NHS
Counter Fraud Authority

The 2019 Strategic Intelligence Assessment

Reporting period: 2017-2018

Version 1.0

May 2019

NHS fraud.
Spot it. Report it.
Together we stop it.

Version control

Version	Title	Date	Comment
1.0	The 2019 Strategic Intelligence Assessment	May 2019	Final version for publication.

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Foreword by the Interim CEO Sue Frith

Our mission is to lead the fight against fraud, bribery and corruption affecting the NHS in England and wider health service and to protect vital resources intended for patient care from the corrosive nature of fraud.

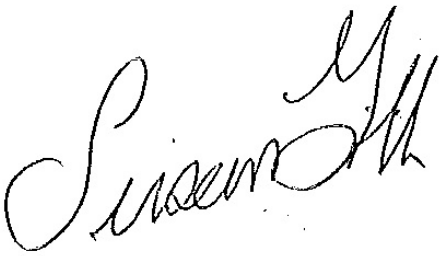
This is the first full year the NHS Counter Fraud Authority has been operational. Through collaboration and partnership working with local and national stakeholders, we have made great strides this reporting period in understanding the risks posed by fraud across the majority of the areas.

This year's 2019 Strategic Intelligence Assessment, covering 2017-18 activity, estimates that the loss to the NHS in England through fraud, bribery and corruption is £1.27 billion.

The estimated loss is a reduction of £20 million from 2018, a real achievement in the fight against fraud from all organisations involved. However more needs to be done, particularly around sharing the necessary data to help improve the accuracy of losses and identify further risks. Fraud affects us all and we should all help to break down pre-existing barriers and truly embrace a collaborative approach.

The complexity and diversity of the systems within the NHS offer significant challenges to the fight against fraud in the NHS. By building on the successes of this year, applying lessons learnt and continuing the sustained synergetic approach, we can and will turn the tide against fraudsters exploiting the NHS.

Finally, I would like to personally thank all our staff and stakeholders for supporting the critical work of the NHSCFA in our first year. The successes achieved here are the successes of every single person involved. I look forward to continuing the fight against fraud, bribery and corruption within the NHS into 2020.



1. Executive summary

1.1 The NHSCFA assesses that fraud, bribery and corruption against the NHS costs the public purse over **£1.27 billion**. The NHSCFA has higher confidence in £337.04 million this reporting period, with a further £935.3 million estimated losses with low confidence. The breakdown of estimated loss is presented within each thematic area.

1.2 The estimated fraud loss is a reduction of approximately £20 million from 2016-17. Whilst some thematic areas have seen a decrease, others have seen an increase. These assessed increases/decreases may not be indicative of fraudulent activity but more attributed to increases in the accuracy of assessments in the applicable thematic areas. That said a targeted and sustained approach from both the NHSCFA and stakeholders in help with health care costs has seen a measured reduction of £90 million this reporting period.

1.5 As the NHSCFA is able to measure fraud losses in more thematic areas, the estimated levels of fraud will fluctuate over time. Therefore it is important when reviewing the estimated fraud loss that the confidence level assigned to the loss figure is also considered. The confidence levels do not reflect the NHSCFA's knowledge and understanding of the fraud risks and threats but rather the confidence in the accuracy of the assessed financial loss.

1.7 Fraud is assessed to be significantly underreported in all areas. This reporting period the NHSCFA received 4799 information reports, an increase of 4.3% from last year. However, The National Crime Agency in 2018 reported that less than 1 in 5 detected fraud incidents are reported to the police. If this finding is applied to the NHSCFA reporting levels, it shows that there could be in excess of 24,000 separate incidents of fraud, with only 4,799 reported.

1.8 The NHSCFA Quality and Compliance team have observed through local assessments that reviewed organisations are not consistently conducting detailed local fraud risk assessments in sufficient detail nor have they considered risk in organisational policies. This means that fraud risks, where identified, are not consistently being placed on the appropriate risks registers and managed appropriately. However it also leaves many fraud risks left unidentified and allows fraud to continue unimpeded. In light of this the NHSCFA Quality and Compliance will be compiling a thorough assessment of the problem to inform future exercises.

Rubric
Unless stated, this report draws on intelligence held within the NHSCFA databases dated from 1 September 2017 onwards, open source reporting and assessments from other government and law enforcement agencies. Unless stated otherwise, the intelligence used is assessed to be reliable. The intelligence presented within this assessment is only applicable to NHS in England. The cut-off date for intelligence used in this report is 30 September 2018.

2. Introduction

2.1 In September 2017 the Cabinet Office produced the *Cross Government Fraud Landscape Annual Report*. The report draws on many sources, one being the National Audit Office's Fraud Landscape Review (2016) which concluded that;

1) the exact scale of fraud within government is unknown
2) there is a large disparity between the level of fraud and error that is reported and the level that other available estimates suggest might be occurring, which needs explaining; and
3) government should publish an annual report on fraud and error data to increase transparency.

2.2 The NHSCFA strategic intelligence assessment mirrors the findings of the Fraud Landscape Review (2016) and has taken steps to provide a clearer picture of the scale of fraud, whilst assessing the possible reasons behind the disparity of estimated losses and the levels of reporting.

