution’s Early Notification Scheme for maternity aims to ensure decisions on liability for maternity incidents are reached as early as possible.
- 3 A letter of notification advises the NHS a letter of claim is likely to be sent because a breach of duty and/or causation has been identified.
- 4 A letter of claim advises the NHS the claimant has decided there is grounds for a claim.

Source: National Audit Office review of NHS Resolution information

1.12 Clinical negligence claims are most likely to be settled without litigation and very few cases reach court. NHSR offers a range of dispute resolution options, such as mediation. In 2024-25, almost all (99.8%) of clinical negligence claims did not proceed to trial and four out of five cases (83.4%) were settled without legal proceedings. Between 2006-07 and 2024-24, an average of 38.5% of claims were settled without damages. In these cases, NHSR did not pay any damages as there was insufficient evidence that clinical negligence had occurred. In 2024-25, the number of claims settled without damages reached a new high at almost half (48%). Of the remaining claims, 26% were low value (£25,000 or less), 20% were medium value (£25,001 to £250,000), 3% were high value (£250,001 to £1 million) and 2% were very high value (£1 million and above).

Settled claims

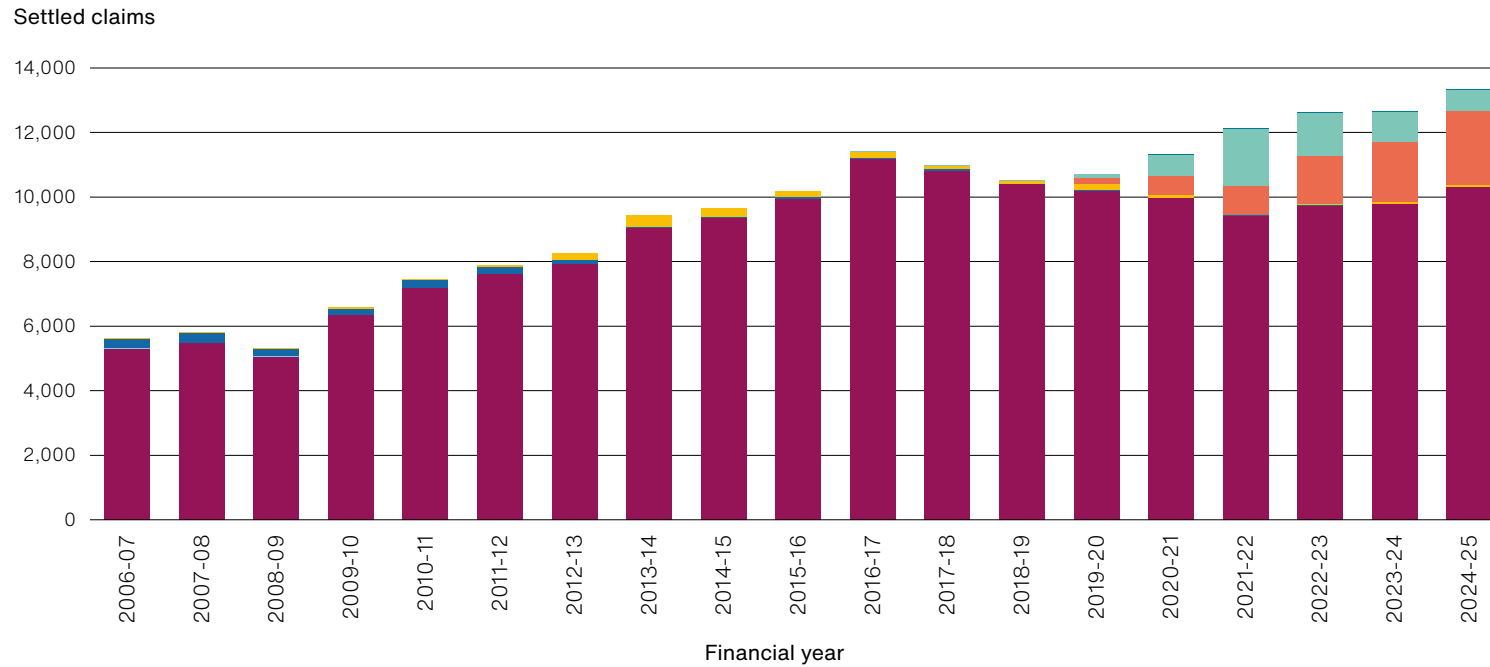
1.13 Since we last reported on clinical negligence, the annual number of claims settled by NHSR has increased by almost 17%. A claim is considered to be settled when there has been a settlement or court order in relation to damages, including those where no damages are to be paid. NHSR settled 13,329 claims in 2024-25, up from 11,397 in 2016-17 (**Figure 4** on pages 20 and 21). Settled claims have also more than doubled since 2006-07, up from 5,625. However, rising numbers of clinical negligence claims should be viewed in the wider context of a changing NHS in England. NHS activity in key areas has increased by around 20% over the last 10 years, with combined inpatient, outpatient and A&E interactions increasing from 126.7 million in 2014-15 to 152.4 million in 2023-24. In its 2024-25 annual report, NHSR noted that claim trends remain broadly similar pre- and post-COVID-19 pandemic.

1.14 Settled claim volumes for hospital activity under CNST have remained relatively stable since 2016-17 (Figure 4). Recent increases in clinical negligence claims are largely due to the introduction of two new indemnity schemes in 2019 covering both current and historic claims in primary medical services. DHSC asked NHSR to create these schemes after its research found the cost of private indemnity cover for GPs was having a negative impact on GP recruitment and retention. The schemes shifted the liability of GP indemnity from private providers to government, making the scale of clinical negligence, and the cost to the NHS, more transparent.

Figure 4

Settled claims by clinical negligence scheme, 2006-07 to 2024-25

If general practice is discounted, settled claims have fallen from a peak in 2016-17



	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
■ CNST	5,314	5,490	5,067	6,360	7,201	7,617	7,956	9,049	9,356	9,953	11,181	10,822	10,404	10,204	9,967	9,425	9,732	9,805	10,304
■ Ex-RHA	7	6	3	2	2	1	-	1	-	-	1	1	-	1	-	-	-	-	-
■ ELS	285	292	229	195	228	237	94	48	46	52	35	37	19	22	16	7	13	8	17
■ DH clinical claims	19	23	30	34	26	49	205	355	252	184	179	113	80	190	78	30	37	32	72
■ CNSGP	-	-	-	-	-	-	-	-	-	-	-	-	-	181	585	905	1,472	1,876	2,262
■ ELSGP	-	-	-	-	-	-	-	-	-	-	1	3	20	92	677	1,747	1,367	940	652
■ CNSC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	12	9	9	22

Figure 4 *continued*

Settled claims by clinical negligence scheme, 2006-07 to 2024-25

Notes

- 1 CNSC: Clinical Negligence Scheme for Coronavirus, launched by NHS Resolution in April 2020.
- 2 ELSGP and CNSGP: Existing Liability Scheme for General Practice (for incidents before 1 April 2019) and the Clinical Negligence Scheme for General Practice (for incidents on or after 1 April 2019). NHS Resolution became responsible for these schemes, both related to general practice, in 2019.
- 3 DH clinical claims cover the clinical liabilities of abolished relevant health bodies and are centrally funded by the Department of Health & Social Care.
- 4 ELS: Existing Legacy Scheme, for incidents involving trusts before 1 April 1995.
- 5 Ex-RHA: Ex Regional Health Authority Scheme, for claims against Regional Health Authorities that were abolished in 1996.
- 6 CNST: Clinical Negligence Scheme for Trusts, for incidents on or after 1 April 1995.

Source: National Audit Office analysis of NHS Resolution data

1.15 **Figure 5** overleaf shows that general practice has the largest number of claims by specialty. Since their launch, the number of GP claims settled by NHSR increased from 273 in 2019-20 to 2,914 in 2024-25. It will take some time for GP claims to stabilise following the schemes' creation, and NHSR expects numbers to continue increasing. An initial review of the GP scheme found that, similar to CNST, most new claims were triggered by delays or failures relating to diagnosis or referrals. Excluding the new general practice schemes, settled claims have reduced from the peak of 11,396 in 2016-17 to 10,415 in 2024-25.

Cost of settled claims

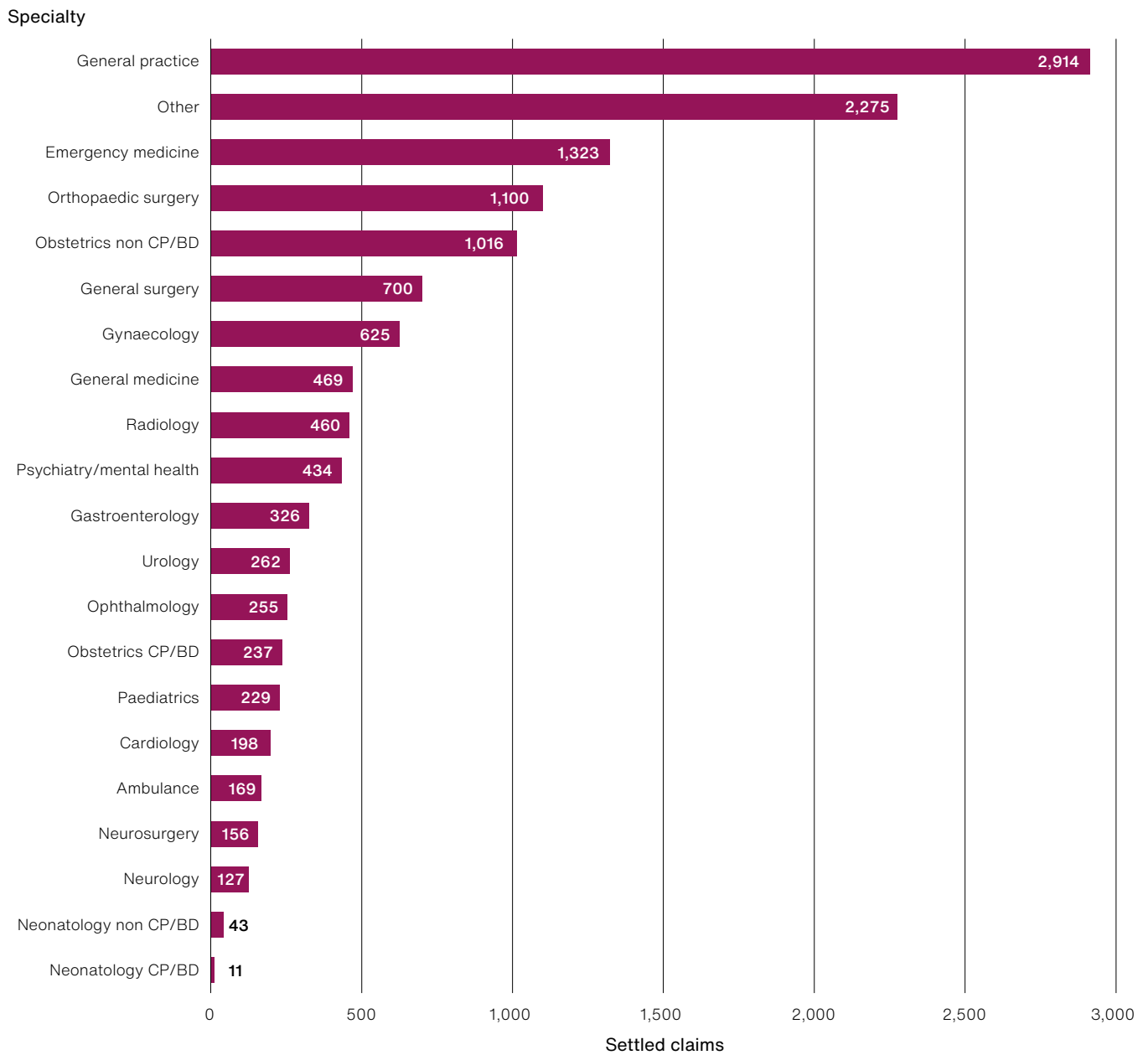
1.16 The annual cost of settled clinical negligence claims includes the total cost of resolving a claim in the year it is agreed. This could include any lump sums and legal costs paid at the time of settlement, interim sums paid prior to settlement, plus estimates of additional costs or payments in future years.

