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Counter Fraud Authority

Strategic Intelligence Assessment 2026

Covering 2025-2026



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

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Foreword

I am proud to share the NHSCFA's Strategic Intelligence Assessment 2026. This document sets out the fraud threats facing the NHS in England and details how we are working to counter fraud, bribery and corruption to protect its vital resources.

The NHS budget reflects the extraordinary scale of investment this country makes in the health of its population. However, the NHSCFA has assessed that the amount of NHS funding vulnerable to fraud, bribery and corruption in England is estimated to be £1.301bn - a reduction of £45.06m compared with the previous year. But this reduction is not a signal to ease our vigilance, and we must continue to fight fraud in the NHS to protect patient care.

Without system integrity it is not possible to deliver good healthcare. Which is why understanding the threats and risks is so important, as you can reduce loss and take control. Therefore, maximising the use of data and data analytical techniques remains a core priority. In an increasingly digitised environment, and with the continued evolution of AI, I believe this is the key to unlocking further savings and strengthening our ability to detect and prevent fraud.

Between 2025 - 2026, we received 8,048 reports alleging fraud, bribery and corruption against the NHS — an increase of almost 19% compared with the previous year. It is worth noting that this increase in reporting is something which can be viewed positively. Greater reporting means greater visibility, and visibility is the foundation of effective counter fraud work.

Underpinning this assessment, as with everything we do, is our commitment to being a genuinely intelligence-led organisation. We are now better equipped than ever before to identify emerging and prevalent threats at local, regional and national levels to allocate resources where they are needed most.

The landscape in which we operate continues to evolve at considerable pace, and this assessment reflects that complexity.

The government's 10 Year Health Plan, the merger of NHS England and DHSC, the restructuring of Integrated Care Boards, and the rapid growth of artificial intelligence present a significant opportunity for fraudsters to adapt quickly and exploit these changes. The threat is not static, but neither are we. That is why collaboration - within the NHS, across government, and with international partners - remains central to what we do, and why we will continue to expand our reach in the fight against fraud.

The introduction of the corporate criminal offence of 'Failure to Prevent Fraud' under the Economic Crime and Corporate Transparency Act 2023, marks an important development in the legislative landscape. This places a new and important responsibility on NHS bodies to ensure that robust fraud prevention measures are in place - and the NHSCFA is here to support them in doing exactly that.

There will always be fraud. Some individuals will look to exploit opportunity wherever it exists, and so robust processes to prevent, detect and respond to fraud and corruption are not optional - they are essential. Finding fraud is a good thing. If we do not find fraud, we cannot fight it. The identification of fraud should be viewed as a positive and proactive achievement, not a source of reputational concern. There is no single solution. Addressing fraud requires a holistic response - incorporating detection, prevention and enforcement.

This assessment is our commitment to that purpose. It is also a reflection of the dedication and professionalism of everyone across the counter fraud community who contributes to this vital work. Together, we will ensure that NHS funding is used for the reason it exists: to protect and improve the health of the nation.



Alex Rothwell, Chief Executive Officer

Executive summary

- For 2025 - 26, the amount of NHS funding vulnerable to loss through fraud, bribery, and corruption in England is estimated to be **£1.301bn**, a reduction of **£45.06m** compared with the SIA 2025.
- This equates to 0.66% of the Total Managed Expenditure for the NHS for 2025 - 2026 of **£198.095bn^a**, a decrease compared to the previous year.
- The NHSCFA received **8,048** reports in 2025 - 26, with **7,645** aligning to the main thematic areas, showing an increase of almost 19% when compared with 2024 - 2025.
- The areas which received the highest number of reports were **NHS staff fraud, patient exemption fraud, procurement and commissioning fraud, and fraudulent access to NHS care from overseas visitors**, accounting for approximately 84% of reporting.
- The five highest financial vulnerabilities are **procurement and commissioning fraud (£442.7m), patient exemption fraud (£268.76m), pharmaceutical contractor fraud (£138.49m), GP contractor fraud (£114.41m) and fraudulent access to NHS care from overseas visitors (£96.5m)**.
- Regional reporting remains highest in **London, the Midlands** and the **North East and Yorkshire**, indicating a continued concentration of reporting in areas with high population density.
- The NHSCFA's approach towards being an intelligence-led organisation has been improved over the last few years, as we now analyse fraud at local, regional and national level, both strategically and tactically, allowing for the allocation of resourcing based on demand, including for emerging and prevalent trends.
- Overall, the assessment shows a **reduction in estimated financial vulnerability alongside rising reporting volumes**, suggesting a continued need for focused prevention and enforcement activity.

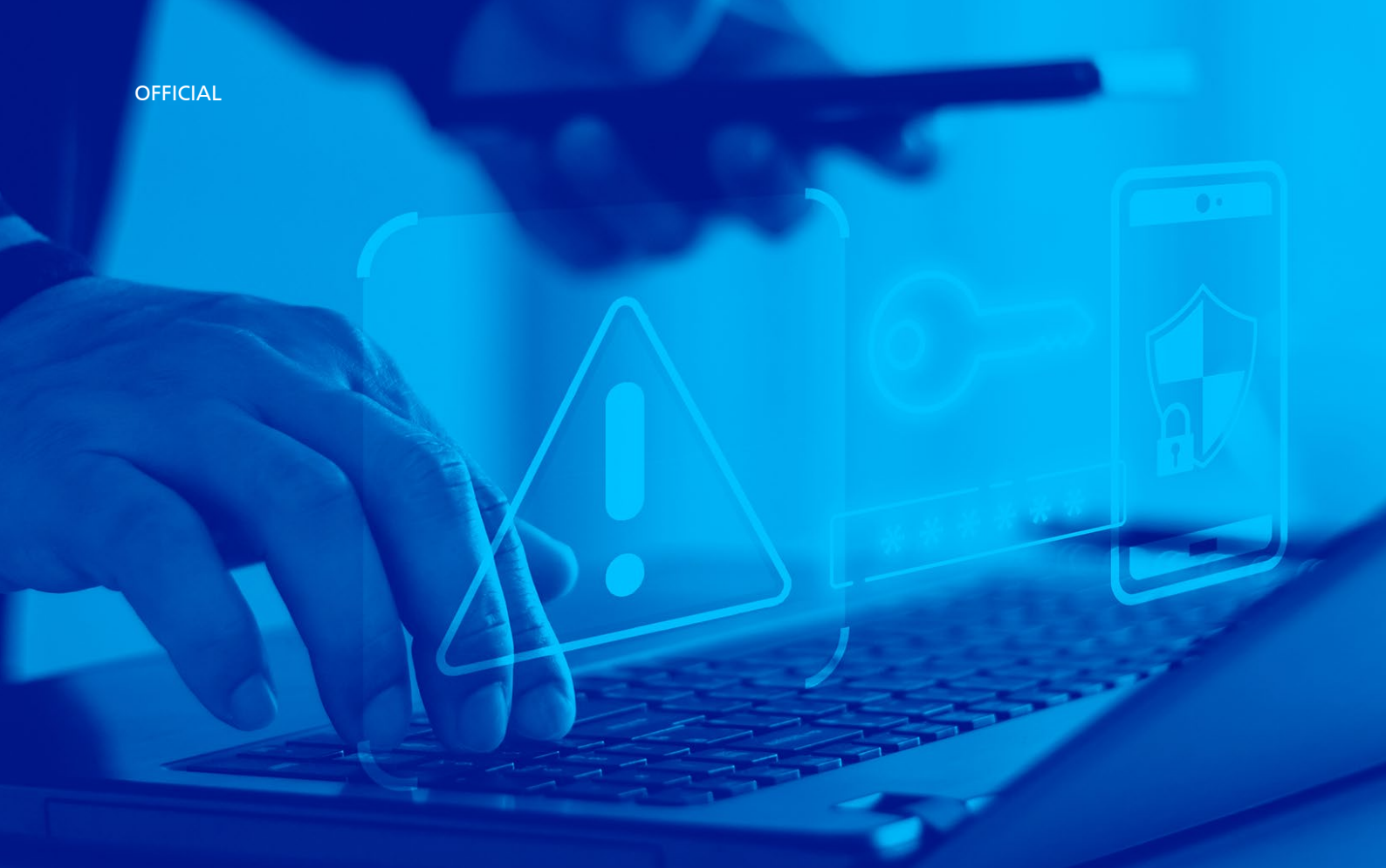
^a Total NHS revenue department expenditure limit (RDEL) as per financial directions



Thematic area	2025 - 2026 financial vulnerability estimate ^b	2024 - 2025 financial vulnerability estimate	Difference (£m)	2025 -2026 reports received by the NHSCFA
Procurement and commissioning fraud	£442.7m	£392.5m	£50.2m	665
Patient exemption fraud	£268.76m	£230.2m	£38.56m	1820
Pharmaceutical contractor fraud	£138.49m	£135.2m	£3.31m	297
General Practice (GP) contractor fraud	£114.41m	£116.7m	‑£2.27m	222
Fraudulent access to NHS care from overseas-visitors	£96.5m	£98.1m	‑£1.58m	544
Optical contractor fraud	£91.22m	£90.7m	£0.57m	45
Data manipulation fraud	57.36m	£189.1m	‑£131.69m	14
Dental contractor fraud	£56.96m	£57.6m	‑£0.62m	176
NHS staff fraud	£28.17m	£27.8m	£0.41m	3753
NHS bursary fraud	£3.69m	£3.8m	‑£0.12m	23
NHS pension fraud	£2.09m	£4.1m	‑2.01m	74
Reciprocal healthcare fraud	£0.99m	£0.8m	£0.17m	12
Total	£1.301bn	£1.346bn	‑£45.06m	7645^c

^b Financial vulnerability estimates run a year in arrears to reporting data; therefore, this assessment will include 2024 – 2025 financial data and 2025 – 2026 reporting data

^c There are an additional 403 reports which did not align to a thematic area; therefore, the overall total is 8048.



Introduction

The Strategic Intelligence assessment (SIA) is produced to identify fraud threats and estimate the amount of NHS funding in England vulnerable to fraud, bribery and corruption annually on behalf of the Department of Health and Social Care (DHSC). This informs the NHSCFA and its stakeholders of the priorities for the year ahead by capturing established, emerging, and potential future threats.

The amount of NHS funding vulnerable to loss through fraud, bribery, and corruption in England is estimated to be £1.301bn, which is a decrease of around £45.06m when compared with the previous year. Additionally, this equates to 0.66% of the NHS budget for 2025 - 2026 of £198.095bn^d, which is also a decrease when compared to the previous year despite an increase in the NHS budget. By comparison, between 3-10% of healthcare spending in the United States of America is estimated to be lost to fraud.

Between April 2025 and March 2026, the NHSCFA received 8,048 reports, an increase of almost 19% compared with the previous year. Of these, 7,645 related to the twelve thematic areas. Each report was analysed as part of the intelligence cycle to identify emerging and prevalent trends for decision making.

As an intelligence led organisation, the NHSCFA has continued to monitor and document the ongoing fraud threat facing the NHS in England since 2016 - 2017. Although the SIA has remained a reliable and consistent source for the fraud community to draw upon, the format in which it is brought to the reader has evolved.

^d Total NHS revenue department expenditure limit (RDEL) as per financial directions

Within the previous SIA, the NHSCFA explained the place of the assessment within the intelligence cycle and the use of the National Intelligence Model (NIM)^e for strategic direction, laying the groundwork for what was to come during 2025 - 2026.

To complete this process, the SIA has been transformed for 2026, focusing instead on prioritising the impact on patient safety and the potential financial consequences of emerging and prevalent trends. Recent prosecutions within the thematic areas are presented as case studies and are followed by a PESTLE^f analysis and an assessment of reporting trends. The number of trends represented visually has been increased and a single horizon scanning section is included at the end of the assessment.

Furthermore, we remain responsible for estimating the amount of NHS funding vulnerable to fraud, bribery and corruption. We continue to strengthen these figures by collaborating with stakeholders, including DHSC, NHSBSA and our data science colleagues to harness the benefits of artificial intelligence (AI).

The SIA has, and will continue to, ensure a coordinated response to fraud, with the merger of NHS England and DHSC presenting an opportunity to raise the visibility of fraud, bribery and corruption at executive level.

^e The NIM is a process dependent on analysis and intelligence to allocate resourcing based on demand

^f Political, Economic, Social, Technological, Legal, and Environmental. As well as looking at organisational and media factors.



The NHSCFA's Thematic Area definitions

Pharmaceutical contractor fraud - Fraud relating to the falsification or exaggeration of services, as well as collusion.

Data manipulation fraud - Fraud through falsifying data to meet targets, increase revenue or hiding undesirable outcomes, including within A&E. It encompasses the '2023 - 2025 NHS Payment Scheme' (NHSPS ^g) and the four different payment mechanisms it governs within secondary care.

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

Fraudulent access to NHS care from overseas-visitors - The term 'fraudulent access to the NHS' refers to when a patient falsely represents themselves as entitled to NHS care without charge, fails to disclose they are chargeable, or when an NHS staff member abuses their position to facilitate fraudulent access.

General Practice (GP) contractor fraud - Fraud relating to the manipulation of income streams or activities that violate contractual terms perpetrated by either GPs or practice staff.

Reciprocal healthcare fraud - Fraudulent use of European Health Insurance Cards (EHICs), Global Health Insurance Cards (GHICs), Provisional Replacement Certificates (PRCs) and various other reciprocal healthcare arrangements. It also includes false representation during the application stage which can enable the card / certificate holder to benefit from a reciprocal healthcare agreement.

NHS staff fraud - Fraud relating to NHS staff who manipulate their income and hours, insider abuses, and false representation during application processes.

NHS bursary fraud - Fraud relating to monthly payments including the basic award, childcare allowance and non-means-tested grant. As well as one-off payments including the hardship grant, tuition fees and travel and dual accommodation expenses.

NHS pension fraud - Fraud relating to an individual who has falsified their circumstances to access an NHS pension or failed to notify of a significant change in circumstances resulting in an overpayment.

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

Procurement and commissioning fraud - Fraud relating to pre-tender activity, the commissioning process, post-tender activity and mandate fraud.

Patient exemption fraud - Fraud within the main NHS services that require payment upfront in return for access, including within prescriptions, dentistry and ophthalmology. It also encompasses the onward sale or supply of prescribed medication.

