NHS
Counter Fraud Authority

Strategic Intelligence Assessment 2023

Contents

Foreword

The NHS Counter Fraud Authority (NHSCFA) are directed by the Secretary of State to prepare an annual “Strategic Intelligence Assessment (SIA) analysing fraud trends in the health service”. Our SIA provides an estimate of fraud losses and vulnerability across the NHS over the last year. It encompasses intelligence collated in 2022 – 2023 and financial vulnerability estimates based on activity and budget data from 2021 – 2022, giving us an understanding of potential threats and vulnerabilities whilst measuring potential losses to fraud in the NHS.

The SIA also gives an overview of the current and long-term issues affecting or likely to affect fraud. It should be used to draw inferences and make recommendations for prevention, intelligence, enforcement, and future fraud strategy.

This year we have seen another year of growth in estimated financial vulnerability to £1.264 billion, up £66 million from last year. There are several reasons for this:

- procurement and commissioning of services spend has increased, partly due to the impact of COVID-19 and through dental and optical treatment returning following the pandemic.

- optical contractor is likely to have risen because of businesses returning to normal following the pandemic.

- financial vulnerability within healthcare linked to travel, such as fraudulent access to the NHS, is estimated to have increased.

Although these are the primary reasons for the increase in financial vulnerability, there will be many more parts of the NHS that are being defrauded every day.

Despite this increase in financial vulnerability, the percentage of vulnerability against NHS expenditure continues to remain below 1% (this year at 0.8%) and is the second lowest percentage since the SIA was launched in 2017. I reflect on what £1.264 billion could deliver for the NHS. More doctors, nurses and ambulances could all be funded through this money, saving lives, and making a real difference to people’s health. We will never lose sight of this in our aim to find, detect and prevent fraud.

I believe it is a good thing to find fraud as it shows that we are doing something right. There is always going to be fraud and there isn’t one solution to it however, our SIA provides us with key areas we need to target as well as trends/patterns to help us identify fraud.

Putting together the SIA is a huge undertaking both internally at the NHSCFA and externally through our partners across the health system. Thank you to everyone who has contributed, and I hope you are able to make good use of the insight it offers.

Alex Rothwell
Chief Executive Officer

Executive summary

The NHSCFA has produced an annual SIA since 2017. Over the course of the last six years, the fraud landscape has changed, and threat increased, with fraud assessed as accounting for 41% of all criminal offences in England and Wales. This is assessed in government reports to have equated to £21 billion of loss in the two years since the pandemic (2020 – 2022) as opposed to £5.5 billion in the two years before the pandemic (2018 – 2020). Despite responses to the threat of fraud evolving, the ability and motivation of criminals to adapt and counter developed systems and best practices remains present.

The NHSCFA assesses the NHS is vulnerable to fraud, bribery, and corruption to an estimated £1.264 billion. This is a £66 million increase on last year and equates to 0.8% of NHS expenditure (£157.9 billion) during the 2021 – 2022 financial year, including additional funding due to the COVID-19 pandemic. Despite this increase in financial vulnerability, the percentage of vulnerability against the NHS budget continues to remain below 1% and 0.8% is the second lowest percentage since the SIA was launched in 2017.

To counter the threat and vulnerability to fraud, bribery, and corruption, the NHSCFA and its partners have realigned strategic priority areas to the current fraud landscape. The response to fraud within the NHS in England is now split into three categories:

- strategic priority: ensure that counter fraud activity is proactively pursued with threats, vulnerabilities, enablers, risk, and financial vulnerability reported on an annual basis.

- intelligence collection: intelligence resources are assigned to improve the intelligence picture with threats, vulnerabilities, enablers, risk, and financial vulnerability reported on an annual basis through the SIA.

- strategic oversight: fraudulent activity is monitored to determine any fluctuations or depreciation in effectiveness of counter fraud functions. These areas will no longer be reported on an annual basis within the SIA; however, a combined notional financial vulnerability figure will be provided for transparency.

Counter fraud mechanisms within the NHS in England have also continued to improve with many initiatives implemented, such as increased emphasis on due diligence against payment diversion fraud, Real Time Exemption Checking (RTEC) to deter patient exemption fraud and continued Post-Payment Verification (PPV).

Despite this, financial vulnerability has increased for this reporting period by £66 million although this is largely due to increases in budgets, and therefore, heightened exposure

to potential fraud, bribery, and corruption. For example, this would include the increase in budgets to both procurement and commissioning of services, most overtly in procuring agency staff. Additionally, there has been an increase in patient service activity and a return to comparable pre-pandemic levels. For example, there has been an increase in those accessing dental and optical treatments and claiming exemption, services largely prohibited during lockdown periods.

Contrary to financial vulnerability, reports received by the NHSCFA this reporting period have decreased by approximately 15% compared to last year (6,161 reports decreasing to 5,252) and largely the result of a significant reduction of 72% in COVID-19 related reporting. This is predominantly due to procurement and commissioning of services fraud reports seeing the largest decrease. However, there has been an increase in payment diversion fraud reporting and likely the result of promoting the reporting of suspicious behaviour through an NHSCFA proactive exercise. Overall, reporting has decreased in almost all thematic areas, and perhaps still a legacy of pandemic restrictions and reduced oversight of suspicious behaviour. Similarly, the impact of NHSCFA prevention guidance and interventions may also be factors in reporting behaviour.

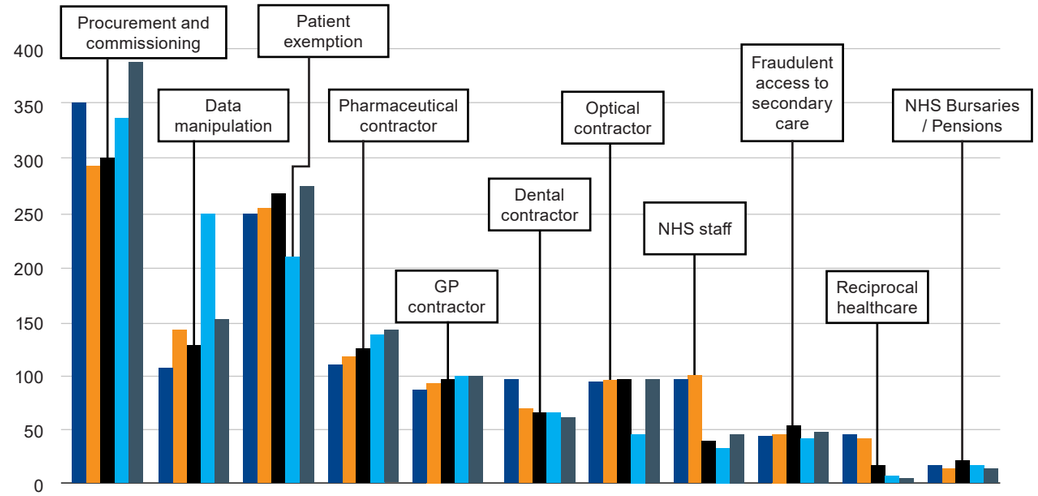
The table below provides an overarching summary of the current financial vulnerability picture compared to last year's SIA. It is important to note these are assessments of the financial vulnerability to fraud, bribery, and corruption and not an indication of direct loss to fraud. These figures run alongside the amount of direct fraud reports made to the NHSCFA.

Due to the time frame for public release of activity and financial data, financial vulnerability estimates run a year in arrears to reporting data, therefore, this assessment will include 2021 – 2022 financial data and 2022 – 2023 reporting data. In addition to the 5,009 reports attributed to a thematic area, there are an additional 243 reports where no thematic area was ascertained.

Strategic priority area	2022 – 2023 financial vulnerability estimate	2021 – 2022 financial vulnerability estimate	Difference (£m)	2022 – 2023 direct reports to NHSCFA
Procurement and commissioning fraud	£391.5m	£336.4m	+£55.1m	652
Patient exemption fraud	£271.8m	£214m	+£57.8m	891
Data manipulation fraud	£155.9m	£249.1m	-£93.2m	15
Community pharmaceutical contractor fraud	£123m	£122m	+£1m	101
GP contractor fraud	£101m	£101m	£0m	190
Optical contractor fraud	£79.7m	£38.7m	+£41m	23
Dental contractor fraud	£57m	£61m	-£4m	78
NHS staff fraud	£31.5m	£22.6m	+£8.9m	2,660
Intelligence collection				
Fraudulent access to secondary care from overseas visitors	£43.5m	£39.3m	+£4.2m	299
Reciprocal healthcare fraud	£0.467m	£1.94m	-£1.5m	4
Strategic oversight				
Additional area (NHS Bursaries and NHS Pension fraud)	£9.5m	£12.7m	-£3.2m	96
Total	£1.264bn	£1.198bn	£66.1m	5,009

A five-year breakdown of financial vulnerability per thematic area is depicted in the chart below. Where a loss measurement exercise has not taken place, or a comparative assessment not available, a baseline financial vulnerability rate of 1% of funding allocation or expenditure is used. This is the case in procurement and commissioning of services fraud, community pharmaceutical contractor fraud and GP contractor fraud. Increases in financial vulnerability within each thematic area reflects increased expenditure and not an assessed increase in fraud, bribery, and corruption.