2.3 This strategic intelligence assessment is not to be used as a risk assessment of all the fraud risks the NHS is exposed to, nor does it serve as an accounting tool. It is an intelligence assessment examining the threats and estimated losses to fraud across 13 different spend areas (referred to as thematic areas).

2.4 Intelligence is not fact but based on an assessment of available data or information. Without oversight of the data or information it is problematic to assign a confidence level of the assessment of loss. Access to data has hindered the NHSCFA attempts to identify the prevalence of fraud across several thematic areas. Although work is being conducted by all parties to increase access, without the data the NHSCFA's ability to develop a comprehensive understanding of scale of fraud is limited.

2.5 This Strategic Intelligence Assessment covers 13 thematic areas:

1. Community pharmaceutical contractor fraud.
2. Help with health costs. (patient fraud)
3. Procurement and commissioning fraud.
4. NHS staff fraud.
5. National tariff and performance data manipulation.
6. General practice fraud.
7. European Health Insurance Card (EHIC) fraud.
8. Optical contractor fraud.
9. Dental contract fraud.
10. Fraudulent access to NHS care.
11. NHS pension fraud.
12. Fraud against NHS Resolution.
13. NHS student bursary fraud.

2.6 One of the primary aims of this the NHSCFA Strategic Intelligence Assessment is to provide an overview of the current and emerging economic crime risks and issues impacting upon the NHS's ability to provide for the nation's health. The assessment seeks to highlight the nature and extent of the identified crime problems and those business

areas where the picture is less clear and in need of enhancement. For the purposes of this report the term ‘fraud’ is used to cover fraud, bribery, corruption and other unlawful activity.

2.7 Furthermore this assessment is published to inform:

- strategic prioritisation and decision-making
- strategic business planning and the allocation of resources
- the development of a long term strategy
- the development of an intelligence requirement, i.e. the additional information required to make an informed decision.

2.8 Within the NHSCFA this assessment is used to inform the control strategy, which outlines long-term priorities and resource allocation. The decision on allocation of resources is therefore made on the best available intelligence picture, with justifiable rationale for recording the decision making process.

2.9 This assessment does include the proactive work and interventions that are being conducted by the Department of Health and Social Care, NHS England and various arm’s-length bodies relevant to these thematic areas and shared with the NHSCFA. The intelligence cut off for this assessment was 30 September 2018; therefore anything implemented since or within a timeframe that does not allow a thorough assessment of impact has not been discussed within this document.

2.10 The assessment is divided into four further sections:

Section 3: A summary of the **method** used to produce this assessment.
Section 4: Our estimate of the **economic cost of fraud against the NHS** across a range of thematic areas.
Section 5: A look at fraud in the **context** of the NHS
Section 6: A narrative for each of thematic areas featured in this report.

3. Method

3.1 This Strategic Intelligence Assessment reflects what NHSCFA think is likely to be happening.

3.2 The method of analysis used during this reporting period is consistent with the analysis method utilised by NHS Protect previously.

3.3 Intelligence is not fact; it is based upon the processing of information and the inferences drawn from that. The intelligence reflected in this assessment is based on the collection, collation, analysis and evaluation of data from both primary and secondary sources. This includes information collected from those working locally in the NHS to tackle fraud and those outside the health service who also deal with crime.

3.4 While every effort is made to ensure the accuracy of the information contained in this report, the intelligence assessment is limited by the availability and quality of the information accessible by NHSCFA.

3.5 In order to reflect and describe the accuracy of any assessment, NHSCFA have adopted four levels of confidences;

- Almost Certain: >90%
- Highly likely: 75-85%
- Probable: 50-75%
- Low probability: 25-50%

3.6 In using these confidence levels NHSCFA has taken into account, the source, the age and reliability of the material used and any extenuating factors when forming the assessment. The use of confidence levels is to provide a consistent approach when assessing information whilst trying to avoid any misinterpretation or misrepresentation of the intelligence.

4. The economic cost of fraud

4.1 NHSCFA estimates that the direct cost of fraud to the public purse was **£1.27 billion** for 2017 - 2018.

4.2 NHSCFA's knowledge and understanding of crime risks is not uniform. While we may have intelligence that crime is occurring in a particular area, the weight of information to support this view may be insufficient to establish this with high confidence. This variance in our understanding is expressed through levels of confidence in each estimate provided.

4.3 Table 1 highlights the associated estimated fraud losses and assessed levels of confidence for each thematic area.

Thematic area	**Estimated loss to fraud (£ millions)**				
Confidence level	Almost certain	Highly likely	Probable	Low probability	**Total**
Pharmaceutical contractor fraud				108	108
Help with health costs (patient fraud)	162.6		89.1		251.7
Procurement and commissioning fraud				351	351
NHS staff frauds				94.6	94.6
National tariff and performance data manipulation				114	114
GP contractor fraud				88	88
European Health Insurance Card			0.64	21.1	21.7
Optical contractor fraud			82.4		82.4
Dental contractor fraud				93.5	93.5
Fraudulent access to NHS care				35	35
NHS pension fraud			2.3		2.3
Fraud against NHS Resolution				18	18
NHS student bursary fraud				12.1	12.1
Total	**162.6**	**-**	**174.44**	**935.3**	**1.27bn**

Table 1. Estimated fraud losses by thematic area and associated confidence levels for 2017 – 2018. Discrepancies in the total figure may occur due to rounding to one decimal point.