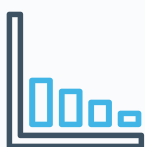
^g Rules, prices and guidance for the payment of services from providers of NHS funded healthcare



How do we calculate fraud vulnerability?

The Fraud Act of 2006 states a person commits an offence if they intend 'to cause loss to another or to expose another to a risk of loss'. Therefore, there does not need to be an actual financial loss for fraud to have occurred, exposing the NHS to the risk of loss is still considered to be fraud. We need to examine direct losses, as well as where the NHS may be at risk of loss. By capturing the estimated financial vulnerabilities in thematic areas, the NHSCFA and stakeholders can develop robust prevention strategies to prevent actual financial losses from fraud.

Various methods are used to calculate how financially vulnerable each thematic area is to fraud, bribery, and corruption and, in some instances, methods are combined. The loss method applied to a thematic area is dependent on stakeholder engagement, available data, landscape, process, and policy. Methods include:



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 the financial vulnerability, we are reliant on vulnerability percentages from others. These would not be 100% comparable, however they are the most relevant in the absence of a loss measurement exercise.

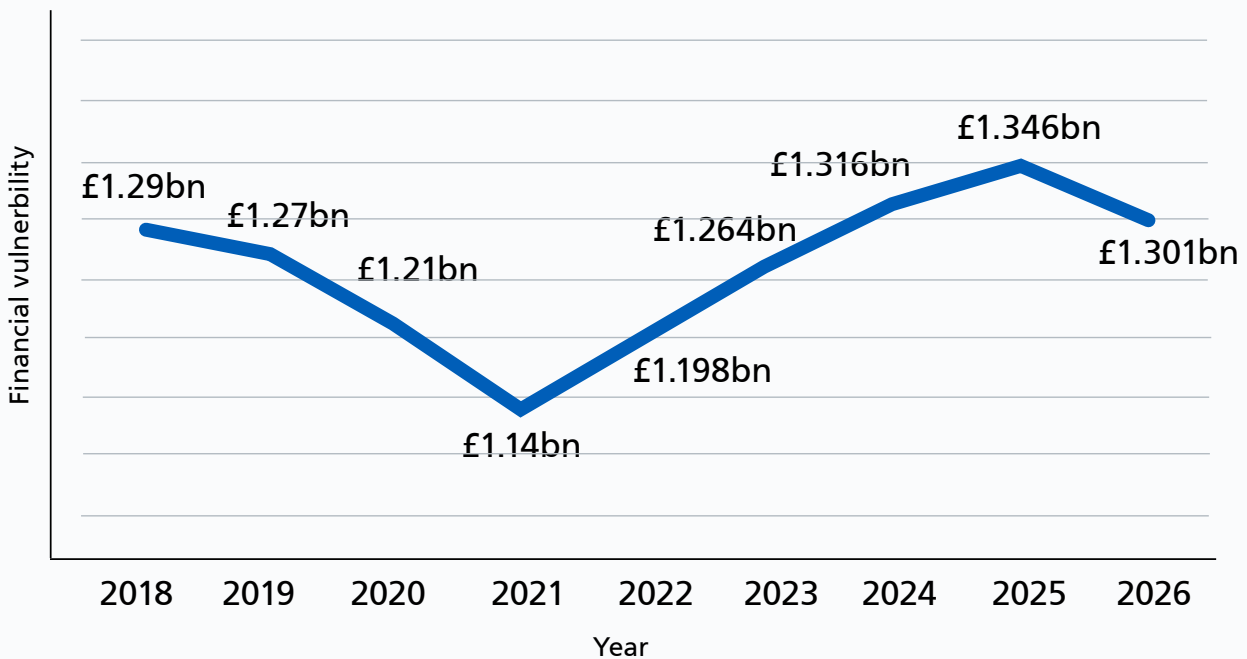


3. Collaboration with policy holders: Where a percentage of fraudulent activity is established through the study of recent data, legislation, and changes to landscape.



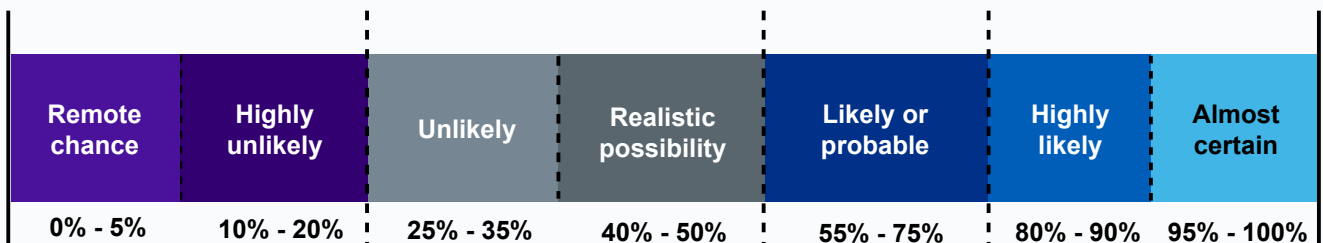
4. Baseline financial vulnerability: A legacy percentage of fraudulent activity which is applied due to no availability of a recent loss assessment, comparative loss assessment or guidance from policy holders. Improvements could be made through stakeholder collaboration.

Financial vulnerability 2018-2026



The probability yardstick

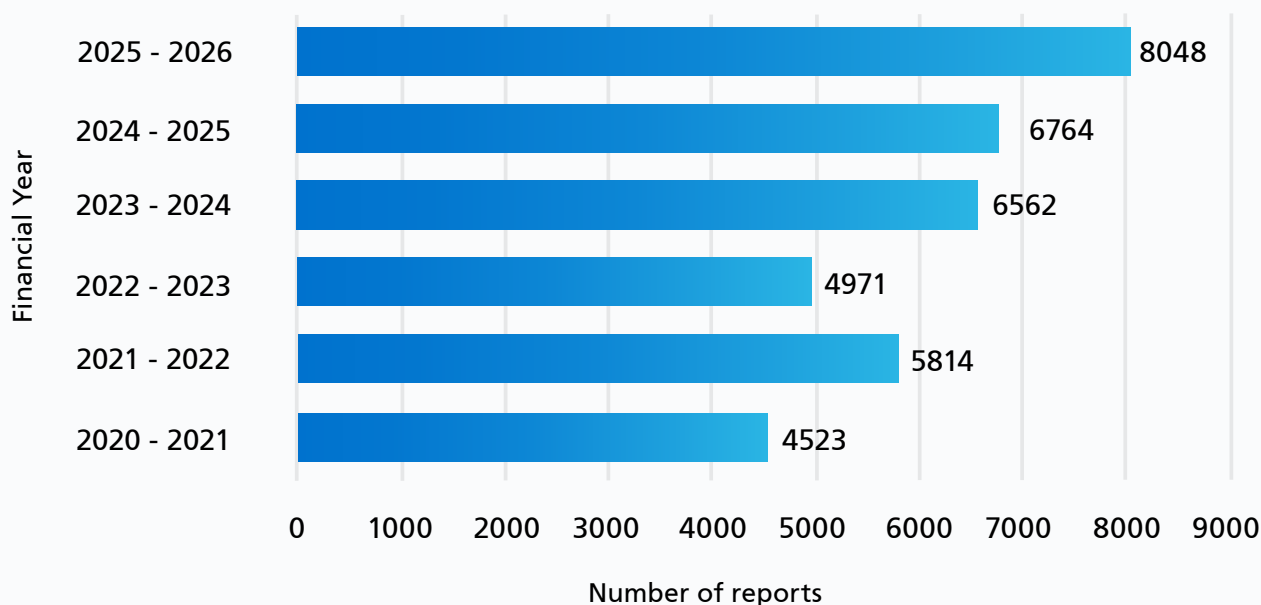
To ensure a consistent approach to assessing the probability and/or uncertainty of reports and intelligence detailed within the SIA, the NHSCFA uses the 'probability yardstick'. When using the measure of probability, the NHSCFA has considered the dependability and frequency of reporting around a prevalent or emerging modus operandi (MO).



Reporting trends

Between 2025 - 2026, the NHSCFA received a total of 8,048 reports alleging fraud, bribery, and corruption against the NHS in England. This is a significant increase when compared with the 6,764 reports received between 2024 - 2025.

Reporting by financial year from 2020 - 2021 to 2025 - 2026



There was an increase of 1,284 reports compared with 2024 - 2025. It is possible that this increase is linked to Artificial Intelligence (AI), as individuals may not have heard of the NHSCFA prior to this year and when searching for 'who to report an NHS crime to', the NHSCFA can be the first suggestion and also the first website on the list of results. Additionally, some reports received by the NHSCFA are believed to have been written by AI or with the assistance of AI. This does not mean the initial incident did not occur, but that AI has been involved in the drafting of the report instead of entirely organic intelligence.

Top four reported areas

Reporting has increased by almost 19% when compared with 2024 - 2025, an increase in all but three thematic areas: GP contractor fraud, data manipulation and NHS bursary fraud. Of the 8,048 reports received in 2025 - 2026 approximately 84% related to the top four thematic areas of NHS staff fraud, patient exemption fraud, procurement and commissioning fraud, and fraudulent access to NHS care from overseas visitors.



There is often a robust hypothesis behind high or increased reporting levels, for example staff fraud is more visible than other types of fraud and patient exemption fraud carries a high volume of patient interactions. If patient exemption fraud is further examined it can be assessed that economic pressures and increasing NHS charges may further increase both deliberate evasion of charges and potential error, driving higher levels of information reports to the NHSCFA. The onward trade of prescription medication for personal gain was the highest reported MO within patient exemption fraud and coincides with the emergence of GLP-1 antagonist receptor weight-loss medications being prescribable via the NHS, like Mounjaro and Wegovy.

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Failure to prevent fraud

The corporate criminal offence of 'Failure to prevent fraud' came into force on 09/01/2025 under the Economic Crime and Corporate Transparency (ECCT) Act of 2023. This offence made organisations accountable for fraud which was committed by 'a person associated with the body', for example an NHS employee, to benefit the organisation either directly or indirectly. However, if the organisation was the intended victim of the fraud, then it will not be held liable.

If large organisations, including some NHS organisations, profit from fraud, they can now be held to account through prosecution and if convicted receive a fine. An organisation is deemed to be large if at least two of the below conditions were met within the financial year prior to the year the fraud took place:



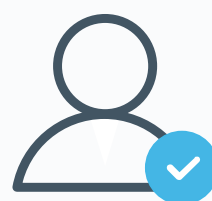
Turnover

£36m



Balance sheet total

£18m



Employee count

+ 250

The intention was for organisations to become more robust in anti-fraud measures, as if an organisation is prosecuted, it would be required to demonstrate reasonable fraud prevention measures were in place at the time the offence took place. Robust measures include a risk assessment and communication including training.

The Home Office advises NHS organisations to follow advice from the NHSCFA, and advisory guidance is available online at [Failure to prevent fraud offence | NHS Counter Fraud Authority](#). These webpages include information on reasonable fraud prevention procedures and the impact on NHS bodies. Additionally, the NHSCFA will be responsible for investigating allegations of failure to prevent fraud and Local Counter Fraud Specialists (LCFSs) should refer any allegations by completing a CFS13c form^h.

There is the potential that the failure to prevent fraud offence could apply to the thematic areas. For example, the area of data manipulation where fraud occurs through falsifying data to meet targets, increase revenue or hiding undesirable outcomes. As the NHS body and not the individual will usually benefit from the manipulation of data via an increase in revenue or averting fines, it is possible the offence could apply.

Ultimately, this corporate criminal offence should help to protect the NHS with improved anti-fraud measures. However, non-compliance could lead to reputational damage and undermine public and staff confidence. Regarding fines, the court must consider the impact on the performance of a public or charitable organisation.

^h [FAQs | Failure to prevent | NHSCFA](#)

Intelligence sharing with domestic and international counterparts

Healthcare is provided across the UK under the umbrella term of the NHS, with healthcare systems, services and entitlements differing across the four nations of England, Northern Ireland, Scotland and Wales. The NHSCFA is the health authority specifically leading in the fight against fraud, bribery and corruption against the NHS in England, which includes identification, investigation and prevention. It is accountable to DHSC and independent from other NHS bodies, both crucial components to ensuring the NHS and its patients come first.

As the NHSCFA is responsible for fraud against the NHS in England and, as an intelligence led organisation, transformation has taken place over the last few years to align to the National Intelligence Model and the Intelligence Cycle. We now analyse fraud at local, regional and national levels, both strategically and tactically, allowing for the allocation of resourcing based on demand, including for emerging and prevalent trends. Similarly, the Canadian anti-fraud centre breaks down fraud reporting and modus operandi (MO) geographically. There are also the nine Regional Organised Crime Units (ROCU) who tackle serious crime which crosses borders, including fraud and economic crime.

The same MOs are frequently seen across trusts, ICBs and regions, as well as different countries. Collaboration and the sharing of intelligence with counterparts is crucial to tackling economic crime, including with the Four Nations, and UKHSA to allow a coordinated response to healthcare fraud across the United Kingdom.

When comparing NHS fraud against a global setting, even though the UK's exact structure of healthcare is not mirrored elsewhere, we have seen similar manipulations among the Five Eyes countriesⁱ and in Europe. In addition, in the United States of America fraudsters are similarly reported to alter patient pathways, perform unnecessary treatments, make use of ghost patients, accept kickbacks and perform upcoding.

However, fraud does not only occur within healthcare, but it is also an issue within every industry and sharing knowledge of the fraud landscape, highlighting fraud through intelligence products and estimating financial vulnerability to fraud are all fundamental to rivalling fraudsters. Thus, in recent years we have increased engagement and dissemination of intelligence to bodies outside of the healthcare sector.

We will continue to collaborate and expand our reach in the fight against fraud, whilst also looking to bodies that experience similar trends and threats in healthcare, as well as those experiencing fraud more generally.

ⁱ Canada, Australia, New Zealand, America, and the UK

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Procurement and commissioning fraud

£442.7m
vulnerable from
an expenditure
of £36.5bn

The financial vulnerability estimate has increased by £50.2m. This is explained by a change in methodology and an increase in procurement spending.

