NHS
Counter Fraud Authority

Strategic Intelligence Assessment 2022

Contents

Foreword

Over the last reporting period significant changes have occurred to the fraud landscape. New threats and vulnerabilities have emerged whilst collaborative action has been taken to close down others. One thing stands out that has impacted on the landscape more than others and that is Covid-19.

Covid-19 not only provided criminals with new opportunities to commit fraud, but also produced unprecedented strain on the NHS in England. To adapt to the increasing demands, the NHS Counter Fraud Authority (NHSCFA) and our partners designed and implemented innovative and streamlined ways of working together. Thus, minimising the impact of fraud on the NHS and enabling the prosecution of those responsible.

This Strategic Intelligence Assessment encompasses the intelligence that was collated in 2021 – 2022 and financial vulnerability estimates based on activity data from 2020 - 2021. It is estimated that the NHS in England is vulnerable to £1.198 billion of fraud. Therefore, the estimated vulnerability has increased during this reporting period by approximately £58 million. This increase is attributed to the fast pace of change and additional funding being released during the pandemic.

Although my tenure as the NHSCFA's Chief Executive is still in its infancy, I can see from the hard work and dedication how much intelligence sharing and collaboration has improved over the last four years, not only from the NHSCFA but from the Local Counter Fraud Specialists and our partners whilst managing pressure from a global pandemic. There is still a considerable amount to do, however I believe we are all moving in the right direction with resources being allocated to the right areas at the right time. I have set out our goals and objectives for the forth coming year in the 2022-2023 Business Plan.

Finally, I would like to personally thank all our staff and stakeholders for supporting the critical work of the NHSCFA since our inception. We are a team here at the NHSCFA and any success is a success shared. I look forward to continuing our successful mission in the fight against fraud, bribery and corruption within the NHS for 2022 – 2023.

Alex Rothwell
Chief Executive Officer

Executive Summary

The NHSCFA have produced an annual Strategic Intelligence Assessment (SIA) since 2017. Over the course of the last five years the response to fraud and the landscape has been constantly evolving. The NHSCFA and its partners have conducted a review of the strategic priority areas during this reporting period. As a result of the review, the strategic priorities have been realigned 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 assessment reported on an annual basis through the strategic intelligence assessment.

- Strategic oversight: fraudulent activity is monitored through trend analysis and horizon scanning 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.

The NHSCFA assess that the NHS is vulnerable to fraud, bribery and corruption to an estimated £1.198bn.

In addition to the changes in strategic priority areas, the timeframes for intelligence collection within the SIA has also been amended to cover financial year to financial year. This is to ensure that all intelligence assessments presented are as current as possible. However, due to the timeframe for the public release of activity and financial data, the financial vulnerability estimates are still currently one year behind based on the previous year's spend. In order to mitigate these amendments, the intelligence assessments made for 2020 - 2021 have also informed the current assessments.

*Diagram highlighting the timeframes for collection of the intelligence and activity / financial data against publication year.

The fraud controls within the NHS in England have improved year on year with many initiatives being implemented or evolving such as post payment verification, stronger vigilance against payment diversion fraud and patient exemption fraud. Although fraud vulnerability estimates have increased by £58m this is primarily attributed to the increase in funding allocated for the Covid-19 response. We have seen a reduction in financial vulnerability to fraud in the majority of thematic areas. However, we have seen a notable increase in Data Manipulation and Procurement and Commissioning fraud.

Data Manipulation fraud increased by £142.1m. The vulnerable funding packages with Data Manipulation fraud have increased due to changes within the allocations and formulas where it is assessed, has generated an artificially inflated financial vulnerability estimate. However, the NHSCFA and stakeholders have not yet been able to fully revise the assessment on the impact to fraud and are relying on the previous financial vulnerability methodology to provide an indication of the financial vulnerability. Furthermore, the pending implementation of Integrated Care Systems has generated new intelligence gaps on what threats and vulnerabilities this will generate.

Changes to the funding envelopes for National Tariff within the Data Manipulation strategic priority area during the pandemic have generated further significant intelligence gaps on what new threats and vulnerabilities these presents. All these changes have meant resources and focus has been aligned to understanding these new emerging areas for the next reporting period. The NHSCFA will be carrying out a thorough assessment of the current threats, vulnerabilities, and enablers to increase understanding and knowledge of the existing risks.

The second area, Procurement and Commissioning fraud has seen a further increase in the assessed financial vulnerability estimate. Procurement and Commissioning has maintained a 1% estimate of total spend. Therefore, this increase is attributed to the increase in spend. Procurement and Commissioning fraud has also seen the largest increase in reporting.

Although a proportion of this is attributed to Covid-19 related reports, the NHSCFA has seen an increase in the threat from mandate fraud. This occurs when the payment for a genuine invoice is diverted into a bank account controlled by a criminal or organised crime group. The increase in the threat from mandate fraud has resulted in the NHSCFA commissioning a mandate fraud prevention project in collaboration with the wider health group.

Conversely the NHSCFA has seen notably reduction of estimated financial vulnerability to fraud in two strategic priority areas; Patient exemption fraud and Optical contractor fraud of £53m and £46.2m respectively. With the financial vulnerability assessment conducted on activity data during a global pandemic, the cause of the reduction is difficult to determine with confidence. For example, the reduction of fraudulent prescription exemption claims within Patient Exemption fraud could be attributed to the ongoing behavioural change element of the Penalty Charge Notices issued under the Prescription Exemption Checking services. Yet, during national lockdown and the implementation of social isolation could have resulted in a reduction of transmission of common illness, thus reducing the need for prescribing medication. In addition, it could be an unknown or multiple factors contributing to the assessed reduction in financial vulnerability.

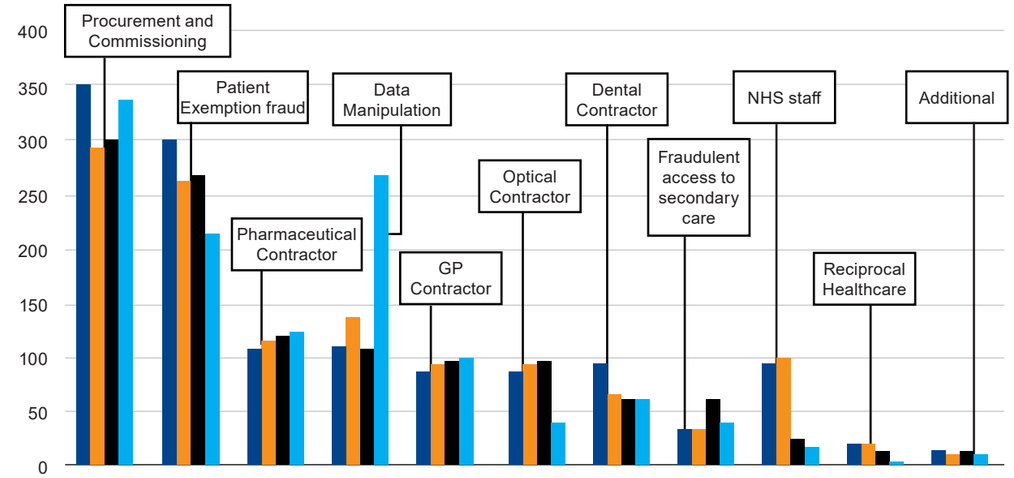
A similar scenario could be assessed for the reduction of financial vulnerability within Optical Contractor fraud. The financial vulnerability assessment is made on activity collating with national-wide closure of Ophthalmic practices due to COVID-19. The closure would reduce the amount of claims made, thus lowering the prospect of fraudulent behaviour. In addition, another cause could have been the ongoing post-payment verification work on claims submitted for valid activity. The presence of the post payment verification could have acted as a deterrence for the minority that could be submitting fraudulent claims.

The table below provides an overarching summary of the current financial vulnerability assessments compared to the last reporting period along with the amount of direct fraud referrals made to the NHSCFA. It is important to note that the figures presented below are assessments of the estimated financial vulnerability for fraud and not an indication of direct loss to fraud.