1.17 **Figure 6** on page 23 shows that since 2006-07, the annual cost of settling claims has increased by £2,563 million in real terms, from £1,082 million to £3,646 million in 2024-25. The cost of settled claims peaked in 2018-19, following a change to the Personal Injury Discount Rate (PIDR) set by the Lord Chancellor. The PIDR can affect the cost of claims because it is used by courts to calculate lump sum damages awarded in serious, life-changing personal injury cases. Changes to the rate resulted in costs increasing significantly in 2017 and then reducing in 2019.¹⁰ Aside from impacts due to the PIDR, the long-term trend has seen settled claim costs increase over time. However, since 2018-19, annual costs have only risen significantly in one year (2022-23) and fallen in other years.

¹⁰ The Personal Injury Discount Rate (PIDR) was changed from 2.5% to -0.75% in 2017, then to -0.25% in 2019. In April 2025 it was changed to 0.5%, which will reduce awards for compensation.

Figure 5
Settled claims by specialty, 2024-25

The highest number of settled claims related to those working in general practice



Notes

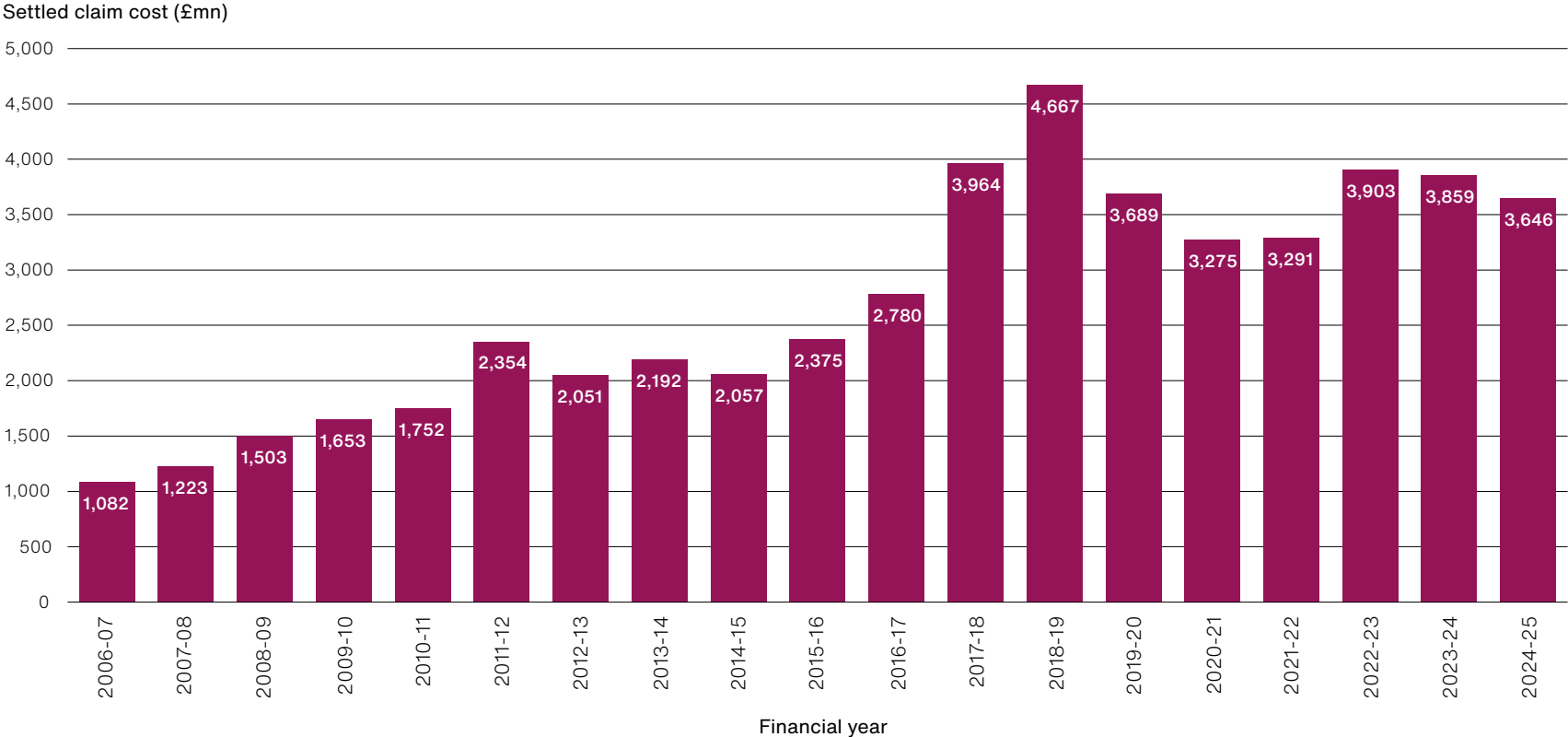
- 1 The 'Other' category groups together around 60 specialities with less significant claim numbers.
- 2 General practice relates to claims from the Clinical Negligence Scheme for General Practice and the Existing Liabilities Scheme for General Practice, both introduced in 2019. These schemes include others, beyond GPs, who are indemnified due to working in general practice, such as nurses and physician associates.
- 3 CP/BD refers to claims involving cerebral palsy or brain damage.
- 4 Non CP/BD refers to claims not involving cerebral palsy or brain damage.

Source: National Audit Office analysis of NHS Resolution information

Figure 6

The costs of settled claims, 2006-07 to 2024-25

The cost of settled claims peaked in 2018-19 and costs have remained slightly below £4 billion each year since



Notes

- 1 Settled claims attribute the full financial impact of claims in the year they were concluded. This impact can include any lump sums and legal costs paid at settlement, interim sums paid prior to settlement, and estimates of additional costs or payments in future years.
- 2 Costs are in 2024-25 real terms using Office of National Statistics GDP deflators published in June 2025.

Source: National Audit Office analysis of NHS Resolution data

The government's liability for clinical negligence

1.18 Clinical negligence is the second largest provision on the government balance sheet after nuclear decommissioning. The provision for this liability is updated at the end of each financial year, and it estimates the total remaining payments for the NHS to settle all claims, including claims not yet received for incidents up to that date.

1.19 Between 2006-07 and 2024-25, the total provision for clinical negligence increased by £45.6 billion in real terms, from £14.4 billion at 31 March 2007 to £60.0 billion at 31 March 2025. This is due to more claims and the rising cost of each settlement (see analysis in Part Two). Of this increase, £3.6 billion related to four clinical negligence schemes introduced during the period.¹¹ As at 31 March 2025, almost 40% (£23.9 billion) of the provision represented an estimate of future costs to the NHS from patient harm that had already occurred but for which no clinical negligence claim had yet been received.

1.20 The value of the provision is heavily influenced by two discount rates. HM Treasury discount rates are used when estimating future provisions in government accounts to reflect the general principle that money is worth more the sooner it is received, due to its earning capacity. In 2021-22, NHR's total provision increased by £42.6 billion in nominal terms due to a change in HM Treasury's discount rates. In 2022-23, a subsequent change in the discount rate then reduced the provision by £74.6 billion in nominal terms. These movements therefore reflect a change in the way the liability is valued rather than a change in the underlying liability. In addition, NHR estimates that the change in PIDR from -0.25% to 0.5% (paragraph 1.17) led to a £1.9 billion reduction in the provision as at 31 March 2025.¹²

1.21 Over the past 20 years the size of the provision has been influenced by greater use of Periodic Payment Orders (PPOs) which pay compensation for higher value claims by way of a smaller lump sum upon settlement with future annual payments rather than as a single lump sum. PPOs benefit claimants as they can meet their care costs with reduced exposure to uncertainty around future inflation and life expectancy. They increase the long-term liability as the commitment to make future payments must be recognised by NHR. The cost of settling PPOs has also increased substantially over the last 20 years. At the end of 2024-25, settled PPOs represented 25% (£14.9 billion) of the total future liability for clinical negligence.

¹¹ The four schemes introduced were the Clinical Negligence Scheme for General Practice, the Existing Liabilities Scheme for General Practice, the Clinical Negligence Scheme for Coronavirus and a scheme for residual liabilities transferred from abolished health bodies.

¹² For England and Wales. Scotland and Northern Ireland adopted a 0.5% PIDR rate from September 2024 following a review by the Government Actuary's Department.

Part Two

Drivers of claim volumes and costs

2.1 This part of the report examines the reasons for changes in clinical negligence claim volumes and costs. In this part of the report we consider:

- movements in settled claim volumes and costs by speciality.
- key drivers of changes in overall settled claim costs.
- how compensation costs have changed and the underlying factors.
- claimant legal costs, and how these compare with compensation and defence legal costs; and
- the wider costs of clinical negligence.

