

Department of Health & Social Care

Proposal to collect the NHS Number as part of the Injury Cost Recovery Scheme process



A response by the Association of Personal Injury Lawyers

14 May 2026

Introduction

APIL welcomes the opportunity to respond to this consultation on the NHS Injury Cost Recovery (ICR) process.

We have long advocated that the ‘polluter should pay’. When a person is injured or made ill as a result of the negligence of someone else, the principle that the responsible party should pay for the injured person’s treatment should be unarguable. It is inequitable that the taxpayer should have to foot the NHS bill for such treatment. The proposal to collect the NHS number as part of the ICR process supports this principle.

There are, however, other problems with the scheme which mean that the at-fault party is only responsible for a fraction of the injured person’s NHS treatment costs. As a result, we continue to strongly recommend that the DHSC consider a fundamental review of the scheme which would address these problems.

The need for reform has only grown in recent years, as the amount recovered from those who cause harm has collapsed. Such reform would also build upon the proactive proposals contained in the DHSC’s consultation.

Question 1: In what capacity are you responding to this consultation?

‘Other’; APIL is a not-for-profit campaigning organisation committed to injured people and is the UK’s largest claimant injury lawyer association.

Question 2: Do you agree or disagree with the proposal to amend the regulations to collect NHS numbers from patients, where known?

APIL agrees with the proposal.

Question 3: Please provide any specific information or evidence to support why you agree or disagree with the proposal.

The proposal will, to some extent, help increase the amount of NHS treatment costs which are recovered from those who cause harm. It will also reduce the administrative costs of the ICR scheme. APIL therefore warmly welcomes the planned changes.

Under the DHSC’s current proposals, compensators will only be required to provide the NHS number “*where known*”. As a result, there is a risk that compensators will fail to provide this information in some cases, which would significantly undermine the effectiveness of the changes.

To address this risk, insurers should be mandated to provide the NHS number or state the reason why they cannot provide it. Where insurers do not already know the NHS number, they should seek to obtain this from the injured person. Failure to seek this information should not be used as a valid reason for not providing the NHS number, and this should be made clear in guidance provided to compensators.

These changes would strengthen the proposals, and help to ensure that they effectively reduce administrative costs and increase recoveries.

Question 4: Do you agree or disagree that, compared to current arrangements, our proposal will better support NHS Trusts in tracing patient treatment records?

APIL agrees that, compared to current arrangements, the proposal will better support NHS trusts in tracing patient treatment records.

Question 5: Please provide any specific information or evidence to support why you agree or disagree that this proposal will better support NHS Trusts to trace patients.

The proposal will better support NHS trusts to trace patients for the reasons set out in the consultation document. An NHS number will provide trusts with a unique identifier that will link a victim of negligence to all their health and care records, enabling these individuals to be more accurately traced.

Question 6: Do you anticipate there being any barriers to implementing this proposal?

No, APIL does not anticipate that there will be any barriers to implementing the proposal.

Question 7: Please provide any specific information or evidence to support your answer to question 6.

As highlighted in the consultation document, individuals can easily obtain their NHS number. Where the claimant finds this difficult, support can be provided by their representative and/or the compensator. Providing this information as part of the ICR process should, therefore, be straightforward.

Question 8: Do you have any additional comments or suggestions?

A fundamental review of the scheme is required

In addition to these proposals, a fundamental review of the scheme should be considered to ensure that the NHS is fully recovering treatment costs where someone has been injured because of someone else's negligence¹.

Problems with the scheme

There are several problems with the existing scheme which mean that the NHS, rather than the at-fault party, must cover a significant proportion of these treatment costs. These aspects of the scheme are outlined below:

- **The cap on the amount which the NHS can recover for treatment, set at £64,856 (roughly 60 days' inpatient treatment).** Any treatment costs above this amount must be covered by the NHS, rather than the at-fault party. APIL's research suggests that, even without changes to the level of the tariff (discussed below), removing this cap would have resulted in £73 million of additional income for the NHS over the last three financial years. In 2025/26 alone, the costs associated with almost 29,000 days of inpatient treatment were not recovered due to the cap. This cost the NHS an estimated £30.7 million².