Thematic areas - Estimated financial vulnerability 2019 - 2023



	Procurement and commissioning	Data manipulation	Patient exemption	Pharmaceutical contractor	GP contractor	Dental contractor	Optical contractor	NHS staff	Fraudulent access to secondary care	Reciprocal healthcare	NHS Bursaries / Pensions
2019	351.0	114.0	251.7	108.0	88.0	93.5	82.4	94.6	35.0	21.7	14.4
2020	291.4	136.0	259.5	114.0	91.0	65.9	82.9	98.2	35.0	20.8	10.9
2021	300.4	107.0	267.7	117.0	93.8	61.3	84.9	26.07	56.7	12.05	14.9
2022	336.4	249.1	214.0	122.0	101	61.0	38.7	22.6	39.3	1.94	12.7
2023	391.5	155.9	271.8	123.0	101	57.0	79.7	31.5	43.5	0.467750	9.5

The impact of the pandemic is illustrated in the financial years covered by this and last year's SIA, 2020 – 2021 and 2021 – 2022 respectively. For example, procurement and commissioning of services, where expenditure increased due to the pandemic, resulted in financial vulnerability increases of £36 million in 2022 and another £55.1 million this year. Conversely, in thematic areas to reflect patient service activity, there were decreases in financial vulnerability in the first year of the pandemic, for example, patient exemption fraud vulnerability decreased by £53.7 million in the 2022 SIA yet has increased by £57.8 million this year. This was the result of a significant decrease, due to pandemic restrictions, in those accessing dental and optical treatments and claiming exemption; however, activity has returned to pre-pandemic levels, and as such, financial vulnerability has increased.

This activity trend was also shown in areas where healthcare access is reliant on travel, with lockdown restrictions meaning fewer people were likely to have travelled, or been allowed travel, to access the NHS or healthcare overseas. With a financial vulnerability decrease in 2022, an increase this year implies pre-pandemic activity and behaviour is starting to be re-established.

NHS budgets have increased by £20.5 billion during the pandemic years and are predicted to remain at these levels over the coming years. Alongside activity largely returning to pre-pandemic levels and the heightened pressures from a cost-of-living crisis, it is assessed that financial vulnerability to fraud, bribery, and corruption will likely increase in subsequent reporting periods. This is due to more finances exposed to fraud and increased temptation by some to mitigate these pressures through fraudulent practices.

However, it is important to note that fraud is only committed by a minority of people. As more and more people become aware of how fraud impacts on the NHS, it is expected that more reports will be submitted to the NHSCFA. Through increased intelligence and knowledge, the NHSCFA and stakeholders are better informed of the ever-changing fraud landscape, and as such, can increase capabilities to effectively direct resources and mitigate against potential vulnerabilities.

Introduction

The COVID-19 period will have inevitably emboldened criminals to exploit the opportunities created by the urgent funding streams generated during the pandemic and the removal of thresholds allowing for an immediate response. These funding streams significantly increased the NHS budget by £20.5 billion between 2019 – 2020 and 2021 – 2022. It is projected the budget will see a 1.2% increase between 2023 – 2024 and 2024 – 2025, and ultimately settle at a significantly larger annual budget than pre-pandemic levels. As such, it appears the pandemic has influenced healthcare spending with a permanent budget uplift, possibly the result of greater public expectation and tackling elective care waiting lists.

The longer-term impacts of the pandemic have increased the burden on the NHS in other areas that may not have seen as much funding over the previous couple of years, hence commitments to increased expenditure in the future. It is assessed, therefore, that financial vulnerability to fraud and error will rise because of this increased expenditure.

Increased financial vulnerability for the NHS could be exacerbated by other factors, such as pressure on the wider economy and a cost-of-living crisis. The impact of this more broadly has already been highlighted by a 17% rise in fraud cases recorded by the National Fraud Database in the first nine months of 2022, when compared to the previous year, and a 11% increase on pre-pandemic levels. As such, there is no reason to suggest this trend will not be replicated in the NHS with increased temptation by some to mitigate financial pressures. For example, those within decision-making positions manipulating the procurement process; patients claiming exemption for prescription items, or NHS staff reporting sick whilst working elsewhere.

To disrupt and mitigate against fraud, the counter fraud community within the NHS in England has developed a collaborative Control Strategy process that includes an annually agreed priority review and strategic action plan. For the strategy period of 2023 – 2026, the NHSCFA and partners will be focussing on four strategic pillars, designed to consider the intelligence picture, assessed risk position, and return on investment:

- Understand (how fraud, bribery and corruption affect the NHS)
- Prevent (ensure the NHS is equipped to take proactive action to prevent future losses from occurring)
- Respond (equipped to respond to fraud when it has occurred)
- Assure (overall response to fraud across the NHS is robust)

With this heightened threat and probably for the longer term, it is important that the strategic priority areas are aligned to the current fraud landscape and remain flexible to identify where resources and activity should be appropriately and proportionately directed for maximum impact.

The NHSCFA and its partners have recently conducted a review of the strategic priority areas, with the organisation evolving its Control Strategy approach to further enhance the response to fraud. This approach consists of an annual review of the intelligence picture, risk landscape and financial vulnerabilities. These inform the integrated planning approach and annual strategies to bring all stakeholders and partners together in a more collaborative manner.

Any assessments made are based on the foundation of intelligence. This is not fact or evidence, but hypothesis and inferences drawn from the best available information at the time of writing. To enrich the intelligence picture and help safeguard valuable NHS resources against those motivated to commit fraud, it is the responsibility of the public and NHS employees to remain vigilant and report any suspicions, whether to Local Counter Fraud Specialists (LCFS) or direct to the NHSCFA using our fraud reporting line (Fraud and Corruption Reporting Online (FCROL)).

The impact of COVID-19

In response to the COVID-19 pandemic, the government introduced emergency funding streams including the procurement of supplies, COVID-19 testing and delivery of the vaccine programme. This allowed for the use of direct awards to suppliers without any competition, and the removal of procurement thresholds. As such, it may have led to increased vulnerability to fraud and error and enabled criminals and organised crime groups (OCGs) to adapt and develop schemes targeted at exploiting the NHS in England and the public.

The urgent nature of the pandemic also impacted NHS staffing resources with anticipated increases within patient admissions alongside increased staff absences due to COVID-19 related sickness and/or testing positive and having to isolate. This will have again seen criminals using this as an opportunity for gain.

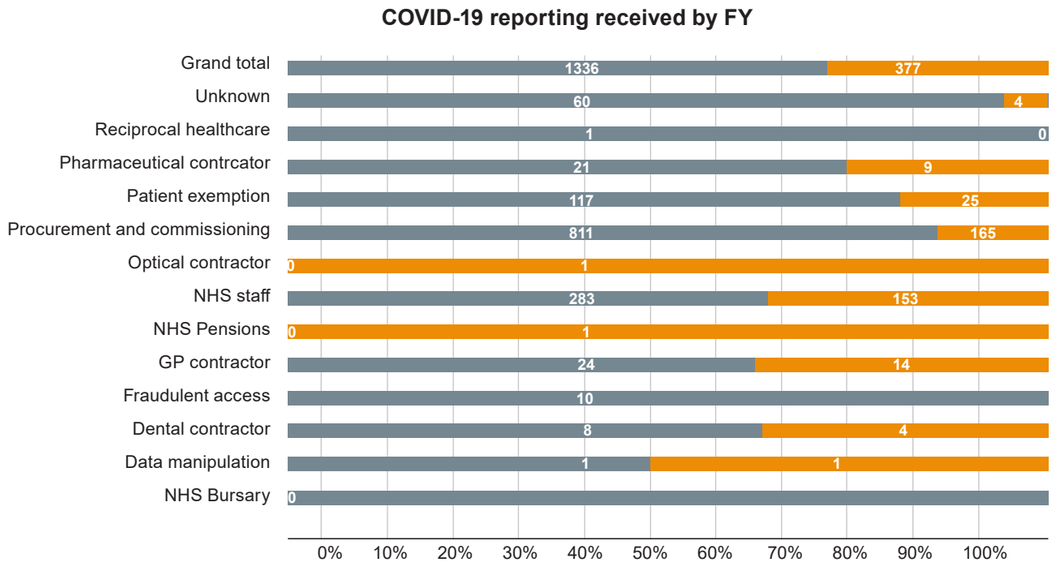
The impact of the pandemic would have been experienced in the financial years covered by this and last year's SIA. For example, procurement and commissioning of services, where expenditure increased due to the pandemic, had financial vulnerability increases of £36 million in 2022 and another £55.1 million this year. These increases have also played prominent roles in why the overall financial vulnerability to the NHS from fraud, bribery, and corruption has increased consecutively, to £1.198 billion in 2022 and £1.264 billion this year.