Movements in settled claim volumes and costs by speciality

2.2 Over the past twenty years, almost all specialties experienced a rise in settled claim volumes. The largest percentage increases were for gastroenterology (472%) and radiology (429%). However, both these specialties started from low baselines of less than 100 claims per year. Claim numbers only decreased for two specialties, obstetrics involving cerebral palsy or brain damage (-25%), and paediatrics (-13%). These specialties are low in volume of claims and so the numbers can be volatile.

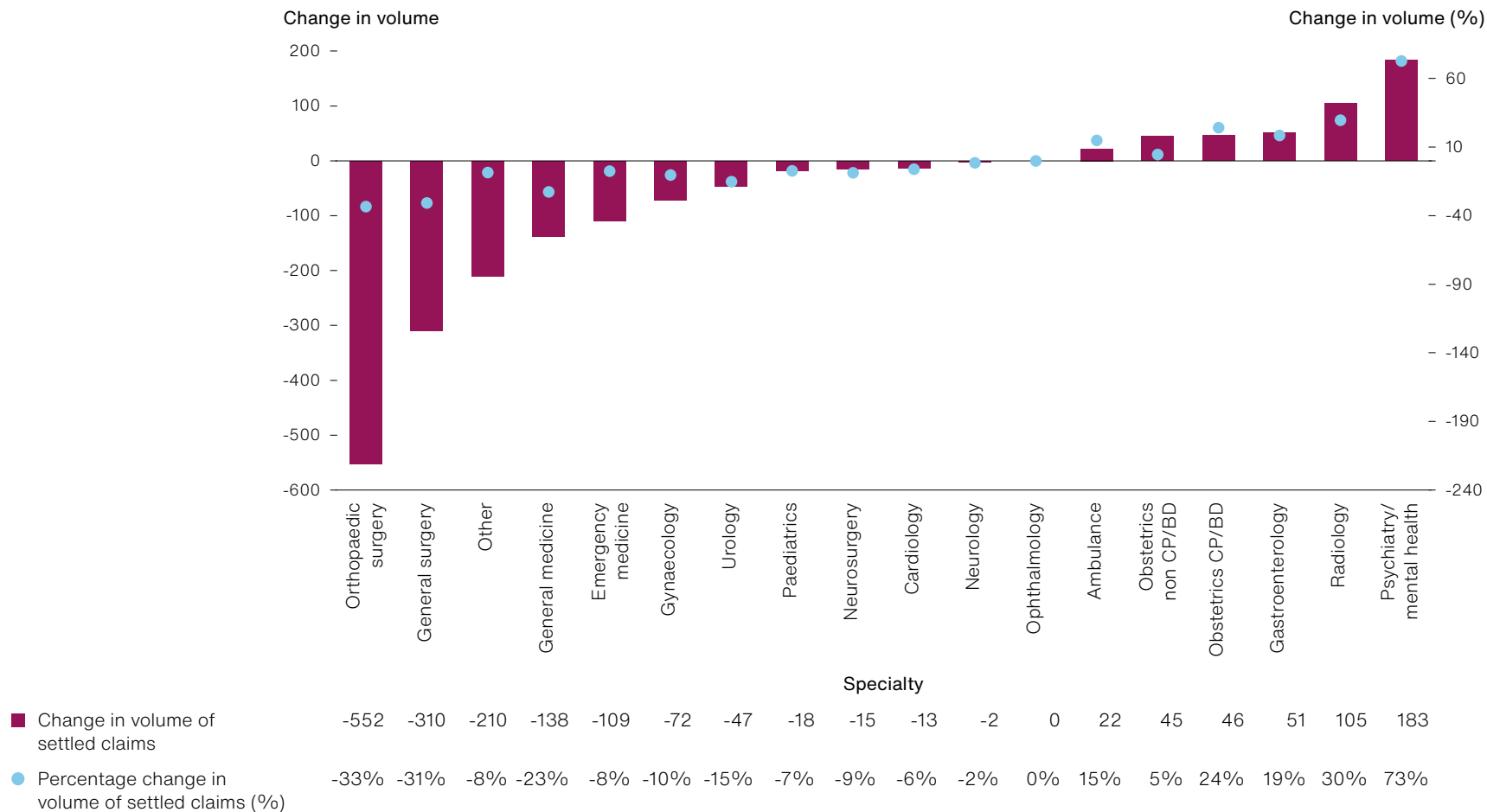
2.3 In recent years the picture is more mixed. Since the peak of numbers in 2016-17, settled claim volumes continued to increase for six specialties, with mental health (73%), and radiology (30%) reporting the largest percentage increases (**Figure 7** overleaf). During the same period, settled claim volumes reduced in 11 specialties, with the most significant percentage reductions in orthopaedic surgery (-33%) and general surgery (-31%).

2.4 Costs have increased for all reported specialties since 2006-07. However, since claim volumes peaked in 2016-17, costs for settled claims by year have fallen for nine areas with the biggest reductions in real terms in orthopaedic surgery (£81 million) and general surgery (£71 million) (**Figure 8** on pages 27 and 28). Neurology (-58%) and general surgery (-43%) saw the largest percentage decreases in costs. Five specialties showed very marginal cost decline since 2016-17. Costs continued to increase for nine, with mental health (88%) and paediatrics (73%) reporting the largest percentage increases in real terms. Obstetrics claims involving cerebral palsy or brain damage (£599 million) and paediatrics (£137 million) reported the largest cost increases by value in real terms.

Figure 7

Changes in settled claims by volume and percentage according to specialty, 2016-17 to 2024-25

Eleven specialties experienced a reduction in claim volumes since the peak of 2016-17, but volumes have continued to increase in six specialties



Notes

- 1 CP/BD refers to claims involving cerebral palsy or brain damage.
- 2 Non CP/BD refers to claims not involving cerebral palsy or brain damage.
- 3 Claims related to neonatology were recorded separately from 2021 onwards and have not been included.
- 4 NHS Resolution became responsible for general practice indemnity in 2019, and these claims have not been included.

Source: National Audit Office analysis of NHS Resolution data

Figure 8

Change in settled claim costs by value and percentage according to specialty, 2016-17 to 2024-25

Costs have increased for nine specialities since the peak of settled claim volumes in 2016-17, however they have decreased for nine specialities

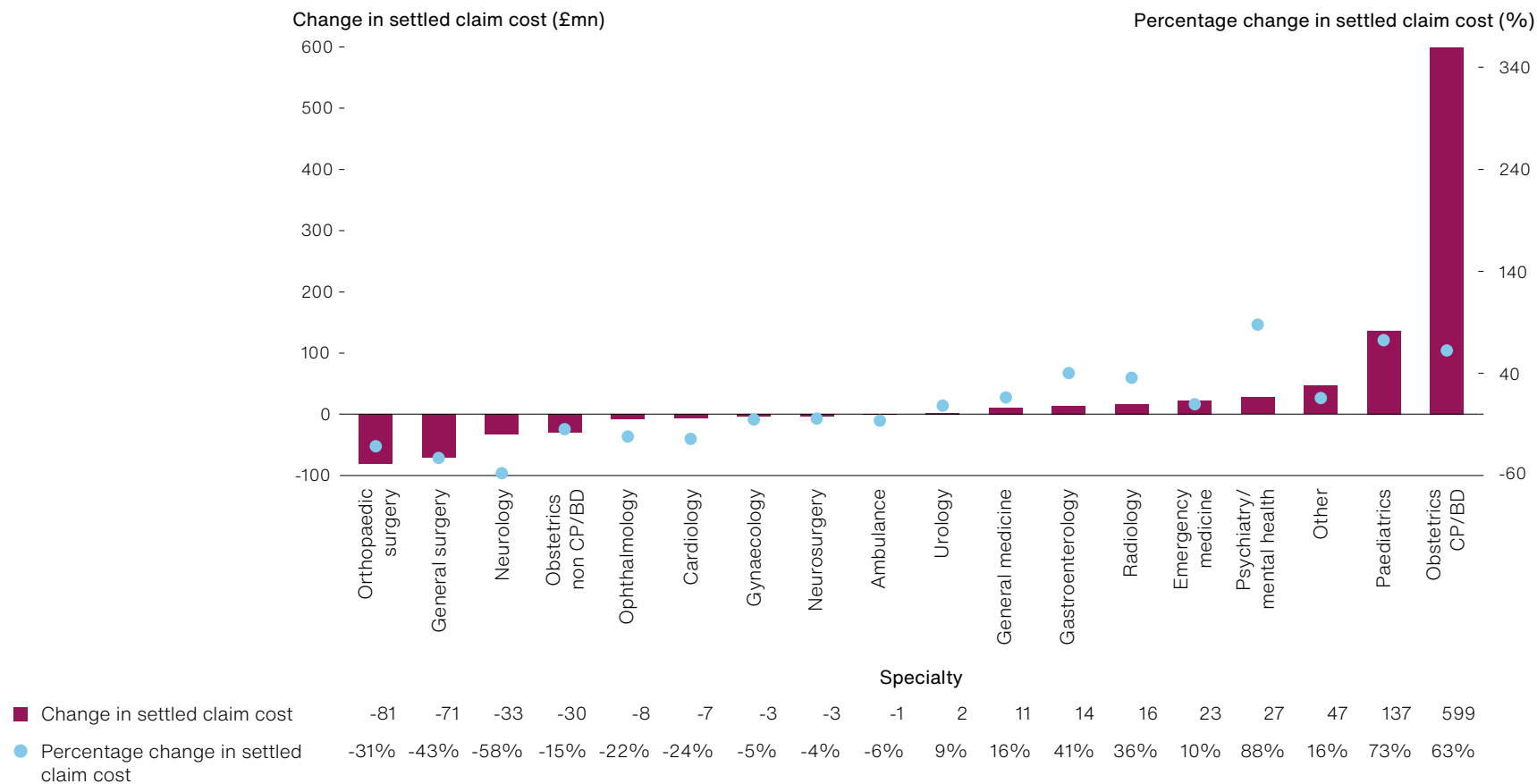


Figure 8 *continued*

Change in settled claim costs by value and percentage according to specialty, 2016-17 to 2024-25

Notes

- 1 Settled claims attribute the full financial impact of claims in the year they were concluded. This impact can include any lump sums and legal costs paid at settlement, interim sums paid prior to settlement, and estimates of additional costs or payments in future years.
- 2 CP/BD refers to cerebral palsy or brain damage.
- 3 Non CP/BD refers to claims not involving cerebral palsy or brain damage.
- 4 Claims related to neonatology were recorded separately from 2021 onwards and have not been included.
- 5 NHS Resolution became responsible for general practice indemnity in 2019, and these claims have not been included.
- 6 Change in costs are in 2024-25 real terms using Office for National Statistics GDP deflators published in June 2025.

