Upfront Charging Operational Framework

Operational framework to support identification and charging of Overseas Visitors
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1. Executive Summary

1.1. The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6 April 2015 and apply to all relevant courses of treatment commenced on or after that date. The Regulations have subsequently been amended, most recently on 23 October 2017 by the NHS (Charges to Overseas Visitors) (Amendment) Regulations ("the 2017 Amendment Regulations").

1.2. The Charging Regulations place a legal obligation on any organisation providing relevant services (relevant services being those provided under the NHS Act except for primary medical/dental/ophthalmic services), to establish whether a person is an overseas visitor to whom charges apply, or whether they are exempt from charges.

1.3. From 23 October 2017, NHS Providers and non-NHS Providers are legally required to recover charges that are not immediately necessary or urgent in full, in advance of providing them. The requirement for upfront charging has previously been recommended best practice. This action is critical in ensuring that only those patients who are eligible receive free care. At a time of increased financial challenge for the NHS, every organisation needs to ensure they are meeting their legal obligation and maximising the cost recovery potential.

1.4. This document supplements the existing DH Guidance on Implementing the Overseas Visitor Charging Regulations, and has been developed with input from NHS Improvement, to set out a framework on the practical steps and key considerations necessary for providers to implement cost recovery and meet the legal requirement to charge upfront. It ensures that the most vulnerable always have access to care, whenever they need it, and that urgent treatment is never denied.

1.5. Section 4 sets out the central role of providers in creating a suitable structure, including at executive level, to oversee and implement cost recovery processes. It also sets out the roles of staff throughout the process to ensure that all staff are aware of, and understand upfront charging requirements, and are suitably resourced and trained to effectively deal with patients and recover costs. Providers should ensure they have in place either a designated specialist for cost recovery, such as an Overseas Visitor Manager (supported by an administrative team), or a suitable person/team as part of an existing role(s).

1.6. For upfront charging to operate effectively, it is essential that providers carry out their roles and responsibilities and embed cost recovery at all levels, so that staff who operate cost recovery processes on a daily basis can successfully recover costs from those patients who should be paying for the NHS services they use.

1.7. The framework also provides the key actions that clinicians and relevant administrative staff should undertake in the upfront charging process. Section 6 sets out the role of the clinician, which is to focus only on assessing whether the patient requires immediately necessary or urgent treatment. It is not the role of the clinician to identify patients who may be required to pay for treatment. This section also includes a number of clinical case studies, specifically to support clinicians when making decisions about whether the care they recommend is urgent or immediately necessary. They relate solely to the clinician decision making process to assist them in understanding their role in the process.
1.8. Section 7 focuses on the responsibility of the OVM/patient facing administrative team to deal with the patient once the clinician has made an assessment on their treatment and handle all activity related to upfront charging and cost recovery.

1.9. Sections 8 and 9 set out the steps required to estimate costs for upfront charging purposes, using a cost estimate price list, and the actions necessary to ensure financial requirements are met, including preparing invoices.

1.10. This framework may be amended on occasion to reflect changes to the Charging Regulations. Providers should ensure that they refer to the latest version. The framework should be used alongside other resources developed by the Department of Health, including the Overseas Visitor Toolkit, which contains a wide range of documents including standardised best practice pre-attendance forms for all patients to fill in when being admitted. There are also a series of E-learning modules which include training on all aspects of cost recovery including upfront charging.
2. The Framework

Purpose

2.1. The purpose of this framework is to supplement the existing Department of Health Guidance on Implementing the Overseas Visitor Charging Regulations.

2.2. This operational framework is intended to be a helpful and practical guide for providers to use to support implementation of new requirements regarding upfront charging of overseas visitors and migrants, where the treatment is not deemed urgent or immediately necessary, nor where another exemption applies.

2.3. Upfront charging became a legal requirement for providers of NHS healthcare services, on 23 October 2017, having previously been recommended best practice.