5. Context within the NHS

5.1 Fraud is estimated to cost the UK government £29 - £40 billion each year. This estimate includes both detected fraud and a much larger amount of fraud that goes either undetected or unmeasured. For the public sector to deliver true value for money, it is imperative to shine a light on fraud affecting it, thereby increasing our capability to prevent, detect and combat fraud.

5.2 Expenditure on health makes up approximately 7%-8% of the UK GDP. The NHS in England, which receives much of this amount, is large and diverse. The NHS in England employs around 1.2 million people and is one of the world's largest workforces. Its budget for the delivery of healthcare in 2017 - 2018 stood at £123.7 billion. The sheer size of the NHS alone presents considerable opportunity for fraud.

5.3 Intelligence gathering within the context of the NHS faces three major challenges:

- Fraud is a hidden crime.
- Collaboration, data sharing and proactive fraud detection.
- Fraud is underreported.

5.4 During 2016 - 2017, NHSCFA received 4,799 fraud information reports. The NHS spends billions of pounds, employs large numbers of staff and commissions patient services widely. It also provides a high number of patient interactions and has numerous high and low value contractual relationships with a wide range of suppliers.

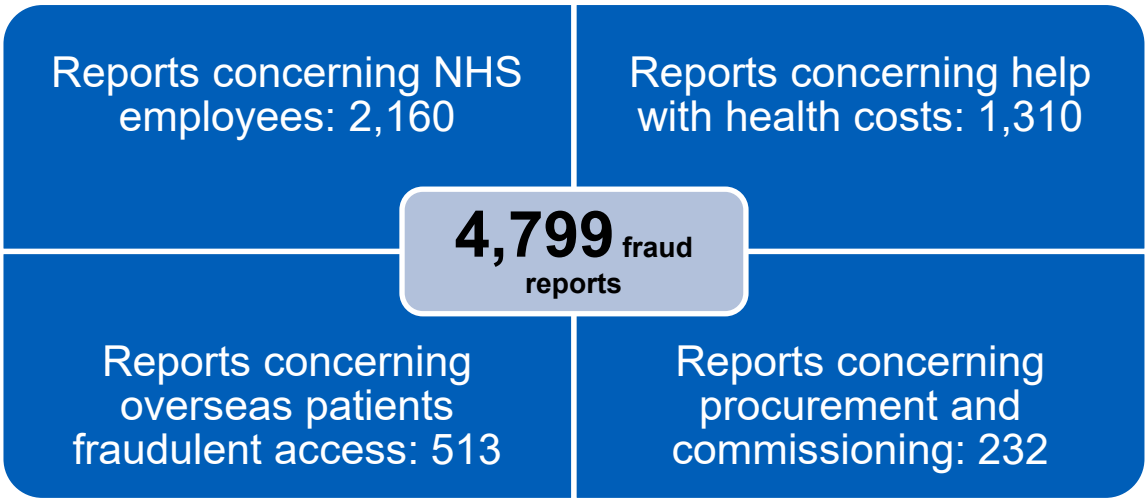


Figure 2. Total number of allegations received, and the top 4 highest reported areas.

5.5 The National Crime Agency's National Strategic Assessment of Serious and Organised Crime 2018 presented the findings of The Crime Survey in England and Wales 2017, which estimates that fewer than 20% or 1 in 5 of detected fraud incidents are reported to the police. Applying the findings to reports received by the NHSCFA there could be in excess 24,000 separate incidents of fraud per year impacting on the NHS in England. However, as many frauds are high volume low value, the expected reporting levels are assessed to be higher than 24,000.

6. Thematic fraud narratives

6.1 Community pharmaceutical contractor fraud

Estimated Loss: £108 million
Confidence: Low probability, 25 - 50%

6.1.1 Community pharmaceutical contractor fraud describes inappropriate claims relating dispensing and enhanced services offered at the premises. Inflation of fees, allowances and reimbursements claimed under the drug tariff and activities that contravene the terms of the contractual agreement.

6.1.2 NHSCFA assesses the loss from fraud to the NHS from pharmaceutical contractor is £108 million.

6.1.3 As per last year's assessment, an estimate of 1% is used, based on historical primary care contractor fraud rates in England of 1%-3.5%. The stated estimate should therefore be treated with low confidence

6.1.4 Pharmaceutical contractors receive approximately £10.8 billion a year from the NHS, £8 billion from payments for drugs[1]and a further £2.8 billion from the annual funding settlement[2].