Source: National Audit Office analysis of NHS Resolution data

Underlying factors of changes in total settled claim costs

2.5 Increases in claim volumes are the main factor behind cost increases over the past 20 years, followed by increases in the amount of damages payable. Annual costs have increased by £2,563 million in real terms since 2006-07 and **Figure 9** shows greater claim volumes account for just over half of this increase (£1,429 million). Of the remaining £1,135 million, rising amounts awarded for compensation account for £970 million (38% of the total increase) and the rising cost of claimant legal services account for 7% (£186 million). The increase in annual costs would have been even greater had NHR not reduced average NHS legal defence costs by 1%.

2.6 The dominant factor behind increases in clinical negligence costs changed after claim volumes peaked in 2016-17. Between 2006-07 and 2016-17, costs increased by £1,698 million, with 88% (£1,501 million) of this increase due to greater numbers of claims. Since 2016-17, annual costs have increased by a further £866 million, with the increase almost entirely due to increasing compensation for damages.

Compensation

2.7 The rising cost of compensation, particularly for very-high-value claims (£1 million and above), is making it increasingly expensive for NHR to settle clinical negligence claims. Damages are by far the biggest cost within clinical negligence, representing 81% of all settled claim costs in 2024-25. Since 2006-07, the annual cost of settling damages has increased from £858 million in real terms to £2,949 million in 2024-25, a rise of over £2 billion in less than 20 years.

Figure 9

Breakdown of the £2,563 million increase in annual costs of settled clinical negligence claims between 2006-07 and 2024-25, by cost area

Higher numbers of claims accounts for 56% of the increase and higher average cost of damages accounts for 38%

Cost area	Change due to numbers of claims	Change due to cost movements	Total
	(£mn)	(£mn)	(£mn)
Damages	1,121 (44%)	970 (38%)	2,091 (82%)
Claimant legal costs	203 (8%)	186 (7%)	390 (15%)
NHS defence costs	104 (4%)	-21 (-1%)	83 (3%)
Total rise	1,429 (56%)	1,135 (44%)	2,563

Notes

- 1 Settled claims attribute the full financial impact of claims in the year they were concluded. This impact can include any lump sums and legal costs paid at settlement, interim sums paid prior to settlement, and estimates of additional costs or payments in future years.
- 2 Calculation of changes relating to damages excludes settled claims where no damages were paid.
- 3 Change in costs calculated in 2024-25 real terms using Office of National Statistics GDP deflators published in June 2025.
- 4 Settled claim costs were £1,082 million in 2006-07 (real terms) and £3,646 million in 2024-25.
- 5 Numbers may not sum due to rounding.

Source: National Audit Office analysis of NHS Resolution data

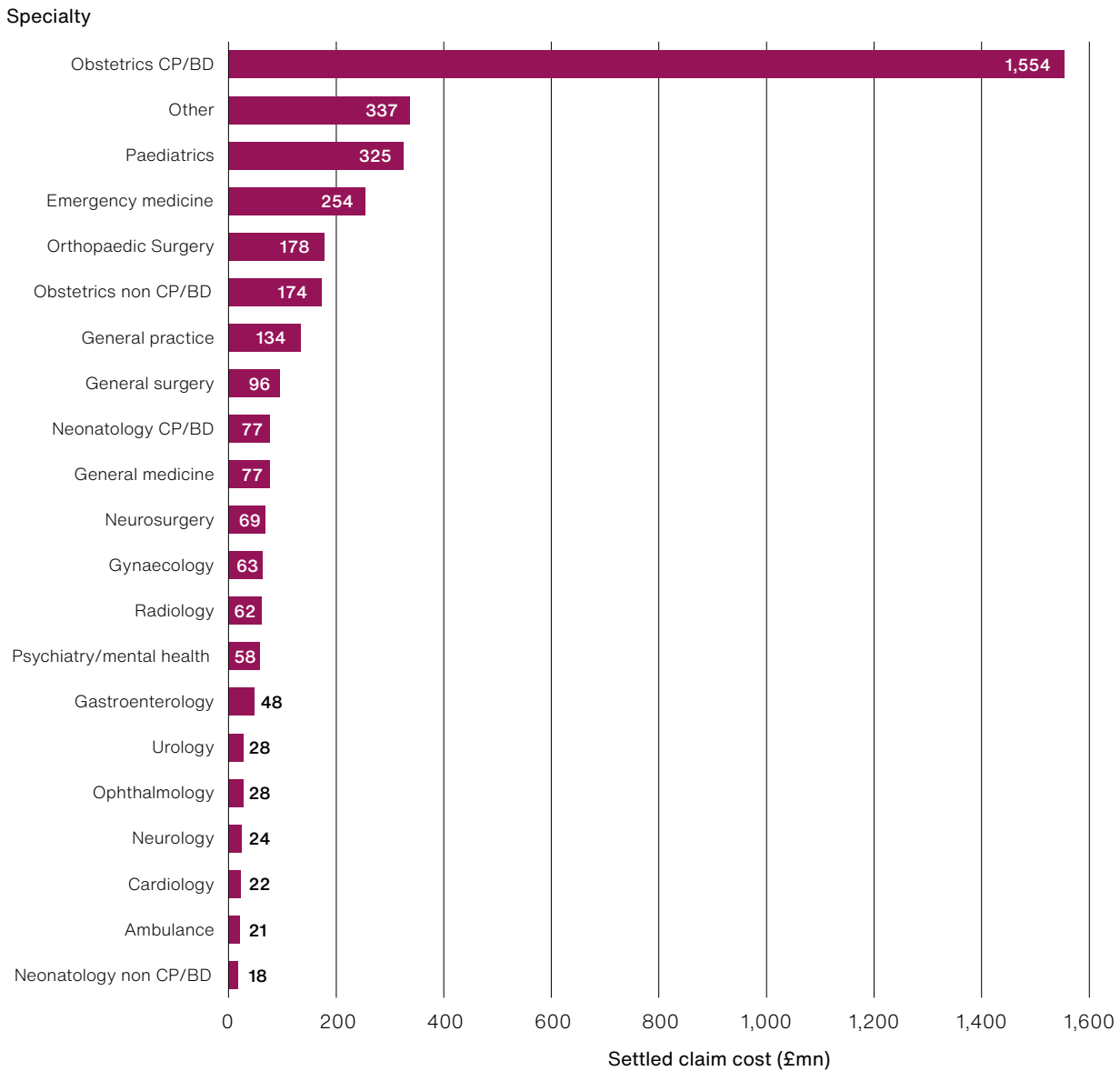
2.8 Damages for very-high-value claims (£1 million and above) account for an increasing proportion of costs settled in year. In 2006-07, damages for very-high-value claims were £640 million in real terms (59% of total costs) but by 2024-25, this had nearly tripled to £2,481 million (68% of total costs). In 2024-25, very-high-value claims accounted for 2% of all claims by volume. Compensation awards for these claims have also increased due to new precedents set by the courts, for example around access to innovative or novel treatment options.

2.9 The highest value claims are typically those associated with brain injuries suffered in maternity care. Over the last 20 years the cost of settling claims involving infants and children has increased significantly. Between 2006-07 and 2024-25, the total cost for obstetrics claims involving cerebral palsy or brain damage increased by over £1 billion in real terms, with average compensation for claims settled with damages growing by 305% (from £2.8 million to £11.2 million).

2.10 Obstetric claims involving brain damage and cerebral palsy have by far the largest settled claim costs by speciality. In 2024-25, costs for these claims were £1,554 million, more than four times the next highest costs reported in the other (£337 million) and paediatrics (£325 million) areas (**Figure 10** overleaf).

Figure 10
Settled claim costs by specialty, 2024-25

Costs for obstetrics claims involving cerebral palsy or brain damage are more than four times the next highest areas of costs



Notes

- 1 Settled claims attribute the full financial impact of claims in the year they were concluded. This impact can include any lump sums and legal costs paid at settlement, interim sums paid prior to settlement, and estimates of additional costs or payments in future years.
- 2 The 'Other' category groups together around 60 specialities with less significant claim numbers.
- 3 General practice relates to claims from the Clinical Negligence Scheme for General Practice and the Existing Liabilities Scheme for General Practice, both introduced in 2019. These schemes include others, beyond GPs, who are indemnified due to working in general practice, such as nurses and physician associates.
- 4 CP/BD refers to claims involving cerebral palsy or brain damage.
- 5 Non CP/BD refers to claims not involving cerebral palsy or brain damage.

Source: National Audit Office analysis of NHS Resolution data

2.11 Very-high-value claims (£1 million and above) are often settled using Periodical Payment Orders (PPOs) stretching into the future to support the claimants' long-term care needs. PPOs pay compensation for high-value claims by way of a smaller lump sum upon settlement with future annual payments rather than as a single lump sum. PPO claims and other claims involving long-term care requirements are sensitive to rising care costs, due partly to shortages of care providers, and increased labour and other costs associated with care. NHSR can request a variation to a claimant's annual payment amount if it believes there has been, or will be, a significant change in need during their lifetime. However, NHSR told us this is almost unheard of in practice.

Legal costs

2.12 Claimant legal fees are payable by the NHS when a claim is resolved with a damages payment. Costs for claimant legal fees have risen substantially since 2006-07. Claimant legal fees for claims settled in-year increased from £148 million in 2006-07 to £538 million in 2024-25, an increase of £390 million in real-terms. NHS legal costs have increased by £83 million in real terms over the same period (from £76 million to £159 million in 2024-25). NHS legal costs include investigations into claims which settled for no damages as clinical negligence was unproven.

2.13 Claimant legal costs have increased as a share of all clinical negligence costs over the past two decades. Since 2006-07, the share of total settled claim costs relating to claimant legal costs has increased 1% (from 14% to 15% in 2024-25). In contrast, NHS's legal costs as a share of total settled costs have decreased by 3% (from 7% to 4%).