Who this framework is for

2.4. This framework has been prepared primarily for use of those individuals in NHS organisations, including Overseas Visitor Managers (OVM), patient facing administrative teams, administrative staff and finance managers, who have responsibilities associated with the identification and charging of those patients not eligible for free NHS services. Although the framework is primarily aimed at individuals in NHS organisations, much in this document will also be of use to non-NHS providers of NHS-funded care, who, from 23 October 2017, are also required to make and recover charges from chargeable overseas visitors.

How this framework works

2.5. This framework supplements published guidance on cost recovery (which can be found on the NHS visitor and migrant cost recovery programme page on the Gov.UK site) setting out the roles and responsibilities of relevant staff. It provides a proposed method of making upfront charges and references the forms and letter templates that may be helpful during the process.

2.6. This guidance will be kept under review and we would welcome comments with regards to changes and improvements. In addition to the Guidance on Implementing the Overseas Visitor Charging Regulations, a range of additional materials produced by the Department of Health are available on the Overseas Visitor Toolkit.

2.7. E-Learning on implementing the charging rules is also available for all staff involved in the cost recovery process, and includes guidance on upfront charging.
3. Cost Recovery Legislation and Principles

The Charging Regulations

3.1. The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the "Charging Regulations") came into force on 6 April 2015. The Charging Regulations have subsequently been amended, most recently on 23 October 2017 by the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations ("the 2017 Amendment Regulations").

3.2. The Charging Regulations apply to England only, and replace previous regulations on charges to overseas visitors. Appendix 1 sets out more detail on the Charging Regulations.

What is new

3.3. The changes implemented by the 2017 Amendment Regulations seek to improve the recovery of costs of NHS-funded healthcare given to patients not ordinarily resident in the UK. The changes include:

- A requirement on all providers of NHS-funded secondary and community care to, where no exemption applies, recover charges from those not eligible for free care upfront and in full unless doing so would prevent or delay the provision of immediately necessary or urgent services;
- A requirement on all providers of NHS-funded secondary care, including non-NHS organisations, to make and recover charges from overseas visitors where relevant services have been provided by them and no exemption applies;
- A requirement on providers to record when a person is an overseas visitor on the Summary Care Record application;
- Removal of the exemption for secondary and community care NHS services provided outside a hospital setting.

A full list of all the changes is set out in the Guidance on Implementing the Overseas Visitor Charging Regulations.

3.4. All these amendments commenced on 21 August 2017 other than rules around upfront charging and the extension of the charging regulations to non-NHS providers of NHS-funded secondary and community care services, which commenced on 23 October 2017.

Immediately necessary and urgent treatment

3.5. Relevant bodies must always provide treatment which is classed as immediately necessary or urgent by the lead treating clinician, irrespective of whether or not the patient has been informed of, or agreed to pay, the charges they may be liable for. This treatment must not be delayed or withheld to establish the patient’s chargeable status or seek payment. It must also be provided even when the patient has indicated that they cannot afford to pay. Failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998.

3.6. Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent. In order to do this they may first need to make initial assessments, and conduct further investigations to make a diagnosis.
Although these initial assessments and investigations will be included in any charges (unless an exemption applies - see Appendix A), they cannot be withheld even if a payment for treatment has not been received for the cost of the assessment.

3.7. Immediately necessary treatment is that which a patient needs promptly:
   • to save their life; or
   • to prevent a condition from becoming immediately life-threatening; or
   • to prevent permanent serious damage from occurring.

3.8. Urgent treatment is that which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to return home. However, urgent treatment should also always be provided to any person, even if a deposit has not been secured, and must never be delayed or withheld.

3.9. Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and if payment is not obtained before treatment then every effort must be made to recover it at an appropriate time.

3.10. See Appendix B for the full definition of urgent and immediately necessary treatment and other factors clinicians will need to consider when making a decision.

3.11. For non-urgent treatment, unless an exemption applies, the provider must receive payment of the estimated full cost of the planned treatment before the treatment can commence.