Strategic Priority Area	2021 – 2022 financial vulnerability estimate	2020 – 2021 financial vulnerability estimate	Difference (£m)	2021 – 2022 direct referrals to NHSCFA
Procurement and Commissioning fraud	£336.4m	£300.4m	+£36m	1193
Data Manipulation fraud	£249.1m	£107m	+£142.1m	15
Patient Exemption fraud	£214m	£267m	-£53m	1050
Community Pharmaceutical Contractor fraud	£122m	£117m	+£5m	155
GP contractor fraud	£100.1m	£93.8m	+£6.3m	160
Dental Contractor fraud	£61m	£61.3m	-£0.3m	83
Optical Contractor fraud	£38.7m	£84.9m	-£46.2m	24
NHS Staff fraud	£22.6m	£26.07m	£3.57m	2303
Intelligence Collection				
Fraudulent access to secondary care from overseas visitors	£39.3m	£56.7m	-£17.4m	308
Reciprocal Healthcare fraud	£1.94m	£12.06m	-£10.14m	11
Strategic Oversight				
Additional area (NHS Bursaries and NHS Pension fraud)	£12.7m	£14.9m	-£2.2m	
Total	£1.198bn	£1.14bn	+58m	

A breakdown of the four-year financial vulnerability per thematic area is depicted below. Where a measurement exercise has not taken place or a comparative assessment is not available, the baseline financial vulnerability percentage is 1% of the funding allocation or expenditure. Therefore, areas such as Procurement and Commissioning fraud, Community Pharmaceutical Contractor fraud and GP Contractor fraud have the financial vulnerability assessment of 1% of the total funding or expenditure. Increases in financial vulnerabilities within these three areas are an indication of increase in funding or expenditure and not an assessed increase to fraud.

Thematic areas - Estimated financial vulnerability 2019 - 2022



	Procurement and Commissioning	Patient Exemption fraud	Pharmaceutical Contractor	Data Manipulation	GP Contractor	Optical Contractor	Dental Contractor	Fraudulent access to secondary care	NHS staff	Reciprocal Healthcare	Additional
2019	351	251.7	108	114	88	82.4	93.5	35	94.6	21.7	14.4
2020	291.4	259.5	114	136	91	82.9	65.9	35	98.2	20.8	10.9
2021	300.4	267.7	117	107	93.8	84.9	61.3	56.7	26.07	12.05	14.9
2022	336.4	214	122	269.6	100.1	38.7	61	39.3	21.9	1.95	12.7

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 this increase in transparency, the NHSCFA and its stakeholders are better informed of the landscape and as such; more capable to direct resources to mitigate against potential vulnerabilities.

Introduction

Intelligence and fraud are never static and are constantly evolving. New methodologies are employed, new technologies utilised, and new vulnerabilities exploited. Conversely so is the response to fraud. Loopholes are closed, system weaknesses strengthened, and criminals prosecuted. With this fluid nature, it is important that the strategic priority areas also remain fluid so that the right resources and activity can be focussed in the right area at the right time.

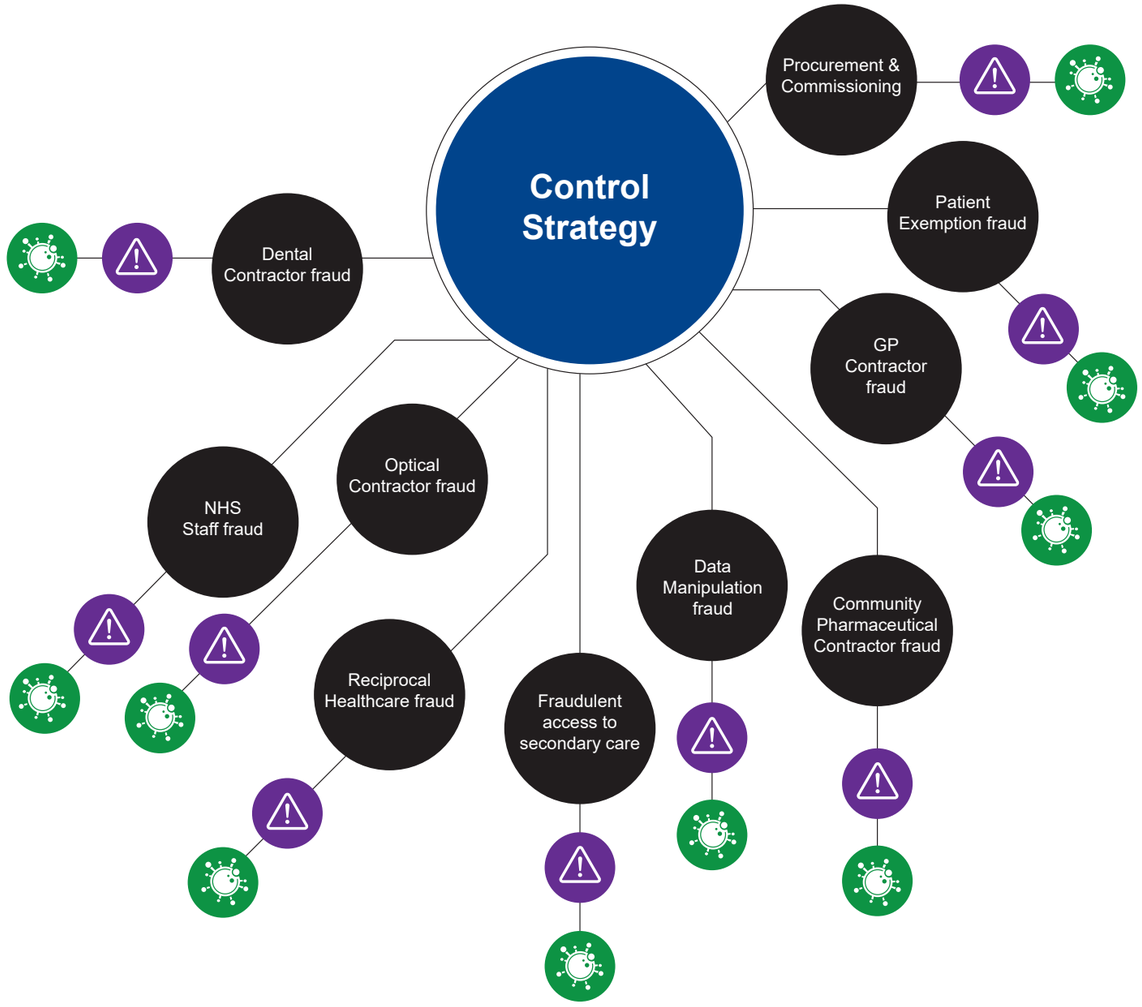
The NHSCFA and its partners have conducted a review of the strategic priority areas during this reporting period. As a result of the review, the strategic priorities have been realigned to the current fraud landscape.

Whilst the budget for the NHS in England continues to rise to meet demands and pressures, it is even more important to ensure that the focus is in the right areas.

In addition to the review, the NHSCFA has evolved its Control Strategy approach further enhancing the response to fraud. This approach consists of an annual review of the intelligence picture, risk landscape and financial vulnerabilities. Together these inform the newly designed integrated planning approach and annual strategies to bring all stakeholders and partners together in a more collaborative manner.

Control Strategy approach

Here we have the depicted infographic of our Control Strategy approach with Covid-19 and cyber enabled fraud that cut through and cover all the thematic fraud areas.



Throughout this document assessments and judgements are presented based on the foundation of intelligence. It is important to note that intelligence is not fact or evidence, but hypothesis and inferences drawn from the best available information at the time of writing. It is the responsibility of every member of the public and NHS employees to remain vigilant and report any suspicions to the Local Counter Fraud Specialist or direct to the NHSCFA. By reporting suspicions, we can all assist in ensuring the NHS remains one of the top health services in the world.

The impact of COVID-19

To reduce transmission of COVID-19, prevent an unprecedented strain on public services and save lives the government introduced a multitude of restrictions and emergency funding streams. With the NHS at the epicentre of the government's plan to tackle the pandemic, it was directly affected. Including through the procurement of supplies, COVID-19 testing and delivery of the vaccine programme.