The impact has also been highlighted within thematic areas that reflect patient service activity, with decreases in financial vulnerability in the first year of the pandemic. For example, patient exemption fraud vulnerability decreased by £53.7 million in 2022 yet has increased by £57.8 million this year. The former, which included three national lockdowns, led to a significant decrease in those accessing dental and optical treatments and claiming exemption. However, 2021 – 2022 saw activity return to pre-pandemic levels with financial vulnerability totals increasing as a result. This is also the pattern within optical contractor fraud and within areas of healthcare reliant on travel, such as fraudulent access to NHS secondary care and reciprocal healthcare arrangements with the EU.

More broadly, it is envisaged that a return to pre-pandemic levels in patient access activity and claiming behaviour will see increased financial vulnerability to fraud. This should be considered alongside the medium to long-term predicted budget increases in the NHS, even after COVID-19 expenditure is withdrawn.

Part of the NHSCFA's response to the pandemic included production of the COVID-19 Threat Assessments to support stakeholders, local government and wider government in detection and deterrence of fraud in the NHS. However, it was decided during this reporting period to pause publication and keep as a watching brief due to decreasing COVID-19

specific reporting levels. The graph below shows these reporting levels compared to the previous year and as proportions for the two years 2021 – 2022 and 2022 – 2023.



How do we calculate fraud vulnerability?

NHSCFA assesses how financially vulnerable each thematic area is to fraud, bribery, and corruption. To achieve this, the NHSCFA adopts a different approach depending on nuances within each area. However, broadly speaking the two main methods are:

1. **Loss measurement exercises** – These take the form of an in-depth analysis and measurement of a particular area to provide a statistically robust percentage of how much funding/reimbursement is vulnerable to fraud. This method provides the NHSCFA with the highest confidence.

2. **Comparative loss assessments** – Where the NHSCFA has not directly measured, we are reliant on vulnerability percentages derived from partners or stakeholders. These may not be 100% comparable, therefore, the NHSCFA has the least confidence in them.

Within the SIA, a consistent language has been used when assessing the probability and uncertainty with the ‘probability yardstick’ defining the language applied to the range. In using the probability spectrum, the NHSCFA has considered the source, age and reliability of the material used, and any extenuating factors to form the assessment. There is no weighting attached to specific factors, but rather a comprehensive approach taken when assigning the probability and uncertainty.

PERCENTAGE RANGE	LIKELIHOOD OF OCCURRENCE
0% - 5%	Remote chance
10% - 20%	Highly unlikely
25% - 35%	Unlikely
40% - 50%	Realistic possibility
55% - 75%	Likely / probable
80% - 90%	Highly likely
95% - 100%	Almost certain

Annual reporting trends

Reporting has decreased by approximately 15% compared to last year (6,161 reports decreasing to 5,252) and largely the result of a significant reduction of 72% in COVID-19 related reporting (1,336 reports decreasing to 377). The pink sections of the bar chart display the additional reports classified as COVID-19 related during the collection period 2022 – 2023 compared with previous years.

The significant contributor to the decrease in COVID-19 related reporting is within procurement and commissioning of services fraud, which sees a decrease of 646, an 80% reduction from 2021 – 2022. This is attributed to a downturn in reporting of COVID-19 related scams such as telephone calls, texts, and emails to book vaccines, vaccine passports and obtain test kits.

It is assessed this decrease is attributable to urgent measures and funding streams reducing or withdrawn completely in the past year, and as such, less opportunity for fraud

to be attempted. It is anticipated this downward trend in reporting will continue in the next collection period of 2023 – 2024.

Once COVID-19 related reporting is subtracted, the number of reports received by the NHSCFA is almost identical compared to the previous year (4,875 vs 4,825). However, these non-COVID reporting totals are still approximately 1,100 fewer per year than in each of the two years pre-pandemic (2018 – 2020). More broadly, non-COVID related reporting has decreased by 18% between 2018 – 2023 (5,943 reports in 2018 reducing to 4,875 in 2023). This is largely attributable to a 42% decrease in reporting of patient exemption fraud (1,486 reports in 2018 reducing to 866 in 2023).

Top four reported areas

The NHSCFA received 5,252 reports in 2022 – 2023, of which approximately 86% relate to these top four thematic areas.

NHS staff fraud

2,660

Reports received

Patient exemption fraud

891

Reports received

Procurement and commissioning fraud

652

Reports received

Fraudulent access to secondary care from overseas visitors

299

Reports received

NHS staff fraud reporting equates to 51% of all reporting received this collection period and a slight increase when compared with the previous year. Both figures are indicative

of a return to pre-pandemic levels after a significant downturn in 2020 – 2021, with the increase attributed to greater oversight of activity following staff returning to workplaces and COVID-19 restrictions being removed. Aside from the anomaly 2020 – 2021, reporting has increased annually with a 12% increase between 2018 – 2023.

Patient exemption fraud reporting has reduced by 18% this period and is at its lowest over the past five years and approximately 40% lower than in 2018 – 2019 (1,486 reports vs 891). This could be explained by expansion of Real Time Exemption Checking (RTEC) and legacy impacts from the lockdown periods.

Reporting for procurement and commissioning of services fraud has almost halved in comparison to the previous period, due to reductions in COVID-19 related reports. Despite this, reporting is higher than all but one of the past five years and 88% higher than in 2018 – 2019 (652 reports vs 346).

Fraudulent access to secondary care from overseas visitors has seen a consistent decrease over the past five years and is now 40% lower than in 2018 – 2019 (498 reports vs 299). This is likely attributable to travel restrictions enforced during the pandemic.

It is assessed these trends are indicative of the transparency and visibility of suspicious activity within these areas and not necessarily the scale of possible fraudulent activity. The impact of NHSCFA prevention guidance and interventions should also be considered when analysing reporting trends.

Procurement and commissioning of services fraud

£391.5m
vulnerable from an expenditure of £35.1 billion

Procurement and commissioning of services fraud is a term used to describe pre-tender activity the commissioning process, post-tender activity and mandate fraud.

In response to the COVID-19 pandemic there was an increase in both procurement and agency staff spending. This has resulted in an increase in financial vulnerability to fraudulent activity.

Those with direct influence on decision-making within the procurement process, such as during the pre-tender phase, may be susceptible to bribery and corruption. This can be carried out multiple ways including using single tender waivers, failing to declare a conflict of interest, contract splitting or falsifying quotes or tenders. These methods will all be enabled by the decision-making process taking place within a closed environment, and as such, very few opportunities for suspicious behaviour to be witnessed and reported on.

The threat of payment diversion fraud, or mandate fraud, remains prominent and often cyber enabled, such as phishing email communications, the hacking of supplier email accounts or the spoofing of genuine email addresses.

A recent NHSCFA mandate fraud priority project has seen recorded savings of £32.8 million this reporting period and indicates the levels likely to have been inadvertently paid out to criminals in previous reporting periods.

Exceeding procurement threshold limits is assessed to remain a vulnerability that may enable fraudulent practice. Previous work carried out by the NHSCFA measured vulnerable spend to fraud and error for procurement contracts that should have gone through the tender process or existing frameworks. Despite this intervention reducing financial vulnerability by £156.8 million in the most vulnerable aspects of non-purchase order spending between 2018 – 2020, a lack of oversight and governance of procurement spending and contracts, still enables existing processes and frameworks to be bypassed.