Stabilise and discharge

3.12. While urgency of treatment is a matter of clinical judgement, this does not mean that treatment should be unlimited; there may be some room for discretion about the extent of treatment and the time at which it is given. In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable NHS charges. This should be done wherever possible, unless ceasing or limiting treatment would precipitate deterioration in the patient’s condition.
4. Provider role and responsibilities

4.1. It is a legal requirement that providers of NHS-funded secondary and community care services charge upfront for treatment that is not immediately necessary or urgent. All staff within the organisation should be aware of and understand the implications of this legal requirement (see section 3).

4.2. The provider should arrange for appropriate training to be given to all staff, and effectively communicate the upfront charging requirements across the whole organisation. Providers should also make patients aware of how the rules may affect them during their time in the hospital.

4.3. To effectively implement upfront charging policies, providers will need to ensure they put in place the necessary structures and processes, if they have not already done so. Where possible, providers should appoint an Executive Board member and/or Senior Responsible Officer to oversee the implementation of cost recovery and upfront charging processes, and ensure the spirit of the policy is understood and embedded across the organisation at all levels. Executive Boards should make cost recovery performance a standing item at appropriate Board level meetings to monitor performance, review implementation and consider any issues that may be affecting performance.

4.4. There may also be a benefit in providers appointing a clinical champion to ensure clinicians are fully engaged in the cost recovery process. The provider should also put in place an individual or team responsible for implementation of charging processes (such as an OVM), at an appropriate level depending on the size of the organisation and the opportunity to recover costs.

4.5. Providers should ensure that relevant teams within the organisation understand their specific roles and responsibilities, as set out below.

4.6. Senior Responsible Officers (or delegated authority) will need to:

- ensure that they have a sufficiently resourced OVM/patient facing administrative team that is able to fully carry out its responsibilities;
- ensure that all departments understand their roles and take responsibility for overseas cost recovery;
- ensure management structure throughout the organisation includes cost recovery requirements, reflected in staff objectives;
- ensure training for staff who have clinical contact (including during staff inductions and for medics on rotation) or are involved in the verification of patients demographic details;
- ensure relevant staff are equipped, trained and resourced to undertake face-to-face interviews with potentially chargeable overseas visitors and carry out charging processes.

4.7. The Finance team will need to:

- prepare final invoices (unless OVM/patient facing team is capable of preparing invoices);
- reconcile European Health Insurance Card data compared to activity and raise invoices to relevant commissioner;
- ensure year end adjustment for risk share and European Health Insurance Card income is accurate and invoicing complete.
4.8. General Managers (supported by an OVM/patient facing administrative team) will need to:

- implement cost recovery policy across the clinical areas ensuring everyone is aware of the policy and understand their roles within the system;
- ensure that the members of the team responsible for operating any parts of the policy - ward clerks, reception staff and clinicians - fully understand the policy, their roles and the actions they need to take.

4.9. The OVM/patient facing administrative team will:

**Actions:**

- be responsible for ensuring the policy operates effectively in the organisation;
- be responsible for eligibility checks;
- be aware of treatment that is not eligible for charging such as the diagnosis and treatment of infectious diseases and female genital mutilation;
- provide cost estimates to patients identified as not eligible for free NHS care;
- request and take payments from patients not eligible for free NHS care;
- liaise with all patients, informing those who do not require immediately necessary or urgent treatment that treatment will not take place until they make the necessary payment;
- trigger the letter to the GP informing them that their patient will be required to pay for future treatment;
- record a chargeable patient's status, via the Summary Care Record application;

**General requirements:**

- work with relevant clinicians and ensure the clinicians' role is focused only on assessing whether a patient requires treatment that is immediately necessary or urgent, and not in any discussion with patients about charging issues;
- assist patients to access legal support where cases require it;
- put in place cost recovery training and learning across the organisation which, although should include all staff, will focus on staff who have an active role in implementing charging processes and recovering costs (including using the Department of Health E-Learning package);
- hold and update Provider policy and ensure all relevant colleagues as well as the general public are aware of policy using internal communications processes.

4.10. Frontline/reception staff will need to:

- understand cost recovery rules and processes;
- ask the baseline questions to all patients whose chargeable status is not known
- attend Overseas Visitor training;
- flag any patients that may not be eligible for free NHS care and inform the OVM/patient facing administrative team who will undertake any investigations.