Emerging trends and prevalent threats

There is a realistic possibility that criminals are impersonating NHS staff members for payment diversion fraud and salary sacrifice fraud. For example, there have been multiple occasions of staff having a salary deduction without their knowledge for electrical goods that are not received.

It is a realistic possibility that fraudsters are sending emails to trusts purporting to be a government department and prompting a log-on to a system or asking for payment. Fraudsters are also altering or selling Certificates of Sponsorship (CoS), offering to write applications and falsely advertising NHS jobs.

Top MOs in reporting



It is almost certain that the NHS receives fraudulent invoices relating to payment for services and goods not required or ordered. Fraudulent invoicing extends to legitimate suppliers claiming to have provided the contracted service yet providing less. Fraudulent attempts also extend to unsolicited direct debits.

It is almost certain that fraudsters use the legitimate details of NHS staff and suppliers, for example CEOs, and make contact via email addresses with suspicious domain names. Fraudulent emails, often purporting to be a GP practice partner, may also include foreign email domains. Additionally, some fraudulent requests have stated payment details of bank account sort codes from challenger platforms to traditional high street banks.

It is likely that conflicts of interest and due diligence concerns exist within the management and evaluation phase of the commissioning cycle. This includes those in positions of influence not declaring a relationship with a supplier ahead of awarding them the contract. Conflicts of interest can similarly exist when NHS practitioners are also directors of the supplier awarded the contract. Due diligence concerns the level of service provided by the supplier, for example, a private contractor delivering below the contract level of service. Due diligence issues can also occur when suppliers misappropriate NHS assets once a contract ceases.

It is a realistic possibility that supplier collusion exists, for example, those in positions of influence meeting with suppliers to secure contracts or receive information ahead of a future tender process; for which those in positions of influence receive payment, whether gifts or work carried out on a home. Post-contract, collusion includes those in positions of influence advising a supplier to increase or fabricate invoices, in exchange for bribes. It is also possible that bid rigging to price fix and influence who wins the contract is taking place.



Case study

Fraud against Guys and St Thomas' NHS Foundation Trust (GSTT) occurred between 2016 - 2019. Where Edias Mazambani (GSTT Credit Controller) faked patient and client refund requests and used a network of money mules to launder these proceeds before the majority ended up with E Mazambani and two other main recipients, George and Rose Magaya.

The investigation identified over £218,000 in fraudulent refunds paid out, with an additional £84,000 in fraudulent claims prevented, bringing the total fraud value to more than £302,000. Edias Mazambani and George Magaya received prison sentences, Rose Magaya received a suspended prison sentence, whilst Sinqobile Pasipanodya and Michelle Tengende (two of the money mules) also received suspended sentences but were also ordered to pay a financial penalty for money laundering.

PESTLE analysis

Political: The Procurement Act 2023 simplifies procurement regulations.

Economic: ICB cost-reduction and restructuring are likely to centralise procurement with larger footprints to cover. Similarly, procurement targets to reduce spend per product could result in the selection of lower priced items regardless of efficacy.

Social: New reforms in the Procurement Act do not extend to commissioning of services where there is a continuous requirement to provide the service, such as agency nurses. The flexibility for trusts to take the 'break glass' option and procure off framework continues.

Technological: The shift towards a digital strategy within health systems, AI tools, and remote delivery as part of the 10-Year Health Plan for England, increases potential exposure to procurement fraud, contractor misrepresentation and cyber-enabled fraud.

Environmental: The new Procurement Act increases emphasis on social value, requiring procurement decisions to account for environmental and community benefits.

Legal: Greater reliance on NHSE approved procurement frameworks and central oversight may improve compliance and reduce fraud vulnerability.

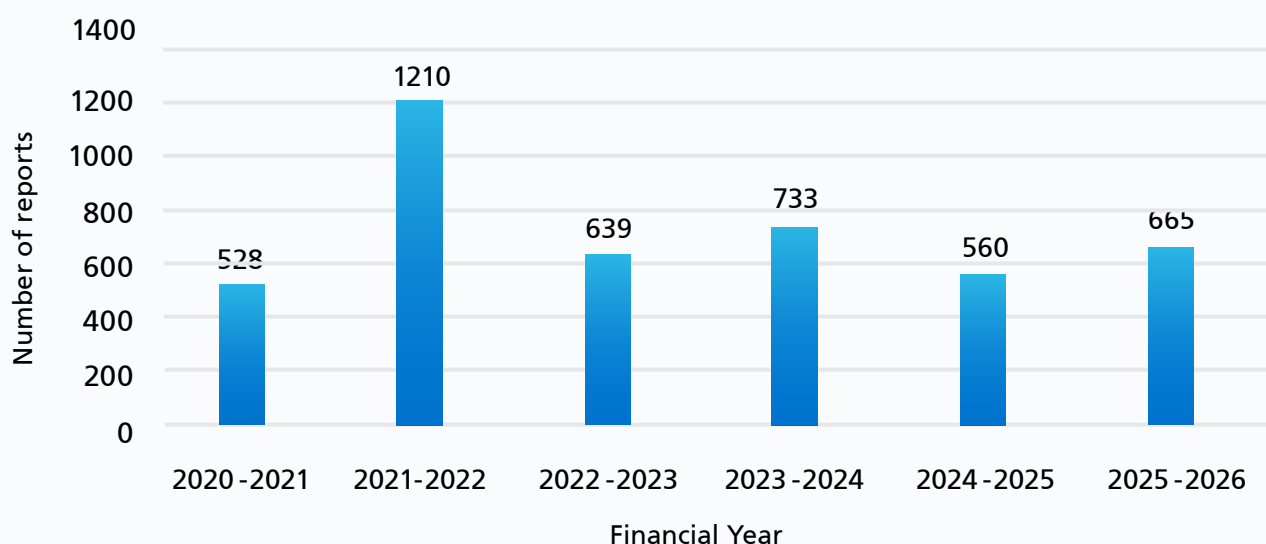
Organisational: Concerns around due diligence and contract management remain, but new legislative changes of greater scrutiny and transparency of suppliers should allow for improvements to be made.

Media Factors: Procurement failures or perceptions of NHS exploitation can attract significant public and media scrutiny.

Reporting

During this reporting period, the NHSCFA received 665 reports compared to last year's total of 560.

Procurement and commissioning



Patient exemption fraud

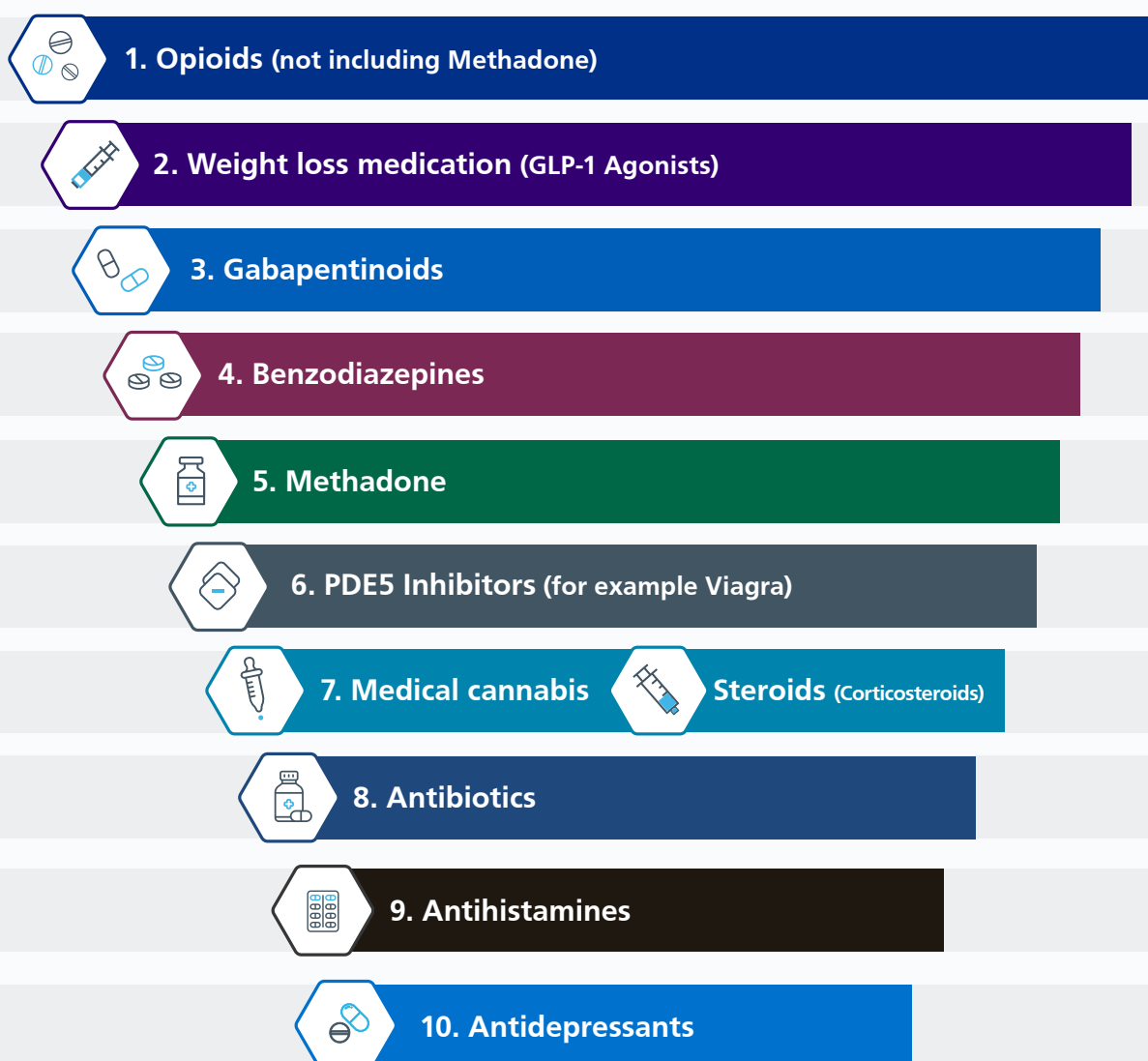
The financial vulnerability estimate has increased compared to last financial year primarily as a result of an increase in patients claiming a prescription exemption via Universal Credit. Also, because of optical charge evasion due to an increased expenditure. However, dental charge evasion decreased.

£268.76m
vulnerable from
an expenditure
of £12.2bn

Emerging trends and prevalent threats

It is a realistic possibility that some patients are onwardly trading prescription medication for personal gain. Controlled prescription medication has a lucrative street market alongside illegal drugs in the UK and abroad. The NHSCFA has noted an increase in the onward trade of prescription weight-loss medications like GLP-1 receptor agonist medications (e.g. Mounjaro and Wegovy) alongside usual prevalent types of onwardly traded medications like benzodiazepines (e.g. Valium, Xanax), opioid painkillers (e.g. oxycodone, morphine) and gabapentinoids (e.g. pregabalin).

Most commonly reported controlled drug within the onward trade of prescription medication sub-type



Identity theft in order to access paid NHS services or controlled prescription medication remains highly likely. Often associated with those unlawfully in the UK due to the common misconception that they are not entitled to NHS treatment, or that NHS staff will inform Immigration Enforcement about their situation. It is also frequently associated with individuals wishing to obtain controlled medications they would not normally be prescribed.

An emerging threat is the likelihood of NHS patients feigning injury or illness to support fraudulent claims for state benefits, in cases relating to claims of incapability to work, medical evidence may be required. This is developing alongside an increase in the number of individuals in the UK claiming Universal Credit, which reached 8.4 million in January 2026. There is also a high probability that those wishing to obtain controlled medications as a result of dependency or with the intent to onwardly trade are likely to feign injury.

Evading NHS charges for services which require payment; primarily prescription, dental and optical charges remain highly likely and prevalent. This is becoming increasingly common as a result of continual increases in these charges alongside inflation, the NHS offers a Low Income Scheme (LIS) which allows patients on low income to apply for exemption certificates from these charges. Although Real-Time Exemption Checking (RTEC) is positively impacting this area.



Case study

A media outlet has reported a patient abusing an NHS-funded patient taxi service by repeatedly using the service for non-hospital related travel. The patient was given a one-time use code by the hospital to give to a local taxi service which entitled them to one trip home after an appointment as they were unable to afford the journey themselves. They then repeatedly used the code over the next few days before it was identified by the hospital, resulting in financial loss to the trust. The patient was ordered at Magistrates to repay the taxi costs plus compensation.

PESTLE analysis

Political: Prescription charges in England remain at £9.90 per item; however, around 89% of prescription items are free due to exemptions and with other UK nations having already abolished charges, there is debate around following suit.

Economic: Rising cost of living pressures may increase false exemption claims or misuse of access to medicines for personal gain, including onward trade.

Social: Rising Universal Credit numbers may drive more exemption claims, though some incorrect claims may be due to confusion rather than intentional deception.

Technological: The use of Real Time Exemption Checking (RTEC) is so far understood to have had a positive impact in the reduction of falsely claimed exemptions, allowing eligibility to be confirmed at the point of dispensing.

Environmental: Increased pharmaceutical waste through patients requesting unnecessary medication or stockpiling can have an environmental impact, as well as the impact of NHS supply chains contributing to emissions.

Legal: Current penalties are civil rather than criminal, raising questions about deterrence for those who repeatedly claim exemptions falsely, but media coverage has also highlighted unfair or erroneous penalties.

