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Overseas Visitor and Migrant NHS Cost Recovery Programme Formative Evaluation – Final Report

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Executive Summary

Ipsos MORI was commissioned by the Department of Health (DH) in June 2014 to undertake a formative evaluation of the Overseas Visitor and Migrant NHS Cost Recovery Programme ('the Cost Recovery Programme'). The primary aims of the evaluation were to:

- Determine how far the Cost Recovery Programme has led to the desired changes in culture and behaviour amongst frontline clinical and administrative staff (and other relevant stakeholders) with regard to practices for identifying and recovering costs from overseas visitors and migrants using NHS services;
- Learn lessons about what works (and doesn't work) in improving cost recovery, including through analysis of the Emergency Care EHC Pilot; and,
- Help refine the Cost Recovery Programme through continuous feedback and inform decisions before proceeding with each stage of the Cost Recovery Programme.

Evaluation methodology

This report sets out the final results of the evaluation, which was based on evidence gathered through the following means:

- Quantitative telephone surveys of NHS staff, conducted at three time-points during the evaluation;
- Qualitative case study research involving in-depth interviews with frontline and administrative staff in a total of thirteen NHS Trusts;
- Consultations with key stakeholders; and,
- Analysis of management information collected nationally with regard to cost recovery.

Further detail of the evaluation methodology is provided in both Chapter One and in the Appendices to this report.

Programme overview

The aim of the Cost Recovery Programme is to increase the revenues available to the NHS by introducing more effective practices to recover costs from visitors and migrants ineligible for free healthcare. Qualitative¹ and quantitative² research undertaken prior to its launch showed that the medical costs that could potentially be recovered from visitors and migrants ineligible for free healthcare from the NHS substantially exceeded levels achieved in practice. The Cost Recovery Programme aimed to increase the costs recovered from this group of patients to £500 million every year from 2017/18.

¹ Qualitative Assessment of Visitor and Migrant Use of the NHS in England, Creative Research, 2013,

<https://www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs>

² Quantitative Assessment of Visitor and Migrant Use of the NHS in England, Prederi, 2013,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

The Cost Recovery Programme was designed to bring about changes in culture, behaviour and processes within Trusts that would support effective mechanisms for charging eligible patients and this was set out in the Cost Recovery Programme's Logic Model (see Chapter One). In order to bring about these changes the Cost Recovery Programme involved four implementation phases:

- Improving the current system;
- Aiding better identification of patients;
- Implementing an immigration health surcharge for non-EEA residents; and,
- Considering the extension of charging beyond secondary care.

Planned activities ranged from publication of guidance to aid NHS staff, the implementation of financial incentive and penalty schemes, and development of IT solutions.

These activities were primarily designed to produce increased awareness and understanding of cost recovery rules and processes, and greater use of relevant information by NHS staff when encountering patients, while the immigration health surcharge was aimed at increasing the amount of money recovered upfront for non-EEA temporary migrants. In turn, it was expected that this would result in a greater number of checks being performed on patients, leading to increased identification of chargeable patients, increased charging of these patients, including charging of patients prior to the start of treatment, and ultimately an increase in the value of costs recovered for NHS services rendered to overseas visitors and migrants.

Programme delivery to date

- Positive progress with delivery of planned activities has been achieved over the first two years of the Cost Recovery Programme since its launch in July 2014. The majority of key planned activities have been delivered within the first two years of the Cost Recovery Programme including:
 - The EEA and non-EEE incentive schemes – in October 2014 and April 2015 respectively;
 - The immigration health surcharge (and the supporting data sharing solution with the Home Office) – in April 2015;
 - The launch of the Cost Recovery Support Team (CRST) - in February 2015; and,
 - The implementation of the cost recovery e-learning package – in October 2015.
- In addition, the introduction of the Overseas Visitors Manager (OVM) Ambassador Programme has been implemented (between April and July 2015), as part of the overall training package, with the aim of ensuring consistent information about the charging rules is shared with NHS staff across England.
- However, some elements of the Cost Recovery Programme were not delivered to the timescales originally anticipated, due in part to delays in getting initiatives up and running (training, CRST) or due to reprioritisation during the first two years. For example, the training package was originally envisaged to be operational within Year One, but was not made available until half-way through Year Two. These aspects have therefore had less time to

bed-in than anticipated and consequently have had less time to influence staff behaviours and the performance of Trusts when it comes to Cost Recovery.

Table A: Programme delivery progress

Phase	Delivered	Outstanding/in progress
Phase 1: Improving the system	<p>2014/15</p> <ul style="list-style-type: none"> Publication of toolkit. Implementation of EEA incentive scheme. New data collection from providers in place. Pilot for EHIC collection in A&E settings. Home Office NHS Debtors Scheme in place. <p>2015/16</p> <ul style="list-style-type: none"> Implementation of non-EEA incentive scheme, and sanction. NHS staff training commenced. 	<ul style="list-style-type: none"> EEA incentive rates under review. Improved metrics to support better commissioning decisions. Roll-out for EHIC collection in A&E settings.
Phase 2: Better Identification	<p>2014/15</p> <ul style="list-style-type: none"> Initial data sharing solution made available. IT system scoping work complete Privacy Impact Assessment. <p>2015/16</p> <ul style="list-style-type: none"> Scoping work on GP processes. 	<ul style="list-style-type: none"> Primary care scoping work ongoing. Scoping of potential improvements to the new processes. Solution for the storage of information in relation to visitors in place in Trusts.
Phase 3: Immigration health surcharge	<p>2015/16</p> <ul style="list-style-type: none"> NHS Regulations (2011) updated. Staff awareness training³ and processes in secondary care put in place ahead of health surcharge introduction. Surcharge and associated supporting legislation in place and all visa applicants and those exempt from paying the surcharge are pre-registered with the NHS and have Biometric Residency Permits (BRPs) issued. 	
Phase 4: Extension of charging ⁴	<p>2015/16</p> <ul style="list-style-type: none"> Pilot of collection of EHIC details in primary care. 	<ul style="list-style-type: none"> Scoping of the extension of charging to primary and emergency care is ongoing.

³ Please note, while the immigration health surcharge was delivered on schedule, the updated NHS England guidance regarding this was not available until May 2015.

⁴ The response to the consultation into the extension of charging will be published by DH in due course.

Programme outcomes

- Awareness of the Cost Recovery Programme has increased primarily amongst administrative staff; similar gains have not been made amongst other staff groups, with no change evident amongst OVMs, Trust Chairs and Board Members, or clinical staff, for example. This is to be expected amongst groups such as OVMs, where awareness was high even at the time of the baseline survey in August to October 2014, but awareness among frontline clinicians has remained comparatively low. Awareness of the Cost Recovery Programme is dependent on the way in which administrative processes and policy changes being implemented are communicated to staff, and therefore low awareness should not be considered a problem for the Cost Recovery Programme as long as behaviour and cultural changes are observed.
- The guidance, supporting documents and materials, and wider support provided for OVMs by DH were well received throughout the evaluation. In particular, during Year Two, the provision of training materials, the OVM Ambassador Programme, and the DH Exchange Forum were all positively spoken of during the case studies as a source of support for OVMs, especially in seeking rapid response to queries about dealing with particular issues around cost recovery processes. However, there were repeated comments requesting an improvement in the clarity of the guidance, to provide more definitive answers in borderline cases, making eligibility easier to establish.

Assessment of programme impact

Knowledge and attitudes

- While levels of awareness that some patients can be charged for the healthcare they receive from the NHS, as measured through the staff survey, have increased over time amongst clinical and administrative staff, significant proportions of all groups (except OVMs) remain unaware. In particular, one in five Trust Chairs and board members were unaware that some patients could be charged.
- Analysis of the surveys of NHS staff and case study findings suggest that the level of buy-in to the principles underpinning the design of the Cost Recovery Programme, for example the principle that charging overseas visitors and migrants is *fair* was high amongst most staff groups over the evaluation period. However, there was also evidence that a significant minority of frontline clinicians are resistant to those principles, and levels of support may be declining over time amongst a number of staff groups (hospital doctors; primary care clinicians; CCG Leads and Boards; and Trust Chairs and Boards). This may make it more difficult to make improvements in relation to upfront charging for non-EEA residents if such changes require treatment to be postponed until payment has been agreed (this is not an issue for EEA residents with a valid EHIC).
- However, case study research highlighted continued issues with senior level support for the Cost Recovery Programme and efforts at improving cost recovery processes. While there have been some improvements, this has inhibited the ability of OVMs to implement process changes, introduce compulsory training, and communicate widely with frontline clinical and administrative staff. This has coincided with a decline in the proportion of Trust chairs and board members citing the Cost Recovery Programme as being likely to bring *financial benefits*, and raising questions about the extent to which OVMs will be able to deliver the necessary process changes if not supported from a senior-level within their Trust. It is likely NHS England and commissioners will have a key role in driving an increase in senior-level support.

- Relatively low proportions of respondents reported the risks outlined in the logic model. The most prevalent was *patients not seeking treatment in case they are charged*, but only by a small minority of respondents (senior Trust and CCG staff), and a similar proportion reported possible impact on *vulnerable groups*. While anecdotal evidence from the case study interviews did not reveal any problems with the unintended consequences, the extent to which the Cost Recovery Programme is generating any such consequences has proven very difficult to measure. This is due to the lack of information available about certain groups accessing healthcare (in order to benchmark against), and the variation in the healthcare needs of overseas visitors and migrants which may mask any deterrent or displacement effect.

Behavioural and procedural change

- The staff survey shows that administrative staff and hospital nurses were increasingly likely to report having a role in cost recovery as the Cost Recovery Programme progressed (either *identifying potentially chargeable patients* or *informing the OVM*), however no such change was seen amongst hospital doctors. However, while the case studies support the idea that OVMs have been able to drive process changes amongst frontline administrative staff, for example through asking more questions at registration, and implementing Trust policies, making more fundamental changes, such as to Trust IT systems, has proved more difficult. The staff survey and case studies highlight that administrative staff have seen more of an increase in involvement in cost recovery than frontline clinical staff. This appears to be because of the role of receptionists in asking questions and collecting information from patients during registration, and the role finance staff must play in calculation of costs and raising of invoices.
- Additionally, while the case studies highlighted a range of efforts aimed at improving the identification of chargeable overseas visitors and migrants, there are continued barriers that require addressing in order for further substantial financial gains to be achieved. In particular, most Trusts are yet to take the steps required to support upfront charging for non-EEA residents, without which they risk accruing increasing amounts of outstanding debt. Upfront charging will require further cultural and behaviour change, as it requires support from clinical staff, and is likely to be harder to achieve, given the need for treatment not being denied unless payment has already been agreed. In addition, systems in Trusts do not appear well set-up to accommodate upfront charging, and the required changes would likely have an initial financial cost in the short-term.
- OVMs who took part in the case studies all raised concerns about the level of resource dedicated to cost recovery within their Trusts. It is clear that OVMs are not delegating responsibility for decision-making in the whole, except in those cases where OVMs are supported by a wider team, creating issues when OVMs are not on duty (it is primarily a 9-5 role) as well as raising questions regarding how far OVMs can drive operational changes within their Trusts without additional administrative support. In only two cases in each of the two waves of case studies did OVMs report that they were able to utilise additional income generated through improved cost recovery processes to further invest in improvements, which while not a core objective of the Cost Recovery Programme, was anticipated to be happening more widely by the end of the first two years.

Progress towards aims for cost recovery

- Analysis of the available management information shows substantial progress in increased identification of EEA residents through EHIC agreements across the first two years of the Cost Recovery Programme. Progress has been made in Year Two with regards to identifying non-EEA residents, but recovery of costs still represents an area for improvement:

- While there has been a sustained increase in the volumes of treatments being processed under EHIC agreements since the launch of the Cost Recovery Programme, the average value of individual treatments has decreased recently, and therefore the overall financial gains have not increased at the same rate;
- There has been significant progress in the value of treatments identified for directly chargeable non-EEA and EEA residents but, as yet, there has not been an equivalent increase in the actual costs being recovered, due to the lack of upfront charging and issues with debts not being paid.
- The immigration health surcharge has brought in an estimated £164m during the 2015/16 financial year, having the biggest single impact on the overall landscape of cost recovery, but still has some way to go to reach the £200m ambition for increased cost recovery through the surcharge as anticipated in the Implementation Plan.
- The total costs recovered during Year Two (2015/16) are estimated to be in the region of £289m against the ambition of recovering £500m annually, meaning that the Cost Recovery Programme has achieved 58% of its ambition at the end of Year Two. While this represents a significant improvement on the state of play prior to the implementation of the programme, significant further progress is required if the £500m ambition is to be realised by 2018/19.

Costs and benefits of implementation

- Data was unavailable to allow a comprehensive cost benefit analysis for the implementation of the Cost Recovery Programme (for example data relating to the costs incurred by Trusts, and time impacts for NHS staff associated with implementing new processes). However, consideration of evidence gathered from across the evaluation suggests that the visible rise in income generated by the Cost Recovery Programme has not been driven by substantial financial investment in process or system change at a Trust level.
- However, the lack of changes to processes across the board could lead to increases in staff related costs in future if more comprehensive changes are made. This would apply to the Cost Recovery Programme in its final year as hosted by DH, and beyond. If an increased focus on cost recovery becomes business-as-usual across the NHS (the Cost Recovery Programme will continue in some form under NHS Improvement).
- In addition, it is yet to be seen whether the significant increase in income being recognised from non-EEA residents will translate into an equivalent increase in cash received. As yet, this therefore represents an unrealised benefit, and potential cost (if converted into non-recoverable debt).

Conclusions

Table B overleaf outlines the nine original questions that this evaluation has sought to answer, and presents an assessment of these based on the evidence generated through the course of this evaluation.

Table B: Assessment of evaluation questions

Evaluation Question	Assessment based on evidence collected to date
<p>Has the awareness and culture around identifying potentially chargeable patients changed since launch of the implementation plan and, if so, has this impacted on behaviour that will support cost recovery?</p>	<p>The staff survey identified high levels of underlying support for the principles of the Cost Recovery Programme.</p> <p>The survey shows that awareness of the potential chargeability of some patients has increased amongst administrative and clinical staff during Year Two of the Cost Recovery Programme, but that significant proportions of Trust Chairs and board members remain unaware of the rules. However, behavioural changes – such as increasing feelings of responsibility for identifying potentially chargeable patients, and increased involvement in flagging such patients to OVMs/relevant staff - are evident only amongst administrative staff and hospital nurses; no such positive change is evident among hospital doctors. These changes appear to be driven by procedural change, often instigated by the OVM, and not due to any underlying cultural change.</p>
<p>How could the Cost Recovery Programme go further to effect a greater change on awareness, culture and behaviour of NHS staff to support cost recovery?</p>	<p>The evaluation has highlighted a number of recommendations for the Cost Recovery Programme to consider going forward, highlighted here, and discussed in full elsewhere in this report. The recommendations include:</p> <ul style="list-style-type: none"> ▪ Providing further support to OVMs – Advice from DH, NHS England, NHS Improvement in improving processes within their Trust, based on a mapping of the processes currently in place across the NHS. ▪ Address barriers to upfront charging – Increasing upfront charging will be central to the future success of cost recovery, but this requires further cultural, behavioural and procedural change that are not yet evident. ▪ Training – Securing senior-level buy-in from Trusts will be crucial in improving the limited uptake of training on cost recovery, given that DH and arms-length bodies cannot mandate such training. ▪ Communications with senior Trust staff – Senior-level buy-in continues to present a barrier to OVMs enacting process changes, and further efforts are required to overcome this hurdle. ▪ Arms-length bodies and commissioners – These organisations are able to provide the levers through which to ensure changes are implemented across the NHS, and further work is required between this group and DH in order to further increase the effectiveness of cost recovery. ▪ Primary care: The identification of potentially chargeable visitors in primary care, and effective sharing of this information with secondary care would help address some of the challenges identified by this evaluation and other research.

What are the indications within the second year of the Cost Recovery Programme around whether the Cost Recovery Programme will achieve its objectives?

Although there has been some progress with regards to the volume of treatments being processed under EHIC agreements, there has been a substantial drop-off in the associated increase in the value of these treatments (the cause of this is unknown, but may relate to possible background variation in the healthcare needs of overseas visitors with EHICs). Furthermore, the costs recovered through EHIC, S1 and S2 agreements at c.£56 million per year, remains significantly below DH's ambition to recover £200 million per year through this route. In addition, while there has been increasing identification and charging of directly chargeable patients, significant progress must be made to move towards a culture of upfront charging if this is to translate into increased income for the NHS in real terms. The immigration health surcharge has contributed 82% of its anticipated annual income in the first year of operation. Unless there is an increase in the volume of people who will pay the health surcharge in the future, either due to increased migration to the UK or through widening the criteria for who should pay the surcharge, it is unlikely that the £200m ambition will be achieved without increasing the fee.

Despite some positive progress, total cost recovery for 2015/16 is estimated at £289m, 58% of the ambition for the Cost Recovery Programme overall. Therefore, significant further progress is required in order to meet this ambition.

How effective is the financial incentive scheme in encouraging providers to identify chargeable patients?

There has been a sustained upward trend in the volume of EHIC treatments being processed since the launch of the EEA incentive scheme, with almost three times as many treatments now being entered on the OHT Portal compared to the year leading-up to the launch of the Programme, suggesting the incentive has positively impacted upon the identification activities when it comes to EEA residents. However, there has been a declining return in the overall value of these treatments, which will reduce the level of incentive being paid out, but also therefore reduce the value of incentives being received by Trusts. In addition, since the launch of the non-EEA incentive scheme in April 2015, there has been a substantial increase in the costs of treatments that non-EEA residents are being charged for, in line with the increase that would be expected due to the 150% tariff now applicable under the non-EEA incentive scheme. However, as yet, this scheme does not appear to have had an impact on the actual recovery of costs from these patients, and the proportion of debt ultimately recovered in the future will determine whether or not the non-EEA incentive can be deemed to have been effective.

Which elements of the Cost Recovery Programme have had the greatest impact on achieving the Cost Recovery Programme's objectives so far?

At the end of Year Two, it is apparent from the analysis of the management information relating to costs recovered from EEA and non-EEA patients that the incentive schemes in operation here can be seen to have had significant impacts. In addition, the introduction of the immigration health surcharge has generated £164m during its first year of operation, having the single biggest impact on increasing income. It is difficult to discern which elements of the programme have had the greatest impact on achieving the cultural and behavioural change objectives. Awareness of charging rules, incentive schemes and the Cost Recovery Support Team have been persistently low among frontline staff, while there is low incidence of training on cost recovery across all staff groups. Evidence suggests that many of the changes seen have been primarily driven by OVMs themselves. The constraints within which DH operates, for example being able to mandate changes at a Trust-level, have added to the difficulties here.

How are the tools and other materials being implemented and used by NHS staff?

Tools such as the OVM Toolbox have been generally well received by their intended audience, primarily OVMs. Case study sites in Year Two have made increasing use of the materials. The e-learning package introduced in October 2015 has yet to see substantial uptake, and therefore the impact of this is likely yet to be realised.

Could the tools and other materials be amended to make them more effective?

To date the OVM Toolbox, including the revised guidance documents, is the primary tool that has been made available as part of the Cost Recovery Programme. Feedback collected during the case studies suggests that OVMs are finding this useful, and are implementing materials provided, such as revised letters. Specific feedback on some of the materials is presented elsewhere in this report. Despite improvements to the guidance documents made during the first two years of the Cost Recovery Programme, it is apparent that there remains the possibility for OVMs to have misconceptions based on the guidance, with feedback suggesting there are sometimes “grey areas”. The low proportions of NHS staff having experienced the e-learning programme precludes any recommendations for further improvement of the content.

What impact has the Cost Recovery Programme had on equalities and health inequalities so far and how effective have mitigating actions been?

Stakeholders consulted during the initial stage evaluation expressed a range of concerns relating to the possible negative impacts of the Cost Recovery Programme on equalities and health inequalities, particularly in relation to vulnerable groups and possible exclusion of these groups from access to health services. However, while this was explored through the case studies and staff surveys, the evaluation has not uncovered any evidence of the Cost Recovery Programme having significant negative impacts. A separate piece of work undertaken alongside this evaluation (detailed in Section 3.4.4) highlighted some of the challenges in measuring the unintended consequences. This is due to the lack of information available about certain groups accessing healthcare (in order to benchmark against), and the variation in the healthcare needs of overseas visitors and migrants which may mask any deterrent or displacement effect. The Cost Recovery Programme should continue to engage closely with stakeholders going forward in order to monitor the occurrence of any unintended consequences.

What are the costs and benefits of each element of the implementation of the Cost Recovery Programme?

The availability of data on the practices in place across the NHS prior to the launch of the Cost Recovery Programme, and the costs associated within any changes (e.g. increased staff time spent on cost recovery related activities) precludes a comprehensive cost benefit analysis of implementation Programme, but further discussion of the costs and benefits is presented in Chapter 4.

The published impact assessment estimated that the total one-off financial cost of implementing Phases One and Two of the Cost Recovery Programme would be £14m (with ongoing annual costs estimated at £1.9m), while the benefits through increased income generated by Phases One and Two was thought to be up to £450m (£250m through Phases One and Two, and up to £200m through the introduction of the immigration health surcharge).

Examining the management information shows that in 2015/16 an estimated £1.64m has been generated by the immigration health surcharge, a total of £69.2m has been recognised (although not yet recovered) in relation to non-EEA residents, and £56.3m in costs have been recovered through EHIC, S1 and S2 agreements. Total cost recovery for 2015/16 is estimated at £289m, 58% of the ambition.

Measurement of the costs has proven more difficult. To date, treatments eligible for the EEA incentive amount to £4.6m in incentive payments, and information provided by DH suggest the Cost Recovery Programme costs have been in the region of £0.9m. It is not possible to estimate the costs incurred across NHS Trusts due to the variation in the way changes have been implemented, but it is likely that increased costs have been incurred through an increased amount of administrative resource being dedicated to cost recovery.

Recommendations

This evaluation has resulted in a number of recommendations being made to maximise the chances of the Cost Recovery Programme delivering against its aims. These recommendations are presented in full in section 5.2 of this report, and summaries of these are presented here.

- **Further support for OVMS:** OVMS appear to be playing a central role in driving changes in administrative processes at a Trust level. However, given the mid-level seniority of most OVMS, they require further support from DH and/or NHS England and NHS Improvement, and in many cases more support from senior Trust leaders, in order to enact further process changes within their Trusts. In particular, there is a need to combat the risk that progress is limited by the level of resource OVMS have to undertake their roles and responsibilities with regards to implementing the charging regulations, and also by a lack of support for and prioritisation of cost recovery among many Trust leaders. Support should address, at the minimum, the following areas:
 - **Process advice:** There remain gaps in the understanding of the various processes in place across the NHS for identifying and recovering costs from overseas visitors and migrants. Further work should be undertaken, perhaps through use of the DH Exchange Forum, to map the various models in place, identify the changes that have been made to these, and how successful each of the models have been (in tandem with analysis of the MI for the Cost Recovery Programme), with the view to providing clearer advice to Trusts and OVMS as to the changes that are expected. This must be done in collaboration with an assessment of the extent to which gains can be made by pursuing further behaviour change amongst frontline clinical staff, and whether focussing more heavily on use of administrative staff may lead to larger gains being made by the Cost Recovery Programme. While this evaluation did seek out examples of best practice as part of the later round of case studies, difficulties experienced in gaining access to those Trusts identified as being potential examples of good practice have hindered the ability of the evaluation to provide examples of good practice.
 - **Clarity around the OVM role:** While the updated guidance published includes recommendations on what the OVM role should entail, further communication to Trusts as to the importance of the OVM role, and the support, and skills, that they require in order to effectively fulfil this role, including the ability to communicate widely with staff, to implement process changes involving frontline clinical and administrative staff, and to draw on additional resource where needed. The limited resources available to OVMS is likely to be a key constraint to the success of any future extension of charging to A&E.
- **Address barriers to upfront charging:** Achieving a further shift to upfront charging should be considered central to the aims of the Cost Recovery Programme during the remaining year of operation. This evaluation has highlighted some of the barriers to upfront charging, which must be overcome, while at the same time achieving a further behavioural shift amongst clinical staff. Further consultation with senior Trust staff, and OVMS may be required to understand how these changes may be driven forward. For example, undertaking a pilot to demonstrate the impacts of upfront charging (e.g. through the implementation of debit/credit card readers) in collaboration with a Trust with a particular problem in this regard, may help generate the evidence needed to drive further change.
- **Training:** While an e-learning package has been introduced, uptake of this to date has been extremely limited. OVMS in the case studies were making efforts to introduce training, but increased introduction of such training, as part of new staff induction for example, would provide OVMS with the levers to introduce this. As neither the

Department of Health, nor arms-length bodies within the health sector are able to mandate non-clinical training, this would likely be reliant on achieving buy-in from NHS Trusts.

- **Communications with senior Trust staff:** Senior-level buy-in continues to present a barrier to OVMs in driving process and behaviour change. Renewed efforts are likely to be required by DH, NHS England, NHS Improvement and other arms-length bodies to emphasise the importance of cost recovery. Focussing efforts on Trusts in high-visitor or high-migrant areas may provide the largest gains in the short-term.
- **Communications with potential visitors:** Significant problems have been reported with the volume of EEA residents who are unable to present an EHIC when required, despite being eligible for one. The promotion of awareness of UK charging rules among EEA residents planning to visit the UK, focusing on the need to carry an EHIC card and present this when interacting with the NHS is an important part of the Cost Recovery Programme going forward in order to facilitate a continued upward trajectory in the rates of cost recovery for EEA residents. One Trust highlighted efforts to have posters put up in a local airport, but had not succeeded here – it is suggested that national-level efforts at this might be more successful.
- **NHS England, NHS Improvement, other arms-length bodies, and commissioners:** Ongoing work is needed to engage NHS England, NHS Improvement, other arms-length bodies and commissioners in providing the levers with which to drive the behavioural, cultural and procedural changes needed across the NHS. This is likely to be particularly key if charging is extended to primary and emergency care services.
- **Primary care:** The lack of provision of information regarding chargeable patients entering the health system through primary care continues to pose a challenge for secondary care services. The provision of better information here would likely have substantial benefits for progress towards targets. The recent communications with primary care, and the outcome of the consultation regarding the extension of charging to primary care will need to be considered before further steps are taken here.
- **Unintended consequences:** It has proven difficult to identify whether any unintended consequences have been realised during the first two years of the Cost Recovery Programme. Therefore, it is recommended that DH continues to make efforts to monitor any potential negative impacts arising from an increased focus on cost recovery on an ongoing basis.

Overall, the Cost Recovery Programme has made much progress during the first two years. However, there remain some key issues to be addressed if the Cost Recovery Programme is to make further progress towards its stated ambitions. In particular, addressing the issue of upfront charging should be considered one of the most pressing areas for consideration, given the potential for an increase in debt at a Trust and NHS-wide level has to undermine the work the Cost Recovery Programme has done to secure buy-in to the principles of charging.

1 Introduction and Programme Overview

This chapter sets out the background and rationale for the Visitor and Migrant NHS Cost Recovery Programme, provides an overview of the intended plan for implementing the Cost Recovery Programme during the period covered by the evaluation, and presents the logic model for the Cost Recovery Programme developed during the inception phase, setting out how the objectives of the Cost Recovery Programme would be achieved. In addition, this chapter presents the objectives of the evaluation, the specific questions it has sought to address, and the methods through which the required evidence was collected.