4.11. The Debt Recovery Team will need to ensure the quick, efficient recovery of outstanding debt (see section 10), although the OVM/patient facing administrative team may do their own debt recovery in some providers. They will also need to refer patients with debts of over £500 and outstanding for two months or more to the Home Office via the Department of Health.

4.12. The Clinical Coding team will need to support the OVM/patient facing administrative team by assisting with urgent coding of liable patients (see section 10).

4.13. The Informatics team will need to:
• support the OVM/patient facing administrative team with predictive reports;
• ensure, where possible, that PAS has a relevant flagging system for patients not eligible for free care.

4.14. Clinicians will need to:
• ensure they understand their role and responsibility;
• be aware of particular treatment that is exempt from charges, for example if a patient is undergoing diagnosis or receiving treatment for a sexually transmitted disease, and communicate these to the OVM/patient facing administrative team as necessary;
• work with the OVM/patient facing administrative team as required to ensure those patients not eligible for free NHS care are assessed to determine whether treatment is immediately necessary or urgent;
• advise OVM/patient facing administrative team of patients that require immediately necessary or urgent treatment;
• implement and comply with the organisations stabilise and discharge policy.

Local Communications

4.15. Providers will need to ensure they effectively communicate overseas visitor charging policy to all teams in the organisation so all staff are aware of legal requirements, as well as either their roles in the process or how they can best support the teams/individuals who are responsible for implementation.

4.16. Providers should provide robust communications to patients about the charging rules so they are aware of and understand any impact they may have on their care. This should include information on the treatment/services that are exempt (see the DH Toolkit which includes examples of posters and letter templates to patients) but also who they can speak to for more information and support, and how to escalate any complaints or concerns they may have about decisions made regarding their chargeable status or care.

4.17. Providers should also seek to work with their local primary care practices and commissioners to help support the process of identifying patients who may need to pay for their treatment.

4.18. Staff who are responsible for liaising with patient groups and forums should also ensure that cost recovery is an ongoing item in discussions.

4.19. Providers should also work with local stakeholders to ensure robust safeguarding policies are in place and that hard to reach groups are identified, supported and encouraged to access the care they need at all times. These groups should be made aware of the treatment/services that are free to all.

Monitoring

4.20. The Provider should ensure that monitoring arrangements are in place to assess the effectiveness of the implementation of the charging regulations for overseas visitors and take steps to address improvement where required (see section 11).

4.21. Providers should ensure there are ongoing checks for unintended consequences that may arise as a result of upfront charging, and put in place steps to mitigate against these to ensure patient safety and quality of care is maintained at all times.
5. Patient pathway

Identifying patients not eligible for free care

5.1. It is important that providers confirm whether a patient is eligible for free care when this is not known.

5.2. It is recommended that the following baseline question is used when patients present, for example at reception, although any other wording is acceptable as long as the meaning of the question remains the same and the same question(s) are asked of all people whose chargeable status is not known. The baseline question needs to be asked every time a patient begins a new course of treatment.

5.3. The recommended standard baseline question is:

"Where have you lived in the last 6 months?"

- If the patient has lived anywhere outside the UK, the individual should be asked whether they have a European Health Insurance Card or other document to demonstrate they are entitled to free NHS care;
- If a non-UK issued European Health Insurance Card is provided, details should be taken from the card regardless of the answer or documents provided in answer to the follow-up question (to note that a provider received a 25% incentive payment for reported EHICs); and,
- If an EHIC or S1 is not provided, the OVM/patient facing administrative team should then be informed that the patient may not be eligible for free NHS care. The patient should be informed that they may need to provide some further information.

5.4. Further information about identifying patients is available in the Guidance on Implementing the Overseas Visitor Charging Regulations and in the DH Toolkit, which includes:

- guidance on establishing ordinary residence status
- an example of a pre-attendance form;
- an example of a request for patient information form;
- Guide to the EHIC Incentive scheme;
- Information for primary care staff providing healthcare for overseas visitors from the European Economic Area.