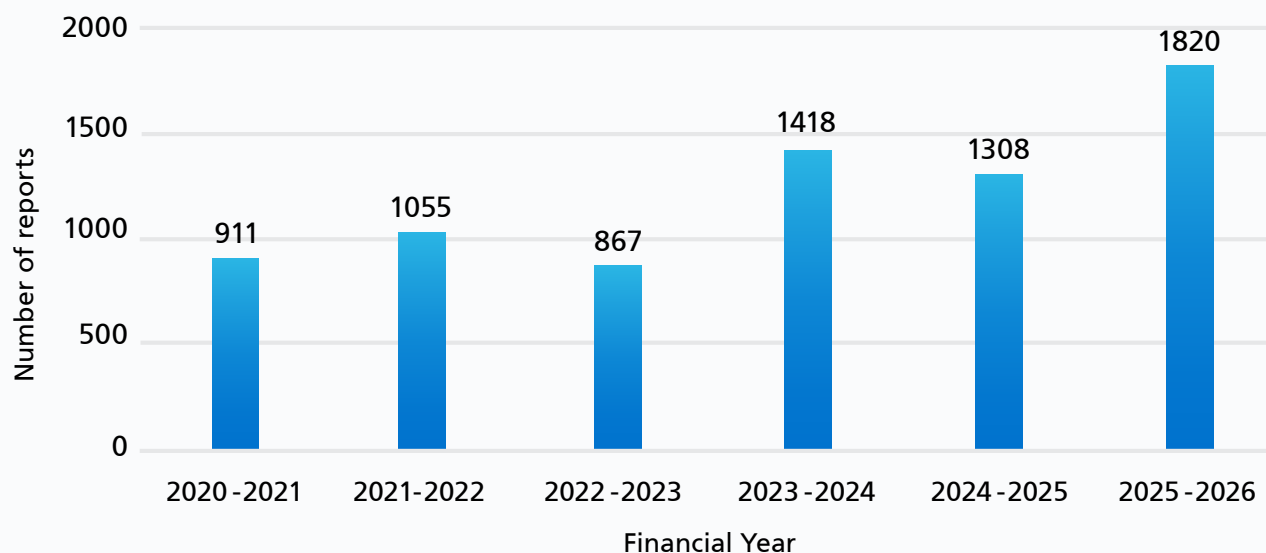
Organisational: There is an overreliance in this area on self-declaration, although the introduction of RTEC helps combat this in prescriptions.

Media Factors: National media outlets have reported on incorrect penalty fines and patients penalised in error which can create distrust.

Reporting

During this reporting period, the NHSCFA received 1820 reports compared to last year's total of 1308.

Patient exemption



Pharmaceutical contractor fraud

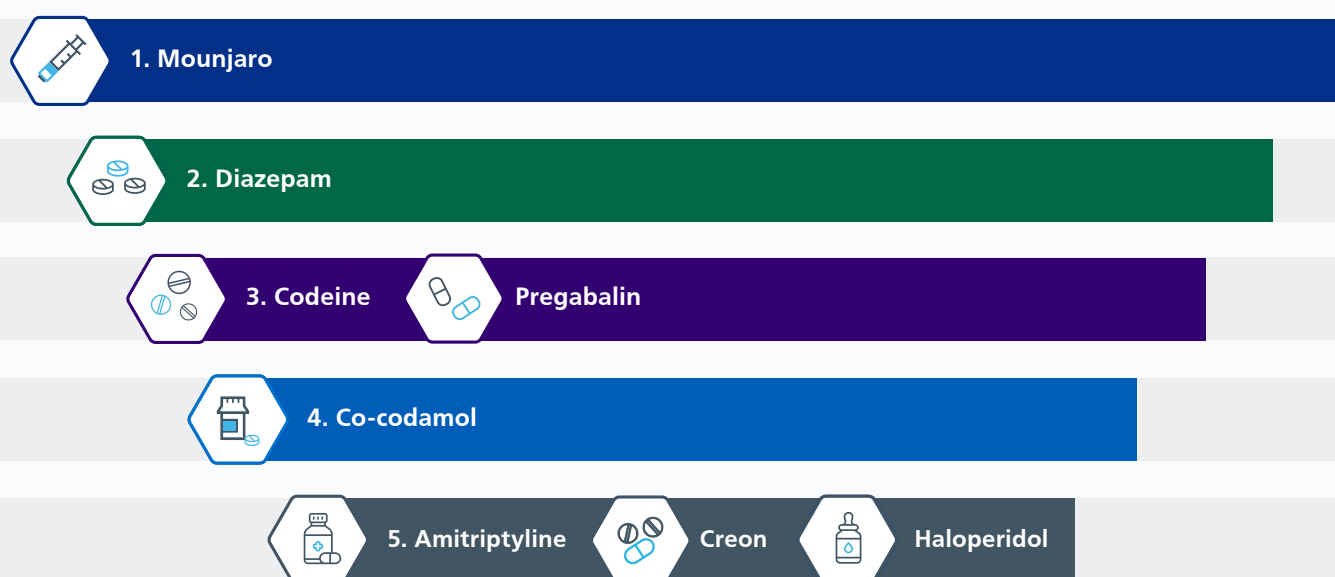
The financial vulnerability estimate has increased because of an increase of prescription items dispensed and an uplift in the annual funding settlement.

£138.49m
vulnerable from
an expenditure
of £13.85bn

Emerging trends and prevalent threats

There is a realistic possibility that some pharmacists may be falsely creating referrals via NHS 111 for the urgent supply of medication when the patient had not been seen or made any request for the referral.

Most popular prescription items mentioned in reporting



It is a realistic possibility that some items claimed for but not dispensed are being shipped overseas or the profits from their sale sent overseas, involving inflammation injections such as Depo-Medrone and Kenalog and anxiety medications such as benzodiazepines.

It is almost certain that prescription items are being claimed for but not dispensed. Recent examples include weight loss medications such as Mounjaro, medications for type 2 diabetes, alongside painkillers and anti-depressants such as co-codamol and amitriptyline respectively.

It is likely that some pharmacies are falsifying patient records. These records may show that a service was provided when it was not, or that a different service was provided. For example, patients receiving a consultation or prescription, such as the Pharmacy First service, when they were just picking up medicine prescribed by the GP.

It is a realistic possibility that some pharmacists are alleged to be appropriating and selling prescribed medication, including fentanyl, pregabalin and diazepam. Part of the motivation for onward selling may be to form a component for another product to be sold in illicit markets. This now extends to selling NHS funded COVID-19 vaccinations to private patients who were otherwise not entitled.

PESTLE analysis

Political: As part of the 10 Year Health Plan, 2026 will see pharmacists having more time to treat patients by expanding those who can supervise the dispensing of medicines. This should assist with managing a higher workload, however opportunities to commit fraud could increase.

Economic: Pharmacy budgets are now subject to clawbacks of £16.8m per quarter to meet the allowed medicine margin, despite wider increases to spending including the Single Activity Fee and expansion of patient services. This may tempt unscrupulous practices if some revenue streams are being reduced.

Social: Expanded pharmacy services, including free emergency contraception and lifestyle-related support, may create opportunities to manipulate patient records or claim for services not conducted or necessary.

Technological: NHSE continues to roll out the 'GP Connect Access Record: Structured' system (linking GP practices and pharmacies) which could help expose record manipulation if inconsistencies are noticed by GPs or patients.

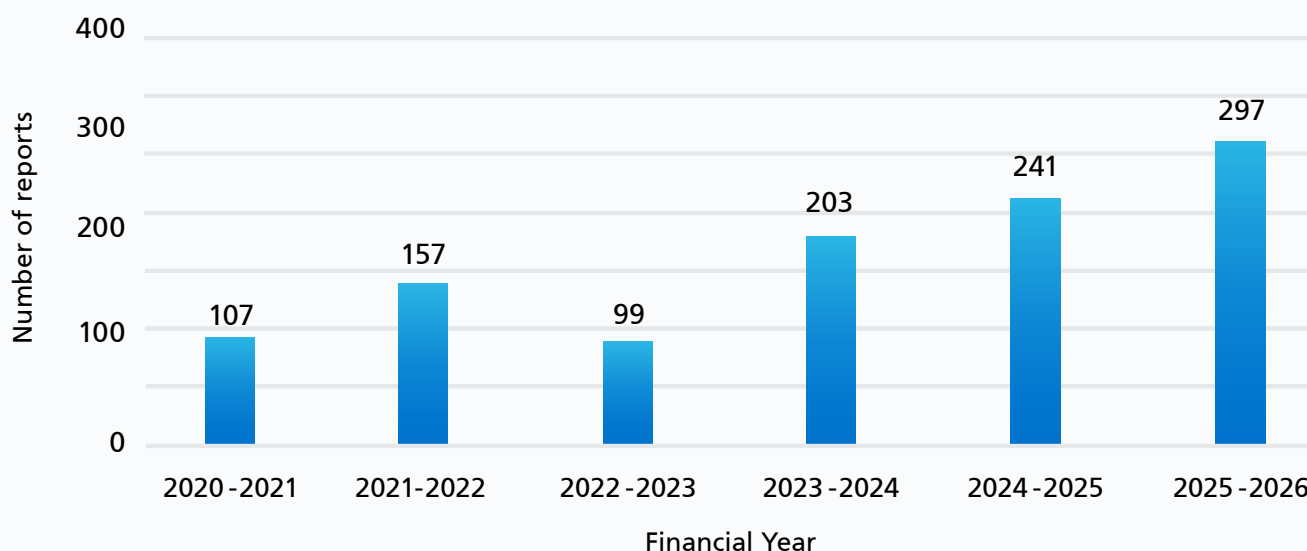
Organisational: Sector polling infers that pharmacies have been increasingly operating at a loss over the last decade. The survey also raised medicine supply issues, resulting in compromised care and increased workloads, potentially increasing vulnerability to improper practices.

Media Factors: Public and media attention on pharmacy services is frequent, including coverage of digital prescription tracking tools aimed at reducing pressure on pharmacies.

Reporting

During this reporting period, the NHSCFA received 297 reports compared to last year's total of 241.

Pharmaceutical contractor



General Practice (GP) contractor fraud

£114.41m
vulnerable from
an expenditure
of £11.44bn

The financial vulnerability estimate has decreased compared to last year, primarily as a result of an apparent decrease in expenditure.

Emerging trends and prevalent threats

Claiming for additional funding to provide services which are not delivered as agreed is highly likely within this area. Services like Additional Roles Reimbursement Scheme (ARRS) and Enhanced Access Services (EAS) are the most commonly abused schemes. False claiming also relates to recording and maintaining inaccurate Quality of Framework (QoF) and Global Sum information; primarily around "patient lists".

Reporting trends around fraudulent claims for additional funding and associated incentive scheme



GPs and practice staff members abusing their position to self-prescribe prescription medication for their own use is a realistic possibility. The assumed position of trust within this process and access to controlled medications likely enables this activity. This may also present a patient safety concern if a GP is misusing controlled medications as it may impair their ability to enact this role safely.

Case study

A GP practice manager, Kellie Preece, fraudulently obtained funds from their practice by transferring money from the surgery into their personal bank account. In total, over £144,000 was stolen from the practice and Kellie Preece pled guilty receiving a suspended prison sentence, as well as hours of rehabilitation and an electronic tag. The NHSCFA will also utilise powers under the Proceeds of Crime Act (POCA).

PESTLE analysis

Political: Ongoing discussions between government and the British Medical Association (BMA) over GP contract changes could create policy instability and potentially increase the opportunity for misinterpretation or exploitation of contracts.

Economic: The GP contract funding uplift increases overall contract value and transaction volumes, which may add billing complexity and create opportunities for fraudulent claims.

Social: High demand, limited growth in the GP workforce, and new technological developments such as virtual appointments may create opportunities for recording compliance without actual delivery.

Technological: Greater emphasis on digitalisation as part of the 10 Year Health Plan; for example, virtual appointments being launched, including more online appointments with GPs to create a 'virtual hospital'. This could introduce new fraud vulnerabilities and cyber security risks around online patient data.

Environmental: Shift to community-based care to free up space in hospitals, as well as the introduction of further digitalisation and electronic recording of information may reduce the environmental impact.

Legal: Due to the complexity of the GP contractual agreements, 'grey areas' of unintentional compliance and opportunities to commit fraud may present themselves.

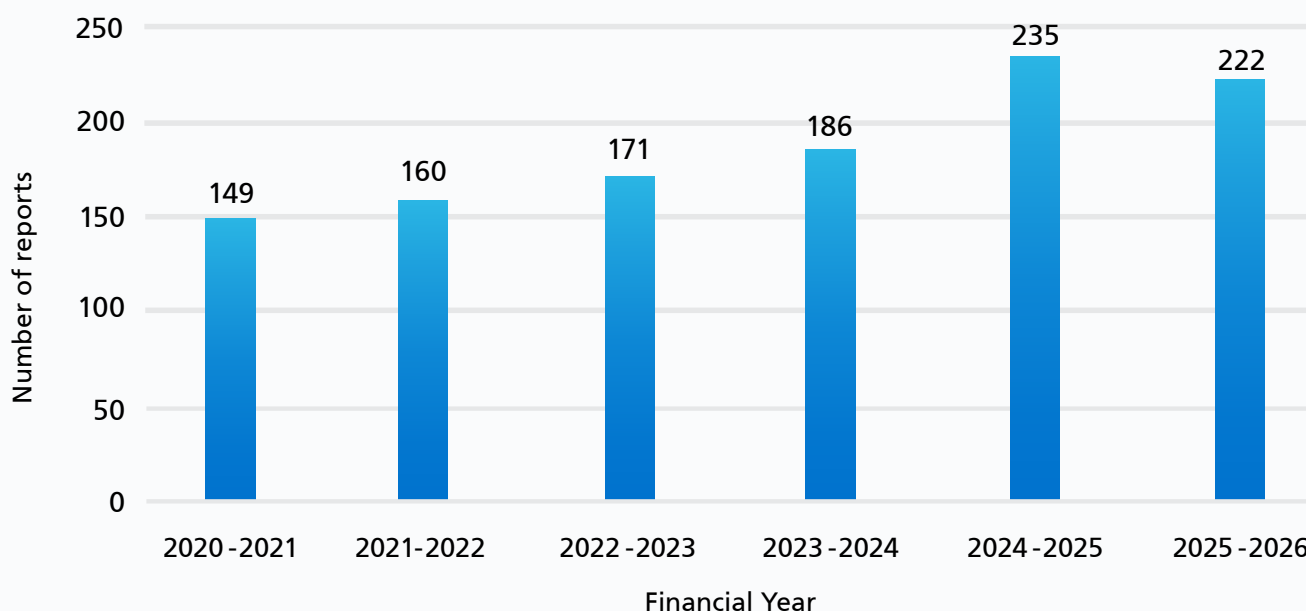
Organisational: Many GPs operate as small businesses which may present the threat of limited separation of duties; creating opportunity for fraud, as well as informal financial processes and a lack of independent audit and assurance.