The threat of commissioning of services fraud remains prominent, especially the necessity for NHS organisations to provide sufficient staffing levels through the procurement of agency staff. For example, NHS expenditure on agency workers increased by £600 million between 2020 – 2021 and 2021 – 2022. Partly due to resourcing implications during the COVID-19 pandemic,

and the basic requirement of the NHS prioritising patient care over cost, it is realistic some off-framework agencies charged inflated rates without scrutiny.

The 2023 – 2024 financial year will be the first to see the impact of Integrated Care Systems (ICSs) through the Health and Social Care Bill. Under the auspices of encouraging collaboration and moving from competition and silo working, ICSs may increase the potential for abuse of positions and collusion. Additionally, there is the possibility for commissioners and providers to work collaboratively whilst sharing finances and thus creating the potential for collusion and conflicts of interest.

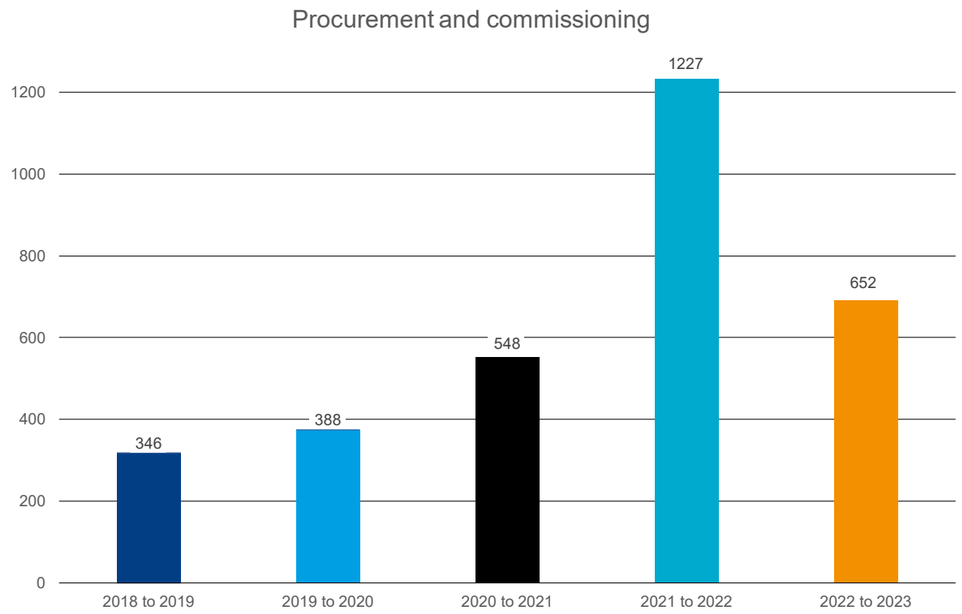
Information reports received for procurement and commissioning of services fraud

This reporting period has seen a significant reduction from 1,227 reports to 652, and largely those relating to COVID-19 scams. This type of allegation accounts for 63% (775) of all reports in this thematic area in 2021 – 2022, compared with 24% (158) this reporting period.

It is assessed that a full year without pandemic restrictions and associated requirements such as testing, has meant there is no longer the same opportunity for criminals to utilise the pandemic to attempt fraud, and the public may be increasingly less susceptible to such attempts.

Once COVID related reports are excluded, procurement and commissioning registered 494 reports this reporting period and comparable to last year's total of 452.

The change in the number of fraud reports received in relation to procurement and commissioning from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Patient exemption fraud

Patient exemption fraud covers a range of abuses within main NHS services that require payment upfront in return for access, including within prescriptions, dental, and optical. In addition, it covers general fraud such as the onward sale of prescribed medication.

£271.8m
vulnerable from an expenditure of £11.5 billion

The increase in financial vulnerability can be attributed to the return of pre-pandemic dental and optical activity once restrictions were lifted, as well as increases in prescription item cost.

The evasion of NHS charges remains a prevalent threat with a realistic possibility that some patients, including repeat offenders, will deliberately avoid paying for medication, and these may remain undetected.

A belief of entitlement to claim these services free, or a belief that it is not the patient's responsibility to check before claiming, are enablers to this fraud.

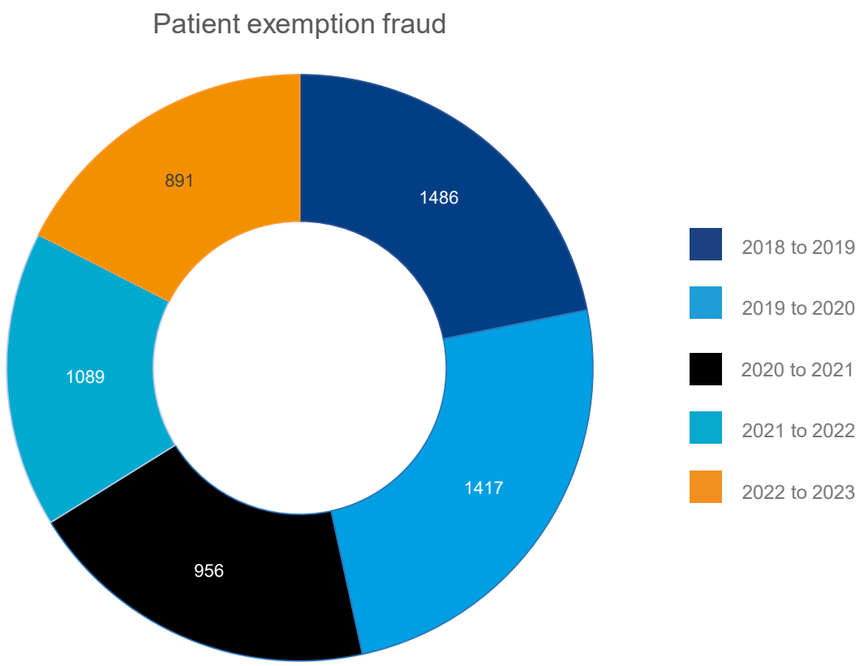
Genuine errors and confusion over exemption qualification, such as through benefits, further complicates this area. However, the significant expansion of Real-Time Exemption Checking (RTEC) in pharmacies will help negate confusion surrounding correct exemption claiming for both patients and pharmacists. However, it is possible that some discrepancies and errors are likely to remain within the system as it heavily relies upon the patient to understand their exemption status and keep their NHS record up to date.

The onward trade of prescription or other controlled drugs has been gaining increasing prevalence with the trading of unwanted or unused prescribed items often ending up in the hands of criminal groups. Medication may be traded via online platforms and sold in more lucrative markets abroad. Commonly traded items are prescription opiates or other highly addictive strong pain-relieving medication, making this a lucrative market.

Information reports received for patient exemption fraud

When comparing this reporting period with 2021 – 2022, reports have decreased by 18% (1,089 to 891). This could be explained by the expansion of RTEC, demonstrated by the decrease in reports relating to prescription charge evasion. Other significant decreases have been seen in obtaining prescriptions for another and the registrations of false identities and addresses. However, the largest number of all reports received involve prescription misuse which accounts for 32.5%.

The change in the number of fraud reports received in relation to patient exemption from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Data manipulation fraud

Data manipulation includes falsifying data to meet targets, increase revenue or hide undesirable outcomes. Previously encompassing Payment by Results and National Tariff fraud, latterly block contracts, and now Integrated Care Board (ICB) funding.

£155.9m
vulnerable from an expenditure of £51.96 billion

The decrease in financial vulnerability can be attributed to the COVID-19 pandemic and the NHS moving to block contracts. Therefore, funding changed and the previous formula used by the NHSCFA to determine expenditure was no longer applicable.

With the new ICB structure implemented in July 2022, it is a realistic possibility for clinicians to abuse their position to acquire more favourable allocations. When determining the level of the fixed element and funding distributions, they may collude with, or be coerced by, certain bodies.

ICB funding, inaccurately distributed or manipulated, is a possibility as the main allocation formula for ICBs uses population density and registrations to each GP practice within the system. Discrepancies within GP registrations/patient lists will directly affect ICB funding allocations.

It is extremely likely that data is falsified to meet targets or hide undesirable outcomes in secondary care. Hospitals may move patients under A&E reporting data instead of a non-inpatient short stay unit, possibly to avoid surpassing the care completion time within the unit.