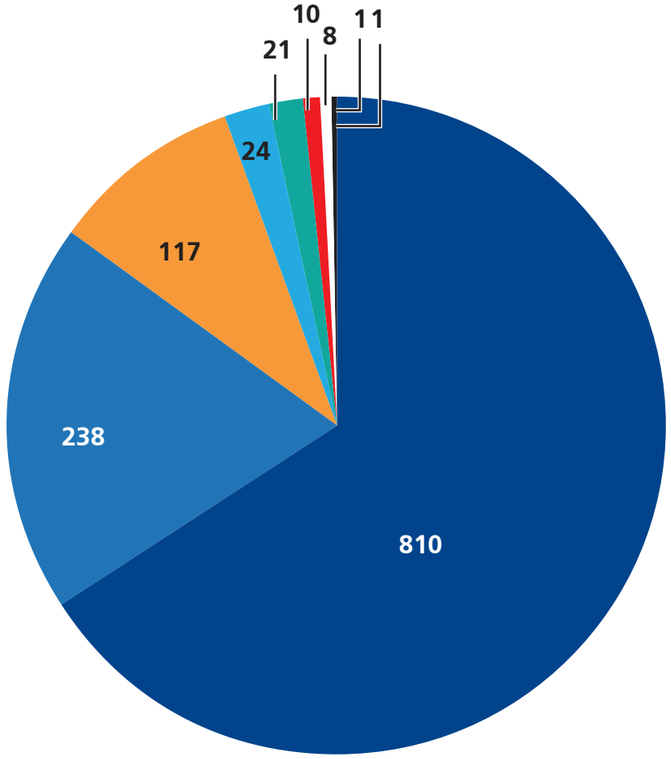
Although the majority of the population perceived the crisis as a time to unite and protect others, some saw it as a financial opportunity. During times of widespread trepidation, opportunistic criminals and organised crime groups (OCGs) adapted and developed exploitative schemes targeted not just at the NHS in England but also the public themselves.

Part of the NHSCFA's response to the pandemic included production of the COVID-19 threat assessments. During February 2020 and February 2022, a total of 22 assessments were produced to inform the counter fraud community and central government of new emerging areas of concerns. These include;

- 186 identified threats within the current thematic areas
- 66 non fraud related warnings
- 32 updates on changes to methodologies or vulnerabilities
- Geo-spatial analysis of allegations made direct to the NHSCFA

The assessments supported the NHSCFAs stakeholders, local government and the wider government in proactively detecting and deterring fraud in the NHS throughout the pandemic. Additionally, the fraud reference guide was adapted, and essential post assurance work was conducted through stakeholder collaboration.

COVID-19 reporting by thematic area April 2021 to March 2022



- Procurement & Commissioning fraud (810)
- NHS Staff fraud (238)
- Patient Exemption fraud (117)
- GP Contractor fraud 24
- Community Pharmaceutical Contractor fraud (21)
- Fraudulent access to Secondary Care (10)
- Dental Contactor fraud (8)
- Data Manipulation fraud (1)
- Reciprocal Healthcare (1)

How do we calculate fraud vulnerability?

NHSCFA assesses how financially vulnerable the current strategic priority and intelligence collection areas are to fraud. In order to achieve this the NHSCFA adopts a different approach depending on the nuances of the area. However, broadly speaking the two main ways are:

1. Loss measurement exercise - These take the form of an in-depth analysis and measurement of a particular area to provide a statistically robust percentage of how much of the funding / reimbursement is vulnerable to fraud. Out of the two methods the NHSCFA has the highest confidence in this method.

2. Comparative loss assessment - Where the NHSCFA has not directly measured an area, we are reliant on vulnerability percentages derived from partners or stakeholders to use. These may not be 100% comparable so therefore the NHSCFA has the lower confidence in them.

Within the SIA a consistent language has been used across thematic areas when assessing the probability and uncertainty. The ‘probability yardstick’ defines the language applied to the range.

In using the probability spectrum, the NHSCFA has taken into account, the source, the age and reliability of the material used and any extenuating factors to form the assessment. No particular weighting is attached to specific factors but rather a comprehensive approach is 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 increased by 19.77% compared with 2020 to 2021, it is therefore a realistic possibility that reporting has begun to recover to former levels. Reporting could stabilise as restrictions are withdrawn and the plan of living with COVID-19 continues.

* Pink sections of the chart indicate COVID-19 reports

Compared to 2020-21, the NHSCFA received an additional 942 reports. The pink sections of the bar chart display the additional reports which were COVID-19 related during the collection period.

From April 2021 to July 2021 and September 2021 to January 2022 reporting slowly increased. This correlates with the roll out of the COVID-19 vaccination programme, flu vaccination programme and later the COVID-19 booster programme. However, reporting in both fraud and COVID-19 related reports began to decline by January 2022 as 90% of the population had received their first COVID-19 vaccine and on the 27th of January all Plan B restrictions were lifted, followed by an end to travel restrictions and self-isolation requirements.

Reports regarding procurement and commissioning saw the largest increase in reporting. The increase of 88.47% can be partially attributed to the large amount of COVID-19 related scam telephone calls, texts and emails which were reported to the NHSCFA and categorised under third party usage in procurement and commissioning. It should be noted that the majority of the COVID-19 related scams were focussed on defrauding members of the public rather than the NHS directly. However, reporting relating specifically to mandate fraud also saw an increase.

Top 4 reported areas

Top four thematic areas by number of referrals received in 2021-22

NHS staff fraud

2303

Reports received

Procurement and Commissioning fraud

1193

Reports received

Patient Exemption fraud

1050

Reports received

Fraudulent access to secondary care from overseas visitors

308

Reports received

In total 5,706 (373 reports relate to allegations not relating to fraud and were appropriately disseminated) reports were received, 85.1% of all reports relate to the top 4 thematic areas, with the remaining 14.9% relating to the other areas.

It is assessed that this is indicative of how transparent and visible suspicious activity is within the areas and not necessarily the scale of possible fraudulent activity.

NHS Staff fraud has experienced an increase in reporting when compared with the previous

year. This reporting figure is close to the number of allegations received in 2018-2019 and potentially indicative of reporting returning to pre-pandemic levels. An increase in reporting could potentially be attributed to staff returning to workplaces and COVID-19 restrictions being removed, thus enabling greater oversight of activities.

Additionally, reporting on Procurement and Commissioning fraud has almost doubled in comparison to the previous period, a majority of which are linked to COVID-19. For example, the high number of COVID-19 related scam telephone calls, texts and emails reported which relate to vaccination passports. Patient Exemption fraud also saw a 7.14% increase in reporting this period, just over 11% of which are determined to be COVID-19 related.

However, fraudulent access to secondary care from overseas visitors has continually seen a year on year decrease from 2017-2018 to 2021-2022. From 2019-2020 this could potentially be connected to the travel restrictions enforced during the pandemic. The decrease also coincides with the introduction of the legal requirement for relevant bodes to recover funds in advance of providing treatment to a chargeable patient in 2017 (unless the care was urgent or immediately necessary).

Procurement & Commissioning

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

£336.4m
vulnerable from an expenditure of £30.4 billion

In response to the COVID-19 pandemic an enormous volume of goods and services were procured for the NHS, potentially driving the increase in the financial figure vulnerable to fraudulent activity this year.

In March 2020 the Cabinet Office highlighted that during unforeseen circumstances of extreme urgency, like a pandemic, public bodies were entitled to directly procure goods and services without competition. Potentially increasing the number of staff who failed to declare any conflicts of interest or abused their position, including by accepting bribery in the pre-tender phase.

It is possible some suppliers provided a lesser service post tender, or external fraudsters received payments for false invoices because less scrutiny was applied. During the pandemic NHSE&I informed providers and commissioners to pay invoices promptly to prevent cash flow becoming a barrier , in addition to the increased pressure on the NHS and relaxation of usual procurement processes, these combined changes may have inadvertently increased the risk of mandate fraud. COVID-19 also increased reliance on electronic communications.

It is realistic to suspect some off-framework agencies successfully inflated temporary staffing prices without scrutiny. The risk to patient safety would have made overriding price caps easy to justify, with the pandemic also providing opportunities for collusion when placing agency staff in vacant shifts.