Media Factors: Public interest in the NHS and the pressures it faces are regularly scrutinised. This may have a positive effect through increased reporting and deterrence but could also increase defensive behaviours, such as selective or fraudulent performance reporting.

Reporting

During this reporting period, the NHSCFA received 222 reports compared to last year's total of 235.

GP contractor



Fraudulent access to NHS care from overseas-visitors

£96.5m
vulnerable from
an expenditure
of £2bn

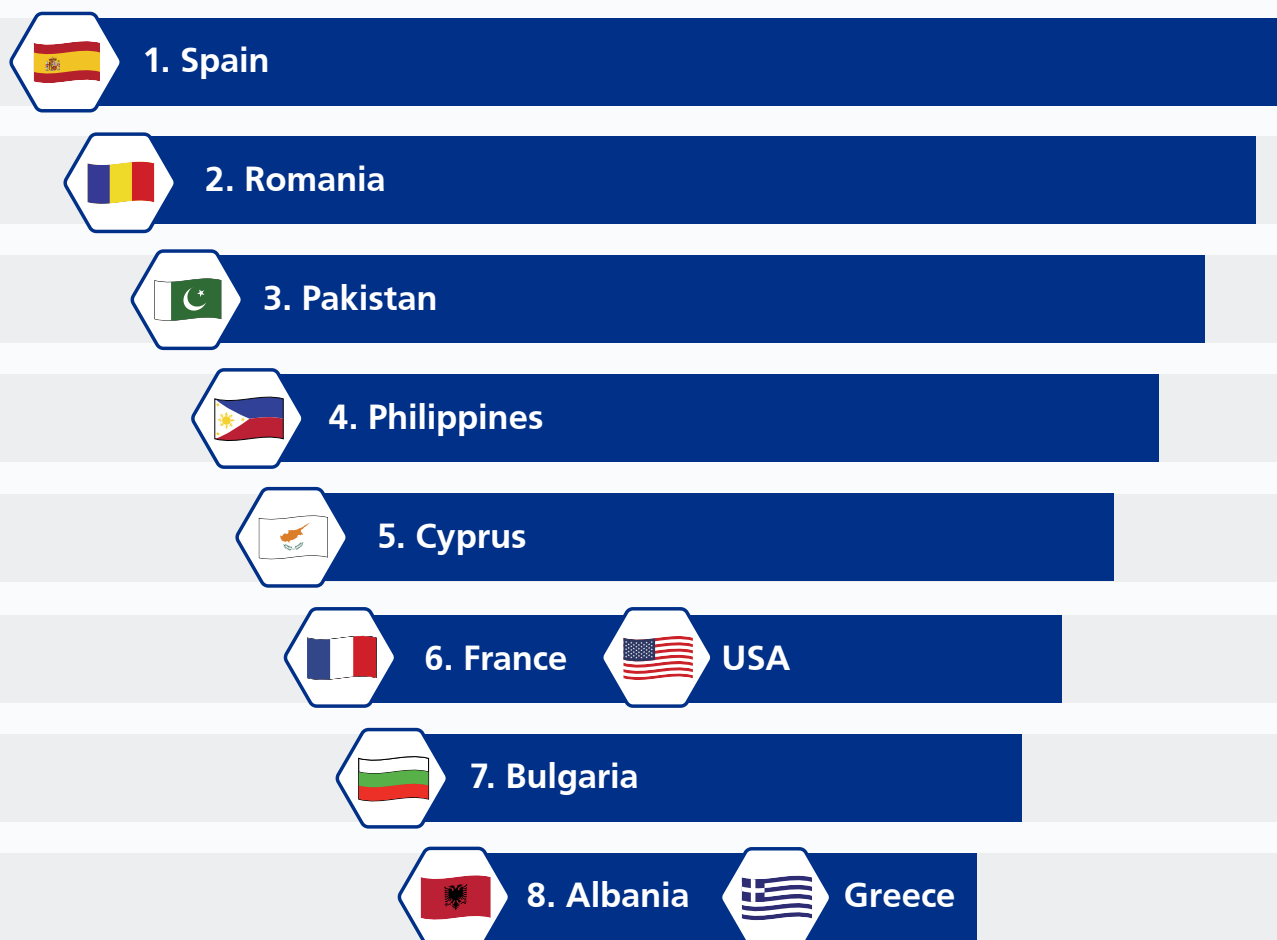
The financial vulnerability estimate has decreased since last year however; this is not indicative of a decrease in threat and is due to a change in data parameters.

Emerging trends and prevalent threats

Individuals returning to or entering the UK to access secondary care services without charge, including to access maternity services is highly likely. Maternity treatment in the UK is categorised as 'urgent and necessary' meaning costs are recovered after the treatment and not before.

It is also likely that individuals will misuse visas in order to access NHS services. Intelligence suggests individuals have entered the UK on a visa specifically to access medical treatment.

Countries travelled from to the UK to access secondary care without charge



Individuals who are not ordinarily resident falsely representing themselves to gain access to NHS secondary care without charge whilst in the UK is highly likely.

It is a realistic possibility that individuals may falsify information in order to falsely claim reimbursement under the Immigration Health Surcharge (IHS) scheme. Individuals can apply online for a refund for IHS fees if they work in a healthcare setting such as a hospital, GP practice, care home or community healthcare facility. They must have worked in the role for at least 6 months and for an average of 16 hours a week.

Individuals receiving primary care, including prescriptions, whilst residing abroad is a prominent threat. Primary care is free at the point of delivery for everyone in England, however if moving abroad permanently you should notify the GP practice to be removed from the NHS register.

Furthermore, former and current British citizens permanently residing abroad but travelling back to the UK for primary and secondary care services is likely.

It is a realistic possibility that individuals are travelling to specific airports to avoid detection by border force and to gain access to the UK for NHS treatment.

PESTLE analysis

Political: Stricter student visa checks from 2025 may reduce abuse of the visa system, including cases where applicants are not genuinely studying.

Economic: Changes to healthcare eligibility and potential tariff-related healthcare cost increases in the United States of America (USA) may result in the continued increase in US citizens seeking NHS secondary care without paying.

Social: It has been reported that the number of paediatric invoices is rising in trusts as parents of babies being born in the UK fail to apply to regularise the child's stay in the UK.

Technological: With advances in AI, it may be possible for individuals to forge identity documents such as passports or visas to fraudulently gain access to NHS services.

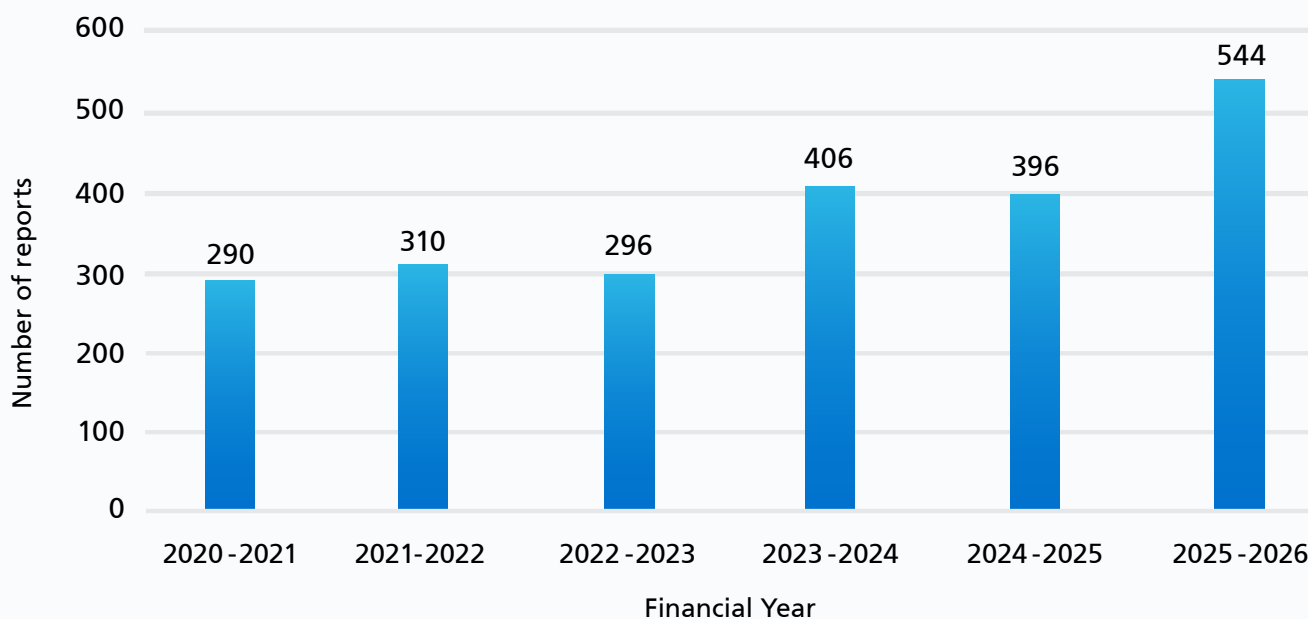
Legal: UK visa rule changes, including higher skilled worker thresholds and tougher English-language requirements, may reduce overseas visitors and dependants entering the UK.

Media Factors: The media reported a drop in UK visa applications in the last year as stricter immigration rules have been introduced, suggesting stricter immigration rules are already affecting net migration.

Reporting

During this reporting period, the NHSCFA received 544 reports compared to last year's total of 396. Higher levels of international travel may have increased the opportunities for fraud to occur, the estimated number of inbound visits to the UK is estimated to have risen to 43.4 million in 2025 from 39.5 million in 2024, potentially creating an increase in reports.

Fraudulent access



Optical contractor fraud

The financial vulnerability estimate has slightly increased. This is alongside the implementation of Post Payment Verification (PPV), the introduction of a centralised electronic claims submission by NHSBSA, and recent changes to the General Ophthalmic Services (GOS) regulations.

£91.22m
vulnerable from
an expenditure
of £555.98m

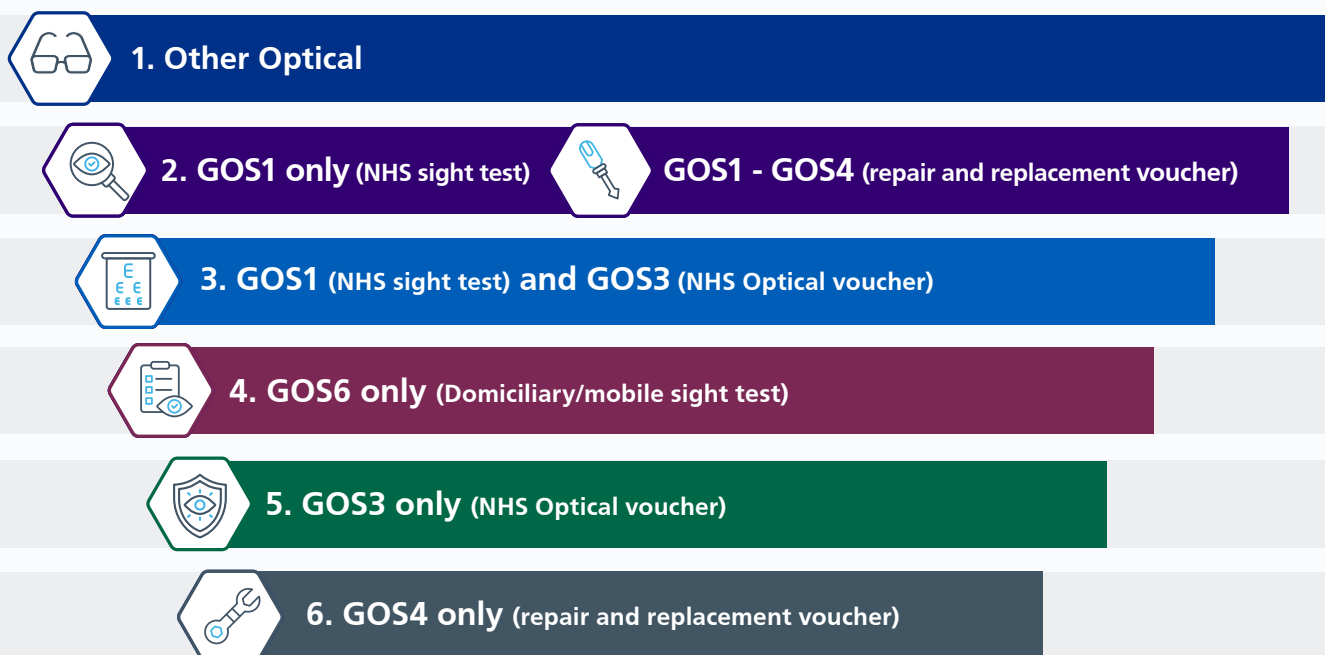
Emerging trends and prevalent threats

A practice could realistically recall a patient regularly without clinical need to inflate claim volumes and benefit financially, with patient safety potentially being impacted through unnecessary testing.

Opticians carrying out NHS Community Urgent Eyecare Service (CUES) assessments during domiciliary visits, even when clinically unnecessary and bypassing protocols is a realistic possibility.

Claiming for services (GOS1/3/4/6) which were not provided is highly likely, this includes GOS claims for ineligible or non-qualifying patients, as well as repeated eye tests within short intervals. False GOS claims involving vulnerable care home residents is a realistic possibility, as well as repeated eye tests and dispensing of glasses within short time periods without informing the next of kin.

False GOS claim reporting trends



The threat of false, manipulated and duplicate GOS claims is highly likely. However, it is possible for patients to identify and report false claims made using their identity.

Additionally, excessive testing and re-dispensing for minors specifically highlights frequent testing and repeat spectacles for under 16s to maximise payments.

Furthermore, forgery and misuse of signatures to enable claims is a realistic possibility.

It is likely that vouchers will be issued to ineligible patients, including opticians issuing vouchers to those who are not eligible or entitled to free NHS optical services.

Within secondary care, it is almost certain that an optical care provider in the independent sector could manipulate their coding activity to increase payments.

PESTLE analysis

Political: DHSC launched a consultation in September 2025 on extending the range of medicines optometrists and contact lens opticians can supply / administer, so minor eye conditions can be treated in community settings without GP / hospital referrals. In response the College of Optometrists welcomed “the government proposed plans to extend [the] range of medicines that optometrists can supply”.