1.1 Aims of the Visitor and Migrant NHS Cost Recovery Programme

The core objective of the Cost Recovery Programme is to *improve NHS cost recovery from visitors and temporary migrants in England (who are not entitled to NHS care that is free at the point of delivery) and to ensure that the NHS receives a fair contribution for the cost of healthcare it provides*⁵.

The Department for Health aims to recover £500 million every year by the middle of the current parliament (2015-2020), through improving the current system of identification of, and cost recovery from, chargeable patients in secondary care. It also aims to enable better identification of chargeable patients through changes to identity verification and registration systems and processes in primary and secondary care, introducing a health surcharge. It was also anticipated that charging policy would be extended to include some primary care and A&E services, and this has been subject to a recent public consultation.

1.2 Rationale for the Visitor and Migrant NHS Cost Recovery Programme

1.2.1 Cost recovery – legislative overview

Certain groups of overseas visitors and migrants are liable to cover the cost of some secondary care received while visiting the UK. NHS organisations providing secondary care services have a statutory obligation to identify potentially chargeable patients and recover this cost⁶. The NHS (Charges to Overseas Visitors) Regulations have been in place since 1989, and were updated in 2011, and 2015, and cover charging of overseas visitors and migrants for their healthcare based on the principle that *a person who is ordinarily resident in the UK must not be charged for NHS hospital services*⁷, and vary depending on the origin of the patient:

- **European Economic Area (EEA)** - where a patient (who is a visitor, including students) is able to provide a European Health Insurance Card (EHIC) – or a Provisional Replacement Certificate - the costs of NHS healthcare can be recovered directly from the Member State where the individual is resident⁸. Some patients will not be eligible for an EHIC, in which case they are ineligible for free NHS care and should be

⁵ Visitor and Migrant NHS Cost Recovery Programme: Implementation Plan 2014-16, Department of Health, July 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementatation_Plan_Phase_3.PDF, p.11.

⁶ www.legislation.gov.uk/ukxi/2011/1556/made and www.legislation.gov.uk/ukxi/2012/1586/contents/made

⁷ Guidance on implementing the overseas visitor hospital charging regulations 2015, Department of Health, p.2, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418634/Implementing_overseas_charging_regulations_2015.pdf

⁸ Ibid. p.4

charged. The S1⁹ (for workers, dependants of worker in home state, pensioners, and people in receipt of other exportable benefits, and their dependants), and S2¹⁰ (allowing patients to travel for medical treatments that are pre-arranged and approved), are different mechanisms for charging residents of other Member States for the costs of their healthcare.

- **Non-EEA** – patients who are not ordinarily resident in the UK are required to cover the cost of treatment themselves, or through insurance policies. Reciprocal arrangements are in place between the UK and some non-EEA states which also provide exemptions for urgent and emergency care, and exemptions also exist to extend free healthcare to patients based on other criteria, for example asylum seekers or those granted asylum, children taken into local authority care, and family members of exempt groups.

1.2.2 Cost recovery performance before the Cost Recovery Programme

An Impact Assessment¹¹ undertaken by DH, and published in 2014, estimated that only a small share of the costs incurred by the NHS in England in providing healthcare to visitors and migrants ordinarily resident in EEA and non-EEA countries was being recovered in practice (25% amongst visitors from EEA countries, and 30% amongst visitors and migrants resident in non-EEA countries), for example equating to just £73m in the 2012/13 financial year.

Even given the overall poor performance by the NHS in identifying chargeable overseas visitors and migrants, and recovering costs from them, it is clear that there was substantial Trust-level variation, with some Trusts already performing well. In the year immediately prior to the Cost Recovery Programme (2013/14), one Trust was able to identify patients receiving **£640k** of treatments under EHIC arrangements, while another was able to identify non-EEA patients receiving treatment worth **£6.2m**. It is clear, therefore, that while there will undoubtedly be substantial variation, the potential for some Trusts to improve their financial situations is considerable.

The available evidence also suggested the presence of a number of possible disincentives and barriers to the identification of chargeable patients:

Possible disincentives

- **Patients resident in an EEA country** – In order to recover costs for providing healthcare to residents of EEA countries, the healthcare provider identifies an overseas visitor, obtains EHIC details and enters them on the Overseas Visitor Treatment web portal¹², so that the Overseas Healthcare Team (OHT) at the Department for Work and Pensions (DWP) can reclaim funds from Member States. However, the Clinical Commissioning Group (CCG) pays the provider for healthcare as per a UK resident, and there is no

⁹ A certificate of entitlement issued by the member state to insured persons. S1 forms should be sent to the Overseas Healthcare Team in DWP, although it is expected that staff in both primary and secondary care may come into contact with patients with S1s that have not yet been sent to DWP and may collect and send these to DWP on behalf of the patient. A fixed annual amount is charged to the member state for as long as the patient with the S1 remains in the UK (with the exception of Worker S1s where actual costs will be recouped from the member state).

¹⁰ An S2 form represents a payment guarantee from the issuing country for planned treatment.

¹¹ NHS Cost Recovery Programme Impact Assessment, Department of Health, July 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331623/Impact_assessment.pdf

¹² This portal is the system through which all treatments relating to patients resident in an EEA country must be logged and processed.

additional benefit for the provider in undertaking the additional work needed to collect the necessary details and enter these on the web portal.

- **Patients resident in a non-EEA country** - Once identified, the risk of not recovering the full income is borne by the healthcare provider who is responsible for recovering costs from the patient.

Barriers to cost recovery

Qualitative research¹³ conducted in 2013 also highlighted other factors contributing to low levels of recovery of costs from visitors and migrants, including:

- **Complexity of charging rules:** The complexity of the existing charging rules and associated guidance was reported to be a problem; indeed, some Trusts were reported to consider the regulations not to be compulsory.
- **Perceived difficulties:** Perceptions about the difficulty of the cost recovery process, and the lack of a culture of identification, charging, and recovery of costs amongst staff.
- **Information barriers:** The aforementioned Impact Assessment identified a fundamental information barrier between providers and patients regarding chargeable status: *'we have a residency-based system of eligibility, but no ready means by which to officially prove our residency status. Consequently, NHS providers are generally unaware of a visitor or migrant's status.'*¹⁴
- **Visitor and migrant populations:** Chargeable visitors and migrants do not visit individual areas of England evenly. Certain areas can be classed as high-migrant or high-visitor (or both), while others may have a much lower throughput of visitors and migrants. Therefore, Trusts in low-visitor or migrant areas will have a barrier (and disincentive) to implement improved processes if they do not see significant potential for recovery.

In addition, the research highlighted that there were significant variations in the cost recovery practices and processes across Trusts in England, all of which contribute to the underperformance of the NHS at a system-level in terms of cost recovery.

The evidence discussed above suggested that interventions to improve administrative processes, staff understanding of both the rules around charging for healthcare, and securing a broader cultural shift to one of charging where appropriate had the potential to deliver significant fiscal benefits. It is on this basis that the Cost Recovery Programme was designed.

1.3 Overseas Visitor and Migrant NHS Cost Recovery Programme

DH launched the Cost Recovery Programme with the publication of the Implementation Plan¹⁵ on 14th July 2014 following a period of consultation in 2013. This plan set out the approach to implementation of the Cost Recovery

¹³ Qualitative Assessment of Visitor and Migrant Use of the NHS in England, Creative Research, 2013, www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

¹⁴ NHS Cost Recovery Programme Impact Assessment, Department of Health, July 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331623/Impact_assessment.pdf (p.10)

¹⁵ Visitor and Migrant NHS Cost Recovery Programme: Implementation Plan 2014-16, Department of Health, July 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementatation_Plan_Phase_3.PDF

Programme during the 2014/15 and 2015/16 financial years, focussing on doing so through four key phases. A table illustrating this phased approach can be found in Table 1.1, below. Full details of the Cost Recovery Programme can be found in the published Implementation Plan.

It was also envisaged that as part of the implementation process a series of pilots would run to test the processes involved. To date, two pilots have been conducted. The first pilot tested the collection of EHIC details in emergency care settings (Accident and Emergency, Urgent Care Centres, Minor Injury Units and Walk in Centres) in six Trusts spread across England. A second pilot exploring the collection of EHIC details in primary care settings was conducted across 10 GP Practices in England between April and June 2015, as mentioned. Phase Four was to be covered in a separate implementation plan, which was originally scheduled for release later in the Financial Year 2014/15, although this will now take place following the Government's response to the aforementioned consultation.

Table 1.1: Implementation for 2014/15 and 2015/16

Phase	Activities in Financial Year	
	2014/15	2015/16
Phase 1: Improving the system	<ul style="list-style-type: none"> • Publication of toolkit. • Implementation of EEA incentive scheme. • Preparations for non-EEA incentive scheme. • NHS staff training commenced. • New data collection from providers agreed. • National Intensive Support Team in place to aid Trusts as needed. • Pilot and subsequent roll-out for EHIC collection in A&E settings. 	<ul style="list-style-type: none"> • EEA incentive rates under review • Non-EEA incentive and sanction fully implemented. • Increased reporting to EEA portal from NHS trusts and primary care leading to increased claims to EEA member states. • Improved metrics to support better commissioning decisions. • Better data sharing with the Home Office to report high-value NHS overseas debtors leading to fewer health tourists.
Phase 2: Better identification	<ul style="list-style-type: none"> • Initial data sharing solution made available. • Scoping work to take place in relation to developing IT systems. • Completion of Privacy Impact Assessment. • Scoping work continuing on GP processes. 	<ul style="list-style-type: none"> • Ongoing scoping work to support identification of chargeable patients in the primary care setting. • Health surcharge in place and the Cost Recovery Programme will have completed the rollout of the new process to support this. Solution for the storage of information in relation to EEA and non-EEA visitors in trusts should be in place. • Scoping in relation to potential improvements to the new processes, and future expenditure around this, will be continuing.
Phase 3: Health surcharge	<ul style="list-style-type: none"> • Support Home Office to deliver Immigration Bill and regulations for health surcharge. • Prepare, redraft and implement NHS Regulations to ensure compatibility with health surcharge arrangements. 	<ul style="list-style-type: none"> • Surcharge and associated supporting legislation in place and all visa applicants and those exempt from paying the surcharge are pre-registered with the NHS and have Biometric Residency Permits (BRPs) issued.

	<ul style="list-style-type: none"> • Staff awareness training and processes in secondary care put in place ahead of health surcharge introduction. • Guidance updated. 	
Phase 4: Extension of charging	<ul style="list-style-type: none"> • Scope and consider extensions of charging. • Scope and consider changes to the exemptions from charging regime. • Scope and consider changes to cost recovery in local authorities and other providers. 	<ul style="list-style-type: none"> • To be determined by decisions in the first year of the Cost Recovery Programme.

Source: *Overseas Visitor and Migrant NHS Cost Recovery Programme – Implementation Plan, Department of Health (2014)*

1.3.2 Programme Delivery and Governance Arrangements

The governance of the Cost Recovery Programme has been based around:

- A **Programme Board** made up of representatives of DH, the Health and Social Care Information Centre (HSCIC), NHS England, Home Office, and the Cabinet Office, and has responsibility for overseeing the delivery of policy and implementation of the Cost Recovery Programme, and is chaired by DH.
- A **NHS External Reference Group** chaired by Sir Keith Pearson and includes representatives from the NHS including doctors, Trusts, local authorities, OVMs, Commissioning Support Units, and vulnerable group representatives. This group's mandate is to provide external strategic leadership to the implementation of the Cost Recovery Programme.
- Delivery has been led by the **policy team** within DH, and supported by the Home Office (delivery of the non-EEA health surcharge) and HSCIC (delivery of NHS IT solutions).
- An **Equalities and Vulnerable Groups** stakeholder group meets with the **DH policy team** on a regular basis.
- **Overseas Visitors Advisory Group (OSVAG)**, to which all OVMs are invited, is one of the primary methods of engaging with this audience regarding the development, and delivery of the Cost Recovery Programme.
- In addition, a national **Cost Recovery Support Team (CRST)** was launched in February 2015 to provide support and advice to Trusts during implementation. The CRST is comprised of members of NHS Staff (OVMs, Clinicians and Finance Staff) on secondment to the Cost Recovery Support Team within DH.

1.4 Programme Logic Model

A logic model for the Cost Recovery Programme is set out in Figure 1.1, which sets out the causal process through which the Cost Recovery Programme is intended to deliver its anticipated outcomes. The logic model depicts the constituent parts of the Cost Recovery Programme and illustrates the anticipated contribution that each input will make to the achievement of the ultimate impacts of the Cost Recovery Programme. This model is based on the principle that it is possible, and sensible, to implement a single-approach to improving cost recovery processes across the NHS. The conclusions from this evaluation should serve to help the policy team within DH in deciding whether this logic model remains relevant in deciding how best to further improve the rates of identification and recovery of cost from overseas visitors and migrants.

Inputs and activities

The main inputs to the Cost Recovery Programme relate to time and direct costs associated with the different elements of the Cost Recovery Programme as outlined in Table 1.1. The costs relate to the staff time required by DH and partner agencies in developing and delivering the Cost Recovery Programme, the direct costs involved in funding financial incentives, and the anticipated time spent by NHS staff in attempting to identify and recover costs from overseas visitors and migrants as a result of the Cost Recovery Programme.

A range of activities have been designed as part of the Cost Recovery Programme. These will be delivered over the first two years and sustained over the longer-term in some instances. The activities identified in the logic model in Figure 1.1 can be directly linked back to the elements of the Cost Recovery Programme set out in the initial Implementation Plan and address the barriers and information gaps identified earlier. These activities range from communications and awareness raising activities to the creation of the financial incentive schemes and the implementation of new IT systems to aid better recovery. A range of different actors are involved in these activities, from DH staff delivering some of the initiatives, staff at HSCIC and the Home Office and clinical and administrative staff across the NHS itself.

These inputs and activities are not solely within the control of DH, but also rely on the support and co-working of partners such as the Health and Social Care Information Centre, Cabinet Office and Home Office. The success of the Cost Recovery Programme depends on both the leverage of cultural and behavioural change amongst frontline NHS staff and the implementation of supporting infrastructural and regulatory changes, such as the introduction of the immigration health surcharge, in order to deliver key outputs and therefore impacts. Table A.1 (Appendix A) sets out the anticipated outcomes of the Cost Recovery Programme in more detail.

Outputs

The activities were each intended to deliver a range of outputs, the realisation of which was anticipated to be crucial if the Cost Recovery Programme is to deliver its intended outcomes and impacts. The delivery of these outputs represent the starting point for some of the metrics against which successful delivery of the Cost Recovery Programme will be measured. The outputs relate to (1) the number of NHS staff who are reached by, and engage with, the communications and training activities delivered and (2) access to better data relating to charging. The final output was anticipated to be the volume of visitors paying the immigration health surcharge.

Outcomes and impacts

The outcomes and impacts of the Cost Recovery Programme depend on both the activities being delivered and the outputs being realised. It was anticipated that both behavioural and cultural change was required amongst NHS staff in order to drive an improvement in cost recovery. The activities, driving awareness and understanding of the importance of cost recovery, and the rules to be followed were intended in turn to bring about cultural change, lead to an increased number of checks being implemented and therefore, ultimately, an increase in the monetary value of medical costs being recovered by the NHS.

There are a number of causal links, underpinned by numerous assumptions, on which these outcomes are dependent. The failure of any of these could cause either a reduction in the level of impact or in the impact not being delivered at all.

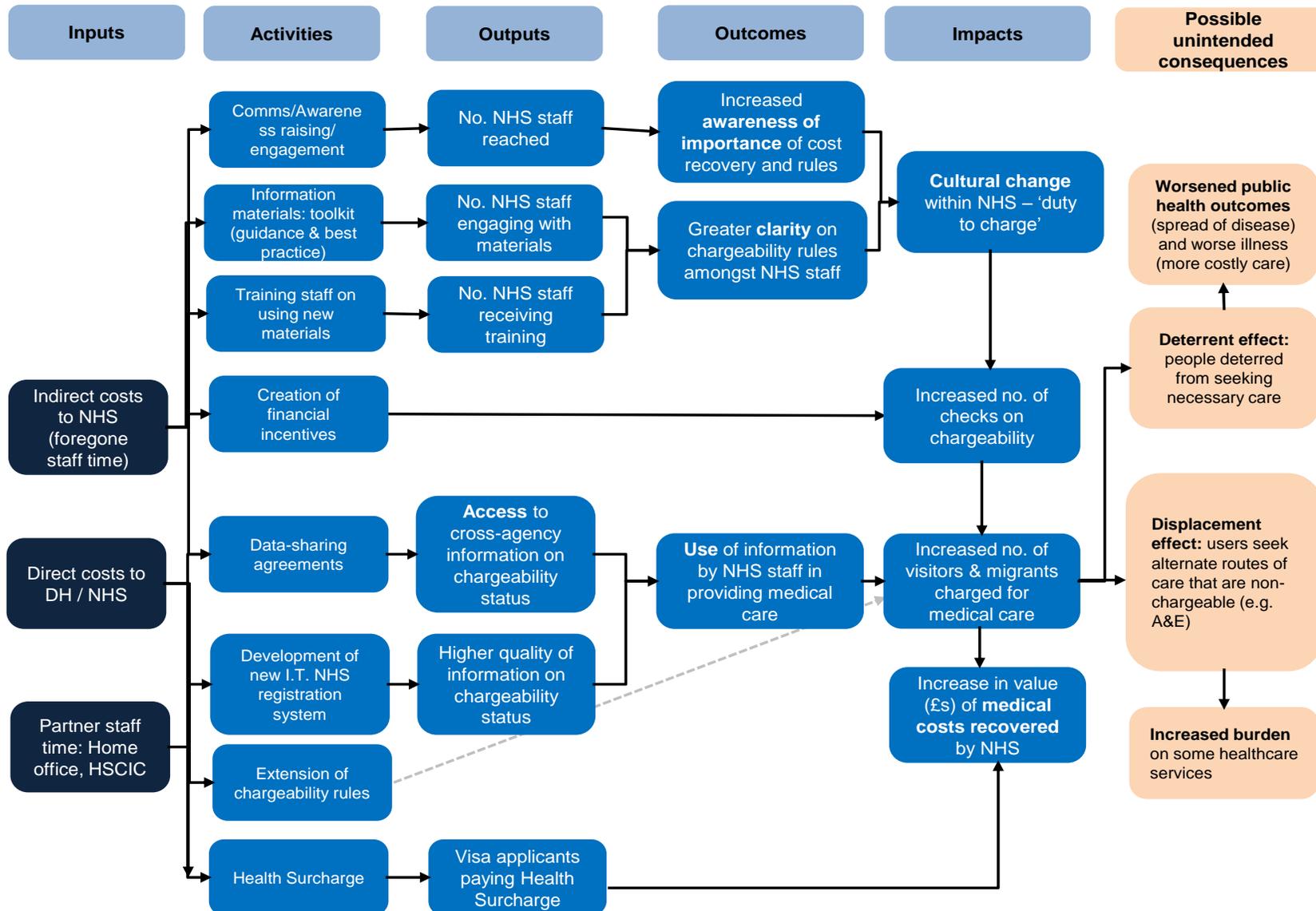
Possible unintended consequences

The nature of the Cost Recovery Programme gives the potential also for a variety of unintended consequences to be manifest. These primarily take two forms. The first are **deterrent** effects, whereby people are deterred from seeking the care they need, leading to worsened public health outcomes. The second are **displacement** effects, whereby users seek alternate routes to access healthcare that are non-chargeable (e.g. emergency or primary care services), leading to an increased burden on these healthcare services.

In addition to the unintended consequences outlined above, there is also the possibility that, if uniform processes for establishing eligibility for free healthcare are not implemented, then conscious or unconscious bias may lead to people being treated differently based on their ethnic background.

While the evaluation has sought to understand, where possible, reported occurrence of unintended consequences, widespread appraisal of these requires the development and use of more tailored research and monitoring approaches.

Figure 1.1: Visitor and Migrant NHS Cost Recovery Programme – Logic Model



1.5 Programme summary

- The aim of the Cost Recovery Programme is to increase the revenues available to the NHS by introducing more effective practices to recover costs from visitors and migrants ineligible for free healthcare. Qualitative¹⁶ and quantitative¹⁷ research undertaken prior to its launch showed that there was a significant shortfall between potential levels of costs recovered and those that were being achieved in practice prior to the launch of the Cost Recovery Programme.
- The fundamental objective of the Cost Recovery Programme was to improve cost recovery from overseas visitors and migrants who are not entitled to free access to NHS health services. As part of the development of the Cost Recovery Programme, an ambition was set to increase the level of costs recovered up to £500 million every year by the middle of the current parliament (2015-2020).
- In order to bring about the changes needed in culture, behaviour, and process within the NHS to drive an increase in cost recovery, a programme of work was designed by DH to be implemented over the financial years 2014/15, 2015/16 and 2016/17. This Programme has four phases aimed at: improving the current system, aiding better identification of patients, implementing a health surcharge for non-EEA residents, and considering the extension of charging beyond secondary care. Activities to be delivered range from publication of guidance to aid NHS staff, to the implementation of financial incentive schemes, to the development of IT solutions to address some existing issues.
- It was hoped that these activities would drive change through producing three primary outcomes: increased awareness of cost recovery rules, processes and their importance; increased understanding of the chargeability rules; and greater use of relevant information by NHS staff when encountering patients. It was envisaged that this would result in a greater number of checks being performed on patients, leading to increased identification of chargeable patients, increased charging of these patients, and ultimately an increase in the value of costs recovered for NHS services rendered to overseas visitors and migrants.

1.6 Evaluation overview

Ipsos MORI was commissioned by the Department of Health in June 2014 to undertake a formative evaluation of the Overseas Visitor and Migrant NHS Cost Recovery Programme ('the Cost Recovery Programme'). This report set out the final results of the evaluation, examining the progress made during the first two years of implementation.

1.6.1 Evaluation Objectives

As a formative evaluation, the overarching objective of this piece of work has been to provide DH with feedback throughout the initial implementation of the Cost Recovery Programme in order to help further refine and improve the Cost Recovery Programme with the intention of maximising its impact. The specific aims of this evaluation were to:

¹⁶ Qualitative Assessment of Visitor and Migrant Use of the NHS in England, Creative Research, 2013, <https://www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs>

¹⁷ Quantitative Assessment of Visitor and Migrant Use of the NHS in England, Prederi, 2013, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251909/Quantitative_Assessment_of_Visitor_and_Migrant_Use_of_the_NHS_in_England_-_Exploring_the_Data_-_FULL_REPORT.pdf

- Determine whether there has been a change in culture and behaviour amongst frontline staff and other relevant stakeholders.
- Learn lessons about what works (and doesn't work) in improving cost recovery, including through analysis of the Emergency Care EHC Pilot.
- Help refine the Cost Recovery Programme through continuous feedback and inform decisions before proceeding with each stage of the Cost Recovery Programme.

Table 1.2 below outlines the central questions which this evaluation has sought to answer, each of which we will consider in Chapter 4 when the evidence of the evaluation is assessed.

Table 1.2: Evaluation Questions

Question	Detail
EQ1	Has the awareness and culture around identifying potentially chargeable patients changed since launch of the implementation plan and, if so, has this impacted on behaviour that will support cost recovery?
EQ2	How could the Cost Recovery Programme go further to effect a greater change on awareness, culture and behaviour of NHS staff to support cost recovery?
EQ3	What are the indications within the first two years of the Cost Recovery Programme around whether the Cost Recovery Programme will achieve its objectives?
EQ4	How effective is the financial incentive scheme in encouraging providers to identify chargeable patients?
EQ5	Which elements of the Cost Recovery Programme have had the greatest impact on achieving the Cost Recovery Programme's objectives so far?
EQ6	How are the tools and other materials being implemented and used by NHS staff?
EQ7	Could the tools and other materials be amended to make them more effective?
EQ8	What impact has the Cost Recovery Programme had on equalities and health inequalities so far and how effective have mitigating actions been?
EQ9	What are the costs and benefits of each element of the implementation of the Cost Recovery Programme?

Source: Department of Health

1.6.2 Evaluation Scope, Methods and Limitations

Evaluation Scope

This evaluation has been concerned with:

- Exploring the progress in delivery of the Cost Recovery Programme between July 2014 and March 2016.
- The impact that these activities have had on driving the cultural and behavioural change identified as necessary during the design of the Cost Recovery Programme.
- Assessing the progress made towards the ambitions for the Cost Recovery Programme.

- Exploring how individual elements of the Cost Recovery Programme may be refined during future stages of implementation.

The underlying design principles of the Cost Recovery Programme, such as understanding the accuracy of the potential £500m ambition for recovery, and the possible extension of charging to primary and emergency care services, have not been considered within the scope of this evaluation.

Methods

Evidence to support the evaluation was gathered from a variety of sources:

- **NHS Staff Survey:** Quantitative data on engagement with the Cost Recovery Programme, as well as indicators of cultural and behavioural change with regard to cost recovery, were collected through telephone surveys of NHS staff groups that would be expected to have some responsibility for cost recovery (covering frontline administrative staff, clinicians and senior Trust management). Surveys were conducted at three points in time: prior to the implementation of the Cost Recovery Programme (August to October 2014), an interim survey at 6 months' post implementation (February to March 2015), and a final survey 18 months' post implementation (January to April 2016). Full details of the survey can be found in Appendix B. Please note that some questions are subject to small base sizes due to filtering of questions based on awareness of charging rules, and results based on less than 50 respondents (beyond OVMs) are not reported. In addition, due to the different ways in which the samples were selected and data weighted for each staff group comparisons between staff groups are indicative rather than conclusive.
- **Case studies:** The second strand of work feeding into this evaluation is a series of case studies and interviews conducted across thirteen NHS Trusts in England during the course of the evaluation. Separate sets of case studies were conducted as part of each of Years One and Two of the evaluation. Case studies were originally intended to consist of full day visits (repeated twice during Year One, and once in Year Two) to Trusts to consult with staff in a number of roles¹⁸. However, difficulties gaining access to Trusts were experienced throughout the evaluation, and as such a number of case studies consisted only of telephone consultations with OVMs. For further details of this strand of work please see Appendix D.
- **Stakeholder consultations:** In addition, a range of stakeholder consultations were conducted in order to gather views on the effectiveness of the Cost Recovery Programme at a national level. In total, 16 stakeholder consultations (with a total of 18 stakeholders) were conducted during Year One, and included the following organisations: Department of Health; Department for Work and Pensions; Home Office; NHS England; Royal College of General Practitioners; NHS Providers; Monitor; the Overseas Visitors Advisory Team (OSVAG); Doctors of the World; Homeless Link; Migrant Rights Network and National Aids Trust.
- **Analysis of Management Information:** Analysis of available Management Information was conducted to establish how far the identification of chargeable patients and recovery of costs relating to treatments provided has changed over time. The data were collected via the Department for Work and Pensions Overseas Visitor Treatment (OVT) Web Portal, covering costs recovered for EEA patients. Data relating to the recovery of costs from non-EEA patients was collected by NHS Improvement. In addition, information on the performance of individual Programme

¹⁸ OVMs, staff in frontline clinical and administrative roles, staff in back-office roles, and senior Trust staff were targeted through the case studies, although difficulty was experienced in achieving interviews with staff beyond the OVM in a number of Trusts.

elements, such as the e-learning package, was provided by DH for consideration during this evaluation. Additional secondary data including was also included in the analysis as detailed in Appendix C.