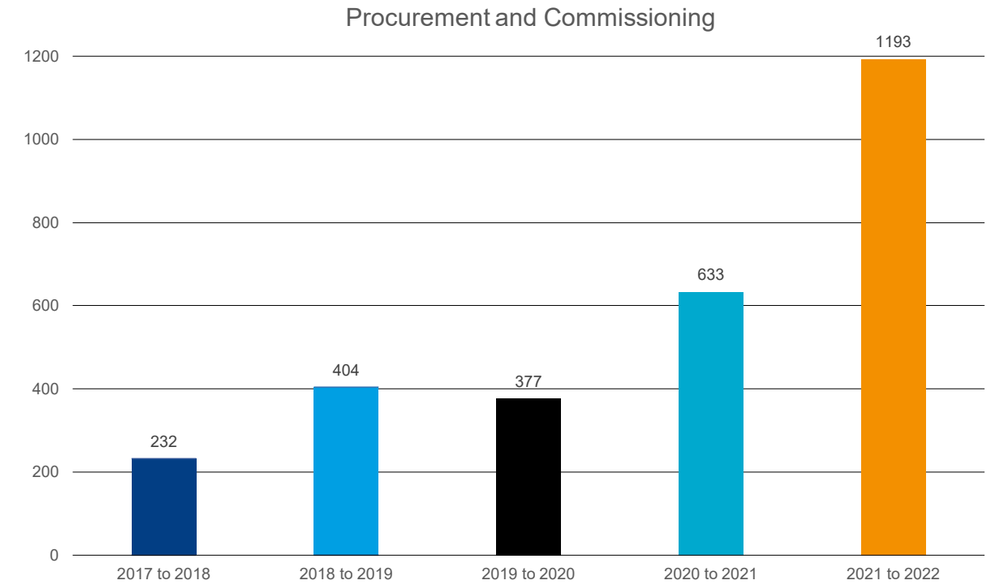
The Health and Care Bill which seeks to join health and social care was in the report stage within the House of Lords on 16/03/2022. Clinical Commissioning Groups (CCGs) would be abolished, and Integrated Care Systems (ICSs) would be legally entrenched, led by an NHS Integrated Care Board (ICB) and Integrated Care Partnership (ICP) . The NHSCFAs assessment previously highlighted vulnerabilities in these changes which may increase collusion and abuse of position within procurement.

Finally, an increase in attempted and prevented mandate fraud has resulted in the commissioning of a mandate fraud prevention project by the NHSCFA which involves improving communications, identifying underreporting and preventing financial losses.

Information reports received for Procurement and Commissioning

As previously mentioned, the substantial increase in reporting can be partially attributed to the large amount of reports relating to scam telephone calls, texts and emails.

The change in the number of fraud reports (allegations) received in relation to Procurement and Commissioning contractors from 2017-2018 to 2021-2022:



88.47%
increase in referrals compared to last year

Data manipulation fraud

Data manipulation includes falsifying data to meet targets, increase revenue or hide undesirable outcomes. Previously encompassing Payment by Results (PbR) and National Tariff fraud.

£249.1m
vulnerable from an expenditure of £89.9 billion

However, in response to the COVID-19 pandemic the PbR activity based funding was suspended and replaced by Block Contracts, which continue into March 2022.

It is likely that unidentified providers may inadvertently be allocated similar funding to when they were falsifying PbR activity.

This could occur as a result of block contract allocation being originally based on a sum equivalent to the provider's historical monthly average expenditure.

There could also be an increase in CCGs overspending without any intent to set up a contingency fund. Under block contract funding, CCGs would be comfortable with the knowledge that their providers can claim additional funding from DHSC.

To avoid surpassing the NHS four-hour maximum waiting time it is highly likely some hospitals may record patients as having been discharged or moved, even though they are still present in A&E. Thus, avoiding detection in the Weekly and Monthly A&E Attendances and Emergency Admissions collection.

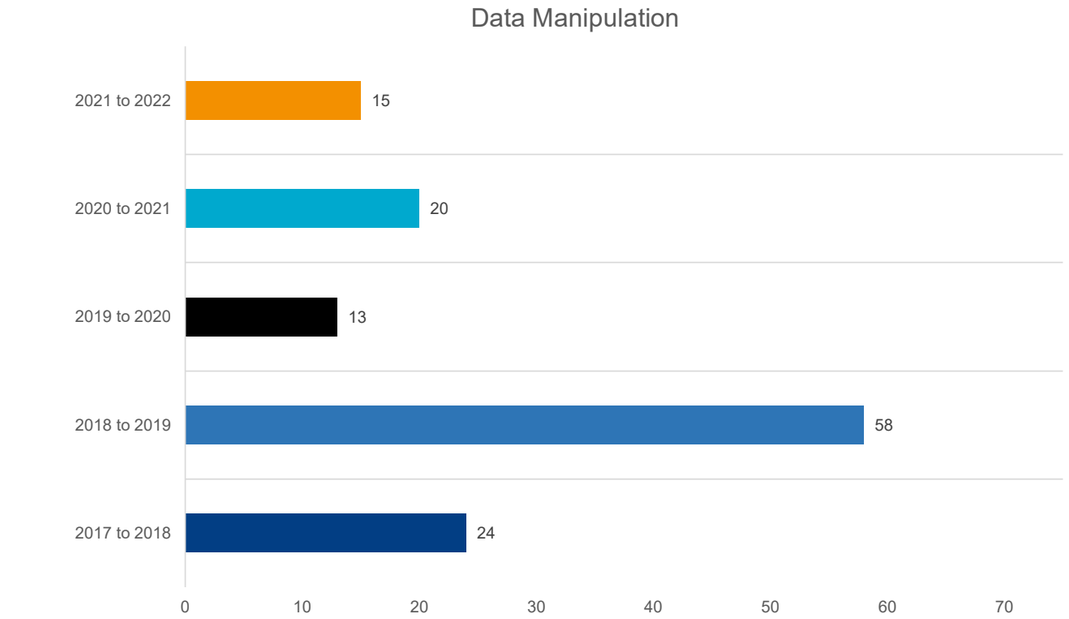
Staff with the ability to dispute Key Performance Indicator (KPI) figures increase the risk of the data being manipulated. KPIs are intended to measure whether a service is meeting its contractual requirements efficiently, but they are also an incentive for providers to earn part of their contractual value through targets. Alternative figures may be used to replace the originals and manipulated to meet targets or hide undesirable outcomes.

Additionally, the NHS payment scheme is predicted to replace the National Tariff. On 16/03/2022 the Health and Care Bill encompassing this change was in the report stage within the House of Lords. Once the Bill receives Royal Assent, the NHSCFA and its partners will review and assess the potential threats, vulnerabilities and enablers related to the new scheme. The NHSCFA will also look to assess the threats and vulnerabilities which emerged within the funding packages during COVID-19.

Information reports received for Data Manipulation

Data Manipulation is believed to be underreported to the NHSCFA, potentially because of the complexity of the processes, or the difficultly in distinguishing between fraud and error in the area. The estimated financial vulnerability has significantly increased this year, but cannot be attributed to reporting or intelligence. It has increased as a direct result of an increase in budget and a longstanding loss percentage which is no longer applicable to the area as the structure and processes have changed.

The change in the number of fraud reports (allegations) received in relation to data manipulation from 2017-18 to 2021-22:



25%
decrease in referrals compared to last year

Patient Exemption fraud

Patient Exemption fraud covers a range of abuses within NHS services that require payment upfront in return for access, including within Prescriptions, Dental and Optical. In addition, it covers general fraud conducted by patient's, such as onward sales of prescribed medication.

£214m
vulnerable from an expenditure of £9.6 billion

During COVID-19 some patients potentially found it easier to falsify symptoms or impersonate another for prescription medications that they did not need. GP surgeries offered limited face to face appointments, instead providing telephone, online and video consultations. Conversely, non-urgent dental care was deferred and routine eye care suspended. The decrease in the financial amount vulnerable to fraud is likely to be correlated with the reduction in routine care.

Patients partaking in the onward sale or supply of prescription medication is highly likely , including via online platforms. Medication may also be sold overseas on lucrative markets. During the pandemic it is assessed that patients would not have been able to tamper with the electronic prescriptions in comparison to paper ones. The Electronic Prescription Service (EPS) allowed pharmacies to receive prescriptions directly from a prescriber, including after remote consultations.

However, there is a realistic possibility some patients, including repeat offenders, deliberately avoided paying for medication or medical services and remained undetected. Additionally, it is a realistic possibility that some staff may be confused which benefits qualify. Pharmacy staff are not required to validate or advise on exemption criteria's, with the responsibility residing with the patient. Therefore, human error continues.