Economic: A consultation was launched for amendments to the 2025 - 2026 NHS Payment Scheme in July 2025, encompassing proposals for price alterations to certain ophthalmology services. Additionally, GOS sight test 2025 - 2026 fees have been updated. However, other GOS payments, grants and patient optical voucher values remain frozen. This may increase financial pressure on optical practices, increasing the potential for fraudulent activity.

Social: More optical care is shifting from hospitals into neighbourhood settings, reducing unnecessary referrals and consequently waiting lists, but requiring ICBs to monitor for tariff manipulation and quality flaws.

Technological: The NHS 10-Year Health Plan includes digital transformation to improve care, reduce costs and provide quicker access. This could potentially impact on ophthalmology, for example with AI diagnostic processing and increased capacity for those requiring in-person care.

Environmental: The College of Optometrists has shared initiatives on reducing single-use plastics, improving recycling and making patient information digitally available.

Legal: The Strategic Commissioning Framework (SCF) provides its ambitions for commissioning with a key role played by ICBs in focusing on local population needs and that eye health is improved through optometry services playing an important part in care pathways.

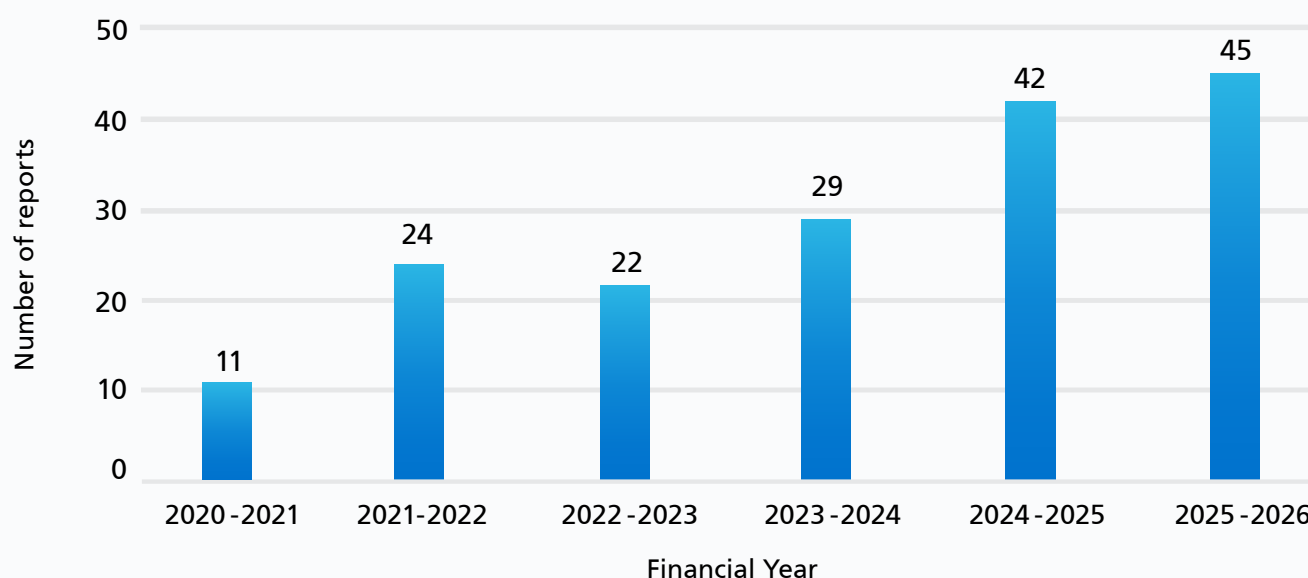
Organisational: The NHSCFA has recently closed an intelligence gap through analysis of the optical landscape, patient charge evasion and contractor fraud.

Media Factors: Online reporting of investigations into private cataract clinics inflating costs or carrying out unnecessary operations may increase public concern about outsourced eye care.

Reporting

During this reporting period, the NHSCFA received 45 reports compared to last year's total of 42.

Optical contractor



Data manipulation fraud

The financial vulnerability estimate has decreased due to a reduction in the financial vulnerability rate. The expenditure figure has increased due to an increase in funding within this area.

£57.36m
vulnerable from
an expenditure
of £77.5bn

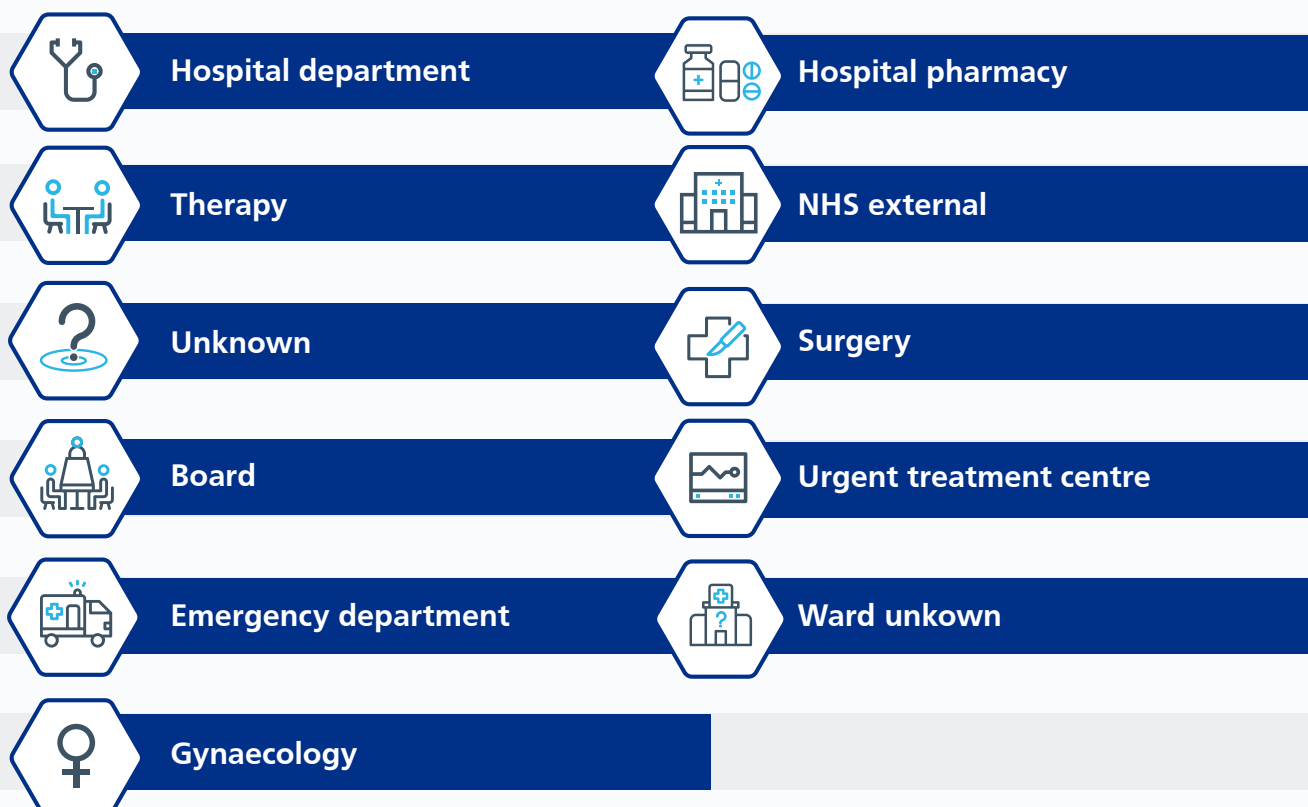
Emerging trends and prevalent threats

Misreporting around ward utilisation is a realistic possibility. Likely impacting on medical wards with an absence of available beds resulting in care being provided to patients in the corridor, leading to patient and staff safety concerns.

Inaccurate coding processes, including upcoding to meet targets and potentially increase revenue is highly likely. Leading to the potential for inaccurate reflections of clinical information from a department. The approach of coding through robotics into the Patient Administration System could be utilised in a trust to meet deadlines, instead of manual coding.

Falsifying or altering data to meet a target was highly likely, with the potential for the discharge times of patients in a trust department to be altered with the intent of ensuring four hour waiting times are met.

Departments where data manipulation was reported to have occurred



Data could also realistically be changed prior to submission to NHSE at a regional level. Possibly with the intent of gaining a promotion based on the falsely reported performance figures. Additionally, falsifying data to gain a higher assurance audit score.

Funding could potentially not be used for the purpose for which it was allocated. There is the potential that staff could be kept at a lower banding once qualified, even though funding has been allocated to support their promotion pathway.

It is a possibility that a hospital pharmacy could retain refunds for medication returned by wards and/or clinical areas. The ward or clinical area would pay the pharmacy for the medication upon initial issue, and if returned would usually receive a refund. However, funds could be retained by the hospital pharmacy. Additionally, if the ward requested the same medication again at a later point, they would likely be charged again.

PESTLE analysis

Political: The NHS Neighbourhood Healthcare Framework includes percentage-based targets, which can be vulnerable to data manipulation.

Economic: As part of the NHS Elective Care Capital Incentive Scheme, providers are incentivised to improve performance for rewards, for example significant progress in reducing waiting list times. Although this may drive progress, it could also performance figure manipulation.

Technological: Health information management professionals reportedly have concerns around the use of artificial intelligence and machine learning for coding within healthcare, specifically around accuracy, bias and nuance.

Environmental: Investments have already been made to roll out AI within trusts; however, data centres contribute to greenhouse gas emissions, threaten local water supplies and consume electricity.

Legal: The Health and Care Act 2022 introduced 42 ICBs, however ICB footprints are changing with mergers, abolitions and new establishments planned.

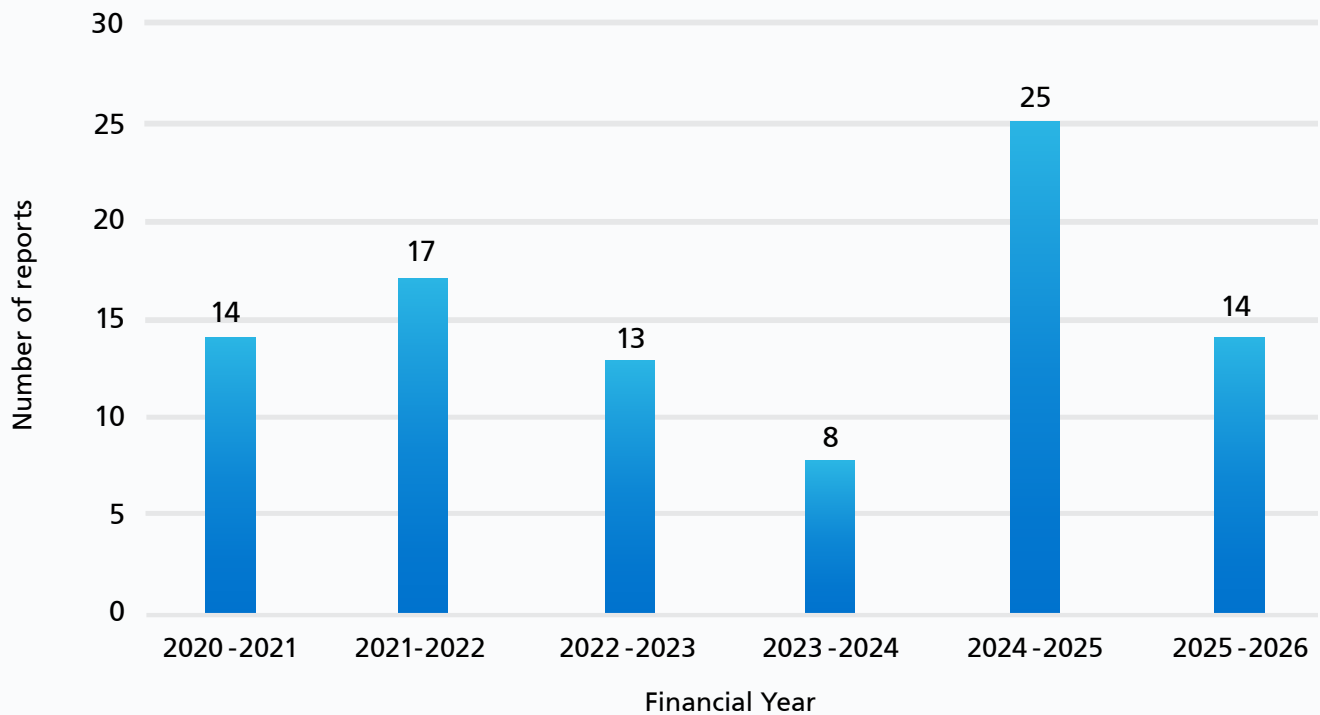
Organisational: The NHSCFA is looking to further harness AI capabilities to improve our knowledge and understanding within the area of data manipulation.

Media Factors: Patients being treated in corridors has been reported online, however, in April 2025 the Secretary of State for Health and Social Care was reported to be looking to combat this ongoing issue with tailored support being developed for trusts to address the issue.

Reporting

During this reporting period, the NHSCFA received 14 reports compared to last year's total of 25.

Data manipulation



Dental contractor fraud

The financial vulnerability estimate has decreased, potentially due to the Dental Recovery Plan introduced in 2024 and reduced activity.

£56.96m
vulnerable from
an expenditure
of £3.3bn

Emerging trends and prevalent threats

Dental contractors carrying out unnecessary treatments is likely. For example, dental contractors may perform unnecessary dental work to claim for treatments in a higher banding.

It is also a realistic possibility that dental practices may onboard NHS patients with the intent of receiving the 'new patient premium' for seeing new NHS patients but then manipulate processes and not deliver NHS appointments.

Dental contractors could potentially be pressuring NHS patients into private treatment after attending an initial NHS appointment.

NHS dental banding in reporting

NHS dental treatments are divided into three bands and the cost depends on the treatment received.



1. Unknown banding



2. Band 2



3. Band 1



4. Band 3

Dental practices are likely submitting false claims for exempt patients. It is also likely that dental contractors may manipulate activity through altering Units of Dental Activity (UDAs) and patient data to secure additional funding. For example, overcharging NHS patients or splitting courses of treatment.

Dental staff claiming a double income remains a prominent and realistic threat, where claims to the NHS are submitted for patients who have already paid privately for treatment or for treatment where the patient is exempt.