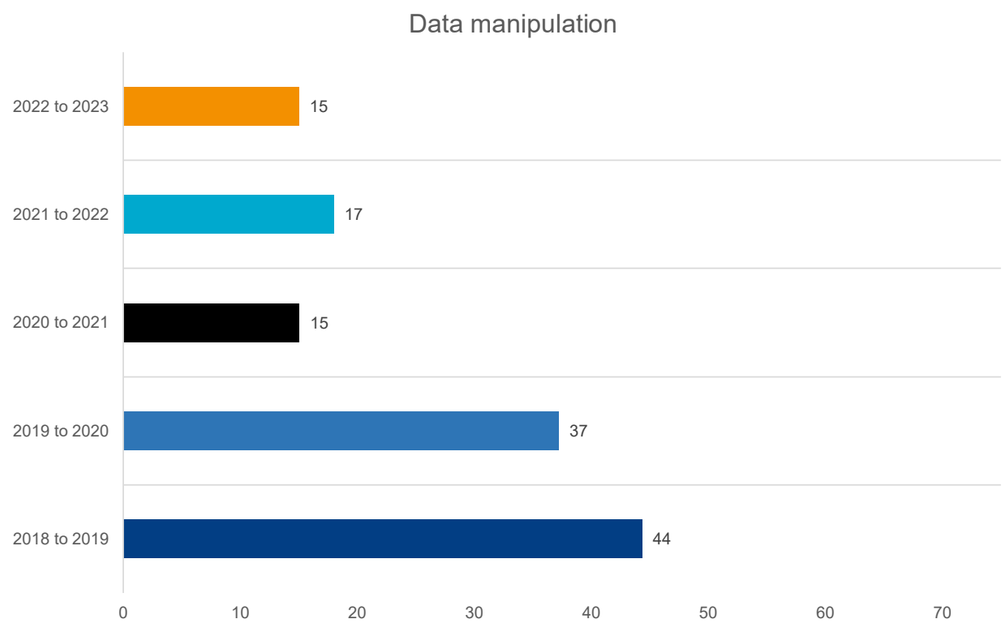
There is the potential for patient transport data to be manipulated to avoid fines by altering patient pick-up times and avoid surpassing the maximum waiting time. This may be achieved through delays and cancellations, as well as employing an individual to manipulate the figures.

The funding structure has the potential to incentivise abuse through activity data being falsified to maintain or increase funding. For example, a trust failing to provide contracted services yet falsifying activity data to appear as if the services were running, and as such, continue to accept funding.

Information reports received for data manipulation fraud

Potentially due to the difficultly in distinguishing between fraud and error, reporting is often low in this area. The implementation of the new statutory ICB structure may have also caused a further decrease in reporting, from 17 allegations in 2021 – 2022 to 15 this reporting period. Reporting may increase once there is a full understanding of the new processes and potential manipulations.

The change in the number of fraud reports received in relation to data manipulation from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Community pharmaceutical contractor fraud

£123m
vulnerable from an expenditure of £12.3 billion

Pharmaceutical contractor fraud involves the falsification or exaggeration of services, as well as collusion.

The increase in financial vulnerability can be attributed to an increase in expenditure. Additionally, pharmaceutical contractors are still receiving additional funding for COVID-19 related services, such as the delivery of vaccinations. As such, this presents an opportunity for unscrupulous contractors to exaggerate their activity to receive increased payments.

Pharmacists have a good understanding of each service they are required to carry out, the process for reimbursement, and the vulnerabilities present for submitting claims, such as misrepresenting activity and inflating funding. It is assessed likely that some pharmacists may use their authority to influence others and create a culture for this type of behaviour.

Commercial chains may also adopt a target-driven approach to generate profit by applying pressure on patients to deliver fee payable services as part of their responsibilities. Used by more people due to accessibility and size, commercial chains may create greater vulnerability to exploitation. It is also likely the public will be unaware of the specific requirements for the service offered to them or the fee paid to the pharmacy from the NHS for its administration.

A target-driven approach may motivate some pharmacists to manipulate the service provided by falsifying patient details. Similarly, monthly price fluctuation may enable some contractors delaying the submission of drug claims to receive payment at the higher price.

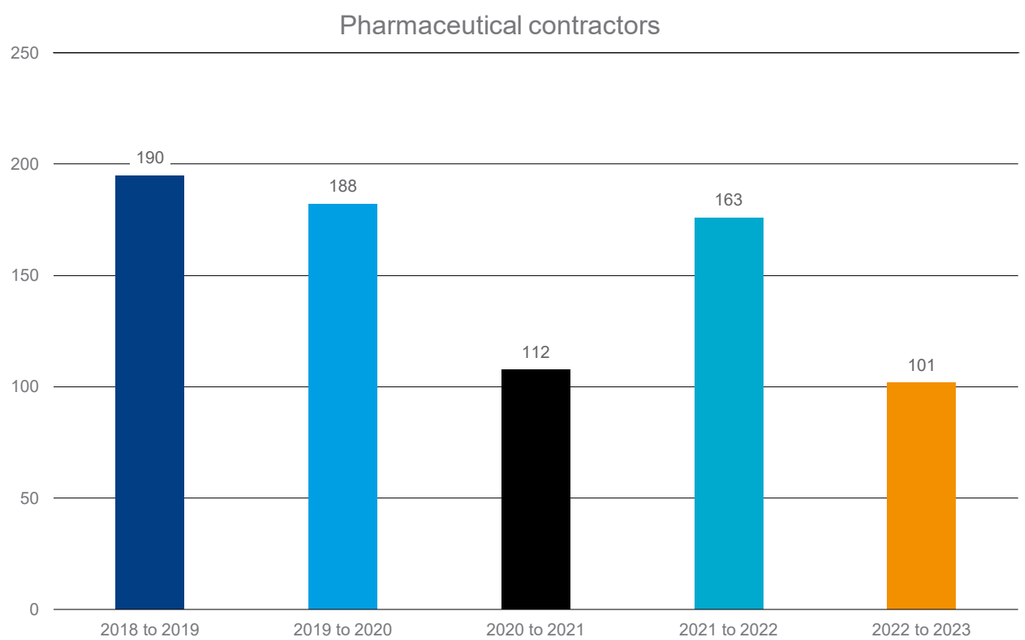
There is a realistic possibility that pharmacists and manufacturers may collude and split profit. ‘Kickback’ payments to pharmacists may also exist where the manufacturer or supplier pay for their products to be ordered above alternative businesses and the handling charge reclaimed by the pharmacist from the NHS.

Manipulation of funding streams may become exacerbated after the launch of ‘Pharmacy First’, new reforms set out to allow patients to get prescriptions directly from pharmacists for seven common conditions without the need to see a doctor or nurse. These reforms will also see pharmacists deal with significantly more blood pressure checks and prescribe the contraceptive pill, alongside patients able to self-refer for services such as physiotherapy.

Information reports received for pharmaceutical contractor fraud

Pharmacy reporting has decreased by 38% this reporting period and is now at its lowest in the past five years, 47% lower than in 2018 – 2019. Aside from 2021 – 2022, reporting has also decreased annually. Another year of reporting will determine whether this is a permanent trend or more a fluctuation as reporting returns to pre-pandemic levels. However, Post-Payment Verification work by the NHS Business Services Authority may have acted as a deterrent, resulting in fewer suspicious instances to report.

The change in the number of fraud reports received in relation to pharmaceutical contractors from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



General Practice (GP) contractor fraud

£101m
vulnerable from an expenditure of £10.1 billion

Fraud in this area is generally considered to be the manipulation of NHS income streams by practitioners or staff members. It could also be considered activities that violate NHS contractual terms for practitioners and services provided.

This is approximately the same expenditure as in 2020 – 2021; however, last year included extra funding in the form of COVID-19 support payments and payments relating to COVID-19 immunisation. The 2021 – 2022 expenditure does not include these payments, so in effect, becomes an actual increase from pre-pandemic levels. As such, financial vulnerability also remains the same. This expenditure is now distributed across fewer providers so the NHS pays on average more per registered patient (£159.61 increasing to £163.65).

The contract could be manipulated due to the reliance upon GPs to provide accurate information relating to patient lists and treatments. This may allow a minority to gain from increased Global Sum Payments. It is also a realistic possibility that some GP partners and practice employees may be enabling contract manipulation by covering up for one another.

It is assessed that some staff members may abuse their position to commit fraud, with those in senior positions and other influential roles potentially having a greater opportunity to divert significant funds without detection or scrutiny. This includes unauthorised salary increases, diversion of funds, and salary overpayments.