5.5. OVMs/patient facing administrative teams should also look to identify patients who may not be eligible for free care in advance of planned outpatient and inpatient waiting lists. If they do not already, providers should consider producing a report that looks at factors that may indicate that particular patients are not eligible for NHS-funded care, such as:

- having an overseas address;
- not being registered with a GP; or,
- having a recently allocated NHS number, as a prompt to indicate which are most likely to need further enquiry.

The OVM/patient facing administrative team can use this report alongside information from the Summary Care Record application (see chapter 5 of the Guidance on Implementing the Overseas Visitor Charging Regulations), past records and contacting the patient for additional information, to establish the patient's chargeable status.
5.6. OVMs/patient facing administrative teams should also seek to use a daily electronic report to advise them of patients who have been admitted to the provider through a non-elective route. The OVM/patient facing administrative team should then seek to check the patient's status and speak to those from whom they may need more information in order to confirm if they are eligible for free care.

5.7. It is important to note that it is now a legal requirement for providers to record a patient's chargeable status, against their NHS record. A patient's status must be recorded via the Summary Care Record application (see paras 5.24-5.31 of the Department of Health Guidance on Implementing the Overseas Visitor Charging Regulations and module 9: Implementing the Charging Rules: The Patient Record and Editing Chargeable Data of the E-learning).

5.8. The chargeable status ‘flag’ will be visible to all who view a patient's record on the NHS Spine but only those with RBAC code B0259 will be able to view the detail behind the flag and only those with the RBAC code B0266 will have edit functionality. In order to receive RBAC B0266, OVM/patient facing administrative teams will need to complete all e-learning modules, and apply to have RBAC code B0266 added to their smartcards via their provider's local Registration Authority. The Chargeable status or ‘flag’ is stored on the personal demographics service (PDS), alongside other NHS patient details, such as name, address, date of birth and NHS number. The PDS is held on Spine, which supports the IT infrastructure for the NHS in England.

**Types of patient not subject to charges**

5.9. A number of patients not eligible for NHS funded care will nevertheless not be subject to direct charging. This includes those who have paid the Immigration Health Surcharge or are covered by transitional arrangements (other than for assisted conception services), and anyone insured for healthcare in another EEA member state and who present either:

- a valid European Health Insurance Card from that member state; or
- a Provisional Replacement Certificate for their non-UK European Health Insurance Card; or
- documentation that establishes eligibility for care under other reciprocal arrangements; or,
- if coming to the UK specifically for treatment, presents an S2 form for that treatment; or,
- anyone who has a UK-issued S1 form registered in another EEA member state or Switzerland except for family members of frontier workers.

In these cases, the treatment should be paid for by the relevant commissioner.

5.10. The European Health Insurance Card or Provisional Replacement Certificate is limited to treatment that is medically necessary during the planned duration of the stay and should not be used when the patient has come to the UK for the purpose of planned elective treatment (which should be covered by an S2).

**Vulnerable patients and those exempt from charge**

5.11. When operating the charging rules it is very important that the OVM/patient facing administrative teams and clinicians, consider the position of vulnerable patients who may not be eligible for free care, or who may be exempt from charging (or require treatment which is exempt from charges), but who are not aware of
this, and who may have difficulty providing documentary evidence of their residency. This includes those unlawfully resident in the UK. Not all people who are vulnerable are exempt from charges; however there are a number of exemptions that are in place for many of the most vulnerable. This includes refugees and asylum seekers, and their dependents, children looked after by a local authority and victims of modern slavery (see Appendix A for full list). Chapter 7 of the Guidance on Implementing the Overseas Visitor Charging Regulations discusses in detail how to consider the position of vulnerable patients.

5.12. To ensure all patients who may be vulnerable receive the care and support they need regardless of their eligibility status, providers should work with local stakeholders and the wider communities to ensure that availability of healthcare is understood, including those services free to all, and every effort is made to communicate this to all potential patients, including those who can be hard to reach. To do this effectively, local organisations will need to work in partnership to develop effective communication and safeguarding processes.