2.14 Stakeholders from the legal sector noted some of the increased cost could be attributed to justice reforms. For example, historic changes to cap legal costs in other sectors of personal injury have reportedly increased the relative commercial appeal to firms of pursuing clinical negligence claims. They also said more recent efforts to improve the accountability of independent experts has led to a significant increase in expert fees.

2.15 NHSR told us it seeks to minimise the cost to the taxpayer of procuring legal services through its panel of legal firms that assist in handling and defending claims. Panel firms follow a capped hourly rate structure with prices fixed according to claim stage. In addition, the hourly rates that NHSR pays to its legal panel firms are significantly lower than commercial benchmarks. NHSR also intends to make further savings by increasing its internal capacity to manage cases at pre-litigation stages.

2.16 Around three quarters of settled clinical negligence claims were low-value in 2024-25 (£25,000 or less, including those settled without damages). Legal costs for low-value settled clinical claims now vastly exceed the damages payable to claimants. In 2024-25, there was a 3.7:1 ratio of claimant and NHS legal costs compared with damages payable for low-value claims. Of the £183 million cost, £98 million (54%) was for claimant legal costs, £45 million (25%) was for NHS defence costs, and only £39 million (21%) was for damages. Claimant legal costs and NHS defence costs for settled claims now account for 79% of the cost of low value claims compared with 67% in 2006-07. In 2006-07, claimants' legal costs for low value settled claims were £30 million in real terms, marginally more than the damages claimants received for low-value claims settled in that year, £27 million (**Figure 11** on pages 34 and 35).¹³

2.17 The total annual cost of claimant legal costs for medium-value settled claims (£25,001 to £250,000) has also increased relative to damages and is close to parity with the total amount payable for compensation. In 2024-25, the total annual cost for claimant legal costs accounted for 42% of the total annual cost of medium-value settled claims, compared with 28% in 2006-07. In 2006-07, the total annual claimant legal costs for settled claims were around half the amount for damages. By 2024-25, the total claimant legal costs for these cases were £186 million compared with total compensation for damages of £216 million. NHS legal costs accounted for 9% of the total cost of medium-value claims, meaning that over half of the total cost of these claims related to legal costs.

2.18 Reported figures for claimants' legal fees only reflect costs directly recovered from the health service and do not include any potential legal fees paid out of a claimant's compensation award. These arrangements have the potential to inflate damages sought by claimants and their lawyers. NHSR does not have sight of these arrangements. Costs are frequently claimed in excess of the guideline hourly rates used to calculate claimants' legal expenses. These rates are set by the head of the civil justice system in England and periodically reviewed by the Civil Justice Council costs committee; NHSR told us they are largely outside of its control.

¹³ Costs are in 2024-25 real terms using Office for National Statistics GDP deflators published in June 2025. The adjustments have been made at the aggregated cost level rather than for individual claims, meaning we have used nominal claim values to categorise claims into different cost categories.

The wider cost of clinical negligence

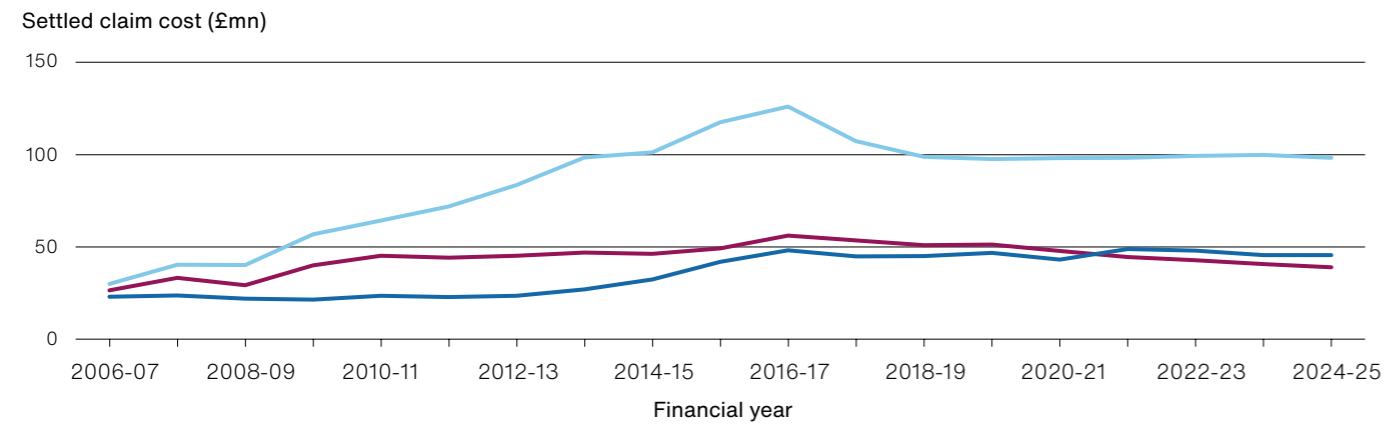
2.19 The cost of settled claims does not include the wider cost to government of harm caused by clinical negligence. Although there is no official estimate of the wider cost of harm, there is evidence to suggest that preventable harm (where harm could have been prevented but was not necessarily negligence) takes up a significant proportion of annual health spend. Research by the Organisation for Economic Co-operation and Development suggests preventable harm costs around 8.7% of developed countries' health expenditure each year. The estimate reflects the additional cost of tests, treatments and other activities associated with delivering the care needed to correct the effects of harm but it does not include the indirect costs such as damage to staff morale, mental and physical wellbeing and lost NHS productivity.

2.20 The government may also effectively be paying twice in some instances of clinical negligence, once through the compensation given to claimants and once again through providing remedial treatment and social care. Section 2(4) of the Law Reform (Personal Injuries) Act 1948 provides that defendants who pay for the future healthcare and treatment of damaged patients must do so on the presumption that such care will be provided by the private sector and not the NHS. Although claimants can be asked to declare in court if they plan to use the NHS for treatment, this rarely happens in practice. Local authorities are also not able to consider clinical negligence compensation awards when assessing eligibility for state social care. There is no estimate of the extent to which successful clinical negligence claimants then go on to use publicly funded health or social care services for their conditions. In 2022, the Health & Social Care Committee concluded the current approach to compensation was "outdated".

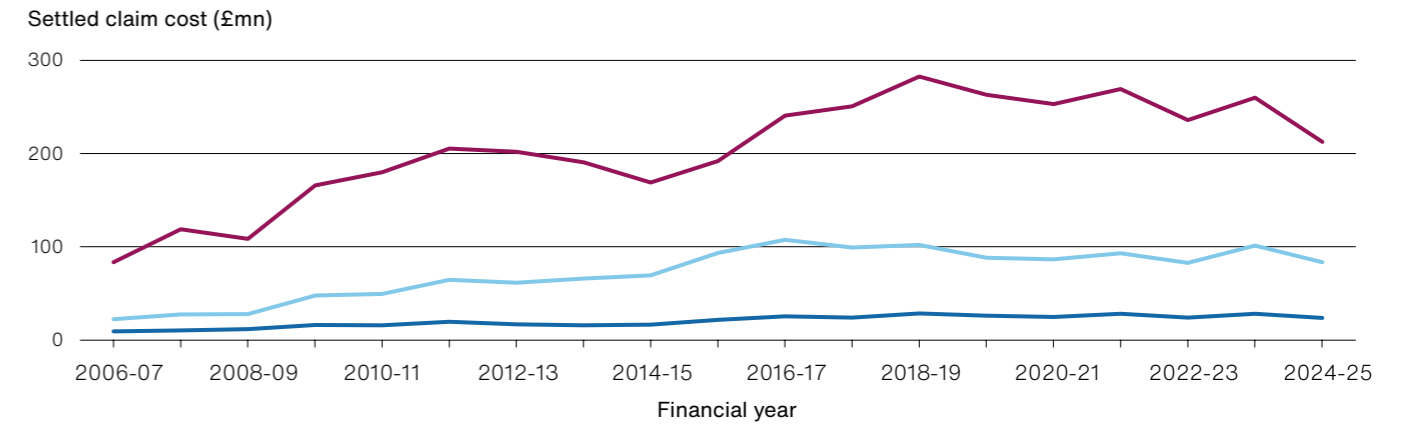
Figure 11
Damages, claimant legal costs and NHS defence costs for settled claims by claim value, 2006-07 to 2024-25

Claimant legal costs for low-value claims routinely exceed the damages payable awarded compared with higher value claims

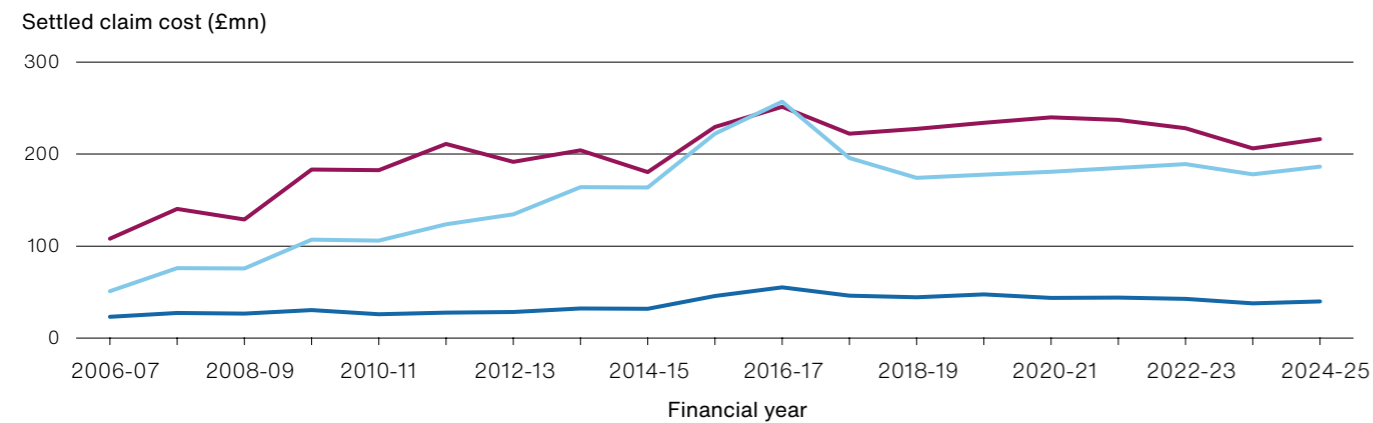
Low-value claims (£0 to £25,000)