6.1.5 In October 2017 the NHSBSA initiated a post payment verification programme regarding Advanced services such as Medicine Use Reviews (MUR). The Provider Assurance team has reviewed 476,252 MURs and New Medicines Service claims to September 2018. Initial analysis, carried out on the first cohort of contractors for the quarter following selection for review, suggests that contractors have reduced their volume of claims. It could be suggested that the reduction in claims is either indicative of a reduction in the requirement to perform an MUR or that historically there was a surplus of MURs being conducted that did not necessarily need to be performed. NHSBSA are planning to conduct further analysis incorporating a larger group of contractors and for a longer period, the findings of which will be included in the next SIA.

6.1.6 Pharmaceutical Specials have also seen a reduction in both spending and prescribing from December 2015 to December 2017. However, despite the reduction in prescribing unlicensed specials, the cost per item has increased. This infers that manufacturers have increased prices likely to safeguard profit margins. No regulation on the price for unlicensed specials allows a manufacturer to charge any amount, inevitable creating potential for market abuse.

[1] https://apps.nhsbsa.nhs.uk/infosystems/report/viewredefaultreport.do?reportId=72 (10/10/2018)
[2] https://psnc.org.uk/funding-and-statistics/historical-funding-arrangements/201516-funding-settlement/ (10/10/2018)

6.2 Help with health costs (patient fraud)

Estimated Loss: £251.7 million
Confidence: £162.6 million (almost certain: >90%)
£89.1 million (probable, 50% - 75%)

6.2.1 Help with health costs relate to an individual who is not entitled to free NHS treatment, services or medication but is purporting to be exempt from paying for NHS services.

6.2.2 The NHS is exposed to patient fraud in three key areas:

- prescription charge evasion £162.6 million
- estimated NHS spend of £8 billion

- dental charge evasion £49.8 million
- estimated NHS spend of £786 million

- optical voucher abuse £39.3 million
- estimated NHS spend of £510.5 million

6.2.3 The NHS has recovery mechanisms in place to recoup losses to prescription and dental charge evasion and influence patient behaviour. NHSBSA have delivered PECS and DECS since September 2014 and June 2016 respectively. In 2016-2017, NHSBSA carried out more than double the number of eligibility checks compared with the previous year.

6.2.4 Penalty charge notices (PCNs) combine the original prescription or dental charge plus an additional penalty charge of five times the original amount owed, up to a maximum of £100. No payment made within 28 days results in a Surcharge Notice (SCNs) of £50 added to the fine. NHSBSA increased the number of PCNs issued by PECS in 2017 to 1,052,430. The number of SCNs also increased to 561,335.

6.2.5 The PECS and DECS initiative has also identified significant numbers of repeat offenders accumulating five or more PCNs since PECS began in September 2014. Since inception, 77,842 patients fit these criteria with 558,165 linked PCNs. At the top end, 17 patients received 40 or more PCNs. Over the last 12 months (24/09/2017 – 23/09/2018) there were 25,167 patients to have received five or more PCNs equating to a total of 160,626 linked PCNs. Furthermore, 1,794 patients received ten or more PCNs.

6.3 Procurement and commissioning fraud

Estimated loss: £351 million
Confidence: Low probability, 25%-50%

6.3.1 Procurement and commissioning fraud relates to allegations of collusion, corruption and bribery within the pre-tender stages of the procurement and commissioning process. False, intentionally inflated or duplicate invoices within the post-tender stages of the procurement and commissioning stages

6.3.2 The total approximate spend in this thematic area is £30.4 billion.

6.3.3 The NHSCFA assesses that there is a low probability that the loss to fraud in the procurement and commissioning process to be approximately £351 million. This is broken down into two main categories:

- Non pay expenditure (£270 million);
- Estimated spend of £27 billion

- Agency workers (£81 million)
- Estimated spend of £3.4 billion

6.3.4 It has not been possible to closely evaluate the likely scale of fraud in the £27 billion of non-pay expenditure due to the complexity and variance in local procurement processes. Both the NFA and the Ministry of Defence Police have previously highlighted that procurement fraud in general represents approximately 1% of spend. By applying a 1% fraud rate, it can be estimated that excluding employment agencies, procurement fraud represents a loss of £270 million to the NHS.

6.3.5 The NHSCFA has previously identified that the likely rate of overcharging associated with employment agency staff invoicing is 4.7%. By applying this rate to the £3.4 billion expenditure on agency and temporary workers, it can be estimated that £162 million is overpaid for agency staff against national framework agreements. There is a low probability that fraud represents half of this total, £81 million.

6.3.6 Mandate fraud is a type of post-tender invoice fraud, where an organisation is duped into changing a direct debit, standing order or bank transfer mandate by someone purporting to be from a supplier they make regular payments to in order to benefit from unauthorised payments.

6.4 NHS staff frauds

Estimated Loss: £94.6 million
Confidence: Low probability, 25-50%

6.4.1 NHS staff fraud relates to member of staff who fraudulent inflates or falsifies their income, expenses or working hours for financial gain. Not the person they presented themselves to be.

6.4.2 The NHS employs approximately 1.2 million staff with an approximate net staffing cost for 2017 – 2018 of £47.3 billion.

6.4.3 With little known on the scale or extent of fraud within payroll and identity fraud the NHSCFA have used the National Fraud Authority's 2013 estimate of 0.2% of total payroll spend. Therefore there is a low probability that the estimated of loss to fraud is £94.6 million

6.4.5 This is a slight increase of £400,000 from 2016 – 2017 which is attributed to the increase in net payroll spend only.