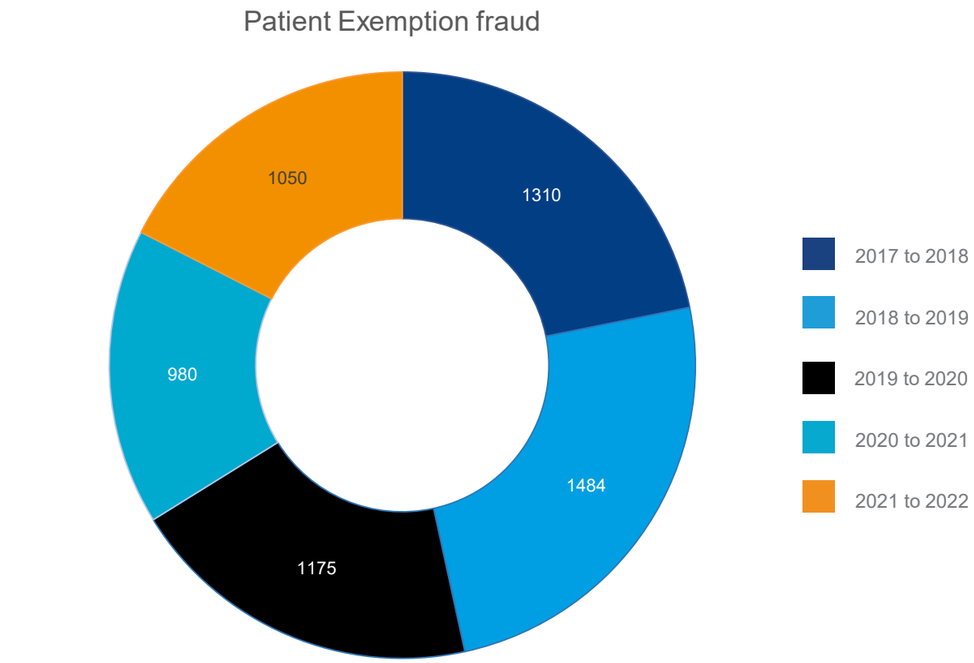
If the consultation to align the upper age for prescription exemptions with the State Pension age is implemented further confusion may be caused. But the expansion of RTEC use and resumption of PECS will improve detection of suspicious exemption claims and potentially deter mis-claimers.

Information reports received for patient fraud

The increase in reporting compared with the previous year is potentially linked to COVID-19 restrictions being slowly lifted and the return to routine care.

The change in the number of fraud reports (allegations) received in relation to patient fraud

from 2017-2018 to 2021-2022:



7.14%
increase in referrals compared to last year

Community Pharmaceutical contractor fraud

£122m
vulnerable from an expenditure of £12.2 billion

Pharmaceutical Contractor fraud involves the Falsification or Exaggeration of Services, as well as collusion. Due to the COVID-19 pandemic, temporary suspensions were introduced for patient signatures on prescriptions and for the consent required from patients for electronic repeat dispensing. Additional income was also offered to pharmacists dispensing over a certain threshold. Therefore, it is likely that some pharmacists exaggerated their activities to receive higher monthly payments, including claims for the uncollected prescriptions of university students or over prescribing in bulk for care homes.

COVID-19 also provided an opportunity to allow some pharmacists to claim for 'ghost patients' within the vaccination programme and to intentionally split transactions when supplying NHS Lateral Flow Device (LFD) home testing kits. Additionally, during the height of the pandemic, it is likely that a number of pharmacists could have used volunteers to deliver prescriptions to shielding patients or falsified deliveries entirely, but still claimed reimbursement for an outsourced deliver.

The intelligence suggests that a small minority of pharmacists may have offset revenue shortfalls by claiming reimbursement for COVID-19 related upgrades which were not undertaken. Reports suggest that some pharmacists could have delayed the submission of claims for drugs dispensed to receive a higher reimbursement. Enabled by the monthly price fluctuation being advertised in advance.

Finally, there is a realistic probability that pharmacists and manufacturers will potentially collude to mutually increase profits. Reports suggest that some manufacturers could have charged an excessive amount for a pharmaceutical special item and then split the profit.

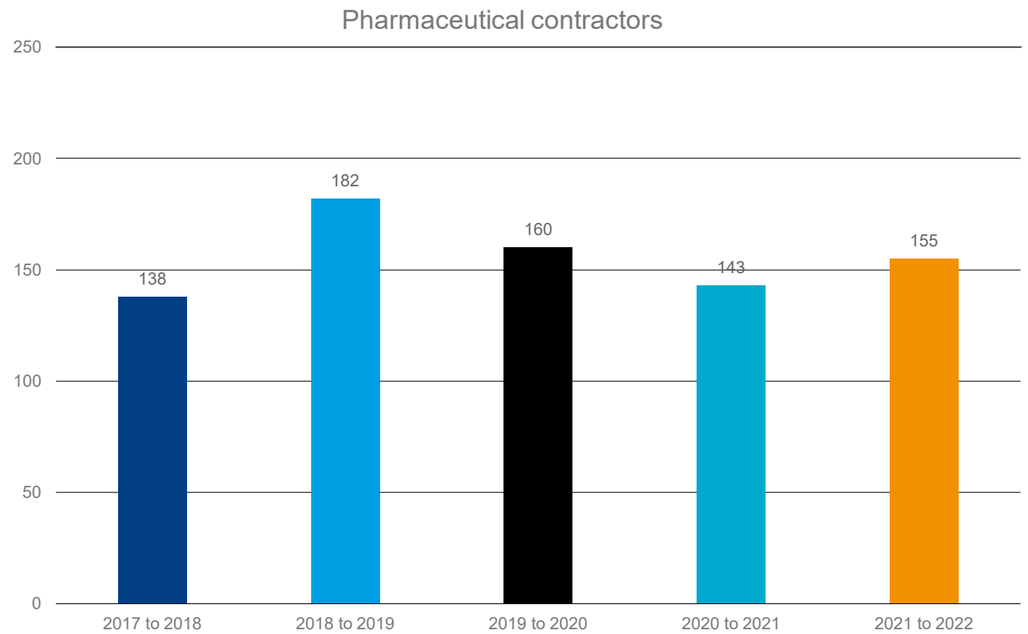
Others are believed to have made 'kickback' payments to pharmacists in exchange for ordering products from them above alternative manufacturers.

From 01/04/22 the government will cease to provide universal symptomatic and asymptomatic testing to the general public for free, therefore a decrease in NHS LFD related manipulations is expected.

Information reports received for Pharmaceutical contractors

Reporting may have increased due to the introduction of various new processes which were required during the pandemic, for example those relating to LFDs, COVID-19 vaccines and prescription deliveries. Similarly, the financial figure vulnerable to fraud may have experienced a legitimate increase because of these new revenue streams, as well as potentially exaggerating those certain costs.

The change in the number of fraud reports (allegations) received in relation to Pharmaceutical contractors from 2017-18 to 2021-22:



8.39%
increase in referrals compared to last year

General Practice (GP) contractor fraud

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.

£10.1m
vulnerable from an expenditure of £10.1 billion

As a result of national lockdown regulations there were reduced opportunities to obtain recreational drugs in Europe. Therefore, the European Monitoring Centre for Drug Addiction (EMCDDA) reported an increase in the use of prescription drugs at the beginning of the COVID-19 pandemic. Organised crime groups (OCG) activity in this area could have been fuelled by the increase in demand and will potentially continue under normal social settings due to the additive nature of these drugs. It is therefore a realistic possibility that OCGs operate in the onward supply or sale of prescription medication. Intelligence suggests non-existent or deceased patient details have been used by GPs when prescribing medication for onward trade. OCGs may fraudulently obtain prescriptions, or even collude directly with GPs themselves.

It is likely that a small minority of GPs could manipulate their contracts to increase profit. The reliance upon GPs to ensure accurate record keeping and declarations to secure funding potentially enables manipulations. For example, keeping accurate patient lists – which account for the majority of income received by a GP practice each year, approximately £159.61 per patient. Additionally, a lack of assurance processes to authenticate patient lists likely allows some practitioners to deliberately fail to remove former patients from their lists, resulting in increased Global Sum payments.

There is a realistic possibility that practice employees may knowingly or unknowingly be complicit in supporting contract manipulations. The staff member may not directly benefit, but could potentially register ghost patients, or intentionally fail to remove patients from surgery lists.