- **Follow-up consultations in primary care:** Following completion of the interim survey in February and March 2015, an additional set of depth interviews was conducted with Practice Managers from six GP Practices across England in order to allow further exploration of some of the findings emerging from the quantitative survey. Practice Managers were identified for follow-up based on their responses to the survey.

Limitations of the evidence

There are some limitations with the evidence gathered through this study. It was not possible to conduct the first wave of the staff survey prior to the launch of the Cost Recovery Programme (July 2014), which means the baseline findings may be coloured by the launch of the Cost Recovery Programme during the fieldwork period (leading to an understatement of its effects). Secondly, significant difficulties were experienced in recruiting case study Trusts, in scheduling visits, in gaining access to the full range of staff desired at each Trust (particularly frontline medical staff and senior management staff within the Trust), and securing additional information regarding cost recovery processes at Trusts. This has impacted the ability of the evaluation to fully explore awareness and understanding of, and engagement with, the Cost Recovery Programme during both stages of this evaluation. This resulted in the revised structure for case studies outlined earlier, and compromised the ability to select case studies in a structured way. In addition, conducting interviews with OVMs over the telephone instead of face-to-face reduced the scope of the discussion that it was possible to have regarding cost recovery. Similar difficulties were experienced in securing interviews with some stakeholders. While it was possible to consult stakeholders from the majority of key organisations, it was not possible to consult as many as had been hoped at NHS England. This was due to issues experienced in identifying stakeholders within NHS England with involvement in implementing the Cost Recovery Programme, and securing interviews with these stakeholders. In addition, the Trust Development Authority, Public Health England and Health and Social Care Information Centre were unable to participate.

Structure of the report

The remainder of this report is structured as follows:

- **Chapter 2 – Programme delivery to date:** Providing an update on where the Cost Recovery Programme is currently, compared to intentions set out in the initial Implementation Plan, and the context necessary for judging the relative success of different elements of the Cost Recovery Programme.
- **Chapter 3 – Assessment of programme impact:** Presenting evidence collected across the evaluation to assess the extent to which it is possible to identify any impacts being delivered as a result of the Cost Recovery Programme, and understanding what the factors driving or inhibiting change are.
- **Chapter 4 – Costs and benefits of implementation:** Presenting a narrative consideration of the potential costs and likely benefits arising from the implementation of the Cost Recovery Programme to date, and an assessment of the progress that has been made in terms of recovering costs across both EEA and non-EEA residents since the launch of the Cost Recovery Programme.
- **Chapter 5 - Conclusions and recommendations:** Focussing on identifying the key successes of the Cost Recovery Programme, any areas for improvement, and making recommendations on how this improvement could be achieved.

2 Programme delivery to date

Before considering the impact that the Cost Recovery Programme has had, it is necessary to outline the progress in delivering the Cost Recovery Programme during the first two years following the launch of the Implementation Plan in July 2014, and the backdrop against in which the Cost Recovery Programme has been implemented.

2.1 Existing cost recovery practice

When evaluating the progress made during the first two years of the Cost Recovery Programme, it is important to consider, as far as it is possible to say, whether there were cost recovery processes in place across secondary care Trusts in the NHS before launch of the Cost Recovery Programme in July 2014.

A qualitative study into NHS use by overseas visitors and migrants, commissioned by DH in 2013,¹⁹ examined how 30 Trusts identified and recovered costs from this group. This report found variation in Trusts' approaches. Variation was found in *'the priority they [Trusts] gave it [cost recovery], the systems they had in place and the robustness of these systems in identifying and charging overseas visitors.'*²⁰ In particular, the findings around the role of the Overseas Visitor Manager (or Overseas Visitor Officer (OVO) as it was named at the time) highlight the important context surrounding the success of the Cost Recovery Programme to date. The Department of Health recommended in 2004 that all Trusts should appoint a staff member with responsibility for implementing the charging regulations. Among the OVOs included in the 2013 research, the range of roles depended on the other responsibilities they held on top of the OVO position. Significantly, the report found that *'those OVOs who were able to work full-time on the role were in the minority.'*²¹

2.2 Progress in delivery

It was in this context that the Cost Recovery Programme was launched in July 2014 with the publication of the Implementation Plan and Impact Assessment. The Implementation Plan described a number of activities anticipated to be delivered during Years One and Two of the Cost Recovery Programme (Financial Years 2014/15 and 2015/16). Table 2.1 (p16) sets out how far each of these activities have been delivered, are still outstanding, or have been revised in some way. While this shows good progress, it is clear that there have been some changes in the timing of the Cost Recovery Programme; some elements were de-prioritised, and others were delivered late - most noticeably the cost recovery training package.

2.2.1 Achievements in implementation

Year One of the Cost Recovery Programme saw a focus on delivering **Phase One (Improving the system)**, with many of the major elements delivered on time; in particular, the cost recovery toolkit, the EEA and non-EEA incentive schemes, and financial penalties. Year Two saw the delivery of one of the major outstanding elements of Phase One yet to be delivered: The Cost Recovery Programme of cost recovery training for NHS staff. However, this was rolled-out in October 2015, half-

¹⁹ Qualitative Assessment of Visitor and Migrant Use of the NHS in England, Creative Research, 2013, <https://www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs>

²⁰ Ibid. p. 50.

²¹ Ibid. p.52.

way through Year Two. The CRST pilot was launched in February 2015 and became operational in April 2015. This was delivered behind schedule; the launch of the CRST was originally planned for Year One.

The first two years also saw the delivery of some key elements of **Phase Two (Aiding better identification of patients)**, including the pre-registration process²² and updates to the NHS National Spine²³. This facilitated data sharing between the NHS and the Home Office. The main element of **Phase Three (Implementing the Health Surcharge)**, was the immigration health surcharge which was delivered on schedule by the Home Office in April 2015.

2.2.2 Outstanding Programme elements

The majority of the core programme elements were delivered during the first two years of implementation. Outstanding elements at this stage relate primarily to **Phase Four (Extending charging)**, which underwent a public consultation during Year Two. The Government's response to this will be published in due course, along with plans for this phase of the Cost Recovery Programme.

²² The pre-registration process generates an NHS record for migrants paying the immigration health surcharge, on which their immigration status is flagged, and is made available to NHS staff via the Summary Care Record portal.

²³ The updates to the NHS National Spine IT system were intended to facilitate the sharing of information from the Home Office to OVMs, via the Summary Care Record portal previously mentioned.

Figure 2.1: Programme timeline

Programme Element	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	
Implementation Plan	█																						
Cost Recovery Tool		█																					
EEA incentives announced			█																				
EEA incentives live				█																			
Baseline survey of NHS staff		█																					
CRST Launched								█															
Interim survey of NHS staff								█															
OVM Ambassador Programme										█													
Non-EEA incentives live										█													
Immigration health surcharge live										█													
E-learning launched																	█						
Consultation re:extension of charging																			█				
Follow-up survey of NHS staff																				█			

Table 2.1: Delivery progress to date

Phase	Delivered	Outstanding/in progress
Phase 1: intensive focus on improving the current system of identification of, and cost recovery from chargeable patients within secondary care	<ul style="list-style-type: none"> Publication of toolkit. Implementation of EEA and non-EEA incentive schemes, and sanction. NHS staff training commenced. New data collection from providers in place. National Intensive Support Team (CRST) in place to aid Trusts as needed. Pilot for EHIC collection in A&E settings completed. Better data sharing with the Home Office to report high-value NHS overseas debtors leading to fewer health tourists. 	<ul style="list-style-type: none"> EEA incentive rates under review. Improved metrics to support better commissioning decisions. Roll-out for EHIC collection in A&E settings.
Phase 2: better identification of chargeable patients through changes to existing identity verification and registration systems and processes in primary ²⁴ and secondary care	<ul style="list-style-type: none"> Initial data sharing solution made available. Scoping work in relation to developing IT systems. Completion of Privacy Impact Assessment. Scoping work continuing on GP processes. Health Surcharge in place and the Cost Recovery Programme will have completed the rollout of the new process to support this. Solution for the storage of information in relation to EEA and non-EEA visitors in trusts should be in place. 	<ul style="list-style-type: none"> Ongoing scoping work to support identification of chargeable patients in the primary care setting. Scoping in relation to potential improvements to the new processes, and future expenditure around this.
Phase 3: Health surcharge (as introduced in the Immigration Bill) is implemented by Home Office. All new (non-visitor) visa applications pay health surcharge alongside visa fees	<ul style="list-style-type: none"> Delivery of legislation change to NHS Regulations 2011 to support rollout of immigration health surcharge. Staff awareness training and processes in secondary care put in place ahead of immigration health surcharge introduction. Guidance updated. Surcharge and associated supporting legislation in place and all visa applicants and those exempt from paying the surcharge are pre-registered with the NHS and have BRPs issued. 	
Phase 4: Extension of charging policy to some primary care and A&E services.	<ul style="list-style-type: none"> Pilot of collection of EHIC details in primary care. 	<ul style="list-style-type: none"> Scope and consider extensions of charging changes to the exemptions from charging regime, and changes to cost recovery in local authorities and other providers.

Source: Ipsos MORI assessment of DH Implementation Plan

²⁴ While primary care services are currently exempt from charging, the Cost Recovery Programme hopes to drive better identification of chargeable patients to aid recovery of costs for those who go on to access Secondary Care services.

2.2.3 Communications

A communications and marketing strategy underpinned the core delivery activities discussed earlier. This strategy is targeted both externally and at staff within the NHS. Communications in Year One of the Cost Recovery Programme focussed on promoting the charging rules, and raising Trusts' awareness of their responsibilities. The communications and marketing strategy in Year Two focussed on changing the behaviour of visitors accessing NHS services, which included a move to communicating with visitors in their home countries.

Communications throughout the first two years of the Cost Recovery Programme revolved around the key milestones detailed above. There were also a range of other communications, as detailed in Table 2.2 below. Communication with GP practices, distributing a leaflet with information regarding EHIC, S1 and S2 forms, and supporting secondary care services was delayed until April 2016, and the effect of this will not be discussed in this evaluation.

Table 2.2: Programme communications activities

Communications type	Details
Implementation team visits to NHS Trusts	The central implementation team within DH undertook a series of visits to Trusts across England in order to meet with OVMs, Chief Executives, and Finance Directors. The purpose of these visits was to build engagement at the senior level. <ul style="list-style-type: none"> During Year One, visits were undertaken to 40 Trusts. During Year Two, visits were undertaken to 23 Trusts.
Newsletter communications	Newsletter communications were sent out via several media during February 2015. The media used were: NHS Employers, NHS Providers, TDA and Monitor.
Communications to OVMs	Communication to OVMs has primarily taken the form of OSVAG meetings, Programme emails to OVMs, the use of the DH Exchange Forum, and through issuing guidance to OVMs.
Communications to Chief Executives	In October 2015, Sir Keith Pearson, the chair of the External Reference Group, wrote to the Chief Executives of all NHS Trusts and Foundation Trusts with details of their Trust's performance in relation to cost recovery, and announced the launch of the public consultation on the extension of charging in December 2015.
Communications to CCGs	NHS England publicised the webinar relating to non-EEA incentives, and an FAQ document via their CCG Bulletin.
Webinars and Tweet chats	A series of webinars, blogs and Tweet chats have been held throughout the course of the Cost Recovery Programme to date, including the below: <ul style="list-style-type: none"> Tweet chat – February 2015. Understanding the true cost of overseas migrants to the NHS – Webinar – March 2015. Non-EEA Chargeable Patients: The tariff, the incentive, the billing mechanisms – Webinar – June 2015. Improving Systems for Cost Recovery for Overseas Visitors & Migrants using the NHS – Webinar – November 2015. Visitor & Migrant NHS Cost Recovery Programme – consultation on extending charging – Webinar – January 2016.
Public facing communications	The main focus of public facing communications during Year Two were EEA residents, targeting students via UniversitiesUK, National Union of Students, and the UK Council for International Student Affairs, and ex-pats/visitors via updated NHS Choices web pages.

2.3 Programme outcomes

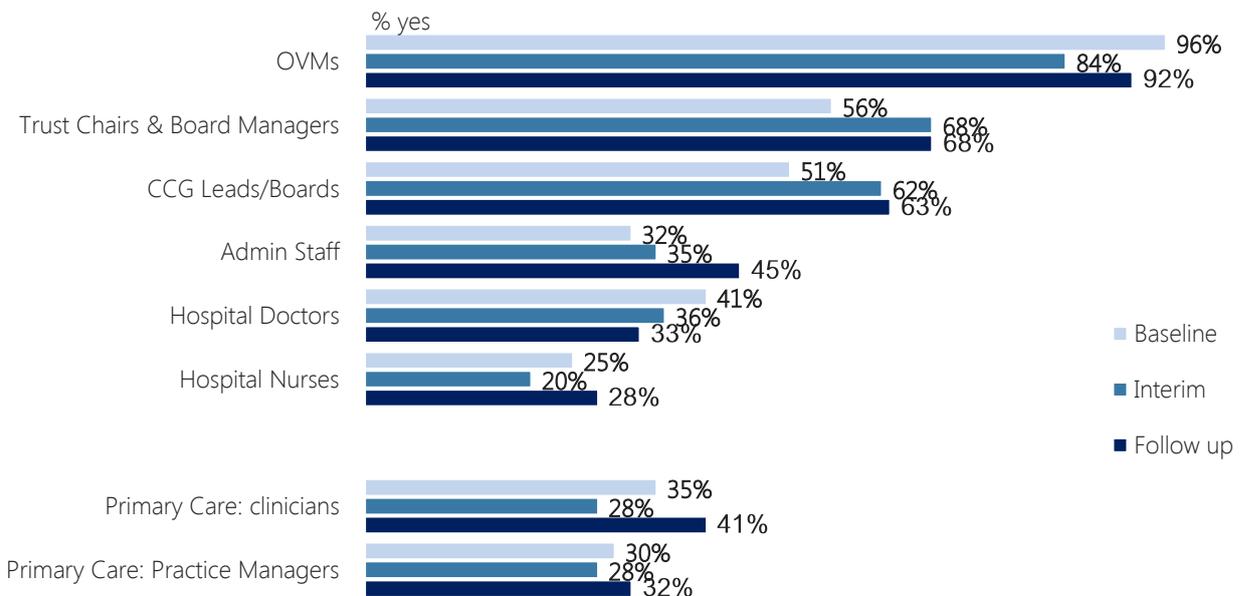
The delivery of the Overseas Visitor and Migrant NHS Cost Recovery Programme relies in part on the leverage of systems and process changes within NHS Trusts to place a greater emphasis on cost recovery where appropriate. Implementing these changes will require that NHS staff understand and buy into the aims of the Cost Recovery Programme and its rationale. In particular, this will need to involve Trust Chairs, Board Managers, CCG Leads/Board Members, and OVMs responsible for implementing changes in working practices. To this end, DH has undertaken a programme of communications across Years One and Two of implementation.

2.3.1 Awareness of the Overseas Visitor and Migrant NHS Cost Recovery Programme

To assess the effectiveness of these communications, survey participants were asked if they were aware that the Cost Recovery Programme was introduced by DH in summer 2014. The baseline survey found levels of awareness were highest among senior management within Trusts and CCGs (as well as OVMs). This increased amongst these groups by early 2015. The latest survey data shows that awareness of the Cost Recovery Programme remains stable, between the interim and follow-up surveys. **A significant proportion of Trust Chairs and Board members (32%) and CCG Leads (37%) were unaware of the Cost Recovery Programme near the end of Year Two.** This may give DH cause for concern; case study participants – in particular OVMs – highlighted the importance of senior support in enabling effective and efficient cost recovery processes within Trusts, (for example by introducing training for frontline staff). A lack of awareness of the Cost Recovery Programme at this level points to a need for further targeted communications about the Cost Recovery Programme.

Figure 2.2: Programme awareness

*PA1. Are you aware that the Department of Health launched a programme of work called “The Visitors and Migrants NHS Cost Recovery Programme” in 2014?**



Base: All interviews with NHS staff: (2165); Interim (2170); Follow up (2156)

*Please note that the wording for this question at the baseline wave was: ‘Are you aware that the Department of Health recently launched a programme of work called the Visitors and Migrants NHS Cost Recovery Programme?’

Source: Ipsos MORI

Among **administrative staff**, awareness of the Cost Recovery Programme has increased significantly over the past year, with more than two in five aware at follow-up compared to around one in three at the baseline and interim surveys.²⁵ As before, senior accountants were much more likely to be aware of the Cost Recovery Programme than consultant secretaries or reception staff. Awareness has risen significantly in this time for this group; 84% said they were aware of the Cost Recovery Programme, compared to 57% in the baseline survey. However, **awareness remains low among clinical staff**, with survey results showing little positive change over time.

The most frequently reported source of information on the Cost Recovery Programme (amongst those aware), was *the Department of Health* for OVMs (39%) and *communication from management* among Trust chairs and board members (25%), CCG Leads and Boards (20%), hospital nurses (23%) and administrative staff (24%). However, amongst hospital doctors and primary care clinicians, the most frequently reported source of information was *Media – TV* (23% and 20% respectively). Primary care practice managers most frequently cited *internet/websites* as a primary source of information, mentioned by 24%. There is a potential risk that understanding of the Cost Recovery Programme and its aims amongst some staff groups may become distorted if it is communicated incompletely or inaccurately (which could in turn influence staff commitment to the delivery of the Cost Recovery Programme).

The evidence suggested two key factors contributing to low awareness amongst clinical and administrative staff:

- **Barriers faced by Department of Health:** A significant barrier to the Cost Recovery Programme is DH's lack of power to communicate directly, at scale, with frontline clinical and administrative NHS staff. Reaching these groups requires a close working relationship with other bodies, in particular NHS England. Communicating with these staff depends on OVMs and senior management within Trusts actively disseminating information about the Cost Recovery Programme from DH. During Year One of the Cost Recovery Programme, it was unclear what role NHS England had played in communicating the Cost Recovery Programme's aims and objectives to the NHS workforce, and this remains the case in Year Two.
- **Barriers faced by OVMs:** The case studies highlighted that, throughout the first two years of the Cost Recovery Programme, OVMs have faced some substantial difficulties in communicating the Cost Recovery Programme and its aims to staff within their Trust. In Year One, there had been no Trust-wide communications to staff in any of the six participating Trusts. Reasons behind this included lack of sign-off on communications and Trust policy on overseas visitors and migrants, when OVMs had developed new or updated policies but were prevented from operationalising these pending sign-off from the Trust board. In Year Two, some training for frontline staff was put into place, or was being developed in most of the Trusts represented in the case studies and OVM interviews. Two of the OVMs had developed, or were in the process of developing training for frontline staff using the materials provided by DH. Where material had been provided by DH to support training, the OVMs considered this to be helpful, in particular the fact that it was provided by DH helped to 'legitimise' the training in comparison to that previously in place.

The Cost Recovery Programme is designed around the premise that all staff within the NHS should contribute to the recovery of costs from overseas visitors and migrants and therefore that it was important to raise awareness of the Cost Recovery Programme across all staff groups. However, while frontline clinical and administrative staff were ultimately identified as being responsible for delivering the processes needed to achieve higher levels of cost recovery, it is possibly less critical that they are aware of or recall the Cost Recovery Programme. Frontline clinical and administrative staff can

²⁵ Follow-up: 45%; Baseline: 32%; Interim: 35%.

play a role in cost recovery without being aware that changes are driven by a centrally co-ordinated programme, provided the changes in administrative processes are integrated into routine activity.

Evidence of large-scale process change happening as a result of the Cost Recovery Programme was limited. Almost one-third (32%) of OVMs reported at the follow-up stage that *no changes* had been made in their Trust since the launch of the Cost Recovery Programme, while large proportions of the other staff groups (Trust chairs and board members; Hospital Doctor; Hospital Nurses; and Administrative staff) asked this question were unable to answer – with large proportions either answering *don't know* or *no changes*.

2.3.2 Awareness of financial incentives and penalties

Incentive schemes

The Cost Recovery Programme involves two incentive schemes, as detailed below.

EHIC incentive scheme: The EHIC incentive scheme came into effect on 1st October 2014. In addition to the payment to cover treatment costs that Trusts receive from commissioners when treating an EEA patient under an EHIC agreement, providers now receive an additional 25% of the cost of the treatment **paid direct to them** when they report the treatment through the OHT Portal. Payments to Trusts are made quarterly in arrears.²⁶

Non-EEA incentive scheme: The updated Charges to Overseas Visitors Regulations (2015) included the provision for Trusts to charge non-EEA residents 150% of the national tariff for the treatment they receive. From 6th April 2016 commissioners must pay 75% of the tariff to the provider (Trust), known as 'risk sharing'. All money recouped directly from the patient (or their health insurance provider/sponsor) will be divided equally between the commissioner and the provider.²⁷

Both of these schemes were anticipated to drive a significant increase in recovering costs from chargeable patients. The primary role of the incentives was to increase efforts at identifying chargeable patients. Although not an explicit aim of the incentive schemes, they may help OVMs to gain support from senior Trust colleagues in implementing changes in practices, through providing a possible source of increased income for Trusts.

The interim staff survey²⁸ suggested that, although seven in ten OVMs were aware of the EEA incentive scheme, this was no higher than one in four amongst the other staff groups.²⁹ However, at the follow-up survey almost nine in ten OVMs (87%) were aware of the EEA incentive scheme, while almost eight in ten (77%) had an awareness of the non-EEA incentive scheme. **Awareness of the incentive schemes among Trust Chairs and Boards and CCG Leads and Boards, remained low throughout the evaluation;** fewer than one in four was aware of either scheme.³⁰

²⁶ For further information, please refer to 'EHIC incentive scheme: Frequently asked questions', Department of Health, 2014

²⁷ Guidance on implementing the overseas visitor hospital charging regulations 2015, Department of Health, 2015

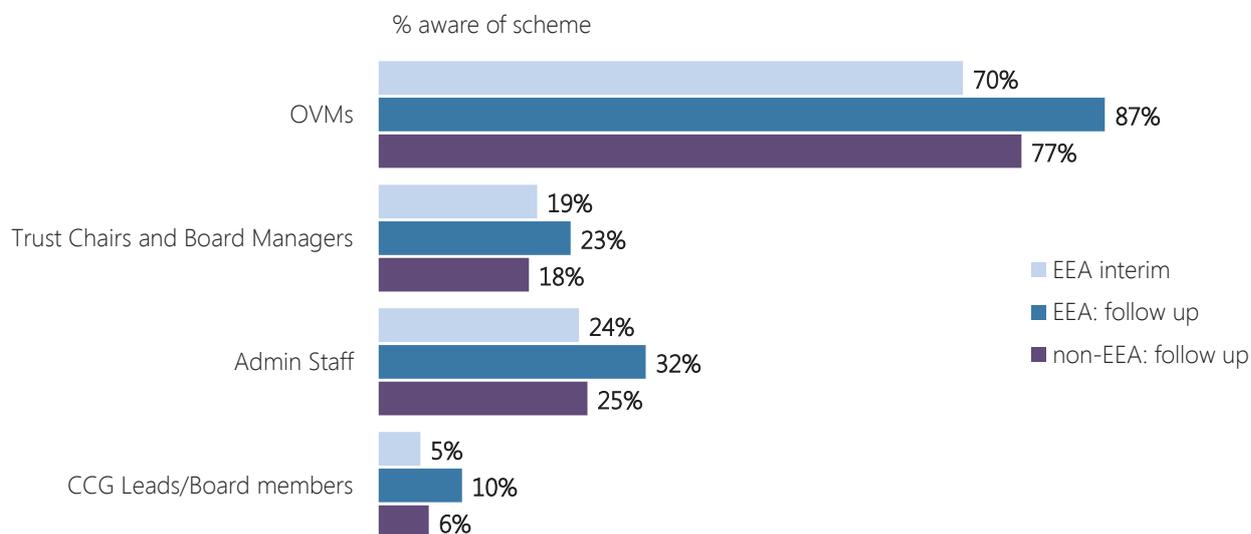
²⁸ At the time of the interim survey the EEA incentive scheme had been operational for four months.

²⁹ Figures regarding awareness of the incentive schemes refer only to staff who were also aware that some patients are chargeable for NHS healthcare.

³⁰ As may be expected given that the schemes were not targeted at frontline clinical staff, no more than four per cent were aware of either incentive scheme in each of the survey waves.

Figure 2.3: Awareness of incentive schemes

IA1. What, if anything, do you know about the EEA incentive scheme that DH has launched as part of the Visitors and Migrants Cost Recovery Programme? IA3. What, if anything, do you know about the non-EEA incentive scheme that DH has launched as part of the Visitors and Migrants NHS Cost recovery programme?



Base: All interviews with NHS staff in clinical, administrative and OVM roles who were aware that some patients are chargeable for NHS healthcare. Interim: (604); Follow up: (701). Follow up wave results only shown for IA3; results not directly comparable between waves due to changes in question wording

Source: Ipsos MORI

Sanctions for underperforming Trusts

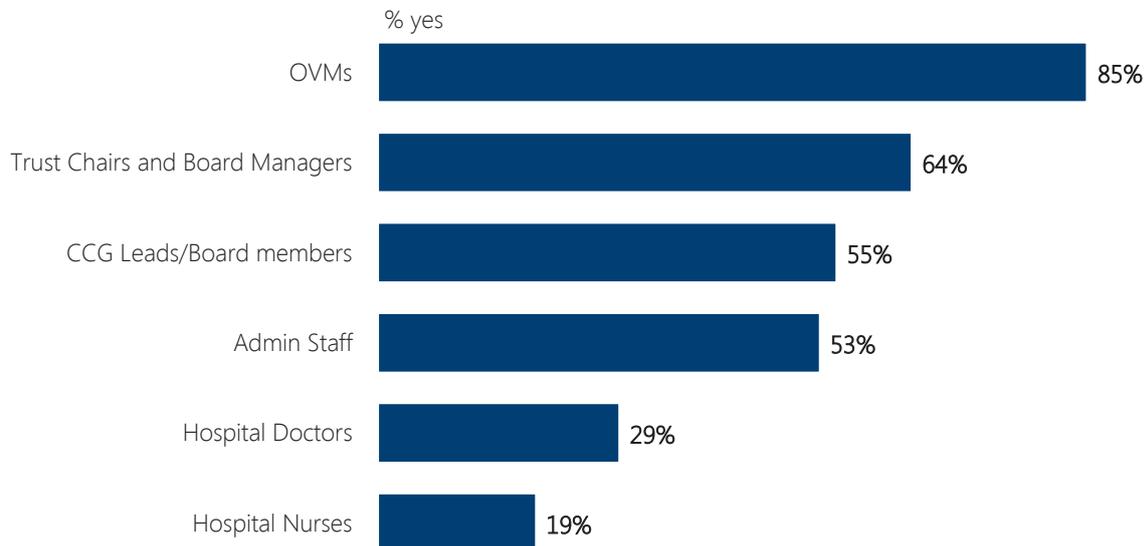
The Implementation Plan also proposed the development and implementation of sanctions for Trusts deemed to be underperforming in the area of cost recovery. These were finalised and communicated in April 2015, in time for the follow-up survey. They empowered CCGs to withhold payment for services if a Trust had failed to take reasonable steps to identify and recover charges from a particular chargeable patient³¹, and this provision was included in the NHS Standard Contract (as discussed in the following section). More than eight in ten OVMs (85%) were aware of the revised plans at the follow-up, as were almost two in three Trust Chairs and Boards (64%) and over half (55%) of CCG Leads and Boards. Just over half (53%) of administrative staff were aware that payment could be withheld; again the proportion was understandably much higher among senior accountants, of whom 85% were aware. As may be expected, awareness was lower among frontline staff, although 29% of hospital doctors and 19% of hospital nurses reported being aware of the sanctions.³²

³¹ Improving Systems for Cost Recovery of Overseas Visitors, NHS England, May 2015, <http://www.england.nhs.uk/wp-content/uploads/2015/05/guidance-chargeable-overseas-visitor.pdf>.

