CONTINUING HEALTHCARE AND PERSONAL HEALTH BUDGETS

Continuing healthcare continues to be an area of high expenditure for clinical commissioning groups (CCG). Consequently, CCGs need to have robust controls in place and clear visibility of costs incurred, to make the best use of the resources available.

Continuing healthcare

NHS continuing healthcare is care and support that is arranged and funded solely by the NHS, and is therefore free at the point of delivery. To be eligible, the patient must be over 18 and assessed by a team of healthcare professionals (a multi-disciplinary team) as having a primary health need.

What are the fraud risks associated with continuing healthcare?

- **Fraud by the provider of the care commissioned.** This might include under provision of services (eg not providing the hours of care contracted for), over-charging for services provided. Failure by the provider to report a change in circumstances in the care situation. This can vary from a change in the care provision; patients becoming deceased; becoming an inpatient at a hospital or transferred to another care provider; and submitting additional invoices for equipment when the equipment is already included in the costs of the care being provided.
- **Fraud by the patient.** This may include misrepresenting their clinical needs.
- **Insider enabler fraud.** Staff manipulating the system to allow care homes to receive payments for a patient who may be deceased or no longer receiving continuing healthcare.
- **Conflicts of interest.** Staff having undeclared interests in care providers which could be perceived as being in a position of influence. This could also include collusion between a member of staff and the care provider to create false or inflated invoices for care provided.
- **Inadequate reconciliation of invoices.** Including invoices not being reconciled to care plans, for example additional invoices submitted by the provider and automatically paid when below an agreed limit without any verification or validation. Inadequate controls to identify duplicate invoices; reduced care packages following re-assessment; reduced charges during hospital stays; over-charges for out of area patients; and high cost / variable care packages.

  Risks can also occur where there are jointly-funded care packages and there is little or no reconciliation in relation to the council invoices to provide assurance that the CCG has paid the correct/agreed amount for the care packages.

Communication

Often there is a multi-disciplinary team from different organisations involved in the patient's care plans. Although not a fraud risk in itself, there is a financial risk of overpayments being made to the care provider when changes to the care plan are not communicated in a timely manner.

Similarly, if care plans are not reviewed in a timely manner, this could lead to potential overpayments.

Personal health budgets

Anyone in receipt of NHS continuing healthcare can ask for their funding to be provided through a personal health budget. A personal health budget is an amount of money to support a patient's identified healthcare and wellbeing needs. Patients are assessed and their needs are captured in a care plan. The care plan is used to calculate the patient's indicative budget.

Personal health budgets can be managed in three ways:

- A notional budget held by the CCG.
- A budget managed on the individual's behalf by a third party.
- A cash payment to the individual (a 'healthcare direct payment').

The personal health budget can be used for a range of things to help the patient meet their health and wellbeing goals, for example therapies, personal care and equipment. The budget cannot be used for emergency care or care which the patient would normally receive from a family doctor. In addition, the budget cannot be used to fund gambling, debt repayment, alcohol or tobacco, or anything unlawful.

What are the fraud risks associated with personal health budgets?

- **False or exaggerated claims of care requirements.** This would include a patient falsely claiming that they require care, using false identities or exaggerating the amount of the care that they require.
- **Fraud directly against the service user by someone managing their funds.** This would include misappropriation of funds made by way of direct payment to the service user, perhaps by a family member or other trusted person.
- **Fraud by the provider of the care commissioned directly by the service user.** This might include under provision of services (eg- not providing the hours of care contracted for), over-charging for services provided, and duplicate invoicing to multiple invoices to NHS teams and or local authorities.
- **Insider enabler fraud.** Staff manipulating the system in the form of creating direct payments for a fictitious person or increasing payments (to a genuine recipient of direct payments) who may be the staff member's friend or relative.
- **Absence of monitoring.** Ineffective monitoring increases the risk of false, inflated or vague invoices being accepted.

If you would like any further advice on how to prevent continuing healthcare or personal health budget fraud, please contact your Local Counter Fraud Specialist.

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