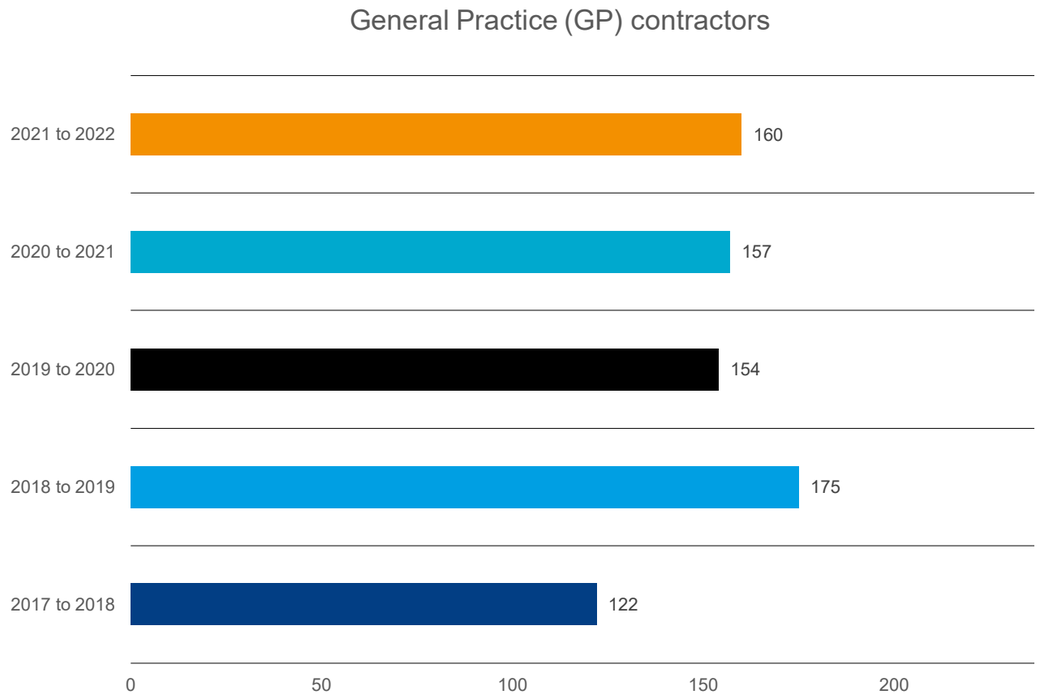
As the country moves towards living with COVID-19, an increase again in face-to-face appointments with patients is highly likely. This could see an increase in reporting within this area due to patients being present, seeing and reporting activity themselves.

Information reports received for General Practice (GP) contractors

The financial amount vulnerable to GP contractor fraud increased this year because a 1% fraud rate is applied to the total spend. Therefore, as the budget increased so did the

estimated loss. This loss is based on the results of a loss analysis exercise completed in 2018/19 where a fraud rate between 1%-3.5% was determined, as the budget increased so does the estimated loss. Reporting also increased this year, with the predominant theme determined to be the submission/ creation of false claims, some of which relate to COVID-19 vaccine.

The change in the number of fraud reports (allegations) received in relation to General Practice (GP) contractors from 2017-18 to 2021-22:



1.91%
increase in referrals compared to last year

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.

£61.8m
vulnerable from an expenditure of £2.6 billion

The COVID-19 pandemic resulted in the suspension of routine dental treatment. During the 2020 - 2021 period, contractual agreements stated no financial penalties would be incurred as long as a targeted percentage of Units of Dental Activity (UDA) and Units of Orthodontic Activity (UOA) were achieved.

This could have enabled manipulation and encouraged the fraudulent submissions of claims by contractors in order to meet or exceed their quota. Additionally, further fraud could have been enabled due to restricted contact with patients, including the suspension of patient signatures on dental treatment forms which could have allowed for fraudulent claims and reduced patient assurance.

It is highly likely that contractors claimed for treatment against patients who are recently deceased, those who have moved areas or those who received simple treatments; but altered the records to appear as more complex courses of treatment, known as Upcoding. If contractual targets are not met, the contractor could be penalised through the clawback of funds, therefore encouraging false claims.

Practice employees could be complicit in fraud due to the potential consequences of poor performance negatively affecting the practice financially. As the General Dental Service (GDS) contract is commissioned with the lead practitioner, owner or a corporate body, pressure from senior staff or contractors to commit fraud is possible. This is enabled by internal assurance procedures and lack of independent oversight, for example audits of contractor claims are usually performed by the practice manager.

Patients could potentially collude with those performing their treatment to receive it at a free or reduced cost. An exemption from treatment charges could be claimed, whilst paying a reduced cash cost to avoid detection. The performer then goes on to claim a higher banded treatment with the NHS. Alternatively, lack of public understanding of how NHS dental treatment and charges operate results in unknowing complicity.

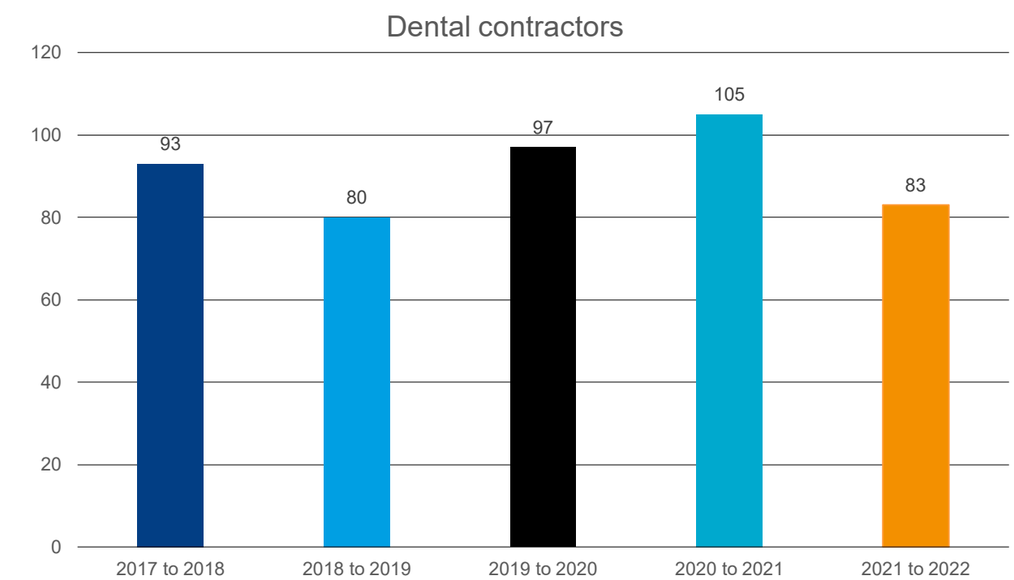
Looking ahead, possible changes to the NHS dental contract are being discussed with the

British Dental Association, although any confirmed changes have not yet been published. As the dental contract dictates precisely how NHS funding and claims are paid, any alterations will greatly impact on potential fraud within this area. The NHSCFA will continue to assess developments in this area.

Information reports received for dental contractors

The decrease in both the financial vulnerability figure and the reporting levels within dental contractor fraud are believed to be linked to the reduction in the dental services provided, as well as the temporary contractual agreements introduced during the pandemic.

The change in the number of fraud reports (allegations) received in relation to dental contractors from 2017-18 to 2021-22:



20.95%
decrease in referrals compared to last year

Fraudulent access to secondary care from overseas-visitors

£39.3m
is a conservative estimate of the vulnerability to fraud

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 that they are chargeable, or an NHS staff member has abused their position to facilitate the fraudulent access.

It is a possibility that the year-on-year decrease in reporting correlates with the downward trajectory in travel to the UK, this is also likely to be linked to the decrease in the financial figure vulnerable to fraud. The reduction likely occurred as a direct result of travel restrictions due to COVID-19, also possibly acting as a deterrent to those wishing to travel for NHS healthcare without charge. Additionally, ward restrictions prevented Overseas Visitor Managers (OVMs) walking freely around hospitals, therefore, it is a realistic possibility that their ability to converse with and advise medical staff was limited.

NHS services including testing, treatment and vaccinations for COVID-19 are free to all patients after the virus was incorporated into schedule 1 of the NHS Regulations in January 2020. However, it is highly likely that some patients used a false identity to obtain vaccines, this could be as a direct result of no requirement for an ID to be presented prior to receiving vaccines.