Exempt Treatment

5.13. A number of specific treatments are exempt from charge. These include:

- family planning services (does not include termination of pregnancy);
- diagnosis and treatment of specified infectious diseases;
- diagnosis and treatment of sexually transmitted infections;
- palliative care services provided by a registered palliative care charity or a community interest company;
- treatment required for a physical or mental condition caused by:
  - torture;
  - female genital mutilation;
  - domestic violence; or
  - sexual violence,
  (except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment).

These treatments should be paid for by the responsible commissioner.

Safeguarding

5.14. OVMs/patient facing administrative teams and other frontline staff are strongly encouraged to speak to their safeguarding leads if, in the course of their work, they are concerned about the welfare of any patient. As set out above, the OVM/patient facing administrative team should build constructive relationships with local agencies which support people in various types of need, or to seek advice and information from relevant national agencies and organisations.

Maternity services

5.15. All maternity services must be treated as being immediately necessary. No one must ever be denied, or have delayed, maternity services due to charging-related issues.

5.16. Although a person must be informed if charges apply to their treatment, in doing so they should not be discouraged from receiving any part of their maternity treatment and it is critical they are supported to continue with their care and that the
Provider communicates all payment options to them, for example affordable repayment plans.

5.17. OVMs/patient facing administrative teams should be especially careful to inform pregnant patients that further maternity healthcare will not be withheld, regardless of their ability to pay or their immigration status. These patients should also be made aware that accident and emergency services and primary medical services remain free to all and that they are also exempt from some other primary medical care services, for example prescription charges.

5.18. If at any point a maternity patient ceases to attend planned appointments, safeguarding procedures should apply with immediate action taken to locate and speak to the individual to discuss any concerns they may have and their options for provision of care. It is important providers work with other stakeholders in their local communities to embed and enforce effective safeguarding procedures, and communicate with potentially vulnerable patients.

Children

5.19. The Charging Regulations apply equally to overseas visitors who are children (someone under the age of 18), except that the liability for the cost of treatment, if the child is not within an exemption category, falls to the person who has parental responsibility for the child.

5.20. Children who are looked after by a local authority are exempt from charge. Children may also fall into other categories of exemption, or be exempt because they are the child of a person who is exempt in particular circumstances (e.g. victims of modern slavery). More information on the exemptions categories is set out in the Guidance on Implementing the Overseas Visitor Charging Regulations.

Equality and Diversity: Interpreter services

5.21. The public sector equality duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between people who share a protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not.

5.22. Providers should therefore ensure that the way it provides services to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds, both as employers and when making policy decisions and delivering services.

5.23. To ensure that there is effective communication with patients, their relatives and carers the provider should ensure that there are arrangements in place to provide appropriate communication and interpreter support to those patients whose first language is not English or who may have a sensory impairment/loss where communication is affected.

5.24. The provider should have in place policies and procedures that meet current national standards for interpretation and translation services for healthcare purposes. The providers policies and procedures should clearly set out the responsibilities of all staff members involved and highlight the need for there to be clear and effective communication between all staff involved.
6. Role of clinicians

Assessing patients

6.1. It is the clinician’s role to provide appropriate healthcare for their patients and to make decisions on their treatment based on their clinical needs. The charging regulations do not change that.

6.2. Clinicians will at times, however, be required to make a decision on whether treatment is urgent or immediately necessary for those patients identified as not eligible for NHS-funded care.

6.3. Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent (for patients whose status is unknown or have been identified as being chargeable). In order to do this they may first need to make initial assessments based on the patient’s symptoms and other factors, and conduct further investigations to make a diagnosis. Although these initial assessments and investigations will be included in any charges (unless an exemption applies - see Appendix A), they cannot be withheld even if a payment for treatment has not been received upfront for the cost of the assessment.

6.4. The final decision on whether a patient requires immediately necessary or urgent treatment lies with the lead treating clinician.

6.5. The clinical team or department should inform the OVM/patient facing administrative team if a patient is receiving a particular treatment that is exempt from charges, for example if a patient is undergoing diagnosis or receiving treatment for a sexually transmitted disease (see paragraph 5.13).