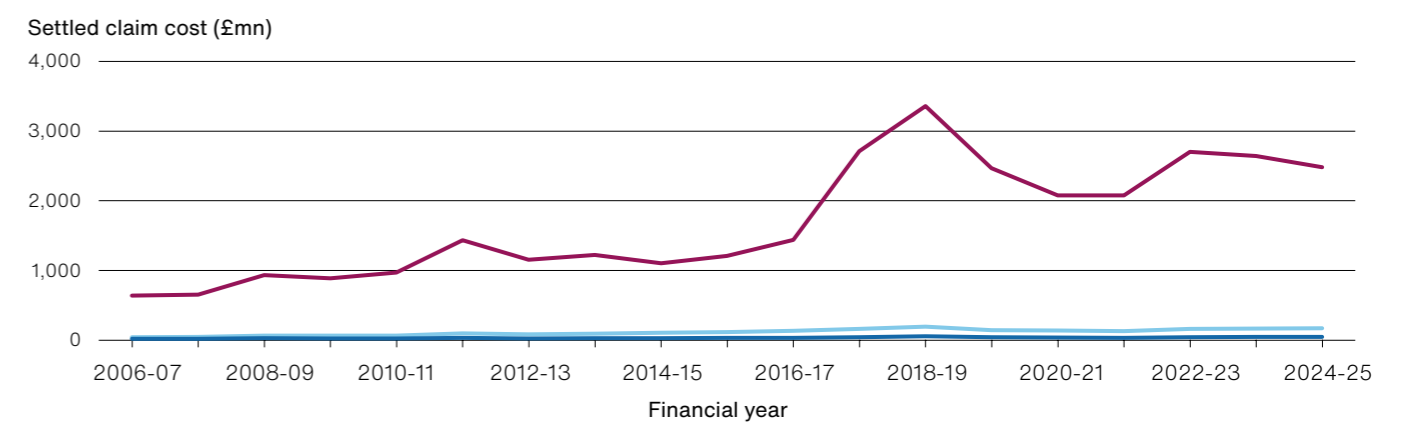
High-value claims (£250,001 to £1 million)



Medium-value claims (£25,001 to £250,000)



Very-high-value claims (£1 million and above)



- Damages
- Claimant legal costs
- NHS legal costs

Notes
 1 Settled claims attribute the full financial impact of claims in the year they were concluded. This impact can include any lump sums and legal costs paid at settlement, interim sums paid prior to settlement, and estimates of additional costs or payments in future years.
 2 Costs are in 2024-25 real terms using Office of National Statistics GDP deflators published in June 2025. The adjustments have been made at the aggregated cost level rather than for individual claims, meaning we have used nominal claims values to categorise claims into the different cost categories.

Source: National Audit Office analysis of NHS Resolution data

Part Three

The factors that will affect the cost of clinical negligence in the future

3.1 This part sets out the expected direction of travel for costs of clinical negligence, and how those future costs may be influenced by actions taken today.

Forecast clinical negligence costs

3.2 NHS Resolution (NHSR) works in partnership with the Government Actuary's Department (GAD) to forecast future spend by assessing past trends at a portfolio level and considering future cost and risk profile. In 2024-25, NHSR made compensation and legal cost payments totalling £3,079 million. Payments can be made for a single claim over multiple years, for example interim payments before settlement of damages or legal costs, payments upon settlement, and periodically in the years after settlement. Payments in a financial year are not necessarily related to claims settled in that year. GAD estimates that annual payments will continue to increase year on year, reaching £4,068 million by 2029-30 in nominal terms (**Figure 12**).

3.3 Although forecasts are uncertain, GAD estimates that the cost of clinical negligence will continue to grow substantially. The trajectory is affected by estimates of life expectancy, developments in treatments and associated technology, and case rulings. For example, the Supreme Court is currently considering whether claimants who are minors should be entitled to compensation for lost earnings beyond their injured life expectancy, for the years they would otherwise have lived and worked had they not been injured. If the Court finds in favour of the claimant, it could increase the long-term liability.

International comparisons of clinical negligence costs

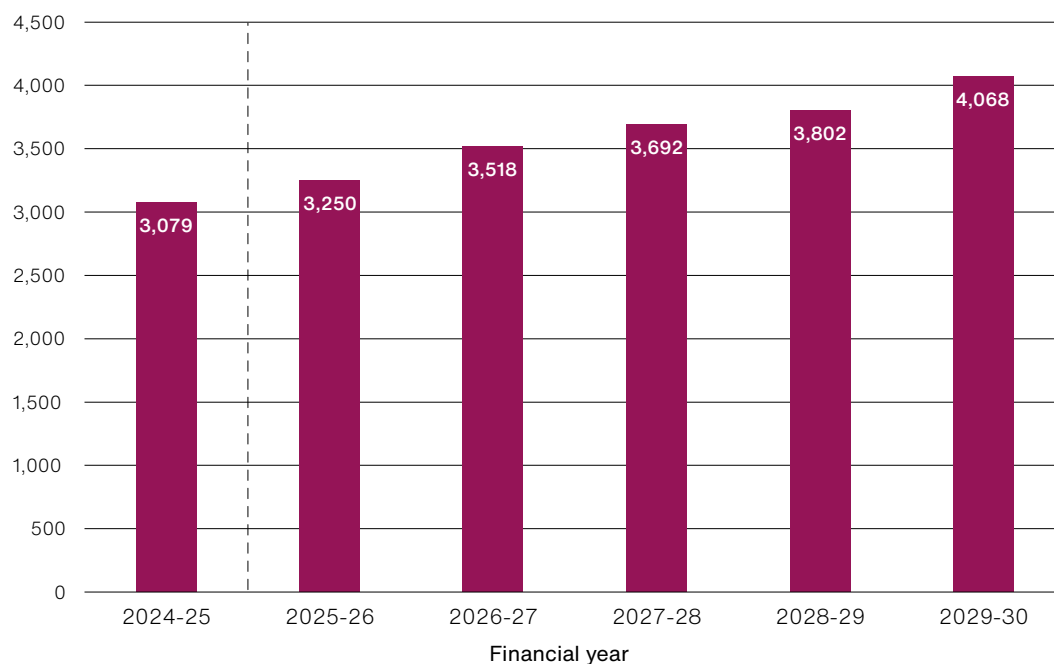
3.4 England has a high cost per capita for clinical negligence (£62.20 in 2024-25) and number of claims per million people (227.5) compared with countries operating similar legal systems (Appendix Two). However, per-capita cost comparisons are skewed by the exclusion or capping of some types of costs and partial coverage.

Figure 12

Clinical negligence cashflow outturn and projections, 2024-25 to 2029-30

NHS Resolution forecasts payments will reach £4.1 billion by 2029-30

Payments (£mn)



Notes

- 1 Data for 2024-25 reflect actual costs (left of dotted line). Data for 2025-26 to 2029-30 reflects NHS Resolution's forecast costs (right of dotted line).
- 2 Figures are in nominal terms.

Source: National Audit Office analysis of NHS Resolution data

3.5 Unlike most other jurisdictions, England provides universal healthcare, and its figures reflect near-universal coverage of all clinical negligence claims nationally. By contrast, Australian figures are only for private hospital care; Canada's figures include 90% of doctors but no other clinicians; and Japan's figures are only for one type of claim. England's costs also reflect the full cost to the government of compensation and legal costs, including of funding private treatment and full loss of income.

3.6 Many other countries cap compensation, particularly for loss of earnings, or provide equivalent services through state-funded support that are excluded from compensation figures. Making direct comparisons between countries is therefore difficult due to factors including differences in healthcare systems, state provision of services, legal systems, coverage of claims data between organisations, and various inclusions and exclusions between the different data sources.

Improving the initial response to harm

3.7 Within existing legal structures, the Department of Health & Social Care (DHSC), NHS England (NHSE) and NHSR each have opportunities to influence the direction of future clinical negligence costs. These include how the NHS initially responds to harm, cost control measures and working to prevent future incidents.

3.8 Stakeholders told us that in many cases patients are compelled to consider legal proceedings for the answers and reassurances they seek. The 2025 Dash review also found that the current system for complaints and concerns is confusing and may lack responsiveness. Patients, users, and their representative groups describe a confusing landscape where it is unclear how to complain, with concerns often poorly handled and characterised by delays and poor-quality responses. In 2022, the Parliamentary and Health Service Ombudsman (PHSO) issued an updated complaints standard for all organisations delivering NHS care. PHSO is working with regulators to explore how the complaints standards could be incorporated into NHS inspection regimes.

3.9 Research commissioned by NHSR suggests that improving the NHS's initial response to harm could reduce the number of patients who pursue clinical negligence claims. This research noted common motivations for making a claim included wanting to prevent similar events happening to others, to receive an apology or explanation, or to trigger a more detailed investigation. Most of the research participants reported dissatisfaction with the existing NHS complaint-handling process due to poor communication and lack of meaningful outcomes.

3.10 Since 2014, the statutory duty of candour has required all providers to be open and transparent with patients and their families when harm occurs. Stakeholders raised concerns about how well the duty of candour is understood by patients and applied in practice. Lord Darzi's review in 2024 found that the NHS "still appears to struggle with the duty of candour" more than a decade after its introduction. DHSC launched a call for evidence to review the duty of candour in November 2024, but it has yet to publish its findings.

3.11 NHSR's guidance to health workers encourages them to apologise to patients as soon as possible after an incident occurs as delayed or poor communication increases the likelihood a patient will seek answers in a different way. Other countries, such as Japan and USA, have reported reduced lawsuits and legal cases following changes to how harm is responded to in health settings.

Seeking alternative resolutions

3.12 Over the last 10 years, NHSR has introduced several new approaches to help keep claims out of court (**Figure 13**). Average claimant legal costs were £96,000 more for litigated claims than unlitigated ones between 2018-19 and 2023-24 (for claims resolved with damages). These alternative dispute resolution initiatives are typically less adversarial and more collaborative than conventional litigation, and provide greater opportunities for claimants seeking non-monetary redress such as an explanation or apology. These new approaches have been well received by the legal sector.

3.13 In 2024-25, the vast majority (99.8%) of clinical negligence cases did not proceed to trial. The proportion of claims resolved without litigation has also increased from 66% in 2016-17 to a record high of 83% in 2024-25. NHSR attributes this success to its strategic priority of achieving fair resolution while keeping patients and healthcare staff out of formal processes.