³² Figures regarding awareness of the sanctions refer only to staff who were also aware that some patients are chargeable for NHS healthcare.

Figure 2.4: Awareness of sanctions for underperforming Trusts

IA4. And are you aware that CCGs do not have to pay for services provided to chargeable patients if the Trust has failed to take reasonable steps to identify and recover charges from that patient?



Base: All interviews with NHS staff who were aware that some patients are chargeable for NHS healthcare (excluding primary care): Follow up: (1125)

Source: Ipsos MORI

There are similar patterns in the follow-up survey for awareness of sanctions, to those seen for awareness of the incentive schemes and awareness of the programme the Cost Recovery Programme as a whole. For example, among administrative staff, Senior Accountants were much more likely to be aware of this (85% vs. 25% of receptionists and 20% of consultant secretaries)³³. Among Hospital Doctors, awareness is again higher among those in more senior roles. Furthermore, there is higher awareness among Hospital Doctors who feel they have at least some level of responsibility for their Trust's finances (34% vs. 11%).³⁴ During the case study visits and interviews conducted in Year Two, all OVMs and finance staff were aware of the incentive schemes and sanctions, and had a good understanding of how these worked. There was a similar pattern during the earlier case study work around the EEA incentives. **The frontline clinical and administrative staff (doctors, nurses and receptionists), knew little of the financial implications of the Cost Recovery Programme.** However, they thought that it would be useful to have access to information about this, and to understand the impact that cost recovery processes were having, or could have, upon the Trust.

Inclusion of cost recovery in Trust strategy and CCG contracts

The Quality, Innovation, Productivity and Prevention (QIPP) initiative,³⁵ and more recently the £22bn 'efficiency challenge',³⁶ have seen a focus across the NHS on increasing the efficiency of service delivery to generate financial savings for the NHS, helping to address financial challenges the system is facing. The potential for generating increased income

³³ Figures in this section are based only on those aware that some patients are chargeable for NHS healthcare.

³⁴ NB: small base size of hospital doctors who are aware that some patients are chargeable and feel they have very little or no responsibility for their organisation's finances (46).

³⁵ http://www.institute.nhs.uk/cost_and_quality/qipp/cost_and_quality_homepage.html

³⁶ The 'NHS Efficiency Challenge' of £22 billion is the level of efficiencies that the NHS must deliver to meet the funding needs for the health service based on the outcome of the NHS Spending Review for 2016/17 to 2010/21.

for the NHS through better identification of, and recovery of costs from, overseas visitors and migrants offers the potential for Trusts to contribute to the 'efficiency challenge'.

The NHS Standard Contract³⁷ represents one of the levers through which NHS England (via commissioners) can ensure Trusts are complying with cost recovery requirements. The contract in place at the start of the Cost Recovery Programme (2014/15³⁸) stated that:

The Provider must comply with all applicable Law and Guidance in relation to the identification of and collection of charges from Service Users who are overseas visitors or migrants.

In addition, following the changes to the Charging Regulations laid down in 2015, the standard contract was expanded to include further specific detail on what is expected of Trusts and commissioners in relation to overseas visitors and migrants. In particular, this specified that providers must take all reasonable steps to identify chargeable overseas visitors and recover charges from them.³⁹

The staff surveys sought to understand how Trusts and CCGs had interacted with both the 'efficiency challenge' and the standard contract during the course of the Cost Recovery Programme.

In the baseline and interim surveys, prior to the changes to the NHS Standard Contract, CCG Leads were asked whether the recovery of costs from overseas visitors and migrants was included in any way in their contracts with Trusts. Only a minority reported that this was the case, although the proportion doubled between the two survey waves (from 13% at the baseline to 26% at the interim survey).⁴⁰

CCG Leads and board members were asked in the follow-up survey about the steps they took to ensure providers' compliance with the new provisions in the Standard Contract outlined above. Around a third (34%) said that they had regular meetings with Trusts to discuss cost recovery, while one in five (21%) asked Trusts to carry out audits of their charging processes. Significant minorities had used the 150% non-EEA visitor tariff (17%) or put in place risk-share agreements for charging non-EEA visitors and migrants (16%). A minority (nine per cent) reported that they had used the portal to check the number of EEA payments made. However, almost a third of CCG leads (31%) that they did not take any steps to ensure Trusts' compliance with the new provisions, while one in five (21%) did not know whether this had been done.

The follow up survey included a question specifically for Trust Chairs and Board members to assess whether cost recovery formed part of Trusts' contributions to the NHS' Efficiency Challenge. Just over half (52%) of Trust Chairs and Board members reported that this was the case, but a significant minority (30%) reported that cost recovery was **not included** in their Trust's plans for improving efficiency. Furthermore, a significant proportion (18%) answered 'don't know.' In the baseline and interim surveys, Trust Chairs and Board members were asked whether cost recovery from overseas visitors and migrants was included in their Trust's QIPP Programme or not; in each wave around a third (30% in the baseline and 37% in the interim survey) reported that this was the case.

³⁷ The NHS Standard Contract is mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care, for more information please see: <https://www.england.nhs.uk/nhs-standard-contract/>

³⁸ 2014/15 NHS Standard Contract – Service Conditions, NHS England (2014)

³⁹ 2015/16 NHS Standard Contract – Service Conditions, NHS England (2015)

⁴⁰ All figures in this section are based only on those participants who were aware that some patients are chargeable for NHS healthcare.

The significant proportions of CCG leads and board members who reported having not yet taken any steps to ensure Trusts' compliance with the provisions in the new standard contract offers a clear opportunity for improvement, as the active involvement of Trusts is required both for the non-EEA incentive and financial sanctions schemes to be effective.

2.4 Training and guidance

2.4.1 Training and support

The Implementation Plan for the Cost Recovery Programme acknowledged that process, behavioural and cultural changes would be required across the NHS to deliver upon the £500m ambition by the middle of the current Parliament. In order to prompt the change required a range of training and support has been put into place as follows.

Training programme

During Year One, an e-learning package targeted at specific groups of NHS staff was scheduled for development by the DH Cost Recovery Team and Health Education England (HEE). Although the training package was originally timetabled for delivery during Year One, the package became operational in October 2015.⁴¹

As illustrated by Table 2.3 below, penetration of the training across NHS staff has been limited. There have been over 2,000 views of the introductory video since it was first made available (although in many cases the video will be shown as part of group training sessions, perhaps by the OVM, and the actual number of NHS staff who have seen this video is unknown). In addition, 155 individuals have created accounts for the e-learning training proper and have collectively completed a total of 474 modules (giving an average of three modules per individual). Those taking part are from a variety of roles: 34 recorded their position as Overseas Visitor Manager, while a further 57 recorded an administrative role (e.g. Receptionist, Clerical Worker, Medical Secretary). While 97 different organisations are represented amongst those who have taken up the training, this typically represented one, two or three members of staff.

Table 2.3: Overseas Visitor and Migrant NHS Cost Recovery Programme – e-learning package

Module	Target audience	Engagement (as of 6 th May 2016)
Introductory video: Introduction to cost recovery and role of clinical staff	All NHS staff	This video has been viewed over 2,000 times. ⁴²
Module 1: Why cost recovery is important and who we recover costs from	All NHS staff	155 individuals had created accounts for the e-learning package. On average, each individual user has undertaken three modules of learning.
Module 2: How we recover costs from overseas visitors	All NHS staff	
Module 3: Roles and responsibilities for Overseas Visitor Managers	OVMs	
Module 4: Roles and responsibilities for clinicians	Clinicians	
Module 5: Roles and responsibilities for administrative staff	Administrative staff	
Module 6: Equalities and vulnerable groups	All NHS staff	

Source: *e-Learning for Healthcare*

⁴¹ This programme of training is hosted through e-Learning for Healthcare and consists of six modules, along with an introductory video explaining the importance of cost recovery.

⁴² NB: This does not equate to the number of **individual** staff who have viewed the video as these are not unique views, nor is it possible to tell whether the videos were being shown as part of a training session/induction to a potentially large number of staff.

Cost Recovery OVM Ambassador Programme

Created as a subset of the cost recovery training package, and in response to experiences during the first year of the Cost Recovery Programme, a total of 13 have been recruited and accredited as training ambassadors. The ambassadors were provided with training materials for four key target groups within their Trusts. The intention was that OVMs would begin by delivering training within their own Trusts, before providing training to other OVMs to equip them to train their own staff in turn. The ambassador programme is ongoing throughout 2016/17, with an increased focus on developing a regional presence to combat the London/South-centric distribution of current ambassadors.

Experiences of training and support

For a programme that required cultural, behavioural and procedural change, it could reasonably be expected that training has the potential to significantly improve the Cost Recovery Programme's success. It was therefore important that the training programme was not delivered within Year One of the Cost Recovery Programme according to the Implementation Plan, but was launched six months into Year Two.

The proportion of OVMs who have received training has increased over time. Almost half (47%) said they had received training at the follow-up survey⁴³. **Administrative staff were also more likely to report having received training** in the follow-up survey, with 20% saying this, compared to 12% at the baseline. Only **very small proportions of clinical staff said that they had had training**; at the follow-up survey just five per cent of hospital doctors and seven per cent of hospital nurses said this, with little change taking place over time.

Among the small numbers of staff who had received training, uptake of the e-learning package developed by DH and HEE was low, with the majority of training being delivered in-house by the Trust. The vast majority of staff who had received training said that they found it useful, this ties-in with the analysis of the available performance data for the e-learning as outlined above.

In the follow-up survey, OVMs and Trust Chairs and Board members were asked whether any compulsory training on identifying potentially chargeable patients had been introduced in their Trust. Responses suggest that compulsory training within Trusts is not common (one in five OVMs (21%) and around three in ten Trust Chairs and Board members (31%) said that compulsory training had been introduced in their Trust.). Nevertheless, a further 47% of OVMs said that they had plans to introduce compulsory training in their Trusts. Awareness of such plans was not as high amongst Trust Chairs and Board members. Almost two in five Trust Chairs and Board members (39%) and around one in four OVMs (23%) said their Trust neither had any compulsory training in place nor had any plans to introduce it.

The importance of training in achieving the outcomes set out in the logic model for the programme is highlighted by **some key differences in survey responses between participants who reported having received training**, and those who had not. In particular, those administrative staff had received training demonstrated an increased awareness of who to contact in their organisation regarding potentially chargeable patients (96% vs 90% who hadn't received training), and were more likely to be engaged in cost recovery work through flagging patients.⁴⁴ They were also more likely to demonstrate awareness of some of the key aspects of the Cost Recovery Programme, such as the incentive schemes and possible sanctions. The apparent impact that training has had on this group demonstrates the need for an increased focus on ensuring a greater take-up of the training package across NHS staff. Case studies during Year One found little evidence of

⁴³ Figures in this section refer to incidence of training only among staff who were aware that some patients are chargeable for NHS healthcare.

⁴⁴ 41% said they did this at least once a week, compared to 16% who had not had training.

any progress towards the introduction of training on cost recovery. The need for senior-level support for initiatives was highlighted by one case, where the OVM had developed a plan for training staff during induction as part of a new policy for cost recovery, but five months later this had still not been approved by the Trust Board, which did not prioritise it over other issues facing the Trust.

During the second year of the evaluation, the case study visits and interviews with OVMs revealed a range of experiences as evidenced by the examples given below. A common theme highlighted through these more recent examples, is that there remains an issue with senior-level support, and in particular obtaining sign-off from a senior level for any changes can slow down the implementation of changes.

- One OVM was developing training material with support from DH, and had found DH's support very insightful and helpful. Prior to this they had developed their own training material, but having something from DH was more effective because it was likely to be taken more seriously by staff. They had already carried out a half-day training session with A&E and maternity ward staff, focusing on how to be an OVM, and how this is undertaken as a wider role.
- Another OVM, who had been trained as an OVM Ambassador, was using materials provided by DH to train staff members within the trust about cost recovery. It focused on what is required from them, and what they are aiming to achieve at Trust level as a whole through improving cost recovery processes and performance.
- Others reported that while they had not personally received any training, they were taking the lead on training frontline staff on an informal basis, routinely visiting different departments to explain cost recovery processes to them and raise awareness of the Cost Recovery Programme and how they can play a role in their Trust.
- Two OVMs said that they were currently pushing to include some training and information on cost recovery in the induction process for new members of staff. One of these was optimistic about this, feeling that they had good support from senior staff and having seen the Trust Board introduce an Overseas Patients Policy in February 2016. The other, however, had faced resistance from senior staff against a number of their efforts to raise awareness about cost recovery, and felt it was not a priority for the Board. This OVM wanted DH to make it compulsory for some training to be introduced at a Trust level, so that senior staff could not ignore it in this way.

From the case studies it is clear that in the absence of formal training, it is often the OVM who provides guidance on processes and roles, although other senior staff members have also taken the initiative to informally train new members of staff in their department, with support from the OVM.

2.4.2 Views on information and guidance among OVMs

Throughout the qualitative research conducted during the evaluation, feedback was sought on how well supported OVMs felt in their role, and in particular how helpful they found the various available materials and sources of information.

During Year One, there was high awareness and use of the 'Cost Recovery Toolbox', launched by DH in August 2014, among OVMs. **The tools were well received and widely used.** In particular, the revised guidance documents were regularly used and relied upon, while the example letters and forms were being adapted and personalised (for example, translating them into different languages, or adapting the wording to suit particular patient groups) to suit the different Trusts' needs. The revised guidance received mixed feedback, with some OVMs finding it clear, comprehensive and definitive, but others finding it more difficult to understand and apply in different circumstances.

The case studies and interviews conducted in Year Two with OVMs yielded similar findings. For the most part, OVMs said they had found the various materials from DH very useful – in particular the example letters, forms and posters. Generally, OVMs said they had all of the information and support from DH that they needed to effectively carry out cost recovery. However, despite generally feeling that the updated guidance was a significant improvement on the guidance initially provided at the Cost Recovery Programme's launch, OVMs and finance staff had some concerns regarding these documents. In particular, some described the guidance as 'contradictory' or 'ambiguous' on some matters, such as some of the rules on exemptions. These individuals said that they would appreciate guidance, such as a list of 'FAQs' which could give more concrete answers on what should and should not be done, to remove any uncertainty.

In addition to the guidance, OVMs also said that they had found the DH Exchange Forum very useful, and frequently sought help and advice from other OVMs when they were unsure of the best approach to take in a specific situation. The variation between Trusts when it comes to approaching cost recovery makes it difficult for DH to provide highly specific guidance for all OVMs. Therefore, **encouraging engagement with the DH Exchange Forum, particularly amongst those OVMs who are not already, will help to further encourage the sharing of experience across the OVM cohort.** This may propagate approaches to improving cost recovery processes.

Some OVMs also stressed the importance of having strong relationships with the Home Office, as a vital source of advice when faced with patients whose circumstances were particularly complex or their residency/visa status was difficult to determine.

2.4.3 Cost Recovery Support Team

Phase One of the Implementation Plan included plans to launch a National Intensive Support Team during Year One. Following a development phase culminating in a pilot scheme in February 2015, the **Cost Recovery Support Team (CRST)** was launched in **April 2015**. The team was made up of existing NHS professionals from a variety of backgrounds relevant to cost recovery (finance, OVMs, clinicians), and supported by staff from the DWP OHT, and the DH Programme Team. The team had four primary objectives:

- Raise the profile of the Cost Recovery Programme at a senior NHS level;
- Spread identification and charging 'best practices' across the NHS and increase Trusts' rates of chargeable patient identification and recovery of costs;
- Encourage local health economies' participation in Trusts' efforts; and,
- Support the NHS through the changes to the charging regulations and NHS IT/information flows.

By 31 March 2016, 23 visits to trusts had taken place as part of the rollout of the CRST. DH is currently undertaking a programme of work to evaluate the initial phase of the CRST, refine the approach, and secure funding for its continuation. If continued, the CRST will be adapted to align with the role of NHS Improvement (NHSI), facilitating a smooth transition of the CRST to NHSI once the Cost Recovery Programme (within DH) has been closed-down.

The staff survey sought to determine awareness and perceptions of the CRST at the various points during its implementation. Prior to the introduction of the CRST, awareness of the plans was relatively low. Unsurprisingly it was highest (58%) amongst OVMs, although a significant minority (42%) even among this group were unaware of it. Opinions were divided as to whether Trusts would make use of the team or not. The majority of OVMs (72%) said they were likely to

use the team, whereas around three in five Trust chairs and board members (58%) and 37% of CCG Leads said their Trusts would be likely to do so. As the CRST was still in development at this stage it is likely that these assessments were only based on a partial understanding of the role the team could play.

During the follow-up survey, a large majority of OVMs (84%) were aware of the Support Team, although awareness among Trust chairs and board members remained fairly low, at 33%, having risen from 20% when first asked about in the interim survey. Among those who were aware of the Support Team, 55% of OVMs and 39% of Trust Chairs and Board members said that their Trust had made use of this resource.

2.5 EHIC Collection in Emergency Care - Pilot

Six Trusts across England have also participated in a pilot scheme to explore the feasibility, and potential impact, of Trusts attempting to identify EEA residents presenting at A&E, and through the collection of EHIC details, recovering costs for treatment provided.

Three of the Trusts involved in the initial case study element of this evaluation were sites participating in the EHIC pilot.⁴⁵ The pilot consisted of reception staff in A&E being required to ask all patients attending a defined set of questions to establish:

- Whether they resided in an EEA country (i.e. should have an EHIC);
- Whether they had an EHIC;
- Whether they had the EHIC with them/if they didn't have one why didn't they; and
- Collect EHIC details and allow recovery of costs via the OVT Portal for these patients.

Through the case studies, feedback was collected on the way in which the pilot had worked, the impact it had, and any barriers faced. In addition, Trusts were asked to return data to DH to record the progress of their pilot and some analysis of this is also discussed here.

While the purpose of the pilot was primarily to explore whether it was possible to collect the necessary EHIC information in emergency care, and identify any barriers to this, it was also shared to give an understanding, at a Trust level, of the possible increase in costs recovered that could be driven by the collection of EHIC details in emergency care. It is also useful to indicate the issues that might be faced with asking frontline staff to conduct more work to establish the chargeable status of patients entering the hospital through A&E/Emergency Care services.

Initial feedback during the baseline visits was that the pilot was relatively simple to implement, as it just required reception to ask a few additional questions as part of the registration process, and one Trust had expressed an intention to roll-out this method of identifying chargeable patients across the Trust following the initial experience of the pilot. However, when visiting for the follow-up visit, it was discovered that the experience of the pilot led to the Trust pulling back from this intention by the time of the second visit, due to the workload involved in following-up with patients who were unable to provide sufficient detail upon initial request to enable their status to be established (for example apparently being eligible for an EHIC, but not having this with them).

⁴⁵ This pilot ran for circa 3 months during late 2014 and early 2015.

However, discussions about the pilot at the follow-up visits to two of the Trusts highlighted a number of issues and potential pitfalls with the collection of EHIC details in emergency care:

- Questions were not always asked of all patients, due to reasons related to the asking of the questions (e.g. not feeling comfortable doing so, or not having the time to do so), and administrative reasons (e.g. paper-based forms rather than questions being built into IT systems meaning questions were easy to miss).
- Additional administrative burden falling on OVM to follow-up patients who should, but did not, have EHICs, with little success in recovery.
- Significant problems with patients not having EHICs with them or not having them at all. A brief analysis of the data collected as part of the pilot substantiates this. Across the three Trusts, the proportion of patients who should have had an EHIC with them but didn't was: 0%, 8% and 35% respectively.⁴⁶
- A further issue is that of language barriers, which could make it difficult for reception staff to ask, and obtain answers to, the questions necessary to establish whether a patient should have an EHIC with them.

Overall, the case studies showed that the collection of EHIC details in emergency care should not, in principle, be too difficult, and should not lead to a significant increase in the amount of time it takes to register a patient upon arrival in emergency care.

However, the pilot did also identify a number of issues in operationalising these processes, such as ensuring the questions are asked of **all patients**, capturing relevant information (often relying on paper-based systems in the pilot) and dealing with language barriers, which hindered the impact of the pilot. Some of these would be surmountable by a focus on implementing processes, the adherence of reception staff to which could be monitored, and particularly the incorporation of these questions into hospital IT systems. This would help to overcome the risk of questions not being asked of all patients and ensure more consistent collection of necessary data. However, other issues, particularly the issue of EEA patients not carrying EHICs, would require addressing at a wider system level in order to be overcome.

While some of the issues outlined above have also been experienced by Trusts seeking to implement identification processes in emergency care settings during Year Two, their impact has been more limited as currently charging is only required for non-emergency treatments.

2.6 Summary

- During the first two years of the Cost Recovery Programme's implementation, progress has been made in overall delivery. The majority of key Programme elements have been delivered within the anticipated timescales. In addition, the introduction of the OVM Ambassador Programme may address some of the potential barriers for OVMs identified through this evaluation, if it is successful in achieving its objectives such as raising the profile of the OVM and their role within Trusts, providing leadership within Trusts and supporting cultural change within Trusts.
- However, some elements of the Cost Recovery Programme have not been delivered to the timescales that were originally anticipated. For example, the training package was originally planned to be operational within Year One,

⁴⁶ The prevalence of patients without EHICs is a particular issue, and was reported in some non-pilot case studies to be the case for patients identified outside of Emergency Care also. This highlights the need for communication to visitors to England from EEA countries regarding the need to carry an EHIC as discussed in the recommendations of this report.

but was not made available until half-way through Year Two. As such, these elements have had less time to bed-in than anticipated, and therefore less time to influence staff behaviours and change Trusts' performance when it comes to the recovery of costs from overseas visitors and migrants.

- Additionally, engagement with DH developed programmes of training and support appeared low relative to the size of the communities of interest, which correlates with the low reported implementation of training in the staff survey.
- Awareness of the Cost Recovery Programme has increased primarily amongst administrative staff; similar gains have not been made amongst other staff groups. Awareness of the Cost Recovery Programme is dependent on the way in which changes are communicated to staff, and therefore low awareness does not necessarily cause a problem for the Cost Recovery Programme if behaviour and cultural changes are observed. However, awareness at senior-management levels (Trust Chairs and Board Members) remains low. Greater engagement of this group with the Cost Recovery Programme may help ensure that OVMs are provided with appropriate Trust-wide support in developing training and embedding effective procedures. Awareness amongst clinical staff also remains low and this may hamper efforts to increase cost-recover through up-front charging.⁴⁷
- Although there has been an increase in awareness of the Cost Recovery Programme amongst CCG Leads and Board Members, only two-thirds of those contacted during the follow-up survey were aware of the Cost Recovery Programme. This coupled with findings of low awareness of CCG Leads and Board Members of relevant aspects of the scheme such as the incentives schemes and sanctions suggests that additional campaigns and engagement with CCGs may be beneficial.
- The high levels of awareness of the financial framework for the Cost Recovery Programme in the form of the incentives and sanctions in place was not reflected amongst senior Trust staff (Chairs and Board Members).
- The guidance, supporting documents and materials, and wider support provided for OVMS by DH were well-received throughout the evaluation. In particular, during Year Two, the provision of training materials, the OVM Ambassador Programme, and the DH Exchange Forum were all positively spoken of during the case studies. However, there were repeated comments requesting an improvement in the clarity of the guidance, to provide more definitive answers in borderline cases, making eligibility easier to establish.

⁴⁷ While clinicians do not always have a role in identifying and recovering costs from overseas patients, their involvement is crucial; if upfront charging is to be successfully operationalised then it will require cooperation from clinicians to ensure payment or payment schedules can be agreed before treatment commences (if not considered to be urgent or immediately necessary).

3 Assessment of programme impact

This section considers the extent to which the Cost Recovery Programme has delivered the impacts anticipated at this stage in its implementation (as described in the preceding chapters of this report). It assesses progress towards the achievement of overall programme objectives, and identifies any factors that may delay their delivery in the future. This section draws on evidence gathered throughout the two years of the evaluation, producing evidence collected across the four strands of the evaluation as detailed in Chapter One. It draws on the evidence generated during the most recent wave of fieldwork, to allow a thorough assessment of the progress made at the end of Year Two of the Cost Recovery Programme's implementation.

3.1 Knowledge and attitudes

One key intended outcome of the Cost Recovery Programme is an increase, across all NHS staff groups, in the awareness of the need to identify and charge overseas visitors and migrants who are not eligible for free NHS care, along with an understanding of the rules and processes to be followed. The follow-up survey results, as well as evidence from the most recent case studies and interviews with OVMs, show some encouraging signs of this targeted increase in awareness becoming a reality, however there remain some important gaps that must be addressed going forward.

3.1.1 Awareness and understanding of charging

Most OVMs (94%)⁴⁸ and eight in ten Trust Chairs/Board members (78%) were aware that some people are chargeable for NHS healthcare. There has been no increase here since the first two survey waves. While awareness amongst these groups is high, the intention was that the Cost Recovery Programme would lead to an increase in awareness. Similarly, there has been little change over time in awareness among CCG leads and Board members, and among primary care clinicians, with 61% and 55% aware that some patients are chargeable respectively. With regard to Trust Chairs, the lack of increase in awareness, and the fact that one in five appear to be unaware that some patients are chargeable for NHS care, may be of concern. Given the importance of having buy-in to the Cost Recovery Programme from this group and their support for cost recovery, this suggests a need for targeted communication with this group to underline the existence of the charging regulations, and the need for Trusts to take action to improve their effectiveness at identifying and recovering costs from overseas visitors and migrants.