6.4.6 Payroll fraud remains the most prevalent type of non-patient fraud reported to the NHSCFA in 2017 - 18.

6.4.7 Payroll fraud often occurs due to the lack of payment verification and inadequate managerial supervision. The intelligence suggests that from information reports and an engagement exercise with Local Counter Fraud Specialists in England that Band 2 and Band 3 members of staff are authorising timesheets.

6.4.8 The NHSCFA receive a high number of information reports relating to payroll fraud, however, very few are resolved with civil or criminal sanctions due to evidential challenges, low monetary value of the fraud, and a reluctance of the health body to pursue. It is considered likely that a large number of payroll frauds are resolved locally without being reported to the NHSCFA.

Identity fraud

6.4.9 The NHSCFA assesses that identifying and quantifying the financial threat of those working in the NHS who do not have the right to work in the UK is challenging. The vast majority of identity and right to work reports relate to provider environments such as NHS trusts, Hospital and Care trusts and Mental Health trusts.

6.4.10 It is considered highly likely that the majority of identity and right to work issues are currently not being reported to the NHSCFA as they are identified during pre-employment checks

6.5 National Tariff and performance data manipulation

Estimated Loss: £114 million
Confidence: Realistic Probability (25-50%)

6.5.1 Nation tariff and performance data manipulation describes the falsification of data and the payment by result (PbR) system to intentionally obtain financial gain.

6.5.2 The PbR reimbursement mechanism is used to fund acute, mental health and community services care. It is estimated that £38 billion of secondary care funding is paid in the manner of PbR. Based upon historic data it is estimated that 0.3% of PbR claims made to them are fraudulent.

6.5.3 If this percentage is applied to PbR data in the NHS it can be estimated that £114 million may be lost to fraud per annum. This is a slight increase of £6 million compared to last year's assessment, which is attributed to an increase in funding rather than an increase in fraudulent activity.

6.5.4 The current system is set up in such a way that commissioners are dependent on data received from providers in order to monitor provision, quality of services and, ultimately, to derive payment.

6.5.5 The NHSCFA assesses that this opens up a real potential for data manipulation for providers to make a financial gain.

6.5.6 The NHSCFA assesses that although performance data is cross referenced with Hospital Episode Statistics (HES) data by NHS Improvement, this is sample based and unusual data is primarily only referred to NHS Improvement due to issues with governance, rather than identified fraudulent submissions.

6.6 General Practice fraud

Estimated Loss: £88 million
Confidence: Realistic Probability (25-50%)

6.6.1 General practice fraud describes the manipulation of income streams or activities that violate contractual terms perpetrated by either practitioners or staff members.

6.6.2 Approximately £8.8 billion was paid towards the different GP contract type for 2017 – 2018 and it is estimated that a 1% loss to the NHS through general practice fraud is approximately £88 million.

6.6.3 The NHSCFA has not measured general practice fraud this reporting period and therefore relies on comparative primary care measurements from Dental and Optical services to provide an indication of the level of fraud. Historic loss analysis exercises for Dental and Optical have identified fraud rates between 1% to 3.5%. As a matter of caution the NHSCFA has applied the 1% estimation.

6.6.3 Contractual agreement funding made available to all practices in England during 2017–2018 is listed as follows;

- £5.95 billion to 5,301 providers with a General Medical Services contract.
- £2.65 billion to 2,127 providers with a Personal Medical Services contract.
- £269 million to 279 providers with an Alternative Provider Medical Services contract.
- £17.3 million to 56 providers with an unknown contract type.

6.6.4 The National Duplicate Registration Initiative (NDRI) undertaken by the National Fraud Initiative in 2009 -2010 matched GP patient list data in England and Wales. It identified 95,000 patients that needed removing from GP lists, of these patients 34% were deceased and a further 31% had duplicate GP registration, these errors would have saved £6.1 million per annum in unnecessary funding[3]. Without undertaking this matching exercise, the loss to the NHS caused via funding of ghost patients would have totalled a £56 million, over the last 9 years.

6.6.5 Data from NHS Digital shows that 59.2 million people are registered with a GP in England, however the office for National Statistics puts the current population at 55.6 million, leaving a gap of 3.6 million between the amount registered with GP practices and population of England.

[3] http://webarchive.nationalarchives.gov.uk/20150423183332/http://archive.audit-commission.gov.uk/auditcommission/subwebs/publications/studies/studyPDF/3701.pdf

6.7 European Healthcare Insurance Card (EHIC)

Estimated Loss: £21.7 million
Confidence: £640,000 (highly likely, 75 – 85%)
£21.1 million (low probability, 25 – 50%)

6.7.1 European Healthcare Insurance Card relates to someone who is not entitled but has obtained or using an EHIC to access care within the NHS or in a member state.

6.7.2 Further assessment of thematic area has not occurred since the 2016 – 2017 strategic intelligence assessment and therefore the NHSCFA estimate the fraud loss and error for the misuse of EHIC[4], in both the application and claims processes, remains at approximately £21.7 million.

