“Available” Next Steps in Invoice Validation (2025) (which are also “reasonably practicable” and cheap, when a purchaser and provider are both already using FDP)

The entire NHS data infrastructure is being poured into the Palantir Federated Data Platform as mandated by the Secretary of State (including all the budget, including the DH/E share of the £600m infrastructure cash announced by the PM a few weeks ago, and including the Single Patient Record) in the Ten Year Plan. This decision creates newly available next steps in invoice validation which are reasonably practical, much cheaper than the status quo, and “available”.

“Invoice Validation” is one way[1] that one part of the NHS gets paid by another for providing care. In short, it is a hospital accountant saying “please pay us for providing treatments A, B, C to person X from address Y with NHS number Z”.

The use of patient data in this way on both sides has been subject to a “temporary” permission for decades, simply because there have always been practical barriers to doing it better. We’ve written on the topic in 2017 and 2015 updated in 2018 (which is where all the background to this topic is if you need it).

The question upon receiving an invoice between NHS bodies is simply “*should we pay this?*”. It is not a complex question, it is just a lot of administration with broad capacity for mistakes. It’s lots of accountants doing careful accounting, and no doctors doing doctoring.

The 2014 Care Act made it a criminal offence to provide false information – to say you have provided care you haven’t – in addition to the professional obligations and requirements to keep accurate records (which is also the obligation to not keep inaccurate records) which will be in the Single Patient Record and the Federated Data Platform.

The Department of Health in England has mandated the Federated Data Platform and can be an impartial arbiter (as previously was NHS Digital). Like existing QOF algorithms, the FDP code should be published for audit, allowing periodic checks by hospitals and ICBs to ensure DH/E accountability. As DH/E controls FDP/SPR processing, it can better prevent errors and misrouting of invoices than siloed Trust or ICB systems. FDP and SPR validates patient responsibility and care provision in one step, unlike the current manual, duplicative process.

The Federated Data Platform can already ensure that ICBs only see and pay invoices for patients they are responsible for, where care has been provided and not already paid for. Each provider’s FDP instance processes patient data to meet ICB standards, preventing duplicate or incorrect billing. Trusts and ICBs can't manipulate the system without falsifying records, which is already illegal (and in an NHS where patients can see their care records, immediately visible).

As the medical records are already being entirely fed into FDP by the Trust, **the DH/E processing in the FDP (for the Trust) can create invoices only for care provided, and FDP only charges them to the ICB correctly responsible for paying for that care,**

[1] For example, most hospital care is provided by your local hospital and charged to your local ICB, and they may skip this entire process; but none of the other processes are covered by this note.

without any opportunity for double charging etc (as FDP would be responsible for the process and not incentivised to inflate/deflate costs). DH/E can use FDP as the neutral processor, getting checked each year by a random selection of purchasers and providers.

The FDP means an alternate method is available for invoice validation, one which does not involve identifiable patient data for those who do not already have it.

The current "temporary" s251 (NHS Act 2006) permission is reviewed every year, and every year it has to comply with s251 subsection 4 which says:

> (4) Regulations under subsection (1) **may not make provision requiring the processing of confidential patient information for any purpose if it would be reasonably practicable to achieve that purpose otherwise** than pursuant to such regulations, **having regard to the cost of and the technology available** for achieving that purpose.

As FDP continues to chew through the data infrastructure of NHS England, where a Trust and ICB both use FDP, as paid for and using products determined by DH/E, and where they rely on the s251 process for invoice validation, **that purpose is increasingly likely to be reasonably practicable to be achieved using FDP given the new technology available at effectively zero cost**.[2]

There are additional complexities on the horizon when NHS England merges into the Department of Health and Social Care resulting in the Secretary of State, responsible for approving s251 exceptions, also becoming joint data controller for FDP and (potentially) of the politically controlled centrally run Single Patient Record.

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[2] For the avoidance of doubt, writing this in July 2025, we assess the current breaches are likely to be zero other than any ICB which has fully embraced FDP and a local Trust that has fully embraced FDP and which uses s251 invoice reconciliation for treatments.