Findings for both clinical and administrative staff in the follow-up survey suggest increasing levels of awareness amongst these groups. Around three in five administrative staff (62%) and hospital doctors (58%) were aware that some patients are chargeable, along with more than two in five hospital nurses (45%). As is to be expected given their role in cost recovery, among administrative staff Senior Accountants were much more likely to be aware of this compared to receptionists and consultant secretaries, with 87% of this group now aware.⁴⁹

Awareness appears to have *decreased* among primary care practice managers, of whom 36% reported being aware that some patients are chargeable, compared to 50% and 51% respectively in the baseline and interim waves. While charging has yet to be extended to primary care, an increase in flagging of potentially chargeable patients by primary care, when referring to secondary care, was expected during the first two years of the Cost Recovery Programme. However, during

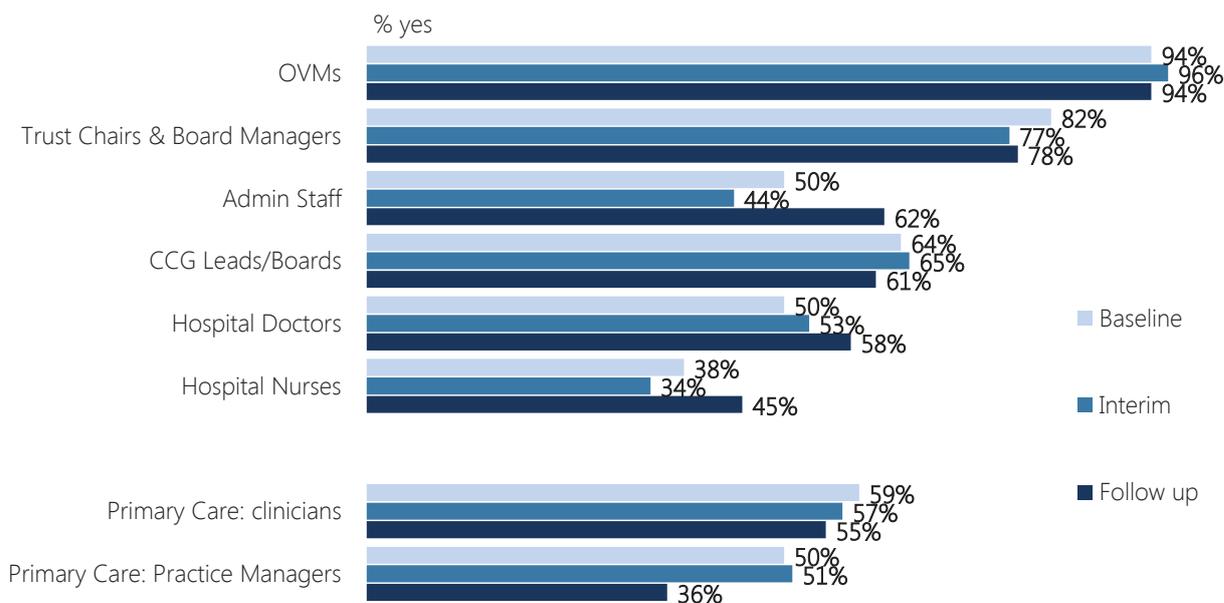
⁴⁸ As only 50 OVMs were interviewed in each wave of the survey this represents just three who reported being unaware.

⁴⁹ Receptionists; 58%; consultant secretaries; 41% aware.

the first two years of the Cost Recovery Programme a requirement for GP practices to attempt to identify and flag chargeable patients when making referrals has not yet been incorporated into the GP Contract set by NHS England. Work will be undertaken during Year Three of the Cost Recovery Programme in order to drive behaviour change amongst primary care staff, and therefore gains would be expected if the survey were repeated in the future.

Figure 3.1: Awareness of charging rules

KR1. Thinking about services other than dental, optical and prescriptions, as far as you are aware, is there anyone who is chargeable for the NHS healthcare they receive, or not?



Base: All interviews with NHS staff : Follow up (2156); Interim (2170); Baseline (2165)

Source: Ipsos MORI

Follow-up questions with those aware that some patients are chargeable show an increasing awareness over time of the reasons patients could be chargeable, the services they could be charged for and the reasons why some patients could be exempt. When asked which patients are potentially eligible to be charged, the top answers related to visitor/non-UK residency status.

While many staff were aware that some patients may be chargeable, there are some misconceptions about exactly which services would be chargeable. For example, in the follow-up survey there were still small minorities among all groups who believe A&E services are potentially chargeable (between 4 and 9%), and up to 40% (Hospital Nurses) reported 'everything' to be chargeable.

Among OVMs and other staff who took part in the case studies and interviews, there was a widespread perception that cost recovery had become more of a priority over recent years, with frontline staff in particular becoming increasingly aware of and involved in the process, and flagging increasing numbers of chargeable patients. The frontline clinical and administrative staff unfailingly described very good relationships with the OVMs in their Trust. However, OVMs frequently reported being the only members of staff with a detailed knowledge of the processes in place; the role of frontline and administrative staff was primarily focused on identifying potentially chargeable patients, through asking standard questions of all patients, and flagging them to the OVM to follow up. The fact that in many of the Trusts it was the OVM who was responsible for communicating elements of the Cost Recovery Programme to Trust staff, rather than staff learning about the Cost Recovery Programme through central communications sources, such as DH or NHS England, can help to explain

why increased awareness of, and involvement in, cost recovery processes can happen irrespective of levels of awareness of the Cost Recovery Programme.

OVMs also said that there was still work to be done in terms of raising awareness among frontline staff; they reported differing levels of awareness and involvement across staff in different departments. Those encountering higher numbers were more likely to be aware of the processes in place, and were more involved in flagging potentially chargeable patients.

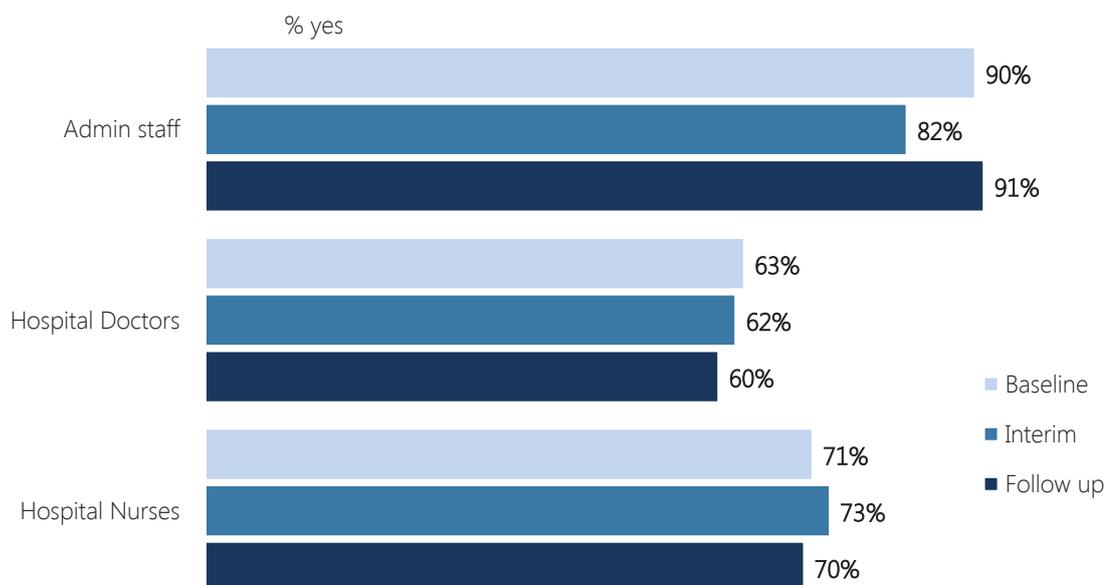
In many Trusts, a lack of formal training for frontline clinical and administrative staff and a lack of buy-in among senior staff had further hindered the efforts of OVMs to communicate the Cost Recovery Programme and disseminate information about chargeable patients.

3.1.2 Awareness of who to contact

The majority of administrative staff and hospital nurses who were aware that some patients are chargeable for NHS healthcare, reported that they know who to contact if they encounter a potentially chargeable patient. Nine in ten administrative staff (91%) were aware in the follow up survey, as were seven in ten hospital nurses (71%). Taking into account those not aware that some patients are chargeable, 79% of all administrative staff and 59% of all nurses were aware. These results remained relatively static over time. Among hospital doctors who were aware that some patients are chargeable, awareness was lower with around six in ten (baseline: 63%; interim: 62%; follow-up: 60%) reporting that they knew who to contact in each survey wave. This equates to 57% (baseline and interim) and 55% (follow-up) among all doctors.

Figure 3.2: Awareness of who to contact

RR3. Do you know who to contact in your organisation if you think someone might be a chargeable patient, or not?



Base: Interviews with NHS staff in clinical and administrative roles who were aware that some patients are chargeable for NHS healthcare: Baseline: (684); Interim: (652); Follow up: (797)

Source: Ipsos MORI

The survey data show positive correlations between knowledge of who to contact regarding potentially chargeable patients and awareness of the Cost Recovery Programme (hospital doctors and administrative staff were more likely to

know who to contact if they reported being aware of the Cost Recovery Programme), and receipt of training (as discussed further in section 2.4).

The case studies and in-depth interviews with OVMs revealed that their role is key in terms of raising awareness and understanding of cost recovery among frontline and administrative staff. With this in mind, the case studies also provided some suggestions as to why awareness of charging rules and of who to contact regarding chargeable patients remains persistently low among some staff groups. For example:

- OVMs in different trusts are based in a number of different parts of the organisation. In Trusts included in this work these locations included the Finance Department, Private Patients Department, and the Nursing Directorate. Based on this, some OVMs therefore may be more or less visible across the Trust, and interact more frequently with staff in particular roles.
- Increased awareness was often described as being primarily the result of the OVMs' own work, in visiting and speaking to staff, sharing information and training them on cost recovery processes. This may have been more effective in some trusts than others because of the individual OVM's approach, and how proactive they had been in communicating their role to staff and encouraging their involvement in flagging chargeable patients.
- Some OVMs said that they had been helped by having been in their role for a long time; this was helpful to them in enabling them to know who to speak to, and to communicate more effectively with staff about the OVM role and cost recovery processes.

The Year Two case studies served to reinforce the impression of earlier stages of the evaluation that the OVM role is fundamental to the success of cost recovery within a Trust. Interviews sought to understand what makes an effective OVM. The most consistently described skillset required was the ability to communicate effectively with multiple audiences. OVMs often have to have difficult conversations, regarding complex and sensitive topics, with potentially chargeable patients. They must also communicate effectively with staff at all levels of their organisation. Many of the advances made in individual Trusts can be seen as directly the result of actions taken by the OVM, driven by their individual motivation and persistence.

In some Trusts, the OVM themselves takes responsibility for the majority of the work involved. They establish patients' chargeability, carry out the administrative processes to ensure the invoicing of chargeable patients, advocate for the Cost Recovery Programme and train frontline staff in identifying potentially chargeable patients. This highlights a clear risk to the sustainability of the changes made for two reasons. First of all, much of their success hinged on the positive relationships they had built with other staff (often through having worked at the Trust for many years before taking on the OVM role), and as such, were they to leave the organisation they would not be easily replaced. Secondly, OVMs facing additional pressures or resource constraints in the other areas of their work, brings the risk that they cannot maintain the focus on cost recovery. However, in some cases the OVM may be supported by other administrative staff to assist with some of the tasks outlined above.

In addition, the case studies and interviews across both waves highlighted that Trusts were not all taking the same approach to improving cost recovery processes (ranging from directing additional OVM/administrative resource to the issue, to seeking to involve Trust staff more widely, and with a range of different process changes being made, for example real-time collection of payment from patients). The design of the Cost Recovery Programme is based on the perceived need to drive cultural and behavioural change across all NHS staff (and therefore the evaluation has sought to

measure whether such cultural and behavioural change is taking place), in order to drive the primary outcomes of increasing identification and recovery of costs. However, the experience of this evaluation raises questions over whether the Cost Recovery Programme could be more effective by a more nuanced approach to targeting specific staff groups, based on a clear understanding of how it is anticipated that each staff group can most effectively be engaged in cost recovery processes. It is apparent that the largest gains have been made amongst administrative staff to date, and therefore the potential role of frontline clinical staff may need reconsidering. However, this must be done in the knowledge that involvement of frontline clinical staff will be crucial if the level of upfront charging taking place is to be increased. The implications of this are considered more fully in the conclusions and recommendations chapter of this report.

3.1.3 Buy-in to programme principles

The design of the Cost Recovery Programme linked success, in increasing the number of checks of eligibility that NHS staff are undertaking, to driving cultural change across staff groups. Specifically, moving towards a culture where staff felt a 'duty to charge' (as outlined in the logic model in Figure 1.1) was identified as being an impact of the Cost Recovery Programme. For a 'duty to charge' to exist, buy-in to the principles of the Cost Recovery Programme is critical. Given the way in which the Cost Recovery Programme is applied differently across Trusts, it is important that in each of these Trusts staff understand and support the principles of fairness and entitlement underpinning the Cost Recovery Programme. As argued in a report produced by NHS South England, *change programmes need to be seen as legitimate and worthwhile at all levels*.⁵⁰

At all stages of the evaluation, the majority of all staff surveyed supported the broad/overarching principles of the Cost Recovery Programme. In particular, there was a very strong level of agreement, across all staff groups, that *charging overseas visitors and migrants for NHS services is fair*. At least two thirds in each group agree, and indeed, almost nine in ten Trust chairs and board members (88%) and OVMs (86%) agree, as do 84% of administrative staff. In addition, at least half, and often much more, of each staff group disagreed that *overseas visitors and migrants should have the same access to free healthcare as UK residents*.

This buy-in was also evident in the case studies, where individuals we spoke to were generally very supportive of the principles of the Cost Recovery Programme, and thought that being able to share information about the financial impact of cost recovery could help get other frontline staff 'on board'.

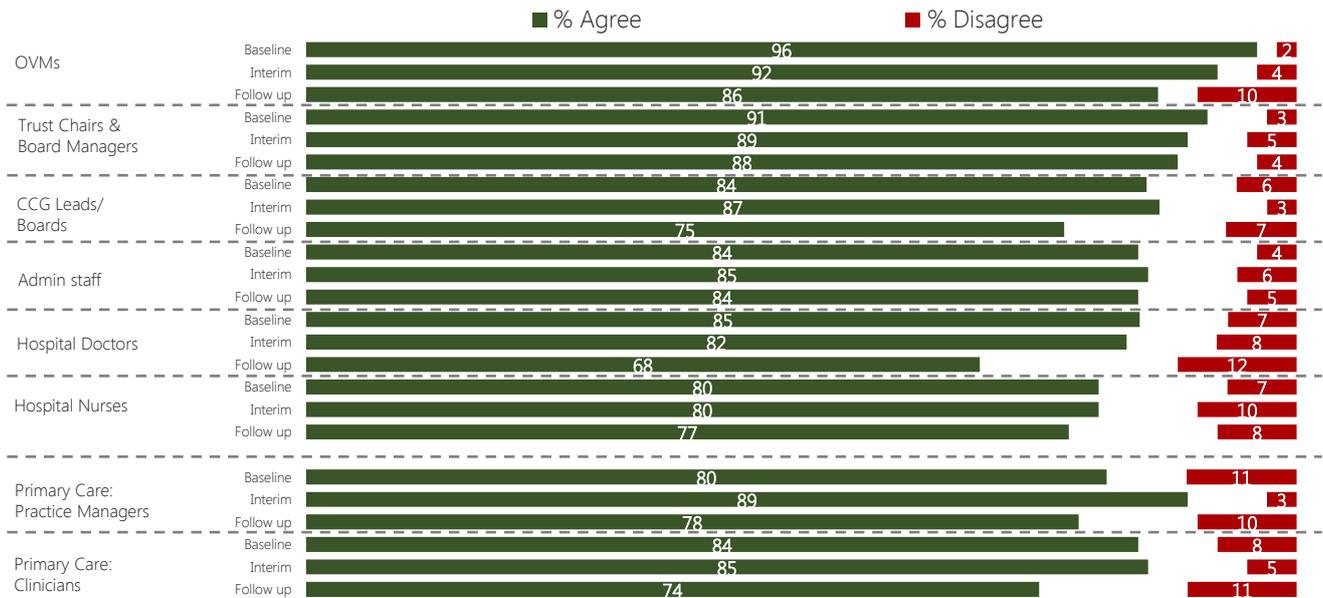
However, whilst there are strong levels of implied support for these principles, a significant minority of both Hospital Doctors (28%) and Hospital Nurses (26%) agreed that overseas visitors and migrants should have *the same access to free healthcare as UK residents*. Furthermore, the most recent survey results saw a decrease in support for the Cost Recovery Programme's principles among some groups. In particular, the proportion of hospital doctors who agree that *charging overseas visitors and migrants for NHS services is fair* has fallen from 85% in the baseline survey to 68% at the follow-up survey, while a similar picture is also evident amongst primary care clinicians, CCG Leads and Boards, and Trust Chairs and Boards. It is somewhat unclear what has driven this decline in the time between the last two waves of the survey. One point to consider in understanding this decrease, supported by anecdotal evidence from the case study visits and interviews with OVMs, is that over time staff have become increasingly aware of the challenges of cost recovery and the difficulties faced by some patients who are not eligible for free NHS care. In particular, OVMs and senior staff stressed the

⁵⁰ *What makes successful change in the NHS*, Roffey Park Institute, July 2012, <http://www.nhs.uk/media/2612249/what-make-change-successful-nhs-south-england-report.pdf> p.5

vulnerability of some patients and the sense of empathy they felt for them; although this did not fundamentally change their views on charging, it did cause them to hold somewhat conflicted feelings and provided a possible explanation for a lack of support among some frontline staff.

Figure 3.3: Fairness of charging overseas visitors and migrants

CV1_1. To what extent do you agree or disagree with the following statement: Charging overseas visitors and migrants for healthcare services which they receive from the NHS is fair?

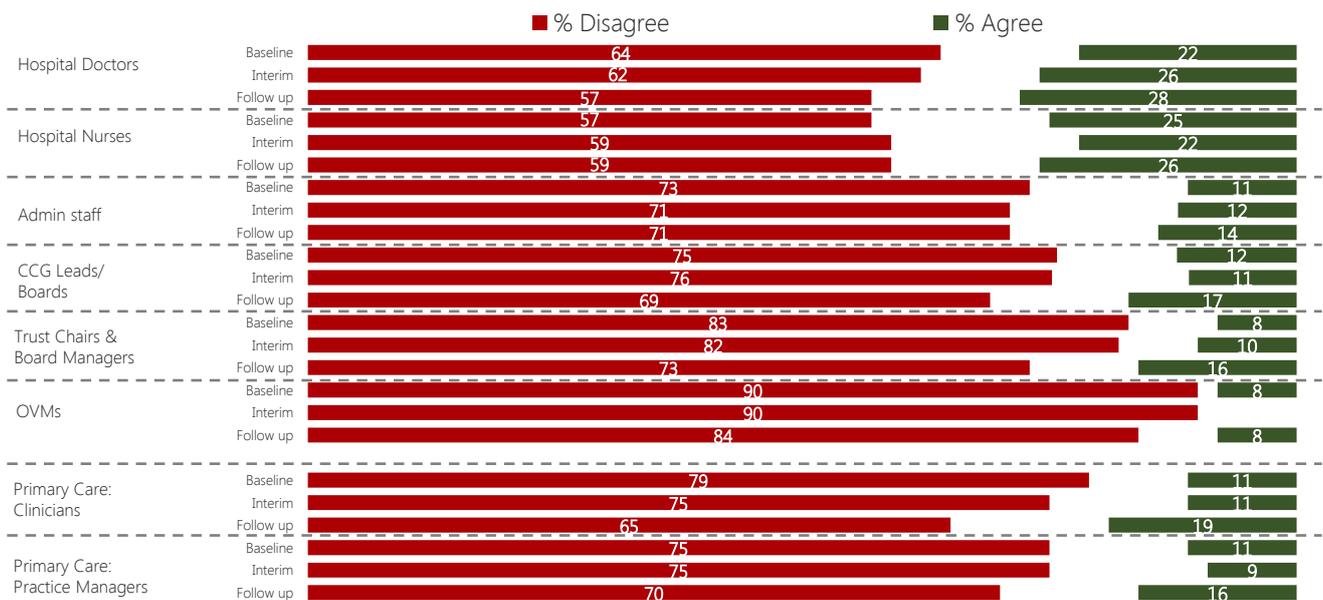


Base: All interviews with NHS staff: Baseline (2165); Interim (2170); Follow up (2156)

Source: Ipsos MORI

Figure 3.4: Overseas visitors and migrants access to free healthcare

CV1_3. To what extent do you agree or disagree with the following statement: Overseas visitors and migrants should have the same access to free healthcare as UK residents



Base: All interviews with NHS staff : Baseline (2165); Interim (2170); Follow up (2156)

Source: Ipsos MORI

The overall decline in support for the principles underpinning the Cost Recovery Programme among some groups raises the possibility that some Trusts will face ongoing difficulty in making the changes required to improve the recovery of costs. The impact of low buy-in was evident in one of the interviews with OVMs: in one of the case study visits conducted during the first year of the Cost Recovery Programme, OVM staff reported hostility from some clinicians, who saw the OVMs as acting against the human rights of the patients in trying to charge them. In the second year, there was no clear evidence in the interviews of strong opposition; for the most part the individuals interviewed strongly supported the principle of recovering costs from overseas visitors and migrants, and this support was the driving force behind their engagement in the cost recovery process. They did, however, acknowledge that other members of staff were not as involved in or as supportive of cost recovery; OVMs and clinicians mentioned that some consultants in particular were reluctant to engage in the processes, seeing their role as purely focused on treating patients and not to get involved in determining whether they should be charged for their care. This tended to take the form of ambivalence or a 'reluctance to get involved', rather than outright opposition to the Cost Recovery Programme or charging processes, and given the small number of case studies conducted in comparison to the overall number of Trusts and the purposive nature of case study selection, it is not possible to make generalisations from these qualitative findings.

OVMs and clinicians did, however, report that levels of engagement in cost recovery processes varied across different departments and between individual frontline clinical and administrative staff members. They explained that some refused to be involved in identifying and flagging potentially chargeable patients because they saw their role as being only to treat the patients, and emphasised that doctors and nurses in the NHS were not automatically inclined towards the 'funding-led' attitude driving cost recovery. For this reason, where frontline staff were found to be particularly engaged, this was largely down to the OVMs' efforts to engage with them and explain the reasons behind cost recovery and the benefits it could bring to their Trust.

Some OVMs also reported facing resistance from some senior staff in their attempts to raise awareness of cost recovery. For example, one OVM explained that at one point she had put up posters explaining the cost recovery process around the hospital, only for these to be taken down by a member of the executive team, who gave the reason that cost recovery was not a priority issue.

Case study interviews showed that across all staff groups, there was a perception that increased communication around the impact of cost recovery would help to encourage staff buy-in at all levels. This particularly related to sharing information on the amount of money recovered and what this might equate to in terms of benefits to the Trust (e.g. being able to purchase a new piece of equipment or employ more nurses). Estimating the potential gains to be made from improving cost recovery processes at an individual Trust level is a significant challenge. Equipping OVMs with the skills and tools to do so could be a way to provide them with levers to engage senior Trust staff.

DH have sought, to some extent, to do this during the second year, for example through sending a letter to the Chief Executives of all Trusts to highlight the increased focus on cost recovery, the launch of the consultation regarding the extension of charging, the support available to Trusts, and the performance of the Trust.⁵¹ One OVM interviewed in more depth about this letter felt that it was not helpful. In particular, they questioned the basis on which the assessment of the expected value of costs recovered for the Trust had been made.

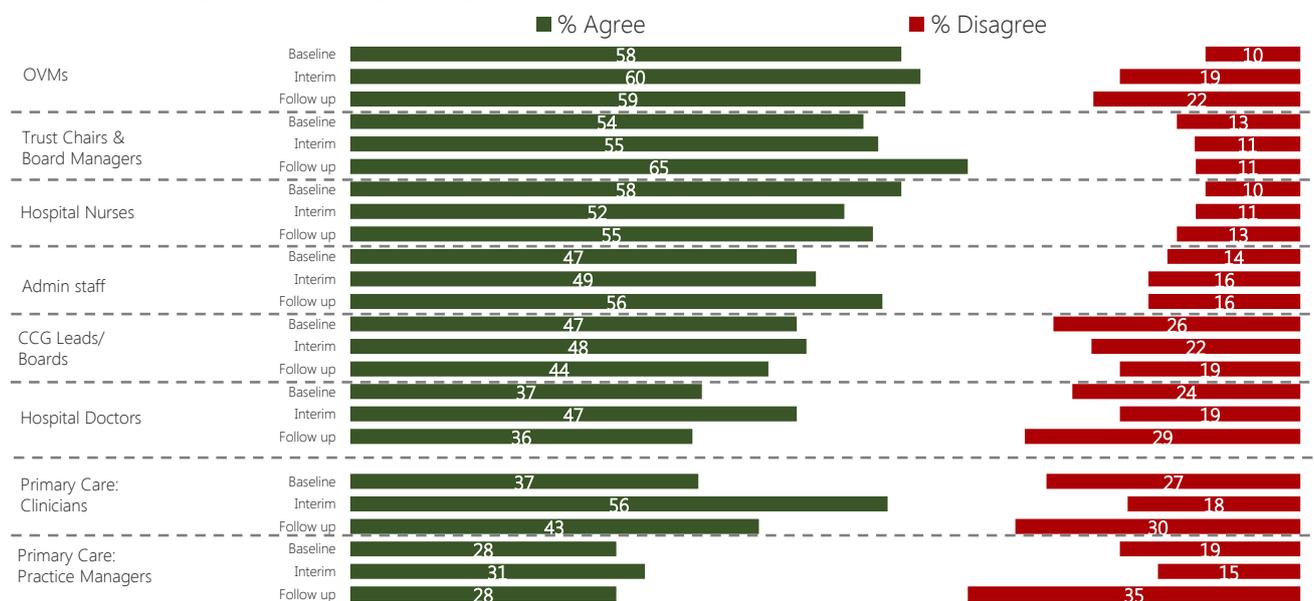
⁵¹ The letter was sent out in December 2015 detailing Trust performance during 2013/14, 2014/15 and 2015/16 to date.

3.1.4 Perceptions of costs and benefits

As well as implied buy-in for the Cost Recovery Programme, measured through the degree of support for the underlying principles, it is also important that the Cost Recovery Programme is not perceived as burdensome for NHS staff. Administrative burdens (real or perceived) could act as a barrier to change. In all three waves of the survey, there was generally a feeling amongst staff who were aware of the Cost Recovery Programme that *the benefits of the Cost Recovery Programme would outweigh the costs to the NHS*, although this varied significantly across staff groups. Trust Chairs and Boards and OVMs are most likely to agree with the statement (65% and 59% respectively), and Stage Two sees an increase in agreement among administrative staff, of whom 56% now agree, compared with 47% and 49% in Year One. Primary care staff and hospital doctors have consistently been the most likely to *disagree* with the statement; 35% of Practice Managers, 30% of primary care clinicians and 29% of hospital doctors did so.

Figure 3.5: Perceptions of costs and benefits of the Cost Recovery Programme

PA5. To what extent do you agree or disagree with the following statement: The benefits that the Visitors and Migrants NHS Cost Recovery Programme will bring outweigh the costs to the NHS?



Base: All interviews with NHS staff aware of the Cost Recovery Programme : Follow up (933), Interim (840), Baseline (805); OVMs: Follow up (46), Interim (42), Baseline (48); Trust Chairs & Board Managers: Follow up (139), Interim (137), Baseline (113); CCG Leads/Boards: Follow up (125), Interim (123), Baseline (99); Primary Care clinicians: Follow up (79), Interim (59), Baseline (63); Primary Care: Practice Managers: Follow up (32), Interim (31), Baseline (29); Hospital Doctors: Follow up (134), Interim (138), Baseline (151); Hospital Nurses: Follow up (118), Interim (100), Baseline (109); Admin staff: Follow up (260), Interim (210), Baseline (193). Source: Ipsos MORI

Those participants who were aware of the Cost Recovery Programme were also asked about specific benefits that the Cost Recovery Programme will bring. Trust Chairs & Board Managers,⁵² and CCG Leads and Boards were initially most likely to cite: financial benefits or recovery of costs; a clearer system; better identification of chargeable patients and a fairer system.

Some significant changes were observed over time. During the follow-up survey, both groups were less likely to cite financial benefits, with 30% of Trust Chairs and Boards saying this (compared to 43% in the baseline survey) and 21% of CCG Leads citing this as a benefit (compared to 30% in the baseline survey and 33% in the interim survey). It is possible that this is related to the slower increase in the value of costs being recovered through EHIC treatments, and the increase in ‘bad debts’ for non-EEA patients evident through the analysis of management information. However, the proportions of

⁵² These questions were asked of these two staff groups only.

each group citing a fairer system and a clearer system are at their highest level in the follow-up survey compared with previous waves.