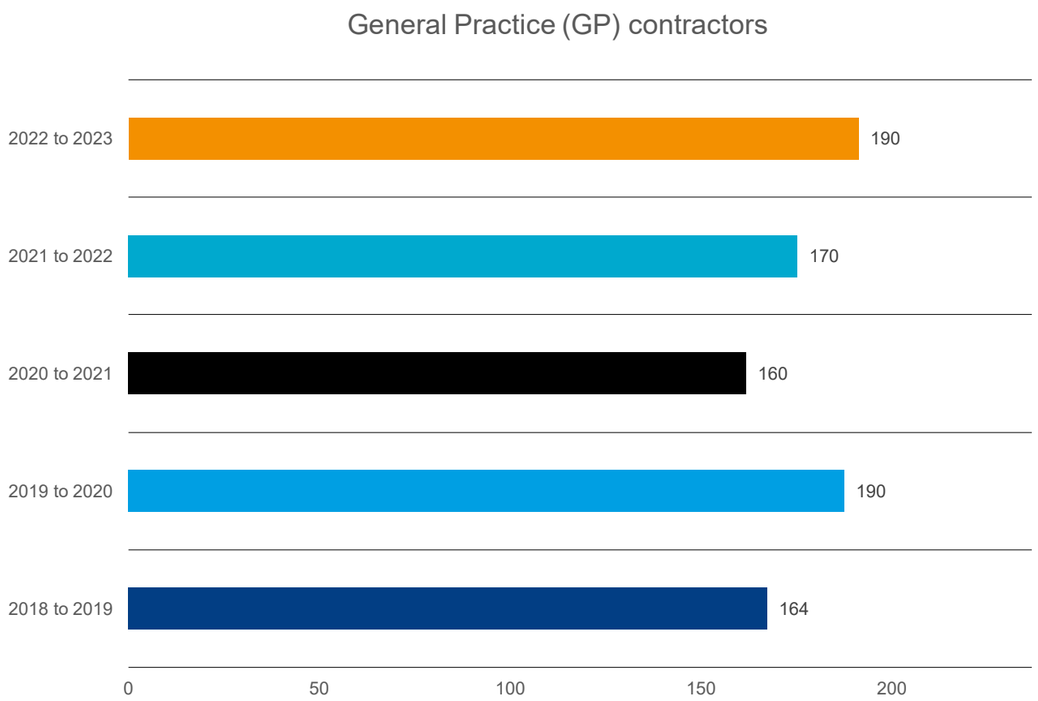
NHSCFA assess the COVID-19 related additional support payments were vulnerable to fraud by manipulation, thus potentially increasing GP practice income. This may mean fraudulent practices are diverted elsewhere in the budget moving forward.

Information reports received for General Practice contractor fraud

During this reporting period, NHSCFA received a total of 190 reports, an increase of 12% from 2021 – 2022. Many reports relate to high-value fraud and irregularities committed by practice managers which include unauthorised salary increases and diversion of funds from practice accounts to personal accounts. Furthermore, GPs and practice employees claiming overtime not worked and staff listed on payroll receiving a full salary but not actually working. The increase in reporting is a return to pre-pandemic levels, suggesting there was an impact

felt by the restrictions seen in 2020 and 2021, such as fewer patients seeing GPs, reduced oversight of suspicious behaviour, and as such, fewer opportunities to report.

The change in the number of fraud reports received in relation to GP contractors from 2018 – 2019 to 2022 – 2023 is illustrated in the chart below:



Optical contractor fraud

Optical contractor fraud involves submitting claims to the NHS for optical treatments, services, or enhancements not delivered or clinically required.

£79.7m
vulnerable from an expenditure of £499.5m

The increase in financial vulnerability of more than double the 2020 – 2021 estimation can be attributed to ophthalmic service activity and associated expenditure returning to normal levels following the COVID-19 pandemic.

It is assessed likely that some contractors will manipulate General Ophthalmic Services (GOS) activity, as well as control and influence other individuals through collusion and co-operation. Fraud can be enabled by submitting false, misleading, or exaggerated claims for treatments not provided or clinically needed. For example, it is a realistic possibility that some contractors may present patients with blank GOS vouchers to sign before any treatment is provided, with prescription details filled in later.

Testing or dispensing irregularities are also present, such as patients recalled earlier than clinically necessary. Some contractors may also carry out unnecessary sight tests on patients in their own homes by offering unauthorised free home visiting services on the NHS, alongside unnecessary tests on vulnerable patients in care homes not physically or mentally able to participate properly.

It is likely double income occurs where claims to the NHS are submitted for patients who already paid for private sight tests or glasses. For example, contractors may complete GOS1 vouchers for patients who are part of employer eye care schemes and have sight tests paid by the employer.

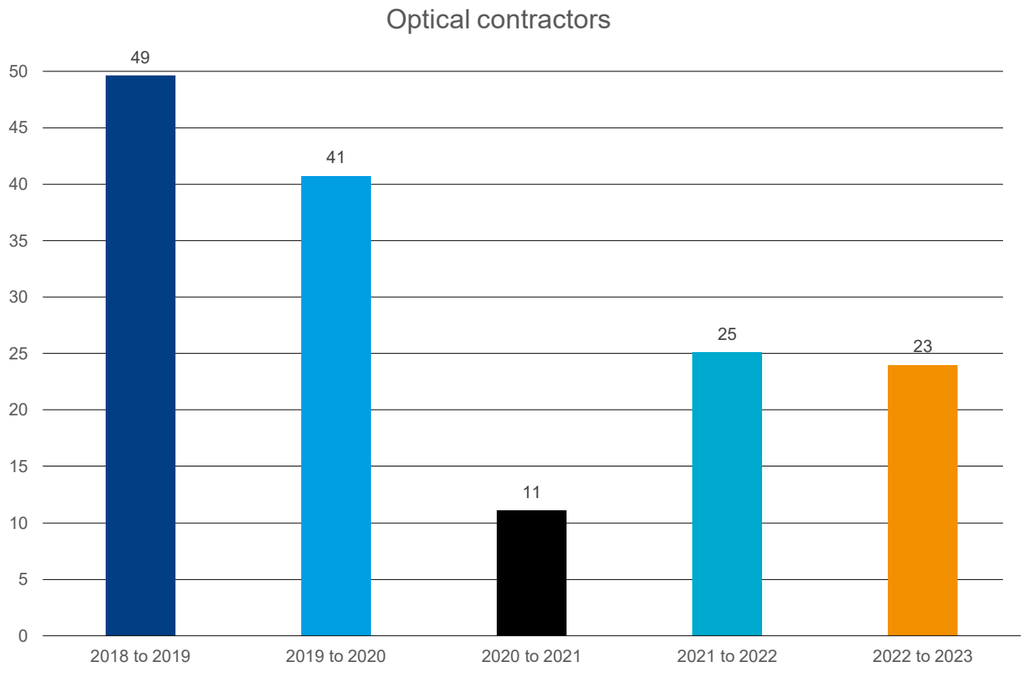
Any fraudulent practices to occur within commercial optical chains would be magnified as they are used by more people due to accessibility and size; therefore, creating greater vulnerability to exploitation.

Information reports received for optical contractor fraud

There were 23 reports of ophthalmic contractor fraud this reporting period, an 8% decrease from 2021 – 2022. As such, reporting is 53% lower than in 2018 – 2019, and aside from 2020 – 2021, has also decreased annually. This could be explained by the pandemic disrupting routine health service provision.

However, low-level reporting in this thematic area may be because ophthalmic is the lowest funded and least utilised NHS primary care service, and as such, reporting is proportionately low. Additionally, some claims are processed in batches due to large volume which could result in irregularities being missed.

The change in the number of fraud reports received in relation to optical contractors from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Dental contractor fraud

NHS dental services in England are provided by dental practitioners under contract to deliver general care and treatment. Dental contractor fraud concerns the fraudulent claims submitted to the NHS by dentists and their staff members for a range of NHS services provided to patients.

£57m
vulnerable from an expenditure of £2.4 billion

The COVID-19 pandemic resulted in the suspension of routine dental treatment, however, contractors continued to receive payments to the full contract value. These restrictions would have continued to impact Units of Dental Activity (UDA) behaviour during 2021 – 2022, and as such, estimated financial vulnerability does not demonstrate UDAs pre-pandemic. However, for this reporting period, the decrease in financial vulnerability is assessed due to a reduction in total expenditure and the number of dental contractors.

It has assessed a realistic possibility that some contractors may be encouraged to fraudulently submit claims to meet or exceed quotas, due to pressure to meet pre-pandemic activity levels and avoid clawback of funds for underperformance of the contract.