¹ When the initial recovery scheme (covering road injury claims only) was announced in the 1997 Budget, the intention of the government was to "*recoup in full the cost of treating road traffic accidents from insurance companies*".

² APIL analysis of data provided by the Compensation Recovery Unit

- **The level of the existing tariff for inpatient treatment (£1,085 per day).** Under this tariff, the NHS can only recover £1,085 per day for inpatient treatment costs. This is likely to be too low to cover the daily costs of treatment. For example, in some major trauma cases, our members understand that treatment costs can be as high as £2,571 per day – more than double the current daily tariff for inpatient treatment.

The need to review and update the tariff is long overdue, as the current daily ‘charge’ is still based on figures that were used in the late 1990s, when the original recovery scheme was introduced. While these original figures have been increased to reflect inflation, they have not been updated to reflect any new NHS data on the costs of treatment. Such an update is now crucial as recoveries have collapsed in recent years, benefiting insurers, and treatment costs are increasing (see below for further information). Furthermore, the original tariff was set conservatively due to concerns about the financial impact on insurers. These concerns have proved unwarranted.

- **In cases where inpatient costs have been recovered, the NHS is unable to recover outpatient costs.** This is likely to deprive the NHS of a significant amount of income. In 2025/26, there were 4,396 claims where the injured person received both inpatient and outpatient treatment.
- **The NHS is only able to recover £883 in outpatient costs for each patient, regardless of how many outpatient appointments are attended.** This severely limits the amount of outpatient treatment costs which the NHS can recover. In many cases, these outpatient costs are likely to significantly exceed £883.

Recoveries are falling

Any changes to the scheme should ensure that the party responsible for causing the injury should also take full responsibility for the resulting NHS treatment costs. While this would increase insurer contributions to NHS treatment costs, it should be borne in mind that this would take place against a backdrop where recoveries have collapsed over recent years. This has benefited insurers and adversely impacted the NHS.

Between 2013 and 2025, the total amount recovered fell by £135.6 million (43%) once inflation is taken into account. This drop in recoveries shows no signs of stopping. Since the height of the pandemic, in 2020, recoveries have fallen by more than a quarter (28%), and last year alone they fell by 7%³. See figure 1 below. This collapse in recoveries will only be addressed if the fundamental problems with the scheme are dealt with. As a result, the need for fundamental reform has never been more pressing.

³ Figures on the drop in recoveries are measured in real terms, i.e. taking into account inflation. CPI inflation increased by 40.51% between 2013 and 2025: <https://www.ons.gov.uk/economy/inflationandpriceindices/timeseries/d7bt/mm23>

Figure 1: NHS Injury Costs Recovery (ICR) scheme: amounts collected⁴

	In nominal prices	In 2025 prices (i.e. taking into account inflation)
2013	£227,029,401	£318,993,595
2014	£212,518,112	£294,125,067
2015	£200,535,543	£277,541,192
2016	£198,732,131	£273,133,336
2017	£198,293,298	£265,413,853
2018	£200,260,409	£261,718,986
2019	£200,504,931	£257,420,060
2020	£199,227,841	£253,662,679
2021	£172,791,040	£214,285,663
2022	£170,848,224	£194,292,475
2023	£172,954,351	£183,424,385
2024	£190,351,898	£196,749,087
2025	£183,376,081	£183,376,081

A significant fall in the number of injured people going onto claim compensation is likely to have contributed to this reduction in recoveries. A drop in claims has an inevitable impact on recoveries, as the NHS cannot recover any treatment costs where the injured person has not claimed compensation. In 2024, for example, the number of compensation claims for road injuries was down by 34% when compared to 2020. During the same period, the number of reported road injuries was up by 11%⁵. This reduction in claims is likely to be related to changes which have disincentivised injury claims and significantly reduced the amount which insurers spend on these claims⁶.