Table 3.1: Perceived benefits of the Cost Recovery Programme

Trust Chairs & Board Managers			
	Baseline (Base: 113)	Interim (Base: 137)	Follow-up (Base: 139)
Financial benefits/financial recovery/recover costs	43%	31%*	30%
A clearer system	9%	22%*	28%
Better identification of chargeable patients	14%	22%*	23%
A fairer system	9%	19%*	23%
None / very little	14%	14%	15%
CCG Leads/Boards			
	Baseline (Base: 99)	Interim (Base: 123)	Follow-up (Base: 125)
None / very little	26%	18%*	25%
Financial benefits/financial recovery/recover costs	30%	33%	21%
A fairer system	12%	14%	16%
A clearer system	8%	11%	16%

All answers 10% and above in the follow-up survey are shown. An asterisk (*) represents a statistically significant change between baseline and interim results; a significant change between follow-up results and previous results is represented by both figures being shown in **bold**.

Base: Trust chairs & board managers and CCG leads/board members that were aware of the Cost Recovery Programme

In addition to the above, while Trust chairs & board managers might have identified financial benefits as being one of the benefits of the Cost Recovery Programme, when asked, the majority (59%) reported that cost recovery was not important in improving their Trust's finances – perhaps helping explain some of the difficulties that have been faced in gaining senior level buy-in.

The survey findings were largely supported by findings from the case studies and in-depth interviews. Among frontline clinical and administrative staff and senior staff, despite relatively low awareness of the overall impact of cost recovery there was a general feeling that it was helping to make the system fairer, by ensuring that all who use NHS services contribute financially in some way, and making it more difficult to take advantage of the NHS. However, as discussed earlier, a lack of awareness among frontline staff regarding the financial impact of the Cost Recovery Programme may be contributing to the lower levels of optimism about its benefits. There were some concerns among these staff groups regarding the additional burden of checking and flagging patients' status.

The stakeholder consultations conducted during the initial stages of the evaluation also highlighted a number of areas of potential concern, which had the potential to hinder buy-in to the Cost Recovery Programme, as set out in Table 3.2. These perceived issues provide some context against which to consider the decline in buy-in amongst some groups.

Table 3.2: Perceived issues with Programme design

Issue	Potential impact and mitigation
Financial penalties/sanctions: One stakeholder highlighted issues with operationalising of sanctions given lack of a standard method of performance measurement for cost recovery at a Trust level.	The Cost Recovery Programme has sought to minimise the impact of this issue through the revised design of the financial penalties, as set-out in Chapter Three.
Administrative burden on staff: Several stakeholders raised questions regarding the level of additional administrative burden the Cost Recovery Programme might place on staff within Trusts.	A perceived increased workload on frontline clinical staff might impinge on levels of buy-in for the Cost Recovery Programme's principles.
Costs/risks outweighing benefits: Increased identification of chargeable patients, without an accompanied improvement in recovery of costs, especially for non-EEA residents, leads to growth in levels of 'bad debt'.	This may both deter Trusts from seeking to improve identification processes, and serve to undermine the buy-in to the principles of the Cost Recovery Programme. The two incentive schemes seek to combat this issue.

In line with the findings from these consultations, Trust Chairs & Board Managers, and CCG Leads and Boards consistently identified *administration costs* as the most likely cost to be associated with the Cost Recovery Programme during the staff surveys. The only significant change over time was the proportion of Trust staff who reported *no costs* (4% at baseline and 15% at follow-up).

3.2 Cultural change

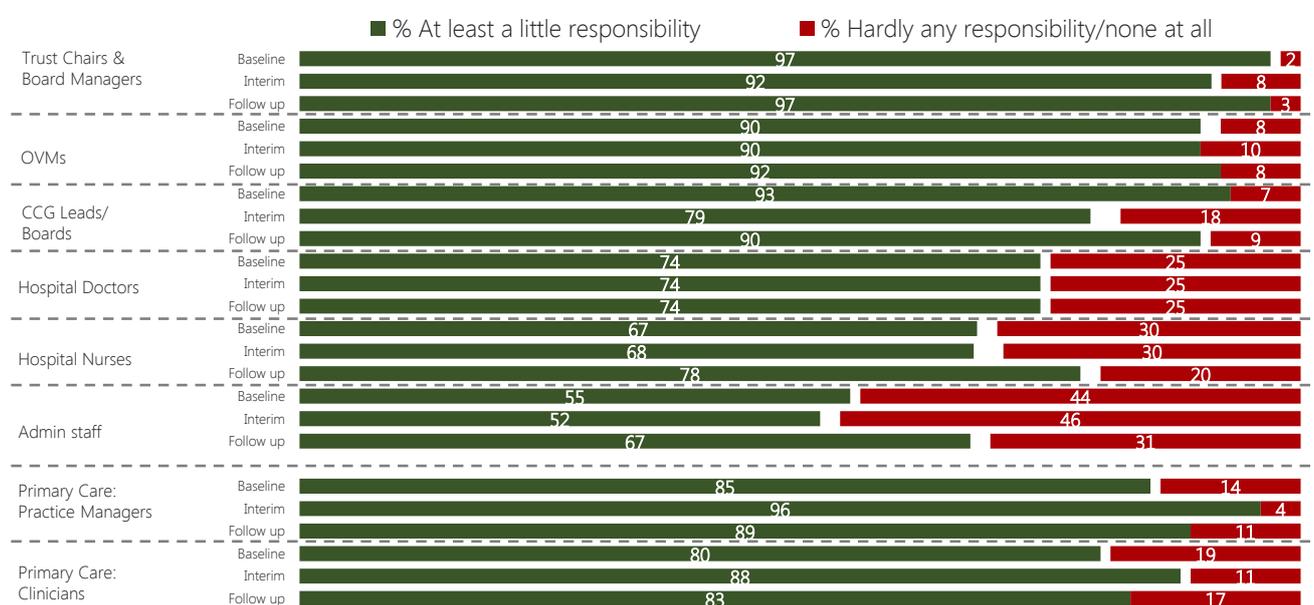
As well as aiming to increase awareness regarding the rules and processes for charging overseas patients, the Cost Recovery Programme also set out to support a culture in which all NHS staff are aware of their responsibilities to identify and recover costs from overseas visitors and migrants. It aims for an attitudinal shift to a point where all NHS staff feel a responsibility for recovering money from chargeable visitors and migrants and, where medically possible, do not treat patients until the eligibility for free NHS care has been established.

The majority of all staff groups said that they felt that at least a little responsibility for their organisation's finances. As seen in previous waves, among OVMs, Trust Chairs and Board members and CCG Leads and Board members more than nine in ten feel they have some level of responsibility.

Encouragingly, the follow-up survey suggested that there were some shifts in attitudes over the second year of the Cost Recovery Programme, with **hospital nurses and administrative staff significantly more likely to say they had 'at least a little responsibility' for their organisation's finances**, when compared with the baseline survey. Almost eight in ten hospital nurses (78%) reported some level of responsibility, up from 67% at the baseline and 68% in the interim survey. Meanwhile, two thirds of administrative staff (67%) reported this, compared to 55% and 52% respectively in the Year One surveys. Figure 3.6 overleaf shows the full breakdown by staff group of perceived responsibility for organisations' finances.

Figure 3.6: Personal responsibility for finances

CC1. How much responsibility, if at all, do you feel you personally have for your Trust's/Hospital's/ Practice's finances?



Base: All interviews with NHS staff: Baseline (2165); Interim (2170); Follow up (2156)

Source: Ipsos MORI

Among frontline clinical and administrative staff there were a number of correlations between responses to this question and other reported awareness and behaviours. These include those hospital doctors and administrative staff aware that some patients are chargeable reporting that they had at least a little responsibility for their Trust's finances. Similarly, those hospital doctors, nurses and administrative staff who were aware of the Cost Recovery Programme were more likely to have at least a little responsibility, as were hospital doctors and nurses who reported having a role in relation to chargeable patients.

3.3 Behavioural and procedural change

As previously discussed, the Cost Recovery Programme is based on an understanding that the various components of the Cost Recovery Programme, would drive a series of changes in behaviour across the various staff groups being targeted, by leveraging the underlying support for the principle of fairness. This evaluation has sought, as far as possible, to understand the extent to which some of the expected changes in behaviour have been realised.

3.3.1 Understanding of roles and responsibilities in relation to chargeable patients

As well as increasing feelings of responsibility for their Trusts' finances, the follow-up survey also saw hospital nurses and administrative staff increasingly feeling that they have a role to play in relation to potentially chargeable patients.

The proportion of administrative staff aware that some patients are chargeable but saying that they did not have a role fell to 36% at the follow-up survey, from 50% and 41% respectively in the baseline and interim surveys. At the same time, they were more likely than in previous waves to say that they had a role in *identifying potentially chargeable patients* (29%).

Taking into account those who were not aware that some patients are chargeable, 48% of all administrative staff identified themselves as having a role in cost recovery.

Among hospital nurses who were aware that some patients are chargeable, the proportion claiming not to have a role in relation to chargeable patients also decreased over time, to 27% in Stage Two, compared to 30% and 41% respectively in Year One.⁵³ Among nurses overall, 48%, 55% and 39% respectively reported that they do not have a role.

There are, however, still some important gaps for the Cost Recovery Programme to consider. In particular, almost half of hospital doctors (48%) who were aware that some patients are chargeable reported that they do not have a role in relation to potentially chargeable patients at the follow-up stage. Among doctors overall, 53% said this. Beyond this, there remains a small, but significant proportion of frontline clinical staff (12% of hospital doctors and 15% of hospital nurses) who, while aware that some patients are chargeable, did not think they had a role, nor know whose responsibility it was to identify such patients. Taking into account those not aware that some patients are chargeable, this rises to 16% of all doctors and 15% of all nurses.

Table 3.3: Roles and responsibilities⁵⁴

Staff group	Response	Baseline	Interim	Follow-up
Hospital Doctors	I don't have a role	41%	45%	48%
	Informing the OVM	24%	26%	22%
	Identifying potentially chargeable patients	31%	25%*	24%
Hospital Nurses	I don't have a role	30%	41%*	27%
	Informing the OVM	19%	28%	35%
	Identifying potentially chargeable patients	40%	27%*	28%
Administrative staff	I don't have a role	50%	41%	36%
	Informing the OVM	15%	24%	22%
	Identifying potentially chargeable patients	21%	18%	29%

Source: Ipsos MORI. Bases: Baseline: 684, Interim: 652, Final: 797 interviews with NHS staff in clinical and administrative roles.

These findings link directly to the processes described by OVMs and by frontline staff who took part in the case studies and in-depth interviews. In those Trusts in Year Two where process changes had been implemented, the focus was primarily on using frontline administrative staff, such as receptionists, to ask questions to flag potentially chargeable patients. Where clinicians are involved in this process, their role was apparently constrained primarily to:

- Making patients being admitted through A&E aware of potential chargeability; and,
- Flagging cases for investigation to the OVM.

⁵³ Please note that the difference between the baseline (Year One) survey results and the follow up (Stage Two) results is not considered statistically significant.

⁵⁴ Please note: an asterisk (*) denotes a statistically significant difference between baseline and interim results; results in bold denote a statistically significant difference between the follow-up wave result and the other figure in bold. Figures shown are based on only those staff who were aware that some patients are chargeable for NHS Healthcare.

OVMs described significant improvements over time, with frontline clinical and administrative staff becoming increasingly involved in identifying and flagging potentially chargeable patients, and increasingly engaged in this role. Nurses and administrative staff tended to be more closely involved than doctors, with the doctors having less time to dedicate to it.

However, some OVMs felt there was still a lot of progress to be made in raising awareness and getting all frontline staff on board. They said that they had faced some resistance, from doctors in particular, and reported that some departments are more effective than others at flagging patients due to the staff being more 'clued-up'.

Frontline clinical and administrative staff also highlighted differing attitudes between individual teams and members of staff, and tended to cite their own support for the principles behind the Cost Recovery Programme and cost recovery as a driving factor behind their own proactive approach. Even those who felt they had a good knowledge of the charging rules and had a role in identifying potentially chargeable patients felt that there were gaps in their knowledge and that they would like to understand more about the processes. Those interviewed thought that they had higher levels of awareness than their peers, and they believed that being able to share this knowledge with other staff could help to encourage greater involvement and bring the more resistant individuals on board.

3.3.2 Changes in practice

One of the primary actions expected to be taken by frontline clinical and administrative staff was the flagging of potentially chargeable patients. The qualitative work suggests that there have been very mixed approaches to this, in line with the findings from the research undertaken in 2013. It is apparent that different Trusts have approached things in different ways, for example administrative staff, such as receptionists, are most often involved in identifying potentially chargeable patients, based on often being the first person to have contact with a patient, for example at registration. Hospital doctors and nurses, on the other hand, have been somewhat inconsistently involved in the process from Trust to Trust – in some cases just being targeted for awareness and achieving buy-in, and in other cases having a larger role in identifying potentially chargeable patients. Significantly, the volume of potentially chargeable overseas patients encountered can vary from department to department, making it very hard to establish an accurate picture through a survey. The variety of systems and approaches in place highlight the need for any process change to be considered at a Trust level, and possibly even below this (i.e. Department/speciality-level), and may cause issues if trying to implement a single process across the NHS.

The three waves of the survey reflect these differences. Relatively high proportions of both Hospital Doctors and Nurses who were aware that some patients are chargeable, reported that they never flagged potentially chargeable patients. Around half of Hospital Nurses said this (48% at follow-up, and 47% and 51% at the baseline and interim respectively). Among Hospital Doctors, the proportion reporting that they *never flag potentially chargeable patients* has in fact increased at the follow-up survey (at 63%, up from 43% in the baseline and interim surveys). Among doctors and nurses overall, 68% and 63% respectively report that they never flag potentially chargeable patients, at the follow-up survey stage.

The results for administrative staff show some improvement of time. This group was less likely than previously to report *never flagging chargeable patients*. At the follow-up survey, just under half (47%) of administrative staff who were aware that some patients are chargeable said they *never flag potentially chargeable patients* (down from 56% at the baseline and 53% at the interim survey). Among administrative staff overall, 58% report at the follow-up stage that they never flag potentially chargeable patients.

Indeed, evidence from the qualitative work supports these findings, with administrative staff and nurses seen as becoming more closely involved over time, and more likely to be involved in identifying potentially chargeable patients than doctors were. Although in some cases there was evidence of doctors' increasing involvement in or awareness of the processes, there was also a sense that this was not generally considered to be part of their role.

The very 'hands-on' approaches being taken by OVMs serve to highlight a potential risk to the long-term sustainability of the gains being made. It is clear that frontline clinical and administrative staff are only engaged to the point of flagging cases to the OVM that need investigation whilst OVMs themselves have retained responsibility for interpreting complex rules, and making decisions on how to proceed. As a result, constraints on their time either from the number of patients they have to check the status of, or from the other responsibilities they have, could restrict growth in income obtained through cost recovery.⁵⁵

All of the OVMs interviewed during Year Two highlighted the need for additional resource within their Trust. They felt that without additional resources, there was limited room for further improvement, for example, constraints cited included those on their own time and on the time of the finance staff involved in calculating invoices as the main barriers. One solution to this would be to increase the role of frontline administrative and clinical staff beyond just flagging potentially chargeable patients towards actually investigating cases. However, given the perceived complexity of the charging regulations and guidance, this would require in-depth training for any staff involved. Unless further efforts are taken to persuade senior Trust staff as to the importance of improving cost recovery, cost recovery efforts may reach a ceiling. One OVM had put together a business case to secure additional staff resource to aid with the identification and recovery of costs, but this was rejected by senior staff.

Highlighting the potential for variation across Trusts, when asked how many patients they had to check the chargeable status for in an average week, 45% reported checking the status of 1-20 patients, while 34% reported checking the status of 21-50.⁵⁶ While there has been some variation during the course of the evaluation this should be interpreted with caution given the small number of OVMs interviewed. There is also a significant degree of variation on the proportion of patients that OVMs check that are actually chargeable – with the largest group at both the baseline and follow-up survey reporting only up to 30% turn out to be chargeable (45% and 57% at each stage). The first two years of the Cost Recovery Programme saw an increase in the proportion of Hospital Nurses and Administrative Staff who reported that it is either *easy* or *difficult* to establish whether or not a patient is chargeable, with a corresponding decrease in the proportion saying that it *is not their role*. Among Nurses, the proportion aware that some patients are chargeable but reporting that they don't have a role dropped from a third (33%) at the baseline, to around one in six (17%) at the follow-up stage, while among Administrative Staff the same proportion dropped from 44% at the baseline and more than half (53%) at the interim survey, to 30% at the follow-up⁵⁷. Figure 3.7 overleaf illustrates these findings.

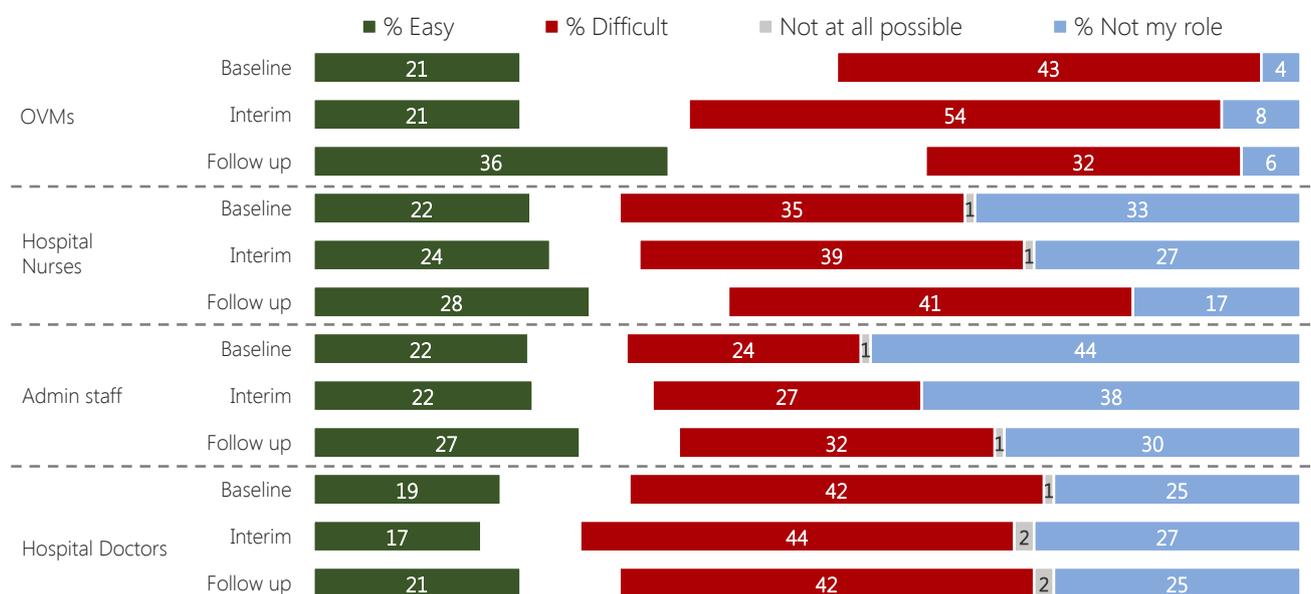
⁵⁵ Just over one-third of OVMs surveyed at the follow-up said that they had to check the status of between 21 and 50 patients per week.

⁵⁶ Figures in this section refer only to those OVMs who were aware that some patients are chargeable for NHS healthcare.

⁵⁷ These findings are based only on those who were aware that some patients are chargeable for NHS healthcare.

Figure 3.7: Ease of establishing chargeability

RR11. In general, how easy or difficult, if at all, do you find establishing whether or not a patient is chargeable to be?



Base: Interviews with NHS staff in clinical, administrative and OVM roles who were aware that some patients are chargeable for NHS healthcare: Baseline (731); Interim (700); Follow up (844)

Source: Ipsos MORI

Hospital staff also reported a number of barriers when establishing a patient’s chargeable status – for OVMs these often related to challenges in getting the relevant information, rather than difficulties with decision-making or understanding the rules. For example, at the follow-up survey, OVMs cited: *patients withholding relevant information* (40%), *patients not knowing relevant information* (19%), and, *language barriers* (15%) as hurdles to establishing whether a patient should or shouldn’t be charged. Exploring the qualitative findings, patient related barriers were less of an issue, language barriers were usually overcome through use of a translator. However, it is expected that the extent of this problem is likely to vary from Trust to Trust.

In line with the information barriers mentioned above, while at the follow-up one-quarter (26%) of OVMs reported that the information passed to them was *always or nearly always* sufficient to easily establish their chargeable status, an equal proportion reported that this was only *sometimes or occasionally* the case.

3.4 Effectiveness of cost recovery

In the follow-up wave of the staff survey, the majority of OVMs reported that the process of identifying chargeable patients in their trust was effective (77%⁵⁸). However, the fact that over half of OVMs in the follow-up survey reported that only 30% of patients they check actually prove to be chargeable provides an indication that while OVMs may feel the processes are effective at capturing chargeable patients, they are not necessarily operating in an efficient way.

As discussed earlier in relation to staff communication and training, the early case study work as part of this evaluation raised significant issues regarding the importance of senior-level support, and the impact of not having this support, on the work of the OVMs. Therefore, during the follow-up survey, OVMs were asked the extent to which they felt *well supported by senior staff within their Trust in recovering costs from chargeable overseas visitors and migrants*. Although

⁵⁸ Figures in this section are based only on those who were aware that some patients are chargeable for NHS healthcare.

the majority (70%) report that they are *well supported*, a significant proportion (26%) said that they were *not well supported*. The qualitative work sheds some light on this; while OVMs interviewed generally reported having had good support from senior staff, some had faced difficulties - primarily when requesting training programmes to be introduced, or for additional staff and resource dedicated to cost recovery. For some, it was felt that cost recovery was simply not a high enough priority for the Trust leadership – for example due to the low-level of potential debt to be recovered compared to other debts faced by the Trust. Therefore, they had reached a limit in terms of their progress in raising awareness of and involvement in cost recovery among frontline staff, and in the number of chargeable patients they were able to identify and collect payment from, without further backing from senior staff.

Figure 3.8: Effectiveness of and support for cost recovery

OVM5. In your opinion, how effective, if at all, is the process for identifying chargeable patients in your Trust?



OVM6. How well supported, if at all, do you feel by senior staff within your Trust in recovering costs from chargeable overseas visitors and migrants?



OVM7. How confident, if at all, are you that the primary care services you work with are correctly flagging potentially chargeable patients?



Base: All interviews with OVMs who were aware that some patients are chargeable for NHS healthcare: Follow up (47). *Note small base size

Source: Ipsos MORI

Some OVMs interviewed also called for the introduction of more uniform processes for cost recovery, dictated by DH, which may help achieve senior management buy-in if changes are seen as compulsory.

The survey also sought opinions from both CCG and Trust Board perspectives on the efficacy of cost recovery processes. A quarter of respondents from CCGs reported that the Trusts they work with were effectively recovering costs from overseas visitors and migrants, while a third said that they were *not effective*. However, perhaps more tellingly, the largest proportion (39%) *didn't know*. The majority of respondents at a Trust board level (71%), however, said that they were confident that they *have the processes in place in order to maximise the recovery of costs from chargeable patients in their Trust*.

The qualitative work paints a mixed picture in conjunction with the survey results. It is perhaps unsurprising that CCGs have a fairly negative view of the efficacy of the processes in place given that they are more likely to be involved in the financial side of cost recovery and aware of the risk-sharing agreement that now forms the basis of the non-EEA incentive. As a result of this, CCGs will see increasing volumes of outstanding or 'bad debt', contributing to their lack of confidence in the efficacy of processes. In one case study during the final round, there was also discussion of the issues non-

recovered costs from overseas visitors and migrants caused for CCG budget allocations, although it is unclear what the exact impact of this is. The small number of senior Trust staff it was possible to consult with during the case studies, generally had confidence in the OVMs in place, but felt that there was much more still to be done in order to improve, including communicating with the public, to counter assumptions that the NHS is free for all.

The case studies conducted during the first part of this evaluation highlighted the serious barriers faced by some OVMs who lacked senior level support or buy-in for some of the changes they were seeking to make. The latest case studies found similar issues with senior level support for improving cost recovery processes, especially where such improvements required increased levels of resource (either capital costs on IT systems or staff recruitment, or opportunity costs through directing more resource to cost recovery).

3.4.2 Challenges in recovering costs

The issues identified earlier with establishing the eligibility of patients for NHS healthcare carried through to the challenge of recovering costs from patients. Given the increase in the volume of 'bad debt' evident in the analysis of management information, this is particularly relevant, as this represents a significant risk to the future success of the Cost Recovery Programme. The management information clearly illustrates that a rise in charging non-EEA residents has not been associated with a rise in upfront charging, resulting in an expansion of 'bad debt'. This is consistent with the survey findings, with OVMs reporting no significant improvement in the proportion of non-EEA invoices reported as being settled in full – just over one-third at the follow-up survey reported that 1-30%, and similar findings for the proportion resulting in a payment plan.

The Year Two case studies and interviews sought to understand why there had been an apparent lack of progress in moving towards upfront charging, with a number of challenges identified:

- **Difficulties estimating treatment costs:** Both in terms of the open-ended nature of some treatments, and challenges in obtaining treatment costs from the Finance Department.
- **Treatments being commenced before eligibility is established:** In cases where treatment has proceeded pending OVMs assessing eligibility, upfront charging is not possible.
- **Lack of facilities to charge upfront:** An inability to take payments 'at the bedside', e.g. using a credit/debit card machine, but instead having to rely on invoicing, which can be time consuming, impinges on the ability to charge upfront.

One Trust reported that they had introduced £1,000 deposits when admitting chargeable patients, but feedback was not available on how effective this had been.

In addition to this, at the follow-up survey OVMs reported *patients being unable to pay* (36%), *being unwilling to pay* (28%), and *not having correct/complete patient details* (21%), as the main barriers to **charging and recovering** costs from chargeable patients.

The role of NHS staff in recovering costs from patients treated under EHIC agreements revolves around ensuring the necessary details are collected. OVMs aware that some patients were chargeable were divided as to how easy or difficult collecting EHIC details was (43% easy, 30% difficult). For other staff groups asked this question, amongst those aware that

some patients were chargeable, the largest proportion of each group reported that they *don't do this*,⁵⁹ and more reported it being difficult than easy.

3.4.3 The role of primary care

Whilst charging itself does not currently apply to primary care, guidance provided by DH encourages Trusts to develop relationships with GP practices and have communications with them with regard to the flagging of overseas visitors or migrants. For this reason, the follow-up survey sought to establish the extent to which such communications are taking place already, and also as a baseline measure ahead of the potential extension of charging rules to primary care depending on the outcome of the consultation on extending charging.