It is likely that some contractors may manipulate activity through altering patient data and UDAs claimed to secure additional funding. These claims may be for treatments or services not delivered or clinically needed. Additionally, it is also likely that double income occurs where claims to the NHS are submitted for patients who have already paid for private treatment or claims for charge paying patients submitted as exempt.

Practice employees could be complicit in fraudulent practice and conceal for the benefit of the practice or contract holder. Pressure from contractors or lead practitioners could be placed on practice staff to endorse fraudulent activity or obey instructions.

There is also potential for patients to act in collusion with dental performers to receive free or reduced cost treatment, such as the dentist claiming the patient is exempt or accepting a reduced cash cost. This may extend to unwitting complicity from the public due to a lack of understanding of how dental treatment and charges should operate.

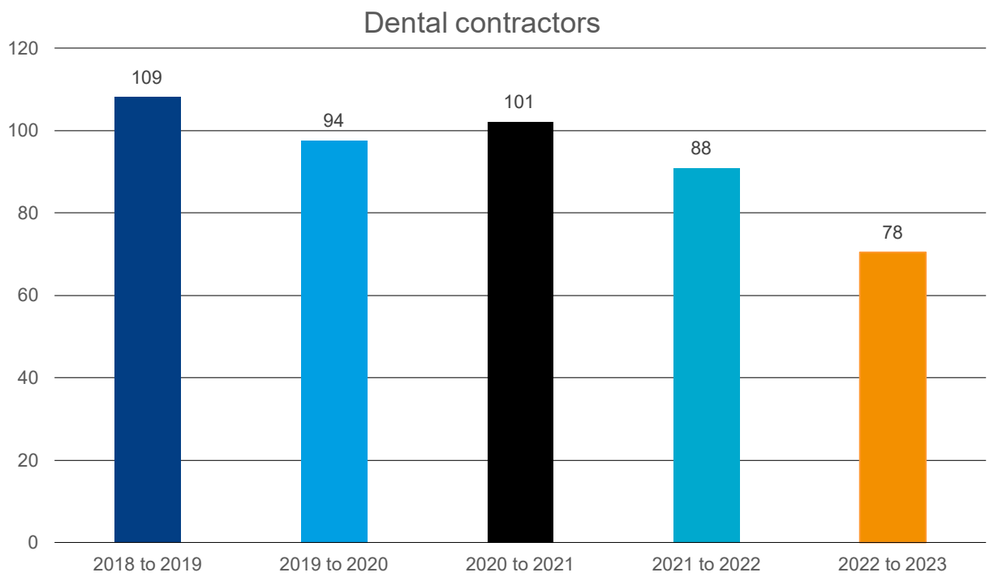
This reporting period has seen implementation of dental contract reforms including changes to payment rates and UDA values. This could impact claiming behaviour and financial vulnerability within this thematic area.

Information reports received for dental contractor fraud

There were 78 reports of dental contractor fraud this reporting period, an 11% decrease from 2021 – 2022. Reporting is at its lowest in the past five years and 28% lower than in 2018 – 2019. Aside from 2020 – 2021, reporting has also decreased annually.

The decrease in reporting levels is assessed linked to the reduction in dental services provided, as well as the temporary contractual agreements introduced during the pandemic. However, this may increase once there is an extended period of business as usual beyond the pandemic restrictions.

The change in the number of fraud reports received in relation to dental contractors from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



NHS staff fraud

NHS staff fraud encompasses staff manipulating income and hours, insider abuses and false representation during application processes.

£31.5m
vulnerable from an expenditure of £78.9 billion

The increase in financial vulnerability can be attributed to increases in expenditure and staff numbers. This may have been the result of covering for NHS staff self-isolating or ill with COVID-19 and the additional hours worked during this period. This also likely explains the increase in agency staff expenditure as detailed within commissioning of services fraud.

Since July 2022, changes to COVID-19 workforce guidance have meant the withdrawal of full pay for NHS staff should they need to self-isolate or become ill with COVID-19. As such, those that may have exploited the pandemic, whether through presenting a false positive COVID-19 test or long term COVID-19 symptoms, may now be motivated to seek other opportunities for financial gain.

It is likely that some will work whilst sick or elsewhere during NHS contracted hours, such as performing bank shifts. Submission of falsified fitness to work certificates, management oversight, and the lack of collaboration between differing NHS staff management and rostering systems, are potential enablers for these frauds.

It is highly likely that inflation of income and hours will occur through staff manipulating timesheets and rostering systems. This includes staff falsely claiming for hours/shifts not worked, bank shifts, and overtime. This may extend to collusion with senior staff to sign off timesheets for unworked hours and changes of pay bands to inflate pay.

False representation by staff failing to declare information or supply false information during the recruitment process is also a realistic possibility. This is enabled by providing forged documents and difficulties in validating and identifying their authenticity.

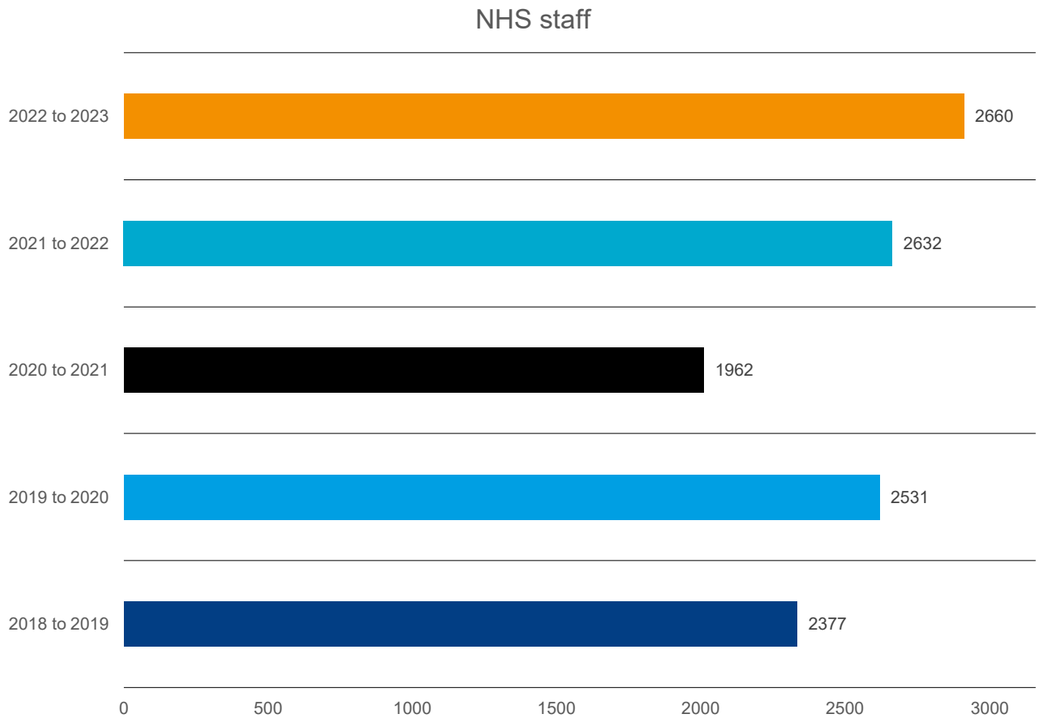
Information reports received for NHS staff fraud

NHS staff fraud is the most significantly reported thematic area annually, inferring a persistent threat within the NHS. During this reporting period, the NHSCFA received a total of 2,660 reports, approximately the same as the 2021 – 2022 total of 2,632, but higher than at any point across the previous five years.

The highest reported staff fraud areas relate to income and hours manipulations including working whilst on sick leave and inflating income by falsely claiming for hours and services not worked. These are committed by those with knowledge of weaknesses within NHS systems and processes and abusing positions of trust.

It is assessed staff fraud reporting may continue an upward trend post-pandemic, in part at least, due to the impact of the cost-of-living crisis.

The change in the number of fraud reports received in relation to NHS staff from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Fraudulent access to secondary care from overseas-visitors

The term ‘fraudulent access to the NHS’ refers to when a patient falsely represents themself as entitled to NHS care without charge, fails to disclose they are chargeable, or an NHS staff member has abused their position to facilitate the fraudulent access.

£43.5m
vulnerable from an expenditure of £2 billion

The increase in financial vulnerability this reporting period can be attributed to an increase in the number of visitors to the UK. This is likely the result of easing in travel restrictions implemented during the COVID-19 pandemic, and which likely deterred many wishing to travel for NHS healthcare without charge.