PESTLE analysis

Political: The Dental Recovery Plan was introduced in 2024 to improve access to NHS dental care and increase appointment availability. Reviews by NHSE and the NAO indicate that delivery has not yet translated into increased UDAs, with new patients per working day reducing by 5% and dental vans not yet deployed following a change in government.

The NHS Dental Reform was proposed to ease strain on dental services and the contract amendments from April 2026 set out the minimum activity, increased payments and the introduction of standardised payment packages. However contractual restrictions may push dentists away from NHS work.

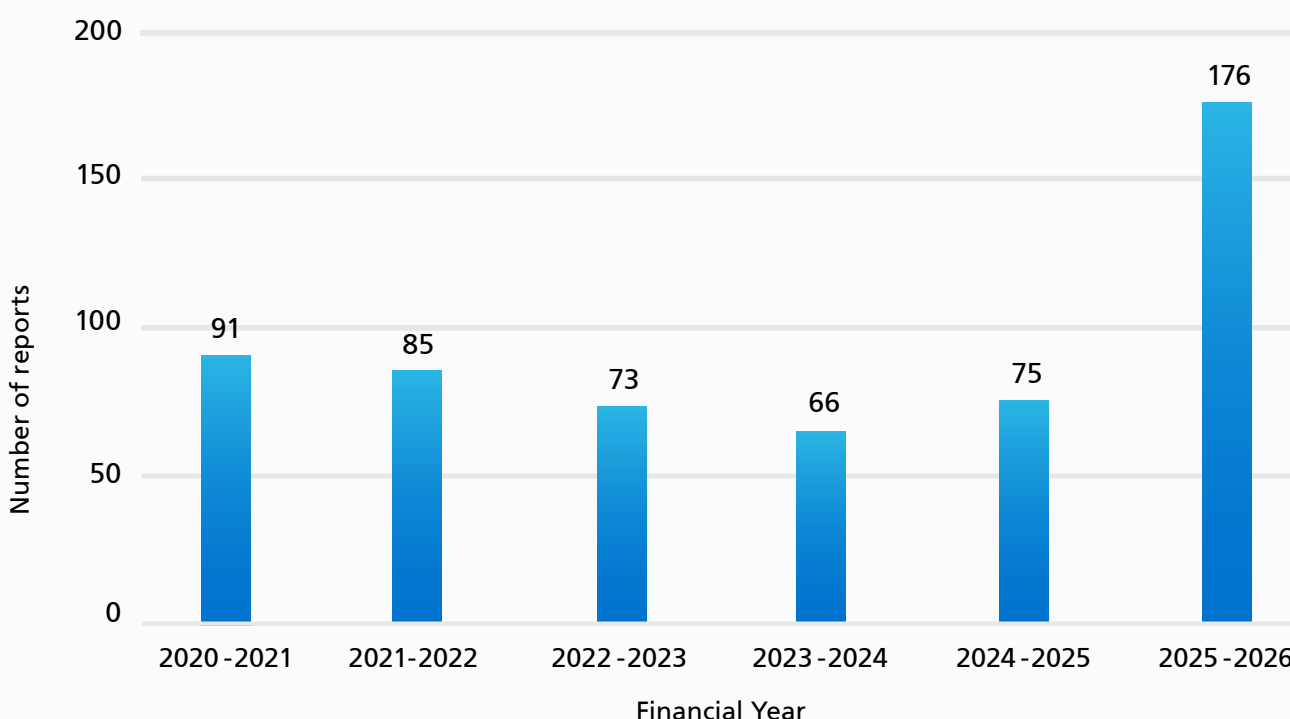
Technological: From April 2026, use of technology and digital monitoring will increase, including more detailed reporting on patient outcomes to NHSE and ICBs. Increased digitalisation of dental records, claims, and treatment logs as well as audits could improve transparency, make it easier to spot discrepancies and reduce opportunities for fraudulent activity such as duplicate claims or inflated UDAs.

Media Factors: Media reports highlight that over £900 million has been repaid to the NHS by dentists who failed to provide NHS appointments, difficulty accessing appointments is ongoing and new NHS dental patient numbers have declined.

Reporting

During this reporting period, the NHSCFA received 176 reports compared to last year's total of 75, which is more than double. This is potentially due to an increase in people reporting dental contractors claiming NHS funding but not providing a service. Also, the recent media attention received by dental contractors may have increased public awareness around reporting concerns.

Dental contractor



NHS Staff fraud

The financial vulnerability estimate has decreased, reflecting reduced reliance on high-cost temporary agency staffing and a lower requirement for additional payments related to high-cost area allowances, unsocial hours, and band-related supplements.

£28.17m
vulnerable from
an expenditure
of £96.07bn

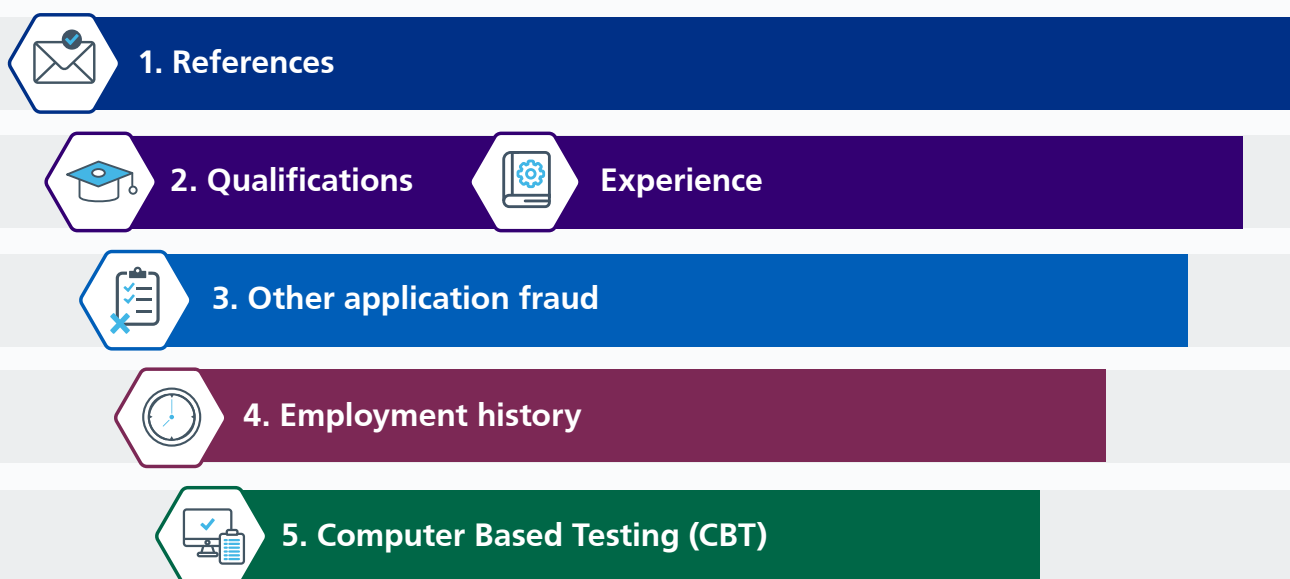
Emerging trends and prevalent threats

Falsified qualifications, references, experience and impersonation of medical professionals in the NHS is almost certain. This behaviour poses a direct threat to patient safety by enabling potentially unqualified individuals to enter roles.

An emerging threat in staff fraud is undeclared conflicts of interest. It is likely that staff are manipulating procurement processes, directing contracts to favoured companies or personal associates, bypassing tendering requirements, and shaping specifications to limit fair competition. This behaviour can also include improper pay decisions, unjustified pay-band increases, and the recruitment of associates without transparency. These actions could compromise service quality, potentially impacting on patient safety.

Another emerging threat with potential implications for patient safety involves suspicious spam calls to patients. It is a realistic possibility that callers will impersonate NHS clinical professionals and ask for personal health information. These calls could undermine patient trust and create opportunities for identity fraud, including exploitation of an NHS patient record.

Areas where staff application fraud is reported to occur



A further emerging issue concerns nepotism within recruitment, it is highly likely that staff are recruiting associates into NHS roles without proper due diligence, relevant qualifications, or transparent processes, including inappropriate pay band uplifts. This can lead to unqualified individuals entering clinical or operational roles, potentially impacting on patient safety.

A persistent and highly likely threat involves the theft, misuse, and unethical prescribing of controlled drugs by NHS clinical staff. Staff are potentially misappropriating controlled medication for onward sale, which raises some safety concerns. Including with the sale of weight loss prescriptions such as Mounjaro. There is also the likelihood of clinical staff prescribing controlled drugs to friends, family, or colleagues.

It is almost certain that NHS staff are working while on sickness leave, including dual or multi-employment during periods of paid absence. This behaviour represents a noteworthy potential financial loss through fraudulent sickness pay claims and double earnings. It also creates operational strain and potential patient safety concerns when staffing levels are misrepresented.

Another almost certain threat involves working elsewhere during NHS contracted hours. Staff are potentially undertaking private work or for their own business, working for/ at another NHS organisation or department, freelancing, treating private patients, or participating in Waiting List Initiatives during their NHS hours, with some failing to declare secondary employment. This behaviour results in direct financial loss through payment for hours not worked and creates patient safety concerns due to staff absence from duties.

Inflation of income and hours, including false claims for shifts, overtime, and enhanced rates, as well as manipulation of e-rostering systems is almost certain and can carry a financial loss. Staff fraud can impact on honest staff who must cover shifts for colleagues committing timesheet fraud.

Reporting trends around staff working elsewhere during NHS contracted hours



1. Dual employment - Private work, own business or other employer



2. Dual employment - working at another NHS site/department



3. Working whilst on sickness leave



4. Other work

Case studies

Fraud against King's College Hospital by Richard Akinrolabu, who was a trust grade specialist registrar in obstetrics and gynaecology, worked on-call and night shifts at three additional trusts between October 2018 and December 2021, despite informing his employer that he was unfit to do the same work for them. He worked these shifts whilst he was on sick leave or on reduced duties from King's College Hospital. This resulted in a loss of more than £268,000 in NHS funding. As well as receiving his full salary, the trust also had to employ locums to cover his shifts. The individual had not sought permission for secondary employment. Richard Akinrolabu pleaded guilty and was sentenced to three years imprisonment.

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Two individuals submitted falsified and inflated timesheet claims between 2022 and 2024, resulting in a potential loss of £63,835 to a regional NHS Trust. Karl Lavender, a locum paramedic, submitted 69 claims for shifts not worked and continued to submit altered timesheets after leaving the Trust, while Adam Kilgallon, a recruitment consultant, was implicated in directing the activity. Both subjects pleaded guilty to two counts of fraud by false representation and received twenty-two-month suspended sentences, with tailored treatment rehabilitation requirements.

PESTLE analysis

Political: Change will be driven by the government's 10 Year Health Plan and a new 10 Year Workforce Plan. The government also aims to eliminate agency staffing by 2029.

Economic: From April 2026, all staff employed under Agenda for Change (AfC) terms will receive a 3.3% pay uplift to support recruitment and long-term workforce sustainability.

Social: NHS care is shifting toward community-based delivery through Neighbourhood Health Centres. Frontline staff will see the introduction of mandatory wellbeing standards and AI tools.

Technological: The government's 10 Year Health Plan and a new 10 Year Workforce Plan strategy shifts focus from increasing pure headcount to achieving a more productive, community-based, and digital-first workforce, with clinicians expected to use AI tools to reduce administrative workload.

Environmental: The workforce strategy moves toward a domestic-first pipeline, doubling medical school places and significantly expanding clinical apprenticeships to reduce reliance on international recruitment.

Legal: The government has confirmed the closure of the Care Worker Visa route as part of the May 2025 immigration white paper. The reforms also introduce new restrictions on skilled worker eligibility and access to work visas.

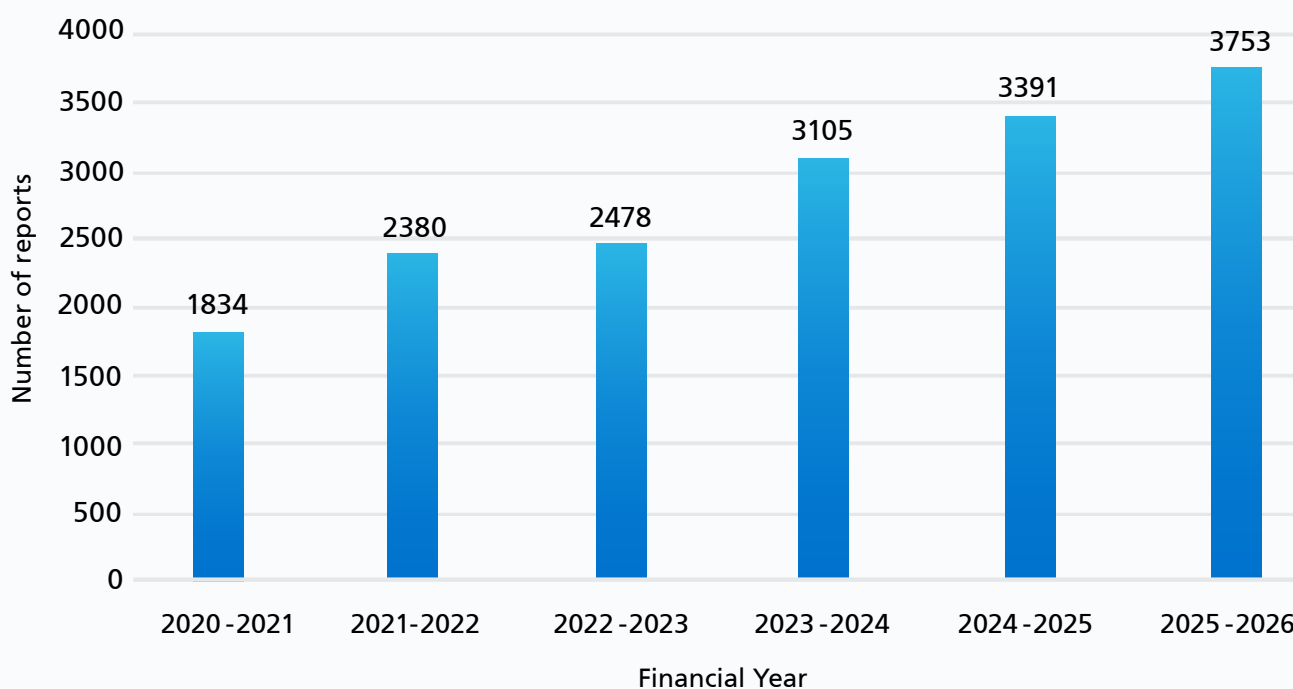
Organisational: The merger of NHSE and DHSC, as well as the merger and boundary changes for some Integrated Care Boards represents significant change for the NHS. From mid-March 2026 those who have opted for voluntary redundancy will begin leaving their roles.