6.6. If a clinician does become aware a person that has not been identified as chargeable is not ordinarily resident in the UK they should notify the OVM/patient facing administrative team. The OVM/patient facing administrative team can then work with the patient to confirm whether they are eligible for free care and enable the patient to make informed decisions about their treatment and travel plans.

6.7. To record their assessment decision clinicians should complete their section of the Clinicians Patient Assessment form (see Appendix C and para 7.6) and sign and date it. This form includes four options which sets out whether treatment is:

- Immediately necessary;
- Urgent;
- Non-urgent, and therefore it is not intended to provide treatment unless payment is made in advance;
- Requires further investigation before assessment of urgency can be made.

Patients who need to be monitored after discharge

6.8. The clinician will decide on a case by case basis when a patient is fit for discharge and the level of monitoring required post discharge.

6.9. Prior to discharge, any patient not eligible for free NHS care should be stabilised to a point where the clinician would be of the view they are fit and able to return home for ongoing treatment, should it be required (see para 3.12).
6.10. As part of the decision around discharge, the patient should be assessed for their clinical fitness to travel.

6.11. There should be an approved discharge planning process for managing the discharge/transfer of patients, including arrangements for clinically necessary post-discharge monitoring that is implemented and kept under review. The arrangements should clearly set out the responsibilities of all staff members involved in the patients discharge/transfer and highlight the need for there to be clear and effective communication between all staff involved and with the patient at all times (including the costs to the patient of that ongoing monitoring).

6.12. While urgency of treatment is a matter of clinical judgement, this does not mean that treatment should be unlimited; there may be some room for discretion about the extent of treatment and the time at which it is given. In many cases, a patient undergoing immediately necessary treatment may be able to be stabilised, allowing them to be safely discharged and giving them time to return home for further treatment rather than incurring further avoidable NHS charges. This should be done wherever possible, unless there is a risk that ceasing or limiting treatment would precipitate deterioration in the patient’s condition.

6.13. Providers should have in place robust, efficient processes for patients who wish to escalate concerns or make a complaint about a decision to cease their treatment. These processes should be clearly communicated to patients.

Patients discharging against medical advice

6.14. A competent patient cannot be detained in hospital against their will except:

(1) under the provisions of the Mental Health Act 2007; or,

(2) under common law in extreme cases where the safety of the patient or another person is immediately threatened.

6.15. In circumstances where a patient wants to discharge themselves from hospital against medical advice, if alerted first the nurse responsible for the care of the patient should try to persuade the patient to stay and summon a doctor, who should explain the risks and consequences of their action.

6.16. If the patient chooses to leave hospital against medical advice then the relevant provider policy and procedures for patient discharge against medical advice must be followed.

6.17. If a patient registers at the Emergency Department (ED), but does not wait for treatment or discharges themselves from ED against medical advice following assessment or treatment, a record should be completed and filed in the patient notes.

6.18. If a patient who is an inpatient leaves the hospital unannounced and where applicable the provider Missing Persons policy may need to be followed.

6.19. In the case of parents or guardians taking their child home against medical advice the nurse should try to persuade the patient to stay and summon a doctor, who should likewise seek to persuade the patient to stay. Staff should comply with Safeguarding Children (including those in need of protection) Policy and the Local Safeguarding Board Guidance, consulting with the Safeguarding Children team and social services if and as appropriate.
Clinical Case Studies

6.20. The clinical case studies below are aimed to support clinicians when making decisions about whether the care they recommend is urgent or immediately necessary. For the purpose of this guidance, the case studies refer to patients who are directly chargeable. They relate solely to the clinician decision making process and not to the processes undertaken by OVM/patient facing administrative teams to identify or charge the patients, which are covered elsewhere in the guidance.

Case Study 1 Emergency Department: Non-Elective Pathway

*A patient presents to Emergency Department via ambulance, with severe chest pain. The patient is a chargeable overseas visitor*

- Following assessment by the clinician the patient is diagnosed with severe angina and a myocardial infarction (heart attack) and on this basis treatment is deemed to be immediately necessary and urgent.
- The clinician decides that an emergency coronary angioplasty procedure is required.
- Following the emergency coronary angioplasty procedure, the patient is transferred to the critical care unit for high dependency observation and management.
- The patient stays in hospital until medically fit for discharge.