This is an area where there is clear room for development, with only a minority of OVMs having confidence that primary care services were correctly flagging chargeable patients, a small minority of primary care staff reporting having communications with secondary care regarding visitors and migrants, and just over one-third of primary care practice managers reporting flagging potentially chargeable patients. Around one in five OVMs (21%) who were aware that some patients are chargeable reported having confidence that the *primary care services they work with are correctly flagging potentially chargeable patients*. Responses to the survey from those working in primary care again present some evidence of this taking place, although only among a minority. One in eleven primary care clinicians (nine per cent) and 16% of practice managers reported having *any communications with those responsible for identifying and charging overseas visitors and migrants at Acute Trusts/Trusts/Secondary care providers in the local area*. Likewise, of these, very few (three clinicians and one practice manager) said that they flagged potentially chargeable overseas visitors and migrants to their local secondary care providers (although contradictory evidence, such as reports of flagging chargeable patients during referral by 37% of practice managers surveyed highlight that there is perhaps a lack of understanding of the rules and processes within primary care). It is clear that there is a lot of progress to be made here, much of which would be helped by an efficient and reliable system for automatically flagging potentially chargeable patients, rather than relying on GPs to flag this in referral letters. OVMs who participated in the qualitative interviews and case studies stressed the importance of establishing such a system if charging rules were to be applied to primary care, and expressed concerns about the potential difficulty and additional burden they might face in supporting primary care staff during the early stages of the rollout.

While generally there were limited communications between primary and secondary care regarding chargeable or potentially chargeable patients, the case study interviews provide evidence of some OVMs reporting improving relationships with primary care, and of good practice in terms of flagging potentially chargeable patients. However, there were equally reports of primary care services issuing NHS Numbers to ineligible patients, causing problems for Trusts who rely upon this approach as a way of sifting out potentially chargeable patients. It was suggested by some OVMs, that the effectiveness of cost recovery would be improved if identification was moved to the beginning of the patient pathway – which in many cases would be during primary care treatment, even if this treatment is not chargeable itself.

3.4.4 Possible unintended consequences

The logic model for the Cost Recovery Programme, Figure 1.1, highlights some of the potential unintended consequences that the Cost Recovery Programme could have. While these unintended consequences would be potentially brought about by increased cost recovery efforts across the NHS, the Cost Recovery Programme, in seeking to drive an increased focus on the importance of cost recovery, may in turn contribute to these unintended consequences. In particular, these

⁵⁹ 69% of hospital doctors, 45% of hospital nurses and 51% of administrative staff.

risks relate to excluding patients from medical care through charging those patients who cannot afford to pay, or deterring people in need from seeking medical care for fear of being charged. The possible consequences of these situations being realised are both worse health outcomes for individuals and/or groups, and possibly worsened public health outcomes through the spread of disease.

During the initial stages of the evaluation, stakeholders raised strong concerns about the possible impact of the Cost Recovery Programme on vulnerable groups, especially in relation to the deterrent effect on seeking necessary medical care. Suggested mitigating strategies focused around clear communications to possible patients regarding their entitlement, and the need for clear guidance for NHS staff on interpreting the charging regulations and associated exemptions, with misinterpretation, leading to unnecessary charging, seen as a significant source of risk.

When asked about the risks associated with the Cost Recovery Programme, at the follow-up stage, relatively low proportions reported the risks outlined in the logic model. One in ten Trust chairs and board members and CCG Leads and Board Members (11% and 9% respectively) perceived *patients not seeking treatment in case they are charged* as a potential risk, while 6% and 9% of each group thought that the Cost Recovery Programme would have an impact on *vulnerable groups*. An extremely small minority (1% and 3%) thought that the Cost Recovery Programme would bring *public health risks*.

Systematic measurement of the manifestation of any of these risks has proven difficult during the course of this evaluation. For example, while the deterrent effect may be evident through anecdotal evidence for individual cases, it is hard to detect at a system-level, given the potential variation in the level of health needs relating to overseas visitors and migrants and lack of information relating to reasons visitors and migrants may not be seeking healthcare. Unless processes are consistently implemented or improved across the NHS at the same pace, then this **deterrent** effect may first of all manifest itself as a **displacement** effect (i.e. overseas visitors and migrants seek treatment at other Trusts in a local area if they are denied treatment at one). One way of measuring whether these effects are happening is through monitoring the volumes of chargeable patients that secondary care clinicians treat. Hospital doctors reported consistent figures across all three waves of the survey. Around one-half reported that just 1-5% of the patients they treat were chargeable, while at least one-quarter in each wave *did not know*.

However, case study work during both years of the evaluation sought to explore this issue. During the first round of case studies, given the lack of wide ranging changes being implemented at the Trusts involved in the case studies, those interviewed did not identify any examples of the Cost Recovery Programme having an adverse impact on vulnerable groups.

While the risks had not yet been witnessed in practice, those interviewed could identify the potential risks, especially for racial bias to play a role in charging. Processes in place to deal with this seemed to primarily focus on ensuring that all patients were asked questions regarding residency when presenting themselves to the Trust. However, this is something that is extremely difficult to monitor or audit in practice.

A separate piece of work was undertaken by the evaluation team during the second year of the evaluation, involving further consultations with representatives of relevant groups, to understand how the Cost Recovery Programme might better monitor its impact on equalities and health inequalities going forward.

This small-scale study found that, the issue of monitoring the impact of the Cost Recovery Programme on vulnerable groups is a complex one, and one to which there isn't a straightforward and comprehensive solution. The interviews

conducted have shown that stakeholders continue to raise concerns about the impacts of the Cost Recovery Programme that are in line with those that have been raised through research conducted elsewhere. However, one of the main concerns raised is about the communication of the Cost Recovery Programme, especially surrounding the purpose (and links to immigration enforcement), the regulations and exemptions. Stakeholders felt that NHS staff, and patients, need more clarity and simplicity when it comes to establishing eligibility for free NHS healthcare.

While none of the stakeholders interviewed were able to provide sources of comprehensive evidence as to any negative impacts the Cost Recovery Programme is having, it has been possible to identify potential approaches to monitoring the impact. However, it is recommended that greater discussion with stakeholders, and investigation into the practicality of some of these suggestions, is undertaken in order to identify an approach that is both achievable, and will deliver the information required. It is likely that a combination of approaches will be required to fully understand and estimate the impact of the Cost Recovery Programme on patients in vulnerable groups.

3.5 Summary

- While levels of awareness that some patients can be charged for the healthcare they receive from the NHS have increased over time amongst clinical and administrative staff, significant proportions of all groups (except OVMs) remain unaware. In particular, one in five Trust Chairs and board members were unaware that some patients could be charged.
- Analysis from the staff survey and the case studies suggests that there is a high level of buy-in among most staff for the principles underpinning the design of the Cost Recovery Programme and higher proportions agree that the benefits of the Cost Recovery Programme will outweigh the costs. However, there is some evidence that a significant minority of frontline clinicians do not demonstrate support for the principles. Indeed, amongst hospital doctors and primary care clinicians the latest wave of the survey demonstrated a decrease in implied levels of support.
- When asked how easy establishing chargeability was, the only significant change over time saw a decrease in the proportion of administrative staff and hospital nurses reporting not having a role. Despite this, around half of frontline clinicians and administrative staff report having *never flagged chargeable patients*.
- Although OVMs generally reported feeling well-supported by senior staff in their Trust, throughout the evaluation, case studies have highlighted issues with senior level support for the Cost Recovery Programme and efforts at improving cost recovery processes. This has inhibited the ability of OVMs to implement process changes, introduce compulsory training, and communicate widely with frontline clinical and administrative staff. This has coincided with a decline in the proportion of Trust chairs and board members citing the Cost Recovery Programme as being likely to bring financial benefits, and raises questions about the extent to which OVMs will be able to overcome the barrier of achieving senior level buy-in.
- While the case studies highlighted a range of efforts aimed at improving the identification of chargeable overseas visitors and migrants, there are continued barriers that require addressing in order for further substantial financial gains to be achieved. In particular, the lack of progress made in moving towards upfront charging for non-EEA residents has implications for the Cost Recovery Programme. A continued lack of progress, will likely result in an increase in 'bad debt', and debts eventually being written off. Upfront charging requires further cultural and behaviour change, and is likely to be harder to achieve, given the need for treatment not to be provided unless

payment has been agreed. In addition, systems in Trusts do not appear well set-up to accommodate upfront charging, and the required changes would likely have an initial financial cost in the short-term.

- The staff survey and case studies highlight that administrative staff and hospital nurses have seen more of an increase in involvement in cost recovery than other frontline clinical staff such as hospital doctors. This appears to be because of the role of receptionists in asking questions and collecting information from patients during registration, and the role finance staff must play in calculation of costs and raising of invoices, while nurses, in some settings, may have more involvement in the initial stages than doctors. Significant proportions of administrative and clinical staff reported knowing who to contact about potentially chargeable patients, although there have been no significant increases in this metric over time, and significant gaps remain. However, large proportions of frontline clinical and administrative staff report not collecting EHIC details from patients highlights that OVMs are apparently doing much of the work beyond flagging potentially chargeable patients themselves.
- OVMs in the most recent round of case studies all raised concerns about the level of resource dedicated to cost recovery within their Trusts. It is clear that OVMs are not delegating responsibility for decision-making in the whole, except in those cases where OVMs are supported by a wider team. As such, there are concerns about the gaps that appear when OVMs are not on duty (it is primarily a 9-5 role), and also concerns about the additional progress that it is possible for OVMs to make within their Trusts without additional administrative support. In only two cases in each of the two waves of case studies did OVMs report that they were able to utilise additional income generated through improved cost recovery processes to further invest in improvements.
- Relatively low proportions of respondents reported the risks outlined in the logic model. The most prevalent was *patients not seeking treatment in case they are charged*, but only by a small minority of respondents (senior Trust and CCG staff), and a similar proportion reported possible impact on *vulnerable groups*. While anecdotal evidence from the case study interviews did not reveal any problems with the unintended consequences, the extent to which the Cost Recovery Programme is generating any such consequences has proven very difficult to measure. This is due to the lack of information available about certain groups accessing healthcare (in order to benchmark against), and the variation in the healthcare needs of overseas visitors and migrants which may mask any deterrent or displacement effect.

4 Costs and benefits of implementation

This chapter considers the extent to which progress has been made towards the aims of increasing cost recovery from both EEA and non-EEA residents during the first two years of the Cost Recovery Programme. In addition, one of the original aims of this evaluation was to assess the costs and benefits of the implementation of each element of the Cost Recovery Programme. However, the wide-ranging nature of the way in which individual Trusts are reacting to the Cost Recovery Programme by amending the processes they have in place, particularly the different ways in which frontline clinical and administrative staff are involved in cost recovery, does not allow a comprehensive cost-benefit analysis.

Here we present a narrative discussion of the costs and benefits drawing on the analysis of management information, the case study work, and the survey of NHS staff, highlighting the potential costs and benefits that might be accrued through the implementation of the Cost Recovery Programme, and any evidence as to whether these have been realised to date.

4.1 Progress towards aims

This section examines the progress made by the Cost Recovery Programme towards its aims for increasing cost recovery.

4.1.1 Recovery of costs from EEA residents

As set out in the Implementation Plan, the ambition of the Cost Recovery Programme is to recover *£200m a year from better identification of EEA patients and recharging to their home countries*,⁶⁰ and to deliver upon this ambition by the middle of the current Parliament (2015-2020). Analysis of the data available up until the end of Year Two of the Cost Recovery Programme (Financial Year 2015/16), shows that there has been strong progress made during the first two years. Total EEA income is the addition of EHIC income, S2 income and S1 income. EHIC and S2 incomes can come via two different routes; individually registered forms from patients and/or direct payments from the EEA member states as part of the bilateral agreements the UK has with them. The data on individually registered forms for EHICs and S2s are collected by the Overseas Healthcare Team in the Department of Work and Pensions, where the **value** of treatments processed under EHIC agreements has increased but not at the same rate as the **volume**.

Table 4.1: Treatments processed from EEA residents

Financial Year						
April 2013 – March 2014			April 2014 – March 2015 (Year One)		April 2015 – March 2016 (Year Two)	
Agreement	Volumes	Value	Volume	Value	Volume	Value
EHIC	4,700	£7.9m	7,760	£12.7m	13,860	£15.5m
S2 ⁶¹	1,790	£11.5m	2,360	£15.4m	1,640	£11.7m

Source: Department of Work and Pensions Overseas Healthcare Team⁶²

⁶⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementation_Plan_Phase_3.PDF, p.11

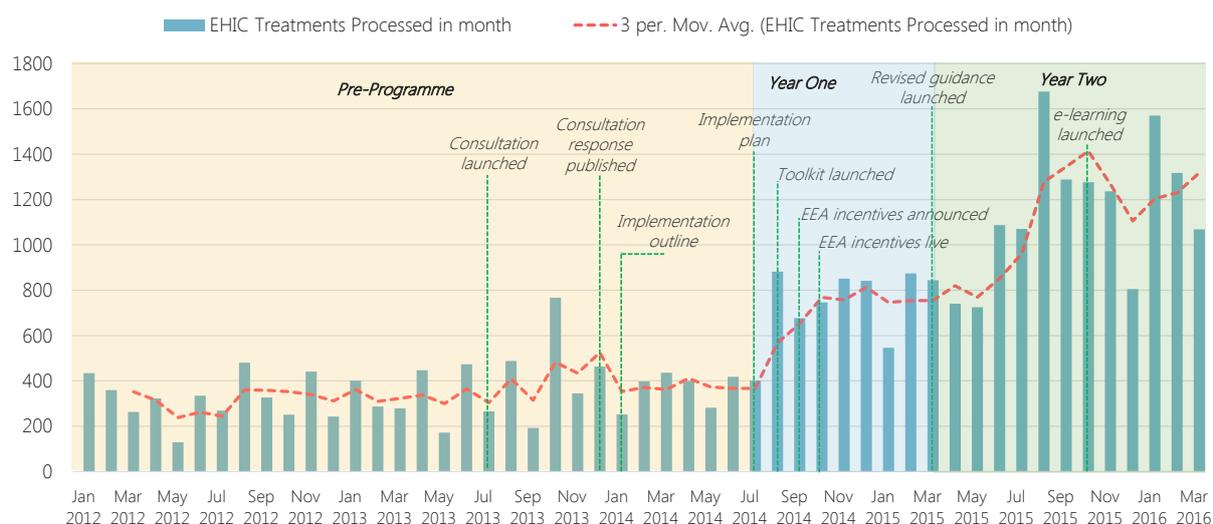
⁶¹ While an increase in recovery via S2 agreements is not a target for the Cost Recovery Programme, costs recovered through this means will contribute to the overall figure and are therefore included here for clarity. As treatments processed under S2 agreements are dependent on pre-arranged treatments, the value of costs recovered is more likely to vary year-on-year based on demand.

⁶² These figures are those identified by the NHS. They differ slightly from the figures presented in Table 4.2, which include recovered costs from those individual patients identified by the NHS and the wider bilateral agreements made between the UK and other EEA countries.

The data outlined in Table 4.1 demonstrate that, for Trusts in England:

- There has been a consistent increase in the **volume** of treatments processed on the OHT Portal between 2013/14 and 2014/15 (65% increase) and between 2014/15 and 2015/16 (79%). There was an immediate increase evident following the launch of the EEA incentive scheme⁶³ in October 2014. This increase has been sustained throughout Year Two of the Cost Recovery Programme (as illustrated in Figure 4.1).

Figure 4.1: Volumes of EHICs processed by month



Base: All EHIC treatments processed January 2012 - March 2016

Moving average calculated based on the average number of treatments processed over the preceding 3 months

Ipsos MORI analysis of DWP OHT Portal Data

- However, the rate of growth in the potential **value**⁶⁴ of treatments identified slowed, rising by 60% between 2013/14 and 2014/15, and 22% between 2014/15 and 2015/16. A decline in the average value of treatments can be potentially explained by two reasons. First of all, it is possible that, at first, Trusts placed a greater emphasis on improving recovery rates on the departments or areas of a Trust where the most expensive treatments were being provided (and therefore greater financial gains could be made, especially given the nature of the financial incentive). As the Cost Recovery Programme progresses, increasingly marginal gains may be seen, as focus shifts to departments where treatments, in general, are less costly. Secondly, it is likely that the health needs of overseas visitors and migrants will vary over the short-term, which may explain some variation year-on-year. Analysis of longer-term trends will allow further assessment of the underlying causes of such variation.
- A robust assessment of the performance of individual Trusts is not possible as part of this evaluation, as there are limited publically available data available against which to benchmark Trust cost recovery figures. The total volume of patients or value of treatments any individual Trust should be identifying and recouping is also unknown given the unknown and fluctuating flows of visitors and migrants in different areas of the country, who have unknown and fluctuating health needs. However, the proportion of Trusts having EHIC treatments processed on the OHT

⁶³ The EHIC incentive scheme came into effect on 1st October 2014. In addition to the payment to cover treatment costs that Trusts receive from commissioners when treating an EEA patient under an EHIC agreement, providers now receive an additional 25% of the cost of the treatment **paid direct to them** when they report the treatment through the OHT Portal. Payments to Trusts are made quarterly in arrears.

⁶⁴ NB: This figure is the total value of the treatments entered on the OHT Portal, and does not account for charges that may not be made based on agreements with individual EEA Member States, and therefore final figures for EEA costs recovered may differ to those quoted in this evaluation report.

Portal rose from 61% in 2013/14 to 81% of Trusts in 2015/16 suggesting more widespread use of cost recovery systems in the NHS. This still leaves a substantial minority of Trusts not processing any EHIC claims in the most recent financial year. While the reasons for the lack of processing of claims at individual Trusts has not been explored through this evaluation, it is possible to establish possible contributory factors:

- **Visitor and migrant population** – temporary overseas visitors and migrants from the EEA are not dispersed evenly across England, and therefore it is to be expected that Trusts in low-visitor or low-migrant areas may encounter only a very small number of migrants.
 - **Lack of focus on cost recovery** – it is clear from previous research, and this evaluation, that not all Trusts are putting the same level of emphasis on cost recovery in comparison to other issues, and therefore are not making the same progress.
 - **Trusts providing services entirely exempt from charging** – some of the non-reporting Trusts will provide services currently wholly exempt from charging such as services delivered in the community rather than at a hospital.
- As noted above, the EHIC incentive scheme, through which Trusts are eligible for payments of 25% of the value of treatment for patients with EHICs, does not come without a cost to DH, who are directly funding the incentive scheme and have paid out incentives totalling £4.6m in the period October 2014 – March 2016.⁶⁵
 - Figure 4.2 overleaf shows that there has been a 16% increase in the volume of EU visitors to the UK in the period 2012-2015. However, the rate of increase in the number of treatments processed under EHIC agreements substantially outstrips this. It is unlikely that the observed growth in portal activity can be attributed solely to increased visitor numbers, therefore indicating that increased cost recovery activity is likely to be driving this trend.⁶⁶

⁶⁵ N.B. This figure accounts for payments made to Trusts in England only, as they are the focus of the Cost Recovery Programme, but incentives have been paid out to Trusts in the devolved nations also.

⁶⁶ In the absence of being able to compare the progress made with what would have happened in the absence of the introduction of the Cost Recovery Programme it is not possible to assert that the changes seen result from the introduction of the programme.

Figure 4.2: Volume of EHICs processed and EU visitors to UK by month⁶⁷

Base: All EHIC treatments by month processed, and all visitors to UK from EU countries, January 2012 - March 2016.

Ipsos MORI analysis of DWP OHT Portal Data and ONS International Passenger Survey

In addition to recovery of costs through the collection of EHIC or S2 agreements, it is also possible to recover costs for treatments provided to EEA residents via S1 agreements.⁶⁸ There are three categories of possible S1s: state pensioners (or people in receipt of another exportable benefit) and their dependants from other EEA countries who are living in the UK, workers (either posted or frontier workers) and dependants in the home state of an EEA worker working and living in the UK. However, due to the way the data is collected, the income for these categories are collected alongside others and so a single S1 income figure is not available.

As S1s relate to residents migrating to the UK rather than temporary visitors, it is likely that the capturing of S1 forms in primary care would be the main source of identification for S1 forms that are not sent directly to the DWP OHT. Given the lack of a focus on primary care or communication with overseas visitors as part of the Cost Recovery Programme so far, this is perhaps to be expected.

Table 4.2: Recovery of costs under EHIC, S1 and S2 agreements

Category	2011/12	2012/13	2013/14	2014/15	2015/16
Temporary Visitors (EHICs and worker S1s)	£27.7m	£28.4m	£29.9m	£28.3m	£31.3m
Temporary Visitors (Planned treatment- S2s)	£7.2m	£8.5m	£10.6m	£10.8m	£10.9m
Dependants in home state of worker in UK (S1s)	£0.5m	£0.5m	£0.3m	£0.5m	£0.7m
Pensioners and dependants (S1s)	£13.3m	£11.5m	£12.2m	£10.1m	£13.2m
Total	£48.7m	£48.9m	£52.9m	£49.7m	£56.3m

Source: Department of Health

⁶⁷ Time series data for EU visitors is only available at the UK level, but given that VisitBritain estimate in 2015 that 94% of visits to the UK are to England (<https://www.visitbritain.org/2015-snapshot>), then this is adequate for the analysis.

⁶⁸S1 agreements cover the provision of healthcare to state pensioners resident in another EEA state upon presentation of a certificate of entitlement, as discussed earlier in this report.

In addition to the income streams detailed above are the direct payments between the EEA member states with which the UK has bilateral agreements in place in.

4.1.2 Recovery of costs from non-EEA residents

Financial income from non-EEA residents receiving treatment through the NHS comes through two sources:

- **Direct charging** of non-EEA residents for use of the NHS for short-term visitors; and
- Payment of the **immigration health surcharge** for visits to the UK for six months or longer.

Direct charging

As Figure 4.3 shows there was no increase in income recognised through this avenue during the first year of the Cost Recovery Programme, which remained stable at around £47m each year. Following the launch of the non-EEA incentive scheme in April 2015, Year Two of the Cost Recovery Programme saw a significant improvement, with identified income⁶⁹ increasing from £46.8m in 2014/15 to £69.2m in 2015/16, representing a 48% increase.

It should be noted that directly chargeable patients are largely those short-term visitors from non-EEA countries but does also cover EEA patients who do not present the correct documentation that enables their home country to cover their costs, making them also directly chargeable.

While this figure is still short of the £100m ambition for better identification and recovery from directly chargeable patients,⁷⁰ taken at face value this represents a significant move in the right direction. However, this 48% increase in **identification** has contributed to a 17% increase in the value of **cash payments received in-year**, so it has not yet achieved an equal increase in recovery. As such, there has been a substantial increase in the level of debt that is classed as impaired (but not yet written-off), with a 50% increase in this figure during the 2015/16 financial year. This debt is defined as outstanding debt but still recoverable, and therefore the proportion of this that is converted into **cash payments** in the coming financial years will be a key indicator of success. While the increase in identification and charging is a positive sign, as is the increase in cash received, there is still much room for improvement in converting a higher proportion of the identified (potential) income into genuine income. An increased focus on this is needed to maximise the chances of the Cost Recovery Programme meeting stated ambitions for improving recovery of costs. The 7% decrease in the value of **debt being written-off** in the second year of the Cost Recovery Programme is also an encouraging sign, and if this becomes a continued trend this is a positive sign for the future direction of cost recovery.

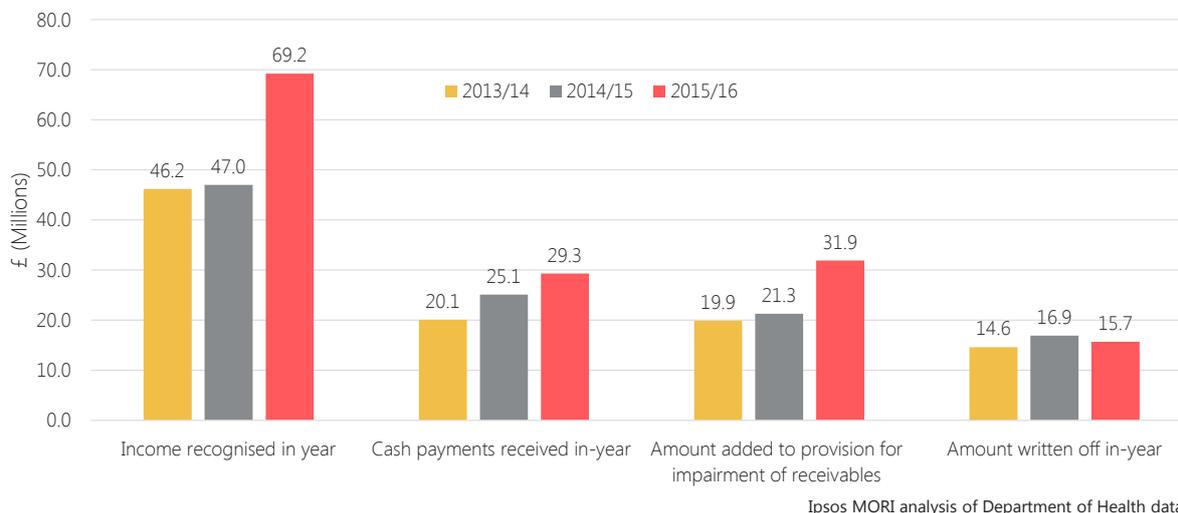
In addition to pursuing debts through following-up with patients after discharge, and through the use of debt collection agencies, the Immigration Rules allow applications for new visas or extension of stays to be refused on the basis of unpaid debts (for debts of £500 or above). DH data suggests that there has been an upward trend in the number of Trusts reporting debt to the Home Office via established data sharing agreements. In March 2016, 55 Trusts reported debtor information, which was an increase on the monthly average over the previous year of 51. Cumulatively they reported the highest volume of debt since records began in July 2013, with trusts reporting 686 cases of debt in that month alone with a value of £4.3m (a high proportion of the impaired or written off debts reported by NHS Trusts in 2015/16). The Home Office accepted 573 of these reports of debt, and of these 507 were new debts with a value of £3.3m.

⁶⁹ **Identified income** represents the total value of all treatments recorded for non-EEA residents during a year.

⁷⁰ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementation_Plan_Phase_3.PDF, p.11

In addition, a significant number of (more than 70) Trusts are yet to recognise any income from directly chargeable overseas visitors and migrants across each of the last three financial years. This group requires further investigation to understand whether this represents a lack of process change, or whether these Trusts are concentrated in low-migration areas, and therefore have an extremely low throughput of directly chargeable patients.⁷¹

Figure 4.3: Cost recovery from directly chargeable overseas visitors and migrants, 2013/14 to 2015/16



Immigration health surcharge

The immigration health surcharge is anticipated to contribute up to £200m per year to the Cost Recovery Programme's ambition of recovering £500m annually.⁷² According to the Home Office, in the first financial year of operation (2015/16) the immigration health surcharge generated £164m income. While this falls short of the £200m annual ambition, changes to the remit of the immigration health surcharge⁷³ means that from April 2016 it has applied to temporary migrants ordinarily residing in Australia or New Zealand, which will increase the income generated through this stream in future years.

4.2 Costs and benefits

4.2.1 Potential and realised costs

Implementation of the Cost Recovery Programme brings with it a range of possible costs. Below we present an overview of the costs, and the extent to which it has been possible to assess the realisation of these.

- **Programme costs:** The monetary cost to Government of implementing the Cost Recovery Programme, for example development of training materials, funding for the CRST, development of new IT systems, and payment of EEA and non-EEA incentives. This was estimated in the Impact Assessment to equate to a one-off cost of £14m for Phases One and Two, of which the largest element (£11.5m) would be incurred as a result of funding the incentives.

⁷¹ These Trusts include specialise cancer centres, community healthcare Trusts and mental health Trusts, many services of which will be exempt.