6.7.3 This is made up of £640,000 lost to fraud and error during the application process whilst £21.1 million is lost due to fraudulent claims or error. The original assessment could not differentiate between fraud and error due to the level of the data and therefore for this thematic area, the error is also included.

6.7.4 NHSBSA assesses over 5 million cards a year are issued at a unit cost of £1.24 each. It is highly likely that £640,000 is lost during the application process attributed to fraudulent or false applications.

6.7.5 Data analysis revealed that 49.7% of all distinct NHS numbers that appear on applications are invalid or erroneous when compared to demographic information associated with medical records. Furthermore, 2.8% of NI numbers that appear on applications do not exist when compared against DWP data. The NHSCFA therefore assess that NHS and NI number applications are a high-risk method that will attract larger than anticipated levels of suspected identity fraud and error.

6.7.6 EU Exit will take place within the next reporting cycle and may affect EHIC application and claim behaviour. The EU and UK have provisionally agreed that all current EU citizens will be able to retain their rights to emergency treatment also covering pre-existing medical conditions, currently incorporated in the EHIC scheme. However, the withdrawal agreement needs ratification by both the EU and UK before the end of March 2019. If successful, this will enable the transition period up to the end of 2020 to allow for further negotiations.

6.7.7 It is unclear whether this timetable will have an impact on the level of operational risk currently identified for this thematic area. However, there may be uncertainty as to whether the UK will remain in some form of reciprocal healthcare agreement with the EU.

[4] People who are ordinarily resident in the UK are entitled to an EHIC card for use in Member States of the European Economic Area (EEA). UK cardholders have the right to access clinically necessary, state provided, medical treatment that cannot wait until a planned date of return during a visit to an EEA country or Switzerland. This can be at a reduced cost or sometimes free of charge.

6.8 Optical contractor fraud

Estimated Loss: £82.4 million
Confidence: probable (50%-75%)

6.8.1 Optical contractor fraud relates to inappropriate claiming \ dispensing at the practice or care provided in homes, nursing, residential or day care facilities

6.8.2 In England approximately £510.5 million was spent on General Ophthalmic Services (GOS) in 2017-2018, provided by 13,141 ophthalmic practitioners. This is an assessment based on the total number of GOS vouchers processed in each service area during 2017-2018, published by NHS Digital, and the average value per GOS voucher identified during the NHSCFA loss analysis exercise, carried out in 2016.

6.8.3 The NHSCFA estimates a probable loss of £82.4 million due to optical contractor fraud. This is a slight increase from the 2016-2017 estimation of £79 million. This estimated loss figure was achieved by applying the individual loss rates per GOS service area, identified during the NHSCFA loss analysis exercise, to the most recent ophthalmic activity data published by NHS Digital.

6.8.4 The main areas at risk of abuse by optical contractors identified by the exercise in England were:

- Unjustified early sight test recall;
- Patient did not warrant domiciliary visit;
- Patient did not receive service;
- Patient paid for service;
- Patient did not need new glasses.

6.8.5 Without any significant proactive or reactive fraud awareness initiatives or fraud prevention programs being introduced into the ophthalmic landscape, these risk areas will remain a cause of concern. Even current guidance and regulations on appropriate claiming could be considered unclear and out of date.

6.8.6 The NHSCFA's E-Learning Team, in conjunction with the Federation of (Ophthalmic and Dispensing) Opticians (FODO) and the General Optical Council (GOC) have developed an online e-learning package, with final assessment, aimed at educating ophthalmic contractors and their staff on fraud awareness and to refresh their understanding of inappropriate claiming. By the end of the e-learning, the learner will be able to:

- describe why the prevention of fraud is of importance to the NHS;
- identify ten elements of the GOC Standards that relate to fraud;
- state the definition of fraud; identify fraud in 14 different contexts that could affect optometrists and opticians;
- identify circumstances where the NHS is at risk from optical fraud;
- identify the responsibilities of optometrists and staff working in opticians;
- and describe how optometrists and their staff may report suspicions of fraud.

6.9 Dental contractor fraud

Estimated Loss: £93.5 million
Confidence: Low probability (25-50%)

6.9.1 Dental contractor fraud relates to inappropriate claiming \ dispensing at the practice relating to services delivered as defined by the contractual agreements. Private work carried out and impact on the NHS.

6.9.2 Approximately £2.8 billion was paid to 8,636 dental contracts in 2017-2018[5] with 24,308 dentists performing NHS activity, an increase of 1.3% on 2016-2017[6].

6.9.3 Applying the individual fraud rates identified from the 2009 loss analysis exercise to the different treatment bands of dental activity, the NHSCFA estimates there is a low probability that the loss to the NHS through dental contractor fraud is £93.5 million for 2017-2018.