It is highly likely that patients will return to or enter the UK, with the specific intent of accessing secondary care without charge, yet permanently reside abroad. By claiming to have returned to the UK on a settled basis, or failing to notify a GP of moving abroad, a visiting patient could access care without charge from the day of their arrival. There is also the possibility that revenue streams, such as online fundraising pages, could be created to pay for travel to the UK.

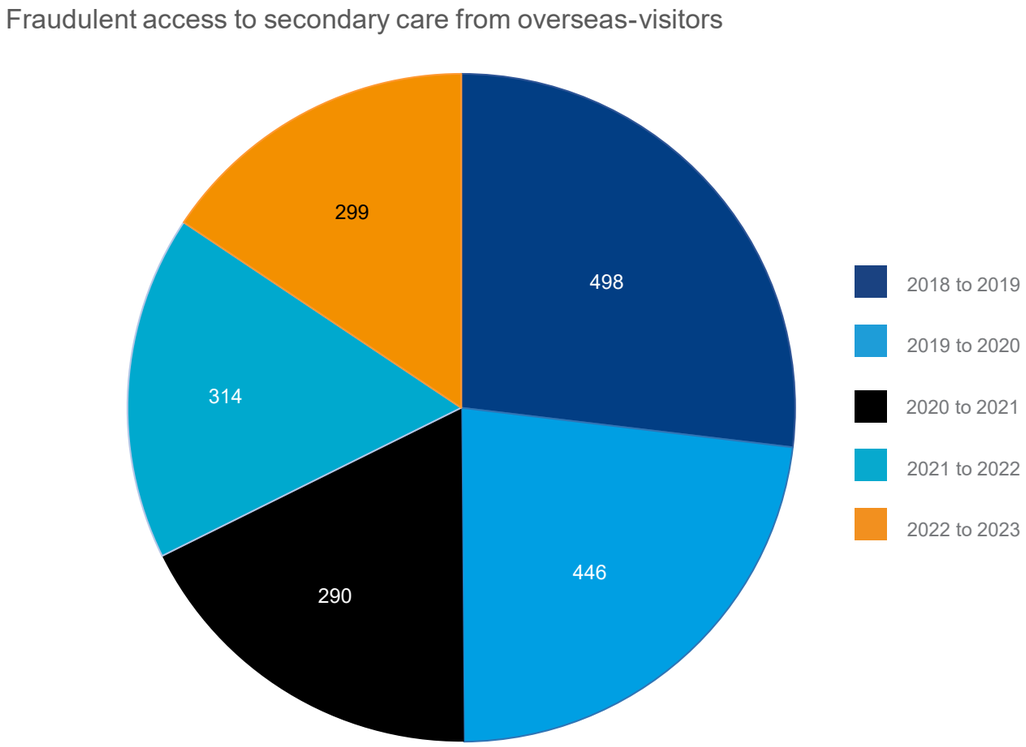
The high cost of healthcare in other countries and the cost-of-living crisis may encourage some to enter the UK with the specific intent of seeking NHS maternity care or fertility treatment without charge. For example, maternity care cannot be delayed for an advance payment as it is considered urgent and immediately necessary. It is therefore highly likely that some patients will enter the UK on a visitor visa and/or use a false address.

It is also highly likely that some patients will abuse the system by continuing to receive NHS repeat prescriptions whilst permanently residing abroad. Repeat prescriptions may be collected and sent abroad by associates.

Information reports received for fraudulent access

During this reporting period, the NHSCFA received a total of 299 reports compared to last year’s total of 314. Aside from 2020 – 2021, reporting is also at its lowest in the past five years and 40% lower than in 2018 – 2019. It is assessed this is due to the various COVID-19 travel restrictions in place over the previous couple of years of reporting. As such, there is a possibility that as travel resumes to pre-pandemic levels, there may be an increase in reporting.

The change in the number of fraud reports received in relation to fraudulent access from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



Reciprocal healthcare fraud

Reciprocal healthcare encompasses fraudulent use of European Health Insurance Cards (EHICs), Global Health Insurance Cards (GHICs), and various other reciprocal healthcare arrangements. Also, false representation during the application stage for a card or certificate which enables the holder to benefit from a reciprocal healthcare agreement. .

£467,750
vulnerable from an expenditure of £92.2m

The decrease in financial vulnerability this reporting period can be attributed to a more accurate data source used through collaboration with the Department of Health and Social Care. Regardless, the number of claims within the collection period is likely to have been affected by the UK not lifting COVID-19 travel restrictions until March 2022. As a result, it is assessed this will increase in the future as more individuals access reciprocal healthcare.

It is assessed that there is a threat that patients continue to use their EHIC/GHIC after permanently moving abroad, with reliance on the card holder to notify any changes in circumstance. It is also a realistic possibility that patients will claim their application has been submitted earlier to gain access to care without charge.

It is a realistic possibility to produce a fraudulent card, creating confusion over appearance and acceptance, especially as varying versions of the GHIC and the new EHIC are currently in circulation.

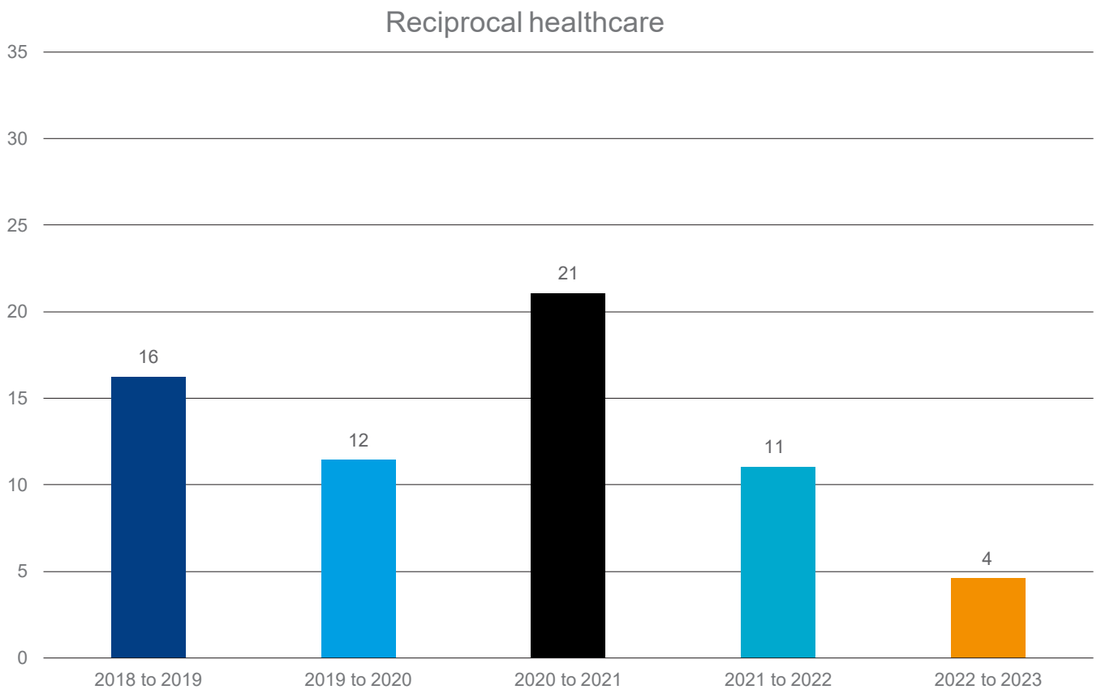
As the application is online, it is also a realistic possibility that some applicants will provide forged documentation to prove entitlement. It is also possible that some applicants may falsify eligibility to an EHIC/GHIC or fail to return one they are no longer entitled to. Some NHS staff may assume a patient is entitled to care without charge when they present an EHIC/GHIC, with confusion and/or presumption that the application is valid.

Information reports received for reciprocal healthcare

During this reporting period, the NHSCFA received a total of four reports compared to last year's total of 11. It is assessed this may be linked to a hangover from the various COVID-19 travel restrictions in place over the previous couple of years of reporting.

Since its launch in January 2021, the GHIC has continued to replace the legacy EHIC, and as predicted, GHIC fraud related reports are appearing for reciprocal healthcare.

The change in the number of fraud reports received in relation to reciprocal healthcare from 2018 – 2019 to 2022 – 2023 is illustrated in the below chart:



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Working together to **find**, **report** and **stop** NHS fraud