Figure 13

Approaches to alternative dispute resolution

NHS Resolution has introduced several innovative approaches to help keep claims out of court

Approach	Description
Claims mediation scheme	Independent accredited mediators facilitate confidential discussions between patients and NHS representatives, focussed on openness and learning. Of 138 claims mediated in 2024-25, 73% settled within 28 days of mediation.
Stocktake meetings	Scheduled pre-litigation discussions between parties to consider evidence and options. Of 40 stocktake meetings held in 2024-25, 39 were subsequently resolved without formal proceedings.
Grouped claims	A consistent approach is used across similar claims to create efficiencies, for example using the same expert witnesses or agreeing protocols with claimant lawyers.
Early neutral evaluators	Independent legal experts provide non-binding, neutral assessments to help parties realistically assess their positions. NHS Resolution piloted the scheme between 2023 and 2025 and is currently evaluating the outcomes.
Early Notification Scheme	Introduced in 2017, the scheme aims to facilitate improvements in the safety of maternity care and to better meet the needs of affected families, including through the early admission of liability where appropriate. It trials innovative ways of managing maternity incidents to ensure NHSR reaches decisions on liability as early as possible. This includes convening experts to review evidence for multiple cases in one sitting, and working with families to put in place immediate support packages pending final settlement. NHSR expects the scheme will deliver savings in the longer term because early settlement will reduce the impact of claims inflation and legal costs.

Note

- 1 Alternative dispute resolution seeks ways to keep claims out of court. They are typically less adversarial and more collaborative than conventional litigation and provide more opportunities for claimants seeking non-monetary redress, such as an explanation or apology.

Ensuring damages are fair and legitimate

3.14 NHSR examines all claims and aims to pay an appropriate level of compensation for legitimate ones. When assessing claims, it considers expert clinical input and, where appropriate, specialist legal advice to determine both liability and value, and ensure only losses attributed to the harm are compensated. Case managers reference case law and previous settlements and use industry standard tools to calculate future financial losses. NHSR is currently piloting an artificial intelligence tool to support consistent initial estimates of claim values.

3.15 NHSR calculates damages in line with established legal principles to try to ensure fair and consistent outcomes. However, people with the same type of injury can receive different compensation due to personal circumstances and specific impact on their life. Issues typically considered in calculating individuals' damages can include age at the time of incident, employment and career prospects, social and physical activity, lifestyle habits, response to rehabilitation, and extent of familial support, among many other factors.

3.16 Where NHSR believes a claim to be fraudulent it will always investigate and pursue the case, regardless of value. An important element of NHSR's role is to challenge claims that lack merit or include unjustifiable elements. NHSR reported that in 2023-24, it prevented £39 million of fraud across 118 claims and also recovered £0.2 million of interim payments later found to be fraudulent, ultimately resulting in no loss to the taxpayer. NHSR can also pursue former claimants for contempt of court, which if proven, often results in a custodial sentence.

Challenging unreasonable claimant legal costs

3.17 NHSR monitors and responds to emerging trends in claimant law firm behaviours. The insights are also discussed with claimant firms, which can often resolve any emerging concerns without further action. We have also seen evidence of how NHSR's market intelligence and collaborative approach supports cost controls, for example, through peer-review learning and joint workshops with the largest claimant law firms.

3.18 NHSR contests points of law related to legal costs that may set a precedent across the legal market or encourage claims for inflationary or unreasonable novel costs. It will also challenge claimant lawyer behaviours that appear to unreasonably inflate claimant legal costs, for example through dishonesty or misleading advice.

3.19 NHSR uses an expert panel to help challenge the reasonableness of claimant legal costs. NHSR estimates the average saving per claim against claimed costs in the period 1 January 2021 to 31 December 2024 was £24,290, and that total savings in 2024 were £138.7 million, an increase on the £80.5 million saved in 2021.

3.20 Most clinical negligence claims fall outside the scope of current rules on fixed recoverable cost (FRC) for personal injury cases.¹⁴ These rules set a fixed sum for the legal fees that can be recovered by the successful party in simple or lower value cases, providing more certainty on costs, faster resolution and helping to ensure legal costs remain proportionate. Currently, unless the NHS admits liability in full and makes this admission in a letter of response, a clinical negligence claim is deemed too complex for FRC to apply.

3.21 DHSC is considering ways to extend FRC to lower-value damages cases (which it defines as between £1,501 and £25,000). Low-value clinical negligence claims (£25,000 or less) cost the NHS around £183 million a year, of which only £39 million is for claimants' damages (see paragraph 2.16). The government is currently considering its position on a wide range of matters relating to clinical negligence reform, including proposals for FRC. Stakeholders representing claimant lawyers have previously raised concerns that FRC will constrain access to justice for some claimants, because there will be lower-value but complex claims that become uneconomical for them to take on.

Balancing timeliness and value for money

3.22 There are considerable benefits to resolving claims quicker both in human terms and in legal costs, because faster resolution reduces the time commitment and emotional distress for claimants, as well as clinical and other trust staff. However, NHR must balance resolving claims more quickly with its wider obligations to provide appropriate redress and to manage public money responsibly. For example, it must gather sufficient evidence to defend claims or justify compensation amounts. Some claims may necessarily take a long time to conclude, particularly where harm and appropriate redress can only be assessed after a medical condition stabilises, or when developmental milestones are reached (in cases involving younger claimants). The time taken to resolve claims can also be subject to factors outside of NHR's control, such as the timeliness of claimants' solicitors, the availability of experts, or delays within the court system.

3.23 NHR's Early Notification Scheme for babies born with a potential severe brain injury trials innovative ways of managing maternity incidents to ensure a decision on liability is reached as early as possible. This includes convening experts to review evidence for multiple cases in one sitting and working with families to put in place immediate support packages pending final settlement. For the 14 cases settled by 31 March 2025, the average claimant age was 6.1 years compared with 13 years for claims settled outside of the scheme.

¹⁴ Clinical negligence cases are usually allocated to the more complex 'multi-track' but can follow a simpler 'intermediate track' (where Fixed Recoverable Costs apply) when specific conditions are met; these include that the defendant has fully admitted fault in their formal response before the case begins.

Sharing learning and insights

3.24 It is generally accepted that learning from past incidents is fundamental to improving patient safety. However, while the recent Dash review acknowledged NHR's role in developing insights from claim data to improve the safety of care, it also found that insufficient use is made of the NHS's data resources to generate insights and support improvement. The perception from stakeholders we spoke to who represented the claimant sector was that there is a lack of learning feeding back into the system, which they contend perpetuates further incidents, and that NHS trusts with historic management issues show unwillingness to learn from their mistakes due to a cultural tendency to defend.

3.25 Sharing learning and insights is one of NHR's key strategic priorities. It holds almost 30 years of experience and data concerning compensation claims' which can help local trend analysis and benchmarking. For example, NHR provides scheme members with annual scorecards containing 10 years' worth of claims data, and its safety and learning team supports members to better understand their claims history by specialty and cause, and target patient safety interventions. NHR told us scorecards help reinforce and highlight a trust's safety priorities and support business cases for quality improvement due to the high financial cost of claims. NHR also has a role supporting data-driven approaches to improving maternity and neonatal safety through the Maternity Incentive Scheme. Under the scheme, trusts pay NHR an additional premium which is then refunded if they can demonstrate they have implemented a set of core safety actions. This includes triangulating local claims and incident data to identify themes and learning, and sharing this information with the trust board.

3.26 The Dash review concluded that more work needs to be done to ensure lessons learnt from NHR reviews are shared more widely. NHR undertakes many activities to share learning and insights, these include:

- producing detailed thematic reviews and sharing illustrative case studies, alongside more digestible and short analysis pieces on key topics, to support learning from claims which can be used to inform patient safety work;
- an E-learning module based on thematic issues identified by the Early Notification Scheme for babies experiencing brain injuries at birth;
- NHSE's Getting it Right First Time programme to improve patient care and safety through joining up data analysis, clinical expertise and insight. NHR co-authored guidance on learning from litigation claims, which emphasised the direct link between clinical incidents, claims for compensation, and trusts' financial contribution to indemnity schemes; and
- the Early Notification Scheme, which seeks to reduce the time lag between incidents and their reporting for obstetrics claims in order to increase the scope for learning, and has informed national and local improvements to maternity services.

3.27 The time lag between a clinical incident occurring and a claim being made means that NHR's data do not provide a 'live' picture of clinical negligence in the NHS. Patterns of clinical negligence claims also do not match patterns of patient safety incidents, most of which do not result in serious harm (see paragraph 1.2). Where patient safety incidents increase with age, clinical negligence claims are skewed towards middle-aged claimants. The relative balance of specialties also differs, with claims weighted towards maternity and emergency care, compared with general medicine and secondary care for safety incidents. NHSE told us the insights it derives from patient safety incident records are therefore more useful for the purposes of improvement.

Responding to a changing landscape

3.28 NHR told us changing technology presents both opportunities and threats to the future costs of clinical negligence. Artificial intelligence (AI) has the potential to greatly improve diagnosis and use of data in the NHS but could also lead to errors as it is developed. Private companies, such as legal firms, are typically faster adopters of new technology than the public sector. NHR and industry stakeholders told us of increasing financial interest in clinical negligence claims by venture capitalists who are actively using AI to triage casework.

3.29 As part of its 10-Year Health Plan for England, DHSC announced it will abolish NHSE and several other arm's-length bodies responsible for patient safety. The consolidation of NHSE's functions and responsibilities into DHSC is expected to take two years to complete. During this period of operational uncertainty, there will be a streamlining of organisations with patient safety responsibilities as new structures are established and embedded. These changes are wide-ranging and will impact the day-to-day operation of both the patient safety and the entire health systems.

3.30 In April 2025, the Committee of Public Accounts (PAC) recommended that DHSC manage the costs of clinical negligence more effectively, including by introducing a mechanism to reduce legal fees. DHSC has accepted the recommendation and said it recognises that clinical negligence costs is an important issue. It will advise ministers on the drivers of costs, how to manage spending on clinical negligence and the potential merits of reform options.

Stakeholder views on opportunities to reduce the cost of clinical negligence

3.31 All types of stakeholders we spoke to saw opportunities to improve the clinical negligence system (**Figure 14** overleaf). Some of these may require legal or policy changes such as capping compensation or legal costs. Others relate to how the NHS responds to incidence of harm, including how candid it is with patients, and how quickly it can learn from its mistakes.