These falling recoveries also do not reflect the increased costs faced by the NHS. For example, while ambulance and hospital costs associated with road casualties increased by 84% between 2019 and 2024, treatment costs recovered from car insurers fell by 4%⁷. This divergence between rising treatment costs and falling recoveries means that the NHS lost out on an estimated £277 million between 2021 and 2024. In 2024 alone, the cost to the NHS stood at £119 million⁸.

Furthermore, while treatment costs arising from road traffic collisions totalled an estimated £3.1 billion in 2024, just 4% of these costs were recovered from car insurers. This

⁴ <https://www.gov.uk/government/collections/dh-nhs-injury-costs-recovery-scheme>

⁵ APIL analysis of Compensation Recovery Unit (CRU) data and Department for Transport data on reported road casualties. For further detail, see [APIL's Industry Report](#) and [APIL's research report on the 'whiplash reforms'](#).

⁶ Data published by the Association of British Insurers shows that the amount spent by motor insurers on settled injury claims fell by 52% in real terms (i.e. taking inflation into account) between 2013 and 2025. Between 2020 and 2025, these costs fell by 30%. Data accessed at: <https://www.abi.org.uk/account/my-statistics/>

⁷ APIL analysis of [Department for Transport estimates](#) on the cost of road injury casualties and Compensation Recovery Unit data, obtained via a freedom of information request. These are nominal figures which are not adjusted for inflation.

⁸ APIL analysis of Department for Transport estimates on the cost of road injury casualties and Compensation Recovery Unit data on NHS recoveries.

percentage has halved since 2019⁹. As a result, the NHS, rather than the wrongdoer, is responsible for an increasing share of road injury victims' treatment costs.

Insurers' role in reducing costs

Insurers should bear full financial responsibility for the harm caused by their policyholders who are negligent. However, they currently do very little to reduce the costs of harm or incentivise their policyholders to drive more safely. For example, for most drivers, the price of their premium is not determined by how safely they drive, but instead reflects factors such as their occupation or postcode¹⁰.

As a result, insurers could reduce injuries and their expenditure on NHS treatment costs if they adopted a more proactive role in preventing harm. This could include incentives and support which helps policyholders to drive more safely. ICR reforms which shift the costs of harm from the NHS to those at-fault could encourage insurers to introduce these changes.

Raising awareness of the scheme

Lack of awareness of the ICR scheme within the NHS remains an issue. This is likely to suppress the amount which the NHS recovers. As a result, the DHSC should consider how to raise awareness of the scheme among relevant NHS staff.

The wrongdoer should bear financial responsibility

Ultimately, the wrongdoer should be responsible for funding the treatment of those who they negligently injure, and the taxpayer should not have to subsidise them for the damages they are responsible for. Wider reform of the scheme should move us closer to that position, and APIL would welcome the opportunity to be involved in any future discussions about such reform.

For any queries about this response, in the first instance please contact:

John McGlade
Senior Research Manager
john.mcglade@apil.org.uk

⁹ Ibid. The picture for work-related injury and illness is similar. NHS treatment and rehabilitation costs associated with occupational illness and injury stand at approximately £1 billion per annum, according to the Health and Safety Executive. Only a tiny fraction of these costs (around £22 million per annum) are recovered from employer liability insurers/ employers, according to Compensation Recovery Unit data.

¹⁰ Just 16% of the most competitive car insurance quotes are from telematics providers, according to the [Consumer Intelligence](#) Car Insurance Price Index. Furthermore, fewer than 6% of UK consumers hold a telematics-based insurance policy, which is below levels in Italy, Spain, Germany and France, according to [survey data](#). Outside of telematics provision, premium prices are not determined by an individual's driving behaviour, but by cruder proxy measures for this behaviour. This includes, for example, occupation or postcode.