Media Factors: Media coverage of fraud and false qualification cases involving healthcare workers may influence public opinion of NHS staff.

Reporting

During this reporting period, the NHSCFA received 3,753 reports compared to last year's total of 3,391, potentially as a result of the increase in staff employed by the NHS since March 2025.

NHS staff



Reciprocal healthcare fraud

The financial vulnerability estimate has increased partly due to an increase in the financial vulnerability rate.

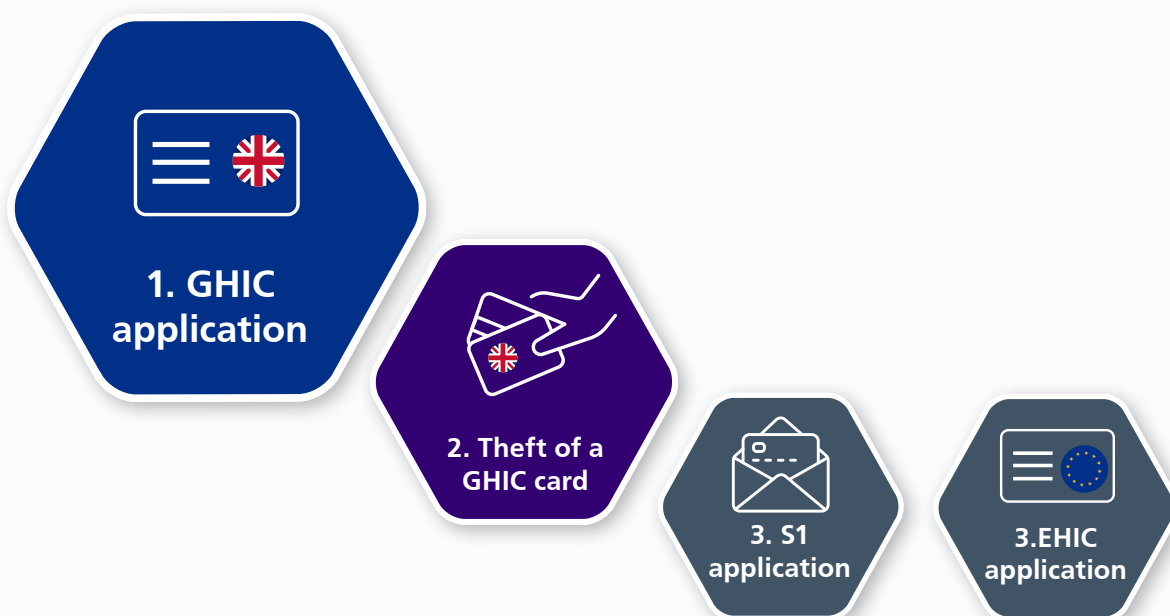
£0.99m
vulnerable from
an expenditure
of £127.3m

Emerging trends and prevalent threats

It is highly likely that false applications are made for UK Global Health Insurance Cards (GHIC)/UK European Health Insurance Cards (EHIC). Therefore, cards can likely be issued without the application originating from a genuine individual.

Similarly, it is probable that an application could be made with false information to prevent a genuine individual obtaining a GHIC.

Areas reported to have been targeted by a bad actor



It is highly likely that an individual may use a GHIC or UK EHIC abroad, or an EHIC in the UK to access care without charge or at a reduced rate whilst knowing they have moved abroad permanently and are no longer insured by the issuing country.

It is a realistic possibility that a fraudulent application for a healthcare entitlement certificate (S1) could be made. An S1 entitles an individual to state provided healthcare cover in the country in which they are residing.

Theft of a GHIC was also likely, including at the airport both in the UK and France. An individual's GHIC may be stolen amongst other items, for example when in a bag or mail/post. Alternatively, theft of the GHIC may be targeted, with other items left untouched. GHICs enable access to necessary state healthcare whilst abroad in certain countries, however, in some cases corresponding identification is required, like a passport.

Locations in which fraud or theft was reported to have occurred



PESTLE analysis

Political: Electronic Exchange of Social Security Information (EESSI) can be used for the reimbursement claims for costs incurred from providing care; however, some claims are making cross-border detection of fraud more difficult.

Economic: Websites charging for GHIC applications continue to exist, however a media outlet recently attempted to make the public aware that the card is free and to avoid these websites.

Technological: The NHSBSA introduced a residency checker in 2021 for UK EHIC, GHIC, PRC and S2, ensuring applicants are ordinarily resident in the UK.

Environmental: To access reciprocal healthcare an individual will likely have to travel abroad, this could involve various types of travel including an airplane, car and train etc. All of which will have an impact environmentally, as well as the footprint of healthcare generally.

Legal: The GHIC has wider coverage, for example a UK EHIC cannot be used in Montenegro, Saint Helena, Ascension Island or Tristan da Cunha. Additionally, UK residents are entitled to state healthcare in the Republic of Ireland and vice versa, a driving license or passport would instead be presented.

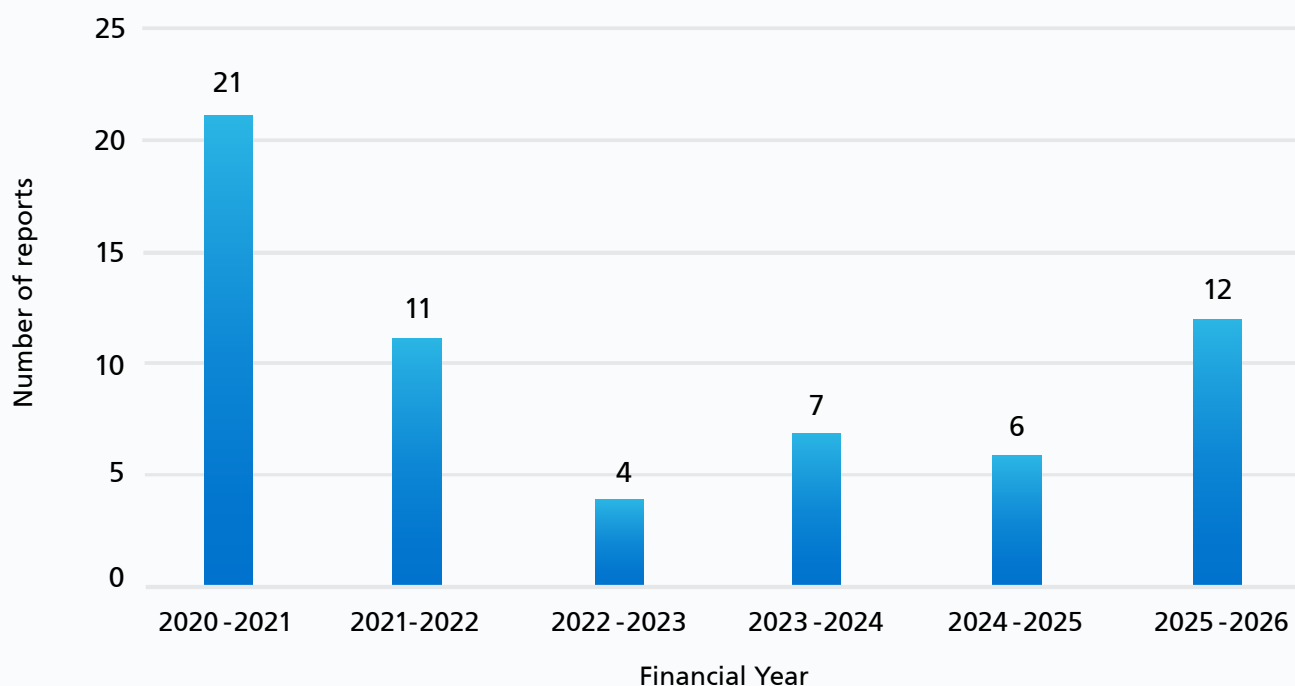
Organisational: The NHSCFA has recently closed an intelligence gap through analysis of the reciprocal healthcare agreements outside of the EEA.

Media Factors: The media, including consumer finance websites, continue to report on the application and use of the GHIC.

Reporting

During this reporting period the NHSCFA received 12 reports compared to 6 last year.

Reciprocal healthcare



OFFICIAL



Horizon scanning

ICB footprints are changing from the 1 April 2026 and 1 April 2027, with some ICBs being abolished and others established, along with mergers. Additionally, the NHS Neighbourhood Healthcare Framework has been introduced as part of the government's 10 Year Health Plan for England, this includes targets with percentage increases and reductions which could inadvertently result in data manipulation.

As part of the 10 Year Health Plan, pharmacists will have more time to treat patients by expanding those who can supervise the dispensing of medicines, pharmacies will also facilitate expansion of patient services. However, Community Pharmacy England has highlighted compromised patient care and increased pressure on pharmacy teams experienced as a result of medicine supply issues.

In addition to the 10 Year Health Plan, the 10 Year Workforce Plan shifts the strategy from increasing pure headcount to achieving a more productive, community-based, and digital-first workforce. Alongside the merger of NHSE and DHSC, as well as the merger of some Integrated Care Boards, the government aims to cut administrative costs and reduce bureaucracy. Furthermore, the Procurement Act 2023 and the merger may remove duplication and overlapping.

The workforce strategy is a move toward a domestic first pipeline, doubling medical school places and significantly expanding clinical apprenticeships to reduce reliance on international recruitment.

The NHS is increasingly shifting ophthalmology services from hospitals into community optometry to ease secondary care pressures and improve patient access, though funding gaps remain a challenge. New commissioning frameworks and expanded services such as CUES and MECS aim to strengthen primary eye care pathways and keep more patients in community settings. National consultations are exploring extended medicines responsibilities for optometrists and changes to ophthalmology payment structures, including price adjustments for cataract and non-cataract services. Despite a small uplift in sight test fees, wider GOS payments remain frozen. However, the NHS's digital transformation plan emphasises better IT interoperability and increased use of AI across eye care.

Investments have already been made in rolling out AI within trusts, however health information management professionals reportedly have concerns around the use of AI and machine learning for coding within healthcare. Frontline staff will see the introduction of mandatory wellbeing standards and AI-driven tools, such as ambient voice scribes, designed to automate paperwork and improve retention. Furthermore, the landscape will transition toward a community-focused model, phasing out expensive agency staff in favour of multidisciplinary teams based in local Neighbourhood Health Centres.

Although the shift towards digitisation in the 10-Year Health Plan for England may increase exposure to procurement fraud, this is against the backdrop of reduced ICB running costs of 50%, and increased emphasis on decision-makers to maximise public benefit through "social value".

The Dentistry Recovery Plan was introduced in February 2024, with the aim of creating 2.5 million new NHS dental appointments. It is possible this may present more opportunities for fraudulent activity as individuals attempt to avoid costs. From April 2026, the dental reform incentives aim to increase the number of patients and improve access to urgent care. However, it is possible that this could be exploited in the way of false claims, including urgent care claims. Practices may also onboard new patients in order to receive incentives but may not actually provide NHS appointments.

If increased funding and incentives are tied to specific targets/UDAs, some dental providers may inflate the number of treatments provided to claim more from the NHS. Urgent care treatment is 1.2 UDA.

The DHSC has reported there are 2,400 overseas trained dentists currently living in the UK who are unable to practise due to limited exam capacity. With new government investments, up to 1,350 overseas-trained dentists will be able to join the General Dental Council (GDC) register by 2028 and will be able to provide dental services in the UK. Increased funding will also allow more candidates to sit the Licence in Dental Surgery (LDS) examination, with the aim of strengthening the dental workforce. However, there are also the risks around fraudulent qualifications during recruitment processes and an increase in dentists and dental activity could potentially result in further fraudulent activity, for example an increase in false claims.

The media reported a drop in UK visa applications over the last year as stricter immigration rules have been introduced. Including the requirement for an application for a Skilled Worker Visa to undertake a degree-level role, with lower-skill jobs no longer qualifying for a visa. The salary threshold has also increased from £38,000 to £41,000 and from 8 January 2026, Skilled Work visa applicants will also be required to speak English to an A-level standard. Following the changes to UK Skilled Work visa rules, fake job or sponsorship offers may also reduce, where overseas workers are promised visas in exchange for money, with no real employment upon their arrival to the United Kingdom.

The introduction of a residency checker in February 2025 could potentially reduce the number of individuals falsely representing themselves as ordinarily resident when applying for a UK EHIC, GHIC, PRC and S2. However, this would not mitigate those using the details of a genuine resident to gain an application fraudulently and so false applications are still likely to occur.

The government pledged to abolish NHS prescription charges in England, following in the footsteps of Scotland, Wales and Northern Ireland, where prescriptions are already free of charge. As a result, the NHSCFA may not need to report on exemption fraud for prescriptions. However, if prescriptions did become free of charge in England, we may see different types of prescription fraud potentially occurring.

For example, individuals may exploit the opportunity to access more medication by falsifying symptoms. For now, the government have taken the stance to freeze charges until a final decision is made on the area.

In 2026 - 2027, investment in the GP contract will increase by £485m, to a total contract value of £13.86 bn^j. The introduction of a new practice-level GP reimbursement scheme should; enable the recruitment of new GPs by practices or increase the number of GP sessions for those already employed by the practice. Additionally, the expansion of the Additional Roles Reimbursement Scheme (ARRS), including the removal of the restriction to only recruit newly qualified GPs, allows opportunity for increased means for manipulation.

Advice and guidance (A&G) incentives were previously a paid enhanced service but have now been embedded into core contract expectations for 2026 - 2027 as an expected standard practice. This may lead to recording A&G without genuine clinical need or inflated activity.

j Source quotes as '£13,863 million'



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