6.9.4 The areas of potential loss resulting from fraud include:

- Patient did not receive the level of treatment claimed - up-coding (£46.8 million)
- Split courses[7] of treatment (£25.2 million)
- Patient did not visit the dentist (£11.2 million)
- Patient does not exist (£9.4 million)
- Patient paid for treatment but was marked as exempt (£0.9 million)

6.9.5 NHSBSA continues its programme of activity to maximise behavioural change amongst dentists, with certain successes in projects such as the Business Rates Audit and the 28-day Re-attendance Dental Activity Review (28DR). As of January 2018 there has been a £4.5 million reduction in the value of business rates claimed. There has also been a 48% reduction in the rate of 28DR claims equating to a value of £19.5 million. Savings are predicted in future years as long as claiming patterns and high-risk contracts remain monitored.

6.9.6 The £4.5 million reduction in claims for Business Rates and the £19.5 million reduction in 28DR after counter fraud projects were initiated could be indicative of the scale of fraud prior to the control mechanisms being in place. This highlights the importance of being able to identify and manage fraud risks appropriately.

[5] https://www.nhsbsa.nhs.uk/fp17-processing-and-payments/nhs-payments-dentists-201718 (11/10/2018)
[6] https://files.digital.nhs.uk/4F/B3B6FE/nhs-dent-stat-eng-17-18-rep.pdf
[7] Split course treatment describes a practice where a dental contractor splits a single course of treatment into multiple courses over a prolonged period, thus increasing the amount of Units Dental Activity (UDA) claims submitted for payment.

6.10 Fraudulent access to NHS care in England

Estimated Loss: £35 million
Confidence: Low probability (25-50%)

6.10.1 Fraudulent access to NHS care in England describes inappropriate access to NHS secondary care by foreign nationals who avoid payment for services delivered.

6.10.2 The Department of Health and Social Care commissioned research which identified that the estimated cost from health tourism was £70 - £300 million. The NHSCFA assess 50% of the lower estimate range could be lost to fraudulent activity, a total of £35 million. This estimate should be treated with caution, as there have been limited studies into the costs attributed to overseas visitors on the NHS. Throughout 2016 – 2017 NHSCFA received seven allegations per 1,250 health tourists.

6.10.3 The NHSCFA assess that there is a low probability that £35 million could be lost to individuals travelling to England with the deliberate intention of obtaining free healthcare to which they are not entitled.

6.10.4 The estimate does not cover the cost of overseas visitors to the NHS, rather just those with a deliberate intention to deceive.

6.10.5 Little is known about the scale and extent of this thematic area, including how much is spent by the NHS in England in providing services to overseas patients. This makes it problematic assigning a fraud loss percentage therefore the same assessment methodology has been adopted as the 2016 – 2017 strategic intelligence assessment.

6.10.6 For Visitors outside of the European Economic Area (EEA) who are applying for a UK visa for more than 6 months are required to make a payment known as the International Health Surcharge (IHS) towards the cost of healthcare in England as part of their visa application.

6.10.7 In 2017 - 2018, the Home Office collected £235 million in IHS payments. The IHS is charged at £200 per annum with a reduction for students at the cost of £150 per annum. The Home Office have announced that the IHS application cost is intended to increase, so that it better reflects the cost of treatment provided.

6.10.8 Overseas visitors who are visiting the UK for six months or less, (including those on multiple entry visas), non-resident UK nationals, or those who are in the UK without immigration permission must be charged for services they receive at the point of accessing care, unless they are exempt from charges under other categories of the Charging Regulations.

6.10.9 With events around EU exit and its impact on the perception of access to UK services from foreign nationals, it is unclear how fraudulent access to NHS care will be affected in the future.

6.11 NHS Pensions

Estimated Loss: £2.3 million
Confidence: Probable (50-75%)

6.11.1 NHS pensions relates to the fabrication or failure to notify pension administrators of material changes to their circumstances that would affect their eligibility for receiving NHS pension.

6.11.2 The NHS pension scheme is Europe's largest pension scheme, paying out approximately £10.3 billion in 2017-2018 in pension payments, lump sum payments, widow and dependent payments, death gratuities, transfers out, and payments to other schemes and refunds. As at 31 March 2018 the number of active members is 1,572,053 and growing.

6.11.3 The NHSCFA assesses that it is probable that the loss due to fraud from the NHS pension scheme is approximately £2.3 million. It is assessed to be a probable loss due to previous data matching activity through the National Fraud Initiative (NFI).

6.11.4 The NFI has estimated the value of pension fraud, overpayment and error, at £144.8 million nationally with approximately 98% of cases being from public sector pension schemes. The NFI has assessed that frauds and overpayments most often occur due to 'suppression of death' fraud, which occurs when relatives intentionally fail to notify the pension scheme that the pension recipient has died.

6.11.5 Another abuse involves survivor pension fraud, whereby the recipient deliberately fails to notify the pension scheme of their remarriage or cohabitation with another person, thereby ensuring the continued payment of a pension which is no longer valid. Some parallels can reasonably be drawn between survivor pensions and DWP fraud reports involving benefit claims as a single person who may be suspected of living with a spouse or partner. Whilst DWP data indicates that cohabitation fraud could be a significant problem, age profiling amongst pension scheme members and their nominated survivors is likely to make remarriage or cohabitation less likely.