Overseas Visitor Regulations: Considerations

- A chargeable overseas visitor patient is diagnosed with a cardiac condition requiring emergency treatment and although still chargeable this is immediately necessary treatment.
- The clinician has decided that treatment in this instance is immediately necessary to save the patient’s life; or to prevent a condition from becoming immediately life-threatening; or to prevent permanent serious damage from occurring.
- Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent.
- It should be noted that treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. The admission and coronary angioplasty procedure is chargeable and will be included in any charges.
- Once stable the patient can be interviewed by the OVM/patient facing administrative team who can then begin the process of charging the patient for the treatment received.
- Following treatment, the clinician will decide on a case by case basis whether the patient is fit for discharge and the level of monitoring required post discharge.
- Prior to discharge, the patient should be stabilised to enable the patient to be fit to return home for ongoing treatment.
- The clinical team inform the patient of the treatment they have received, provide a written discharge letter and advise them to contact their local healthcare practitioner as soon as possible on their return to their home country. A letter is sent to their GP advising of the treatment and discharge arrangements.
- The patient should be assessed for their clinical fitness to travel, either travelling independently or using in flight medical services arranged at their own expense or to seek home office support to travel home.
- Once the patient is stabilised and deemed to be medically fit for discharge, the patient should then travel to their home country for further ongoing treatment.
Case Study 2: Outpatients: Elective Pathway

A chargeable patient has been referred by a GP to the Orthopaedic Clinic with an arthritic hip

- The patient is identified as being chargeable by the OVM/patient facing administrative team between being referred and attending their first outpatient appointment with the consultant.
- The consultant assesses the patient and advises them that they would benefit from a hip replacement. However they deem that treatment to be non-urgent. They then complete the Clinician Patient Assessment form, which is returned to the OVM/patient facing administrative team.
- The OVM/patient facing administrative team explains the decision to the patient and provides an estimate of costs for a hip replacement procedure. The OVM/patient facing administrative team explain that the patient will have to agree to upfront payment for the procedure, ahead of any clinical intervention.

Overseas Visitor Regulations: Considerations

- It should be noted that treatment is not made free of charge as a consequence of being referred by a GP, or having an NHS number.
- While the elective referral would typically be considered non-urgent, it is important the first consultant assessment goes ahead to ensure there are no reasons why the treatment should be deemed urgent or immediately necessary.
- Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent.

Case Study 3: Dialysis

A chargeable patient attends the Emergency Department presenting with acute renal disease requiring dialysis three times a week

- Following clinical assessment and admission, the consultant advises that the patient requires urgent dialysis to prevent their illness from causing any further renal damage or risk to life.
- The OVM/patient facing administrative team identifies the patient as chargeable and asks the consultant to complete a Request for advice from dentist/doctor form. The consultant determines that the treatment, and ongoing dialysis programme, is necessary to prevent the patient’s condition from becoming life threatening.
- The OVM/patient facing administrative team informs the patient that they should pay for their treatment, however the provider will not withhold treatment should they find themselves unable to pay.

Overseas Visitor Regulations: Considerations

- Despite dialysis treatment being planned and routine, denial of this treatment would result in serious worsening of the patient's condition within a matter of hours. Therefore the treatment should be considered urgent and immediately necessary.
- Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent.

Case Study 4: Emergency Pathway

A patient attends the Emergency Department (ED) having an acute exacerbation of their long standing asthma
• In order to stabilise the patient immediately necessary and urgent treatment is required and delivered in the ED. A clinical decision is made to admit the patient in accordance with the asthma pathway; the patient is informed they will be required to remain in hospital overnight.

• As the patient was having difficulty breathing on arrival in the ED the clinical team assessed the patient as requiring immediately necessary/urgent treatment to prevent life threatening deterioration to their health. Treatment to stabilise the