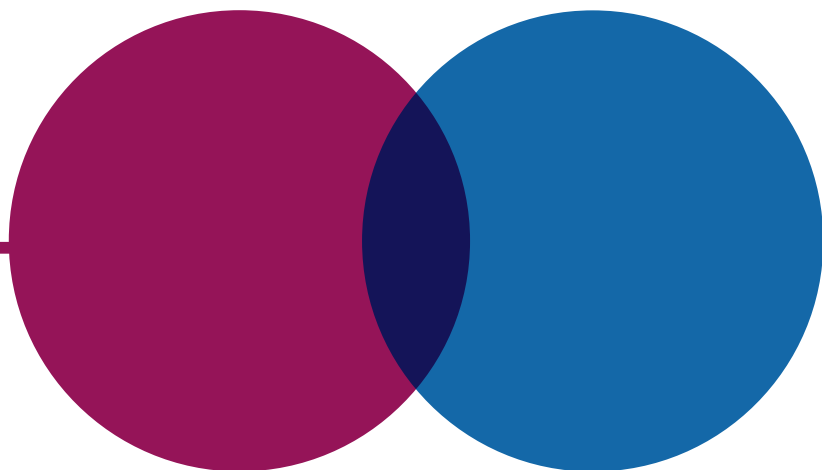




National Audit Office



REPORT

Costs of clinical negligence

Department of Health & Social Care

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CORRECTION SLIP

Title: Costs of clinical negligence

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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

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 NHSR, 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.