6.11.6 Historically the NHS has extensively recruited non-British nationals from overseas, and as this population ages, it is considered likely that more NHS pensions will be paid overseas, as employees retire and return to their homeland. The impact of EU Exit has also seen a large number of foreign-born employees leaving the NHS and returning to their homeland. The NHSCFA judge that the threat of 'suppression of death' fraud may increase as the number of NHS pensioners and the number of NHS pensions paid overseas rises, since the deaths of non-British nationals living overseas may not always be recorded on systems available within the UK and so deceased non-British nationals may not always be identified through 'mortality screening' exercises.

6.12 Fraud against NHS Resolution administered funds

Estimated Loss: £18 million
Confidence: Low probability (25-50%)

6.12.1 Fraud against NHS Resolution (formerly NHS Litigation) relates to fraudulent accident / insurance claims under the Liabilities to Third Parties Scheme (LTPS) or through clinical negligence.

6.12.2 NHS Resolution estimates that there is a combined realistic probability of fraud losses for 2016 – 2017 at £12.3 million. The estimated loss is spilt into two risk areas:

- Fraud within the LTPS scheme of £1.56 million
- Fraud within clinical negligence claims of £16.32 million

6.12.3 Insurance industry fraud risks are widely reported. These reports reflect opportunistic, planned and organised fraud. Fraudulent claims against NHS Resolution administered schemes broadly falls into two categories;

- The serious exaggeration of legitimate claims for damages (i.e. the claim does not reflect the harm actually suffered).
- The falsification of the circumstances which led to a claim for damages being made (i.e. the incident did not occur as described).

6.12.4 Claims under the Liabilities to Third Parties Scheme (LTPS) where payments in Damages totalled £31.2 million are likely to represent the most prevalent fraud risk encountered by NHS Resolution. LTPS typically covers employers' and public liability claims from NHS staff, patients and members of the public. These claims include, but are not limited to, slips and trips, workplace manual handling, bullying and stress claims. The risk profile reflects insurance business undertaken in the private sector.

6.12.5 The risk of clinical negligence fraud is considered significantly less prevalent; however, the value of individual claims is usually much higher. The costs associated with these claims can amount to several millions of pounds over their lifetime. In 2017-2018 NHS Resolution received 10,673 new clinical negligence claims, compared to 10,686 in 2016-2017. This suggests a plateauing following a surge in the numbers prior to a change in funding arrangements following the Legal Aid Sentencing and Punishment of Offenders Act 2012.

6.12.6 Based on 2017-2018 Damages payments for clinical claims of £1.63 billion and a reduced estimation from the general insurance claims experience of 5% to 1% it can be conservatively estimated with moderate confidence that clinical negligence claims fraud costs the NHS approximately £16.32 million. The variable nature of clinical negligence damage claims provides the potential for future estimates to be varied significantly by any single claim.

6.13 NHS student bursary scheme

Estimated Loss: £12.1million
Confidence: Low probability (25-50%)

6.13.1 NHS student bursary scheme relates to falsified application or supplied false documents to support a Bursary application or other NHS funded training or financial support stream.

6.13.2 Annual spend under the NHS student bursary scheme in 2017-2018 was approximately £450.1 million[8]. If we apply the 2.7% fraud rate from the NHSCFA loss analysis exercise from 2007 to this level of expenditure, it can be estimated that fraud within the NHS student bursary scheme currently costs the NHS approximately £12.1 million, although the biggest area of risk within this loss is childcare allowance.

6.13.3 The NHSCFA last measured losses in specific areas of the NHS student bursary scheme in 2006-2007. Although individual fraud rates were identified within the specific areas examined, the exercise revealed a combined loss to fraud of 2.7% of total expenditure.

6.13.4 The exercise identified four key areas of fraud risk:

- Identity fraud;
- Personal eligibility fraud;
- Course attendance fraud;
- Childcare allowance fraud.

6.13.5 Our confidence in the estimate is limited due to the age of the original research, the limited scope of the original research (i.e. it did not include all available allowances), and the potential but unevaluated impact of fraud prevention work which has been initiated since the original loss analysis exercise took place.

6.13.6 As part of the Government's Healthcare Education Funding Reforms, from August 2017, new non-medical students (including nursing, midwifery and allied health students) will no longer be eligible for NHS bursary funding. Instead, they will have access to the same level of tuition fee and maintenance support funding as other students, via the Student Loans Company, which effectively replaces tuition fees and NHS bursary funding for new nursing, midwifery and allied health students. It is not currently anticipated that existing medical or dental students will be affected and so tuition fees and NHS bursary funding will remain available as before for these students.

6.13.7 The NHSCFA assesses that it is too early post-reform to make an informed assessment over the risk of fraud to the LSF scheme. However, forecast bursary expenditure for 2018-2019 illustrates a significant decrease to approximately £243.3 million, brought about by the introduction of the LSF scheme and the phasing out of the NHS Bursary scheme. Applying the 2.7% fraud loss rate against this forecast would mean an estimated loss to fraud of £6.6 million.

[8] https://www.nhsbsa.nhs.uk/sites/default/files/2018-07/Student%20Services%20Annual%20Report%202017-18%20%28V1%29_0.pdf