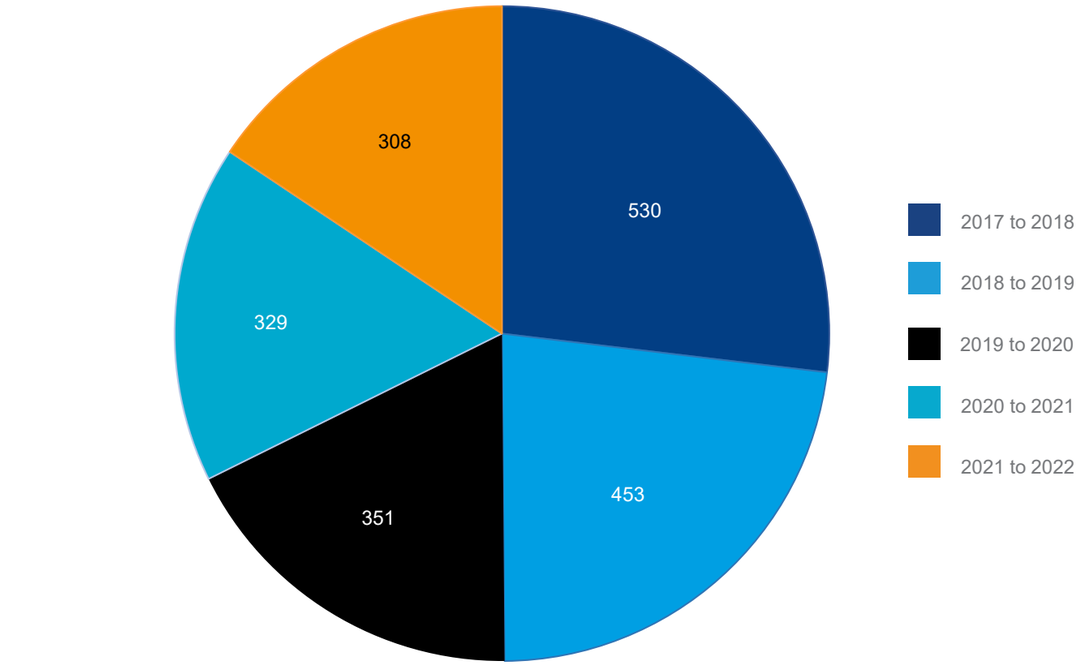
It is highly likely that some individuals use their visitor visa to access the NHS without charge. Therefore, an overseas visitor with a visitor visa, legitimate NHS number and false address may routinely access care without charge.

The high cost of healthcare across the globe is potentially encouraging some people to enter the UK with the specific intent of seeking NHS maternity care without charge. As maternity care cannot be delayed for an advance payment, patients are likely to use a false identity or leave the UK soon after treatment to avoid payment.

There is the possibility that as travel resumes to pre-pandemic levels fraudulent access may see an increase in reporting. From 18/03/22 all COVID-19 travel restrictions were removed by the government and quarantine hotels were to be withdrawn towards the end of the month. Additionally, COVID-19 testing will no longer be free to all from 01/04/22. The NHSCFA will continue to monitor the reporting levels as the landscape changes.

Information reports received for fraudulent access

The change in the number of fraud reports (allegations) received in relation to Fraudulent access to the NHS from overseas visitors from 2017-18 to 2021-22:



6.38%
decrease in referrals compared to last year

Optical contractor fraud

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

£38.7m
vulnerable from an expenditure of £225m

In response to COVID-19, routine eye care was suspended and the optical workforce were proposed for safe redeployment elsewhere in health and social care. There was also the potential of furlough uptake, although hospital optometrists received their normal income. Additionally, to reduce the pressure on GPs and hospitals, some of the workforce were required to maintain urgent and essential eye care. The decrease in the financial vulnerability figure is potentially related to the suspension of routine eyecare.

In response to COVID-19, practice staff were advised by an optical Standard Operating Procedure (SOP) to remotely triage or risk assess patients unless a face-to-face appointment was essential. However, as appointments were dealt with via telephone there is a realistic possibility that claims were submitted for services which were not actually provided.

It is a realistic possibility that some opticians falsely claimed to have dispensed items or conducted activity to receive a reimbursement/fee as routine services resumed. This could be as a direct result of a temporary suspension in the requirement for patient signatures on electronic General Ophthalmic Services (GOS) forms during COVID-19 or having to meet 40% GOS contributions to maintain income support.

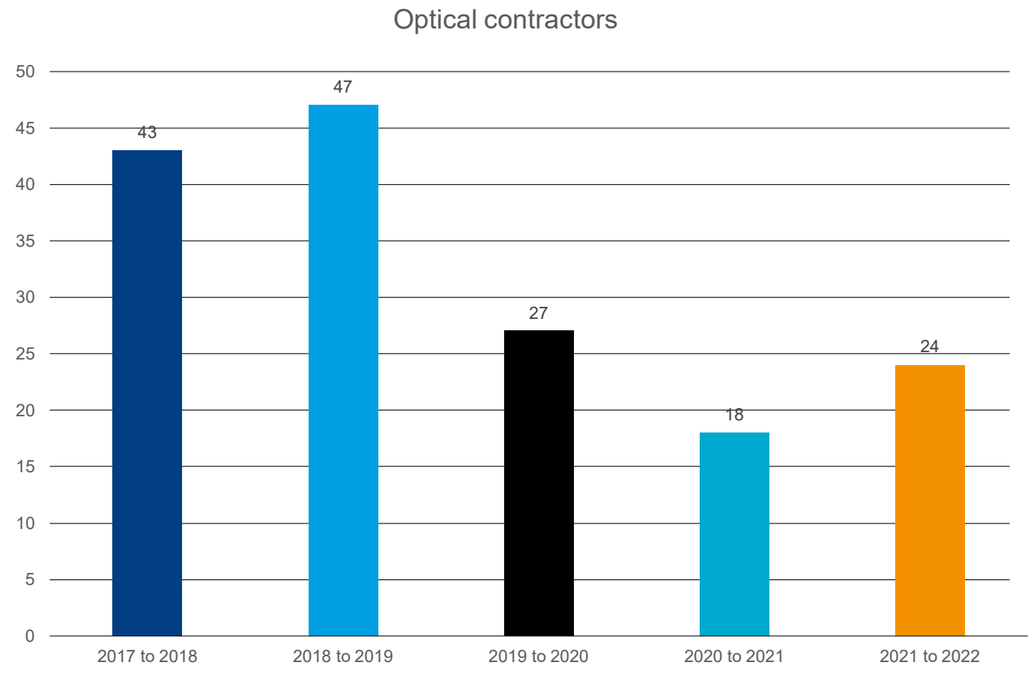
Similarly, some staff may even go as far as to submit false claims for providing treatment to deceased former care home residents. Others may charge both the NHS and the patient for the same private appointment or prescription. However, each month a sample of selected GOS contractors partake in a post-payment verification (PPV) administered by NHSBSA to review the accuracy of claims.

It is likely that as optical contractors return to routine care there will be testing or dispensing irregularities, including dispensing more glasses than required or recalling patients for check-ups sooner than clinically necessary. High reporting has previously been experienced in this area and as opticians are already reporting an increase in sight impairments/loss compared with before the pandemic it may increase again.

Information reports received for optical contractors

The suspension in routine eye care may have inadvertently caused an increase in reporting as those working in optical settings began to develop initiative ways to manipulate the new optical processes. Alternatively, when routine care resumed fraudulent activity may have increased to achieve the required GOS contributions and maintain income support.

The change in the number of fraud reports (allegations) received in relation to optical Contractors from 2017-18 to 2021-22: Spend decrease and reporting increase.



33.33%
increase in referrals compared to last year

NHS staff fraud

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

£22.5m
vulnerable from an expenditure of £10.95 billion

The COVID-19 pandemic has affected the NHS in a seismic way, including some staff working from home, others being redeployed, recruitment of volunteers, retired individuals returning to work, the introduction of the COVID-19 Digital Staff Passport and the requirement for some to self-isolate or shield.

As the landscape changed some NHS Staff applied existing fraud methodologies to new circumstances. These potential exploitations include presenting a false positive COVID-19 test or long term COVID-19 symptoms to acquire full paid sickness leave yet work elsewhere instead. It is also highly likely that some staff were working 'on call' for the NHS or shielding with full pay, yet performing private work for agencies etc.

It is extremely likely that a small number of staff inflated their hours by continuing to claim for shifts which were not performed. Especially with the realistic possibility of a manager colluding with an employee over timesheets, or even altering pay bands to enhance pay. Certain services were reduced during the pandemic and some trusts had web-based systems to record shifts.