Figure 14

Common stakeholder views on opportunities for improvement in the current clinical negligence system

Stakeholders told us they saw potential opportunities for improvement

	Number of stakeholders expressing opinion			
	Clinical	Claimant legal representatives	NHS legal representatives	Other
There needs to be a more collaborative culture around learning and improvement	3	1		1
A less defensive and more restorative response to harm would be beneficial for clinicians and patients	3	3		1
Patients often want reassurance that the same issue will not happen to someone else but find the existing redress systems confusing		1		1
The NHS does not make enough use of the data it holds	4	1		1
Advances in medical care and treatments are driving up the cost of compensation		1	1	
Capping compensation costs, as done in other countries, could save the NHS money	2		2	
The current legal requirement to assume health and social care will be provided privately when awarding compensation needs to be revisited	1		2	
There is little to no information on how claimants use their compensation award			1	1

Notes

- 1 Summary of opinions expressed by stakeholders in interviews. For further information, see Appendix One.
- 2 'Other' includes patient representative groups and other government bodies with a policy interest in clinical negligence.

Source: National Audit Office analysis of stakeholder interviews

3.32 Stakeholders also shared concerns that compensation costs are growing fast, with no upper limit in place, and that there is little information on how claimants use their compensation award to settle legal fees, or for private care. Stakeholders also told us it is not clear to what extent the government pays twice for clinical negligence, firstly, in settling a claim, and secondly in providing health and social care through public services.

Appendix One

Our audit approach

Our scope

- 1 We investigated the costs of clinical negligence in England. Our report aimed to transparently set out the facts about clinical negligence, describe how the system currently operates – including what NHS bodies can and cannot do – and explain the consequences of legal and operational constraints. We do not evaluate or conclude on value for money.
- 2 Our report considered:
 - the extent of clear plans to reduce clinical negligence costs;
 - the timeliness and consistency of clinical negligence claims handling; and
 - ways that the clinical negligence system helped to reduce harmful incidents.
- 3 We carried out fieldwork between November 2024 and August 2025 and the substantive areas of our evidence base are described below.

Our evidence base

Interviews

- 4 To inform our audit we conducted interviews during scoping and fieldwork with organisations and stakeholder groups involved with, or interested in, clinical negligence.
- 5 We met with officials and staff at key government and public bodies. This included:
 - NHS Resolution (NHSR), to understand the clinical negligence landscape, how claims are managed, significant developments in recent years, and future risks, opportunities and threats;
 - the Department of Health & Social Care (DHSC), to understand clinical negligence policy, NHSR sponsorship and support, fixed recoverable costs, and the extent of any plans in place;

- NHS England (NHSE), to understand issues around patient safety, oversight of health bodies, and complaints and escalation processes following patient harm; and
- the Ministry of Justice, to understand relevant civil litigation issues, particularly regarding policy and market developments in personal injury and compensation.

6 We also carried out interviews with wider government and public bodies, such as HM Treasury, the Government Actuary's Department, the Health Services Safety Investigations Body, and the Parliamentary and Health Service Ombudsman, to understand aspects of clinical negligence related to their individual activities and policy areas.

7 We met with stakeholders in the legal sector to capture different perspectives on issues such as drivers of damages and legal fees, double recovery, policy and market changes, legal precedents, and fixed recoverable costs. We met with representatives of claimant and defence firms as well as a wider group of stakeholders, such as charities and other indemnifiers, including:

- Action against Medical Accidents;
- Association of Personal Injury Lawyers;
- The Cohen Consultancy;
- the Forum of Insurance Lawyers;
- the Medical Defence Union; and
- the Society of Clinical Injury Lawyers.

8 We spoke with stakeholders in the health sector to gather views on patient safety, maternity, NHS complaints processes, general practice indemnity, and data sharing. These included:

- Professor Tim Draycott, Consultant Obstetrician, and Senior Maternity Clinical Advisor to NHR;
- NHS Confederation;
- the Royal College of General Practitioners; and
- the Royal College of Obstetricians and Gynaecologists.

Document review

9 We reviewed more than 200 published and unpublished documents. Around half of these were provided by NHSR in response to a structured evidence request drafted in line with our report areas. We also received evidence from DHSC and NHSE in response to less substantial requests, and evidence from some stakeholders following fieldwork interviews.

10 Documents we reviewed included internal reports, briefings and impact assessments, board papers and minutes, case studies, policy statements, parliamentary reports and related submissions, National Audit Office reports, guidance for health bodies, and publicly available articles, think-tank pieces and analyses.

International comparison

11 We reviewed existing literature and evidence on different countries' approaches to managing harm caused during healthcare. This included compiling and analysing available data from separate sources on different countries' claim quantum, costs and population levels.

12 We acknowledge limitations on international comparisons at relevant points throughout the report due to differences in factors such as healthcare and legal systems, state provision of indemnity, claims coverage, and data, notably at paragraphs 3.4 to 3.6 and in Appendix Two.

Financial analysis

13 We reviewed and analysed data relating to the financial impact of clinical negligence. Key financial data reviewed included:

- annual settled claim values by scheme, damage tranche, cost category and clinical specialty;
- annual clinical negligence payments by scheme and cost category; and
- long- and short-term projections related to clinical negligence costs and liabilities.

14 To account for inflation and assess the true financial impact of clinical negligence over time, all financial comparisons throughout the report are presented in 2024-25 terms using Office for National Statistics GDP deflators published in June 2025 (unless otherwise stated). We note these adjustments do not account for potential inflation differentials in individual cost areas relevant to clinical negligence, for example costs for care and carers, medical adaptations, and accommodation, among others.

15 For our analysis of claims by damage tranche, we categorised claims as follows:

- Low-value: £0 to £25,000.
- Medium-value: £25,001 to £250,000.
- High-value: £250,001 to £1 million.
- Very-high-value: £1 million and above.

For our analysis of claims by damage tranche over time, inflation adjustments were made at the aggregated cost level rather than for individual claims, meaning we used nominal claim values to categorise claims into different cost categories.

16 We are grateful to the Government Actuary's Department for hosting focused teach-in sessions that greatly assisted our understanding of how clinical negligence costs are measured and calculated, particularly relating to forecasting future liabilities and provisions.

Quantitative analysis

17 We reviewed and analysed data on volumes of clinical negligence claims over time. Key data reviewed included:

- new claims by clinical negligence scheme; and
- annual settled claim volumes by scheme, damage tranche, cost category and clinical specialty.

18 To evaluate changes in numbers and costs of clinical negligence claims in the context of overall NHS treatment volumes, we compiled data on major NHS activities (inpatient, outpatient and accident & emergency attendances) and created a proxy indicator of overall activity over time. We were limited by data availability across different years and note this proxy is not a comprehensive picture of all NHS activity.

Volume and value analysis

19 To understand the relative balance of quantum and inflationary factors contributing to movements in overall total clinical negligence costs over time, we undertook a basic cost/volume analysis of annual settled claims by cost category (damages, claimant legal, and NHS defence).

20 In calculating the contribution of damages to overall cost movements, we disregarded 'nil claims' where no damages were paid because these have no material impact on damages costs. However, nil claims were included in calculating the contribution of claimant legal and NHS defence costs, because both are generally incurred regardless of whether damages are payable.

Appendix Two

Clinical negligence data in other countries

1 The cost of clinical negligence appears to vary significantly between countries, but this is likely due to the coverage of healthcare and the extent to which all types of negligence claim are recorded. Countries vary in the extent to which their clinical negligence indemnity or insurance cover is centralised to one organisation. Schemes and their data also vary in which types of cost they include or exclude, such as legal costs or how compensation interacts with state services.

2 We include data from other countries where available below, with any limitations on completeness set out in the notes (**Figure 15** overleaf). Few firm conclusions can be drawn. However, it appears that avoidable harm systems have many more claims per million people, though this can be at much lower cost overall.

Figure 15

International comparisons of the annual numbers and costs of clinical negligence claims per capita, August 2025

There is wide variation in different countries' populations and clinical negligence claims and costs

System	Location	Population	Number of claims per year	Cost of claims per year	Claims per million people	Cost per capita
		(mn)		(£mn)		(£)
Tort law	England	58.6	13,329	3,646	227.5	62.2
	Australia	27.2	4,818	185	177.1	6.8
	Canada	41.3	1,021	301	24.7	7.3
	Scotland	5.5	351	47	63.8	8.5
	USA	340.1	11,601	3,679	34.1	10.8
	Ireland	5.4	705	279	130.6	51.7
Avoidable harm	Sweden	10.6	21,965	51	2,072.2	4.8
	Denmark	6.0	14,759	104	2,459.8	17.3
	Finland	5.6	8,536	34	1,524.3	6.1

Notes

- 1 Population data is for 2024.
- 2 We calculated GBP values using the Bank of England exchange rate as at 30 June 2025.
- 3 In tort law systems, it needs to be established that the claimant was injured as a result of negligent medical treatment.
- 4 In avoidable harm systems, once the injury is established to have been caused by a decision, act or omission of the health care provider, the core test is whether the injury was preventable not whether negligence has occurred.
- 5 England: Data is for settled claims from 1 April 2024 to 31 March 2025 and includes claims settled for no damages.
- 6 Australia: Claims data is for 2023. Claims data source for number of claims covers private providers of indemnity only and excludes claims arising from public hospitals and public services. Cost of claims data is from 2018 and has not been adjusted for inflation.
- 7 Canada: Claims data is for 2024. The source covers an estimated 90% of doctors only and includes claims for non-clinical issues.
- 8 Scotland: Claim data is from 1 April 2023 to 31 March 2024 and does not include a deductible amount of up to £25,000 per claim which must be funded separately by scheme members. It also does not include any claims settled by members privately.
- 9 USA: Claims data is for 2024 and only includes successful claims.
- 10 Ireland: Claims data is for 2024. Number of claims reflects new claims received in 2024. Cost of claims reflects the legal and compensation costs of resolving and managing active claims.
- 11 Sweden: Claims data is for 2024. Number of claims represents new notifications received in year. Medical care and personal assistance costs are covered entirely by Swedish social security system so are not reflected in cost of claims. Legal costs are also excluded.
- 12 Denmark: Claims data is for 2024, covers public healthcare only and excludes legal costs.
- 13 Finland: Claims data is for 2024 and excludes legal costs. Number of claims is those where a decision was reached in year.
- 14 We selected the countries above based on the availability of published data on clinical negligence claim volumes and cost.

Source: National Audit Office analysis of published data

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