⁷² https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implementation_Plan_Phase_3.PDF, p.11

⁷³ <https://www.gov.uk/government/news/immigration-health-surcharge-extends-to-australia-and-new-zealand>

Information provided by DH suggests that the total cost of the implementation during the first two years have been:

- £0.9m expenditure on the Cost Recovery Programme itself;⁷⁴ and,
 - A total of £4.6m in EEA incentive payments has been made to Trusts in England between October 2014 and March 2016.
- **Costs of bad debt:** The potential increase in ‘bad debt’ associated with non-recovery of costs from non-EEA patients. During the first two years of the Cost Recovery Programme, the value of the debt that Trusts have written-off (bad debt) has actually decreased by 7% to £15.7m by the end of Year Two. There has been a significant increase in the value of outstanding debt overall, but the majority of this is currently classed as recoverable debt, and the proportion of this that translates into future income will play a key role in the success of the Cost Recovery Programme in meeting the stated ambition.
 - **Trust level costs:** These can be defined as the costs incurred by Trusts as a result of changing processes for cost recovery in their Trust. For example, additional staff time spent on administrative tasks, whether that represents an opportunity cost from staff resource being diverted from other tasks or a direct cost if staffing levels are increased or additional equipment is required.

It has proven difficult to capture estimates of the costs incurred across the NHS as a result of implementing the Cost Recovery Programme. Case study interviews and the survey findings, as discussed in Chapter 3, suggest that the anticipated increased administrative burden on frontline clinical staff has not been realised as yet. Rather, it is apparent that administrative staff, such as receptionists and accountants, are experiencing an increased involvement in the processes. This can lead to an increased burden (e.g. invoicing and pursuing outstanding debts for non-EEA residents was reported to be time consuming). Where it was possible to speak with receptionists during the qualitative work, this involvement primarily revolved around asking questions during patient registration – and as such was not perceived to be adding a significant workload/causing a delay in processing patients. The case studies did, however, highlight the potential for significant one-off costs in relation to training. If Trusts seek to implement training on cost recovery across all staff groups, this would represent a significant opportunity cost. However, Trusts who seek to incorporate training on cost recovery into existing training programmes/induction sessions for new staff, are likely only to see a marginal opportunity cost.

In addition, OVMs were keen to make more substantive changes to the systems supporting cost recovery, for example updating Patient Administration Systems, or introducing debit/credit card readers. Such changes would also be associated with a capital outlay.

OVMs and finance staff interviewed did report that processing, invoicing and chasing debt could take a long time and that, as they were often undertaking these additional tasks alongside their other work, additional administrative resource would be welcomed.

4.2.2 Potential and realised benefits

The potential financial benefits to be accrued by the Cost Recovery Programme relate primarily to two areas:

⁷⁴ Excluding the cost of DH staff time in delivering the Cost Recovery Programme.

- **Increased income from chargeable overseas patients:** Potential for increased income (at a Trust and NHS level) from increased recovery of costs comes from two sources: EEA countries (EHIC, S2 and S1 agreements), and patients themselves (immigration health surcharge, direct charging of non-EEA and EEA patients). The Impact Assessment estimated that this increased income would be £250m from Phases One and Two and up to £200m from the immigration health surcharge.
 - **Immigration health surcharge:** £164m has been generated during the first year of operation in 2015/16.
 - **Directly chargeable patients:** a total of £69.2m income has been recognised during 2015/16, representing an increase of 50% compared to the year preceding the launch of the Cost Recovery Programme (2013/14). However, in terms of actual cash recovered, this has increased by 46% over the same period (to £29.3m).
 - **EHIC:** The value of treatments covered under an EHIC agreement via patients with EHIC forms has risen from £7.9m in the year of the launch of the Cost Recovery Programme, to £15.5m during Year Two of the Cost Recovery Programme.⁷⁵ In addition to this, the UK receives income from other EEA member states via the bilateral agreements that are in place.
 - **S1:** S1 figures are collected as part of other categories and so it is not possible to know exactly how much they total each year in isolation, with the nearest estimates presented in Table 4.2.
 - **S2:** During Year Two, treatments processed under S2 agreements equated to an estimated £11.7m of potential income for the NHS. In addition to this, the UK receives income from other EEA member states for S2s via the bilateral agreements that are in place.
- **Cost savings through reduction in unnecessary use of NHS services:** A possible cost-saving from the reduction in the use of NHS services by chargeable overseas visitors and migrants due to the possible deterrent effect of an increased focus on charging. It has not been possible to estimate the cost savings generated here through the course of this evaluation.
- **Total financial benefits:** The Department of Health estimates that income from visitors and migrants in 2015/16 was £289m.

4.3 Summary

- Analysis of the treatments processed through the DWP OHT Portal for treatments provided to EEA residents under EHIC agreements shows a sustained increase in identified treatments, which has coincided with the launch of the Cost Recovery Programme. While this increase in volume has been sustained through both Year One and Year Two, the upward trend in the monetary value of these treatments has slowed significantly.
- Significant progress has also been made in the value of treatments identified relating to non-EEA residents. However, the extent to which these translate into real gains is unknown as yet as outstanding debts are still in the process of being recovered. So far, it has not translated into a like-for-like increase in actual costs-recovered, raising the question as to whether Trusts are undertaking sufficient work to ensure charging takes place before treatments are provided. There has been a substantial increase in the value of outstanding debt still thought to be

⁷⁵ NB: This is the total value of treatments entered on DWP's Overseas Healthcare Team Portal, and not the value that will actually be recovered from Member States.

recoverable, and a decrease in the value of debt being written off in the second year of the Cost Recovery Programme, which if continued in future years bodes well for overall cost recovery.

- The immigration health surcharge, bringing in an estimated £164m during the 2015/16 financial year still has some way to go to reach the £200m ambition, despite being the biggest single impact on the overall landscape of cost recovery. The inclusion of Australia and New Zealand having to pay the surcharge from April 2016 will make a relatively small contribution to this required increase.
- It should also be noted that there is substantial variation in the performance of individual Trusts year-on-year, with regards to the value of costs identified and recovered for both EEA and non-EEA residents alike.
- Data collected precludes a comprehensive cost benefit analysis for the implementation of the Cost Recovery Programme, but consideration of evidence gathered from across the evaluation suggests that the visible rise in income generated by the Cost Recovery Programme has not been underpinned by substantial financial outlay at a Trust level.
- However, the lack of process changes implemented across the board leaves the door open for potential rises in staff related costs in the final year of the Cost Recovery Programme and beyond.
- In addition, it is yet to be seen whether the significant increase in income being recognised from non-EEA residents will translate into the same increase in cash received, and as yet represents an unrealised benefit, and potential cost (if converted into non-recoverable debt).

5 Conclusions and recommendations

5.1 Conclusions

At the end of Year Two, this evaluation shows that the implementation of the Overseas Visitor and Migrant NHS Cost Recovery Programme has proceeded broadly in-sync with the expected timelines set-out as part of the initial Implementation Plan published to coincide with the launch of the Cost Recovery Programme in July 2014.

The majority of the key elements of **Phases One – Three** of the Cost Recovery Programme that were expected to drive the broader cultural and behavioural change identified as being necessary during the design of the Cost Recovery Programme have been delivered. In particular, these include:

During Year One

- Delivery and publication of guidance on cost recovery that has been well received by OVMs, supporting clarity around charging rules.
- Launch of the EEA incentive, which became operational on 1st October 2014 on schedule.
- Delivery of pilot activities focused on the collection of EHIC details, that demonstrate that in some cases, relatively small changes in administrative process can deliver substantial changes in cost recovery.

During Year Two

- Launch of the non-EEA incentive and immigration health surcharge in April 2015.
- Launch of the update to the NHS Spine IT system in April 2015 to support information sharing regarding the immigration health surcharge.
- Launch of the Cost Recovery Support Team in April 2015.
- Launch of e-learning cost recovery training package for NHS Staff (6-12 months later than originally scheduled).

In addition, the OVM Training Ambassador Programme, not originally included in the Implementation Plan, was launched in June 2015, and is aimed at tackling many of the barriers identified by OVMs during the first year of implementation.

The only substantial element to yet be delivered is **Phase Four (Extending charging)**. A public consultation was held between December 2015 and March 2016, and the Government's response to this, and DH plans for Phase Four will be published in due course.

The available information for the financial performance of cost recovery across the NHS in England throughout the first two years of the Cost Recovery Programme highlights both substantial progress in some regards, but also highlights some areas where progress has not been as significant. There has been good progress towards increasing cost recovery from EEA patients, although this has slowed significantly in terms of value during Year Two of the Cost Recovery Programme. In addition, the immigration health surcharge, introduced at the outset of Year Two is generating 77% of its anticipated

revenue at the end of its first year of operation. However, recovery of costs from non-EEA residents has not progressed to the same degree. While the value of income being recognised in relation to non-EEA residents has increased substantially during the first two years of the Cost Recovery Programme, in particular during Year Two following the introduction of the non-EEA incentive and financial penalties, this has yet to equate to an increase in actual money received by the Trusts, and in turn the NHS in England as a whole. Case study evidence highlights some of the barriers to upfront charging, as experienced by OVMs, and the Cost Recovery Programme must seek to further understand and address these during the remainder of its operational lifespan if it is to meet its goals for cost recovery by 2017/18. It is clear that an increase in upfront charging requires a further shift in behaviour amongst clinical staff to ensure decisions about eligibility have been reached before proceeding with treatment, where this treatment is not deemed to be urgent or immediately necessary.

The original Implementation Plan for the Cost Recovery Programme set targets for the cultural and behavioural changes that were sought during the first two years of the Cost Recovery Programme across each of the key staff groups identified. Table 5.1, overleaf, considers the extent to which the evaluation has generated evidence that these changes have been realised.

This shows that there are some substantial gaps, particularly in relation to changes in the roles and responsibilities reported amongst frontline clinical staff, while more significant changes are evident in behaviour amongst administrative staff. Case study evidence shows that this is broadly in line with the way in which OVMs have sought to approach the challenge of improving cost recovery in their Trusts. In addition, the late introduction of the training package, and the fact that DH lack the ability to make this training compulsory, and Trusts have not enforced this either, have limited the take-up, and therefore potential impact of the training package.

Substantial issues with securing senior-level buy-in for the implementation of changes at a Trust level persist throughout the first two years of the Cost Recovery Programme, with OVMs reporting difficulties in securing support for communicating with Trust staff, and in assigning additional financial or staff resource to cost recovery. Given the concerns voiced by OVMs regarding resource constraints, this represents an area for further consideration during the remainder of the Cost Recovery Programme.

Significant efforts have been made by the team responsible for delivering the Cost Recovery Programme within DH to achieve senior-level buy-in for the Cost Recovery Programme, including through visits to over 60 Trusts throughout the first two years. However, the inability of DH to mandate priorities at a Trust-level, and to create and enforce standard processes, inhibits its ability to drive change across the system.

However, there has thus far been a lack of comprehensive communications with possible visitors and migrants, especially those resident in EEA countries, and a programme of work aimed at educating EEA visitors of the need to both bring, and present, their EHCs when seeking NHS treatment may have substantial impacts on progress, as this was still cited as a barrier to improving rates of cost recovery.

In addition, a lack of progress in Primary Care in relation to the flagging of potentially chargeable patients and supporting secondary care services in cost recovery has likely hindered progress of the Cost Recovery Programme. In particular, the fact that cost recovery has not yet been included in the NHS England GP Contract has hindered the Cost Recovery Programme's ability to attempt to drive cultural and behavioural change in primary care. A leaflet published and distributed to GP Practices in April 2016, and therefore outside of the scope of this evaluation, which is the start of a programme of work between DH, NHS England and the British Medical Association's (BMA) General Practitioners

Committee over the next year to develop arrangements for identifying patients with an EHIC, S1 or S2 upon registration with primary care, may help address this during the third year of the Cost Recovery Programme.

The progress that the Cost Recovery Programme has made must also be set against the backdrop of wider pressures facing the NHS, which may help understand why the Cost Recovery Programme has struggled, to some extent, to take root, and over which DH has no control.

Table 5.1: Progress against targets across staff groups

Staff Group	Expected changes due to programme (at end of Year 2) ⁷⁶	Experience of programme to date
<ul style="list-style-type: none"> Frontline clinical and administrative staff in secondary care 		
OVMs	<ul style="list-style-type: none"> Senior support for cost recovery and debt reduction. Clarity about the system and support available. Understanding of surcharge system/exemptions from paying it; established system to identify whether a patient has paid or is exempt. Effective regional support network established. Systematic collection of EHIC/status information for EEA & non-EEA patients. 	<ul style="list-style-type: none"> A majority of OVMs (70%) now report being very or fairly well supported by senior staff in their Trust in recovering costs. However, a significant minority (26%) do not feel well supported; this is substantiated through the qualitative research, which showed that senior-level support remains an issue for some OVMs. OVMs demonstrate high levels of awareness of the Cost Recovery Programme (92%) and key elements (87% aware of the EEA incentive scheme, 77% aware of the non-EEA scheme). OVMs who took part in the qualitative research reported some issues with identifying patients who had paid the immigration health surcharge. Some OVMs have good support networks – qualitative participants mentioned seeking advice from other OVMs, finance colleagues and the Home Office. Qualitative participants describe significant improvements over time, with processes becoming more embedded; however, this was often described as inconsistent across staff groups/departments, and some ‘gaps’ exist. High proportions of frontline (48% of hospital doctors and 37% of hospital nurses) and admin staff (26%) still believe they do not have a role in cost recovery.
Hospital Doctors	<ul style="list-style-type: none"> Understanding of charging rules and how to assist in cost recovery. Understanding of the information to give to OVMs and finance team. Routine identification and systematic collection of relevant information from EEA and non-EEA patients. 	<ul style="list-style-type: none"> There has been increasing awareness of rules (58%, vs. 50% in the baseline survey). However, awareness of the Cost Recovery Programme has decreased (33%, vs. 41% in the baseline survey). Incidence of training has remained very low over time – no higher than nine per cent across the three survey waves. The survey sees no increase in knowing who to contact about chargeable patients (baseline 63%, interim 62%, follow up 60%), and more than half (48%) still say they don’t have a role in relation to chargeable patients. Two thirds (63%) have never flagged potentially chargeable patients – with this proportion increasing over time, but 69% say they don’t collect EHIC details from them. Case studies show the role of clinical staff is mainly in asking initial key questions of patients, then flagging to OVM if they think a patient may be chargeable, or passing on information regarding patient status to OVMs. While OVMs generally reported improvements among frontline clinical staff, they said that there was inconsistency between wards/teams/individuals/Trusts.
Hospital Nurses	<ul style="list-style-type: none"> Understanding of charging rules and how to assist in cost recovery. Understanding of the information to give to OVMs and finance team. Routine identification and systematic collection of relevant information from EEA and non-EEA patients. 	<ul style="list-style-type: none"> Increasing awareness that some patients are chargeable (45%, vs. 38% and 34% in the baseline and interim surveys), and of Programme (28%, vs. 25% and 20% in baseline and interim surveys). Increasingly likely to report having a role in cost recovery - in informing OVM (35% vs. 19% and 28% in baseline and interim surveys). Receipt of training remains low (no more than nine per cent across the three survey waves).

⁷⁶ Adapted from *Visitor & Migrant NHS Cost Recovery Programme Implementation Plan 2014–16*. Department of Health, July 2014.

		<ul style="list-style-type: none"> There has been no improvement in the proportion aware of who to contact about chargeable patients (baseline 71%, interim 73%, follow up 70%). However, this group is now more likely to say they have a role in relation to chargeable patients, specifically in informing the OVM (35% follow up, 28% interim, 19% baseline) and less likely to say they have no role (27% follow up, 41% interim, 30% baseline). They are more likely to feel responsibility for their organisation's finances, with 78% saying they have <i>at least a little responsibility</i> at the follow up survey (vs. 68% and 67% in the interim and baseline waves). Half (51%) have never flagged potentially chargeable patients; with no change over time (Baseline 48%, interim 47%). However, they are less likely to say that they don't collect EHIC details (46% in the follow up survey, vs. 61% and 54% in the baseline and interim waves). Among those who do, though, this is more likely to be seen as difficult than easy (19% vs. 11%). Nurses interviewed during case study visits reported increased involvement in identifying chargeable patients and flagging to OVMs, while OVMs reported that frontline clinical staff were getting better at this. However, as with doctors there were some inconsistencies, with not all staff performing to the same standard.
Administrative Staff	<ul style="list-style-type: none"> Clarity about the system with more straightforward identification of chargeable patients to flag up to OVMs and/or finance teams. (Finance Teams): Established financial incentives and debt management systems working effectively. Reinvestment of income from incentives into better cost recovery systems. 	<ul style="list-style-type: none"> This group shows increasing awareness of chargeability (follow up 62%, interim 50%, baseline 44%); increasing awareness of the Cost Recovery Programme (follow up 45%, interim 35%, baseline 32%); increased incidence of training (follow up 20%, vs. baseline 12%). Increased awareness of EEA incentive scheme (follow up 32% vs. interim 12%). They are increasingly likely to report a role in cost recovery (informing OVM: 22% at follow up and 24% at interim, vs. 15% at baseline; identifying chargeable patients: 29% at follow up vs. 18% at interim and 21% at baseline). They are also more likely to flag potentially chargeable patients (47% say they <i>never</i> do so in the follow up survey, vs. interim 53% and baseline 56%). They are also more likely to say they have a role in establishing chargeable status (in the follow up survey 30% say they <i>do not have a role</i>, vs. interim 53% and baseline 44%), and in collecting EHIC details (follow up; 51% say this is not part of their role, vs. 68% interim and 67% baseline). They are increasingly likely to feel responsibility for organisation's finances (67% say they have <i>at least a little responsibility</i> in the follow up survey, vs. 55% and 52% in the baseline and interim). There is limited evidence from the qualitative interviews of reinvestment of financial incentives in improving Trust cost recovery processes.

Staff Group	Expected changes due to programme (at end of Year 2) ⁷⁷	Experience of programme to date
<ul style="list-style-type: none"> Senior management and commissioners 		
Trust Chairs/Board members	<ul style="list-style-type: none"> More attention given to overseas cost recovery processes and debt management within trust Understanding of the system, charging rules and requirements and support available. Training introduced for administrative and clinical staff. Routine reporting/sharing of performance data and data on high-cost NHS debtors with DH/Home Office. 	<ul style="list-style-type: none"> Trust leaders and OVMs in case studies report increased emphasis on cost recovery in Trusts over time. An increasing proportion of Trust leaders now say that cost recovery is included in their Trust's contribution to the NHS Efficiency Challenge (52%, vs. 37% and 30% reporting at the interim and baseline waves that cost recovery was included in QIPP programmes). However, there has been no significant increase in Programme awareness (follow up 68%; interim 68%; baseline 56%), with a significant proportion (32%) still unaware. There has been no significant increase over time in the belief that the benefits of the Cost Recovery Programme outweigh the costs (baseline 54%; interim 55%; follow up 65%); and the majority (59%) think that cost recovery is not important in improving their Trust's finances. While, the majority (71%) have confidence in processes in place at their Trust to ensure effective cost recovery, a significant proportion don't. The majority (78%) are aware that some patients chargeable; this has seen no change during the Cost Recovery Programme (baseline 82%, interim 77%). However, there are some signs of increasing understanding of the rules on chargeability and exemption, and increased awareness of the Support Team (follow up 33%; interim 20%), although still only a minority are aware of this and very few (13% of all Trust leaders in the follow up survey) have used it. Qualitative work suggested that senior staff rely on OVMs and finance staff quite heavily for detailed understanding of systems and processes. Only a minority of Trusts (31%) have introduced compulsory training, and OVMs in the qualitative case studies and interviews say they are dealing with low levels of senior support for this.
CCG leads/Board members	<ul style="list-style-type: none"> Aware of the cost recovery mechanism and processes to aid identification of chargeable patients. Working with providers to ensure better identification system is embedded. Cost recovery included in QIPP programme. Established financial incentives and debt management systems working effectively. 	<ul style="list-style-type: none"> The majority (63%) are now aware of the Cost Recovery Programme, although this has seen little change over time (baseline 51%, interim 62%). A significant proportion (37%) remain unaware of the Cost Recovery Programme. However, among those who are aware there is evidence of increasing understanding of the rules behind chargeability and exemption. One in three (34%) have regular meetings with Trusts to discuss cost recovery; one in five (21%) ask Trusts to carry out an audit of their charging processes, and one in six (16%) have risk-share agreements in place with Trusts. Only a relatively low proportion (25%) say that the Trusts they work with are effectively recovering costs, with many (39%) unsure.

⁷⁷ Adapted from *Visitor & Migrant NHS Cost Recovery Programme Implementation Plan 2014–16*. Department of Health, July 2014.

Staff Group	Expected changes due to programme (at end of Year 2) ⁷⁸	Experience of programme to date
<ul style="list-style-type: none"> ▪ Staff working in primary care 		
Primary Care staff	<ul style="list-style-type: none"> ▪ Clarity about the charging rules, system and support available. ▪ Systematic collection of EHIC and other status information relevant to EEA and non-EEA patients, and status recording and notification underway. ▪ Flagging potentially chargeable patients when referring them to secondary care. ▪ Increased communications with secondary care providers. 	<ul style="list-style-type: none"> ▪ Awareness of chargeability is relatively low for this group; around half (55%) of clinicians and fewer Practice Managers (36%) are aware. Awareness actually appears to be decreasing over time among Practice Managers (interim 51%, baseline 50%), however there are apparent increases in understanding of charging rules across both groups. ▪ There is a distinct lack of evidence to suggest systematic collection of status information from patients, across both the survey and case study work. Around half (54% of clinicians and 52% of Practice Managers⁷⁹ in the follow up survey) say their practice has any steps in place to identify visitor/migrant and/or chargeable status, while only nine per cent of clinicians and 16% of Practice Managers⁹⁷ have any contact with secondary care providers regarding potentially chargeable patients. ▪ There is little evidence of effective flagging of potentially chargeable patients to secondary care providers (24% of clinicians and 37% of Practice Managers⁹⁷ say they <i>always/nearly always</i> do this), and OVMs interviews during case studies felt there was room for improvement in terms of communications with secondary care providers.

⁷⁸ Adapted from *Visitor & Migrant NHS Cost Recovery Programme Implementation Plan 2014–16*. Department of Health, July 2014.

⁷⁹ Please note that these figures are based on a very small number of Practice Managers who were aware that some patients are chargeable for NHS healthcare (N = 36) and should be considered indicative only.

5.2 Recommendations

In light of the evidence collected throughout this evaluation, and the conclusions drawn in this chapter so far, a number of recommendations can be made in order to help inform the improvement of the Cost Recovery Programme going forward.

- **Further support for OVMS:** OVMS appear to be playing a central role in driving changes in administrative processes at a Trust level. However, given the mid-level seniority of most OVMS, they require further support from DH and/or NHS England and NHS Improvement in order to enact further process changes within their Trusts. In particular, there is a need to combat the risk that progress is limited by the level of resource OVMS have to undertake their roles and responsibilities with regards to implementing the charging regulations. Support should address, at the minimum, the following areas:
 - **Process advice:** There remain gaps in the understanding of the various processes in place across the NHS for identifying and recovering costs from overseas visitors and migrants. Further work should be undertaken, perhaps through use of the DH Exchange Forum, to map the various models in place, identify the changes that have been made to these, and how successful each of the models have been (in tandem with analysis of the MI for the Cost Recovery Programme), with the view to providing clearer advice to Trusts and OVMS as to the changes that are expected. This must be done in collaboration with an assessment of the extent to which gains can be made by pursuing further behaviour change amongst frontline clinical staff, and whether focussing more heavily on use of administrative staff may lead to larger gains being made by the Cost Recovery Programme. While this evaluation did seek out examples of best practice as part of the later round of case studies, difficulties experienced in gaining access to those Trusts identified as being potential examples of good practice have hindered the ability of the evaluation to provide examples of good practice.
 - **Clarity around the OVM role:** While the updated guidance published includes recommendations as to what the OVM role should entail, further communication to Trusts as to the importance of the OVM role, and the support, and skills, that they require in order to effectively fulfil this role, including the ability to communicate widely with staff, to implement process changes involving frontline clinical and administrative staff, and to draw on additional resource where needed. The limited resources available to OVMS is likely to be a key constraint to the success of any future extension of charging to A&E.
- **Address barriers to upfront charging:** Achieving a further shift to upfront charging should be considered central to the aims of the Cost Recovery Programme during the remaining year of operation. This evaluation has highlighted some of the barriers to upfront charging, which must be overcome, while at the same time achieving a further behavioural shift amongst clinical staff. Further consultation with senior Trust staff, and OVMS may be required to understand how these changes may be driven forward. For example, undertaking a pilot to demonstrate the impacts of upfront charging (e.g. through the implementation of debit/credit card readers) in collaboration with a Trust with a particular problem in this regard, may help generate the evidence needed to drive further change.
- **Training:** While an e-learning package has been introduced, uptake of this to date has been extremely limited. OVMS in the case studies were making efforts to introduce training, but increased introduction of such training, as part of new staff induction for example, would provide OVMS with the levers to introduce this. As neither the Department of Health, nor arms-length bodies within the health sector, are able to mandate non-clinical training, this would likely be reliant on achieving buy-in from NHS Trusts.

- **Communications with senior Trust staff:** Senior-level buy-in continues to present a barrier to OVMs in driving process and behaviour change. Renewed efforts are likely to be required by DH, NHS England, NHS Improvement and other arms-length bodies to emphasise the importance of cost recovery. Focussing efforts on Trusts in high-visitor or high-migrant areas may provide the largest gains in the short-term.
- **Communications with potential visitors:** Significant problems have been reported with the volume of EEA residents who are unable to present an EHIC when required, despite being eligible for one. The promotion of awareness of UK charging rules among EEA residents planning to visit the UK, focusing on the need to carry an EHIC and present this when interacting with the NHS is an important part of the Cost Recovery Programme going forward in order to facilitate a continued upward trajectory in the rates of cost recovery for EEA residents. One Trust highlighted efforts to have posters put up in a local airport, but had not succeeded here – it is suggested that national-level efforts at this might be more successful.
- **NHS England, NHS Improvement, other arms-length bodies, and commissioners:** Ongoing work is needed to engage NHS England, NHS Improvement, other arms-length bodies and commissioners in the providing the levers with which to drive the behavioural, cultural and procedural changes needed across the NHS. This is likely to be particularly key if charging is extended to primary and emergency care services.
- **Primary care:** The lack of provision of information regarding chargeable patients entering the health system through primary care continues to pose a challenge for secondary care services. The provision of better information here would likely have substantial benefits for progress towards targets. The recent communications with primary care, and the outcome of the consultation regarding the extension of charging to primary care will need to be considered before further steps are taken here.
- **Unintended consequences:** It has proven difficult to identify whether any unintended consequences have been realised during the first two years of the Cost Recovery Programme. Therefore, it is recommended that DH continues to make efforts to monitor any potential negative impacts arising from an increased focus on cost recovery on an ongoing basis.

Overall, the Cost Recovery Programme has made much progress during the first two years. However, there remain some key issues to be addressed if the Cost Recovery Programme is to make further progress towards its stated ambitions. In particular, addressing the issue of upfront charging should be considered one of the most pressing areas for consideration, given the potential an increase in debt at a Trust and NHS-wide level has to undermine the work the Cost Recovery Programme has done to secure buy-in to the principles of charging.

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