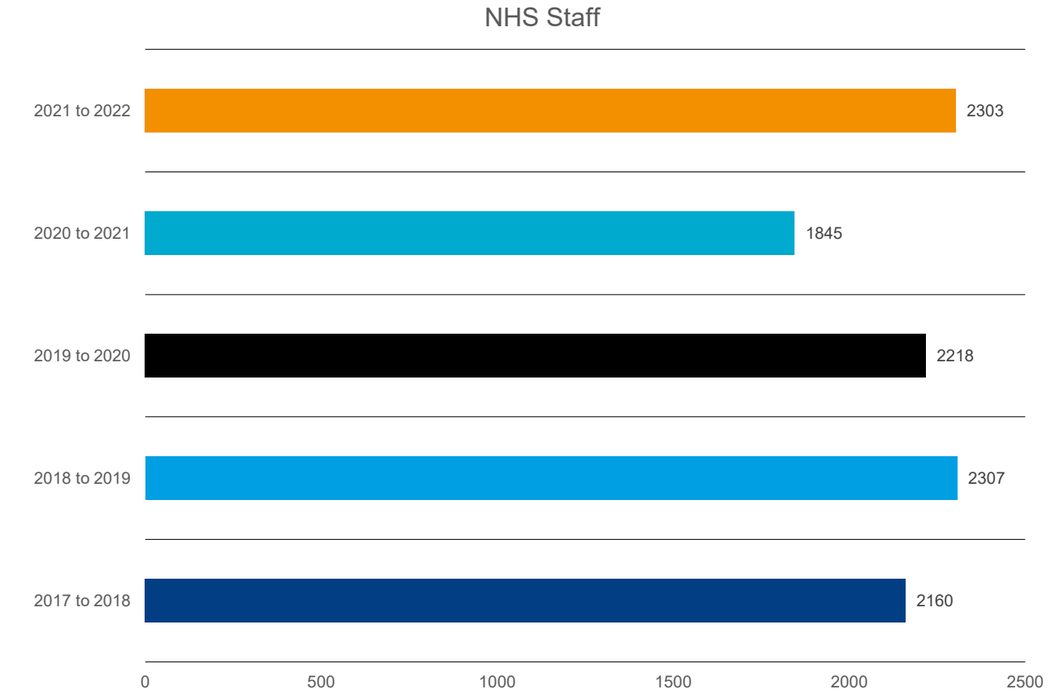
There is a realistic possibility that a fraction of NHS staff appropriated COVID-19 vaccines, including to sell or administer to associates. Additionally, it is almost certain that a number of NHS staff have been falsifying vaccine records for individuals in exchange for payment. The government's mandate to NHSE&I includes the priority commitment for the recruitment of an additional 50,000 NHS nurses. A large recruitment drive could directly increase reporting on applications containing false information, for example fake references or providing counterfeit documents. The NHSCFA will continue to monitor reporting for any increase directly correlated with the recruitment drive. Additionally, the 2021 3% pay uplift for NHS staff and a further potential increase in 2022 may naturally increase the amount that is financially vulnerable to manipulation rather than an indication of increased risk.

Information reports received for NHS staff

A majority of the reports received around NHS staff fraud relate to income and hours manipulations, including working elsewhere, manipulating timesheets and sickness. The increase in reporting within NHS staff fraud could therefore be attributed to a combination of

the COVID-19 related changes mentioned above. However, the financial figure vulnerable to fraudulent manipulation decreased this year. This is most likely due to the figure of potential loss being derived from non-basic pay expenditure and sickness absence, but not staff expenditure in its entirety.

The change in the number of fraud reports (allegations) received in relation to NHS Staff from 2017-18 to 2021-22:



24.82%
increase in referrals compared to last year

Reciprocal healthcare fraud

Reciprocal healthcare (RH) 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 RH agreement.

£1.94m
vulnerable from an expenditure of £126.4m

There is a realistic probability some individuals visiting the EU without travel insurance would have required treatment for COVID-19, resulting in an application for a retrospective EHIC/ GHIC instead of a Provisional Replacement Certificate (PRC).

It is also a realistic possibility that patients may falsely claim to be insured by the UK through presentation of a British passport when seeking care in Norway. The new GHIC and most legacy EHICs are no longer valid in the European Economic Area (EEA), but a British passport can be used in Norway to access entitlements. Thus, allowing individuals who are not ordinarily a resident in the UK to access healthcare without charge whilst in Norway.

It is highly likely that the reliance on the EHIC/GHIC card holder to notify the NHSBSA of a change in circumstances enables fraudulent use. It is also highly likely that these individuals continue to use the cards when they move abroad, including for planned care. There is also the potential for a deceased individual's card to be used by another.

It is possible for EHIC/GHIC holders to share their genuine card with an individual of a similar age who is not entitled to care without charge. It is also a possibility that an individual who is insured by the UK may share their personal information with an associate, so they are able to request a PRC via a telephone call. Most EHIC/GHICs and PRCs are lacking in security measures to confirm a patient's identity, including no facial image.

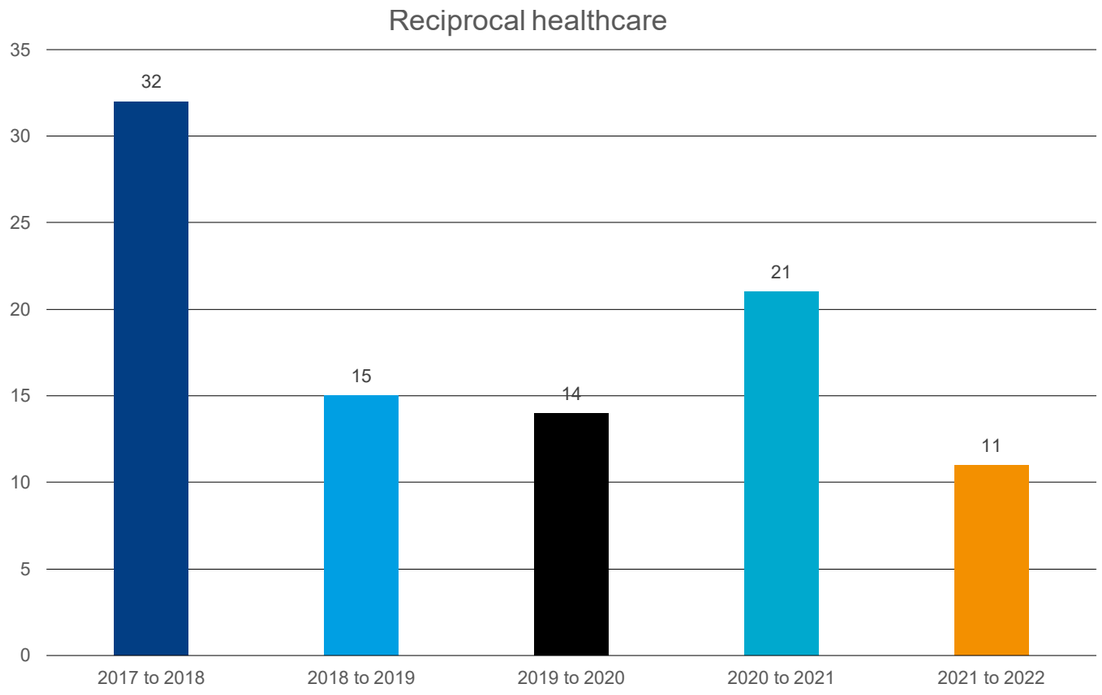
The NHSCFA is almost certain that some GHIC/EHIC applicants submit false addresses, documentation, or another's personal information to falsify ordinary residence in the UK. This is because an applicant's address is used to confirm their eligibility / residency.

A new reciprocal healthcare agreement between the EU and UK was introduced on 31/12/2020, it includes the GHIC, a new UK EHIC and the legacy EHIC. As the GHIC will gradually replace the EHIC for most individuals in the UK, the NHSCFA is likely to see an increase in GHIC specific fraud reports alongside a reduction in EHIC. Also, the return of travel to pre-pandemic levels may result in increased fraudulent activity. The NHSCFA will continue to monitor reporting for both trends.

Information reports received for reciprocal healthcare

The increase in reporting in 2020-21 could potentially be attributed to the media attention around the UKs exit from the EU and a GHICs introduction. However, this year's decrease is more fitting for the downward trajectory in travel and the reduced financial vulnerability.

The change in the number of fraud reports (allegations) received in relation to reciprocal healthcare from 2017-18 to 2021-22:



47.62%
decrease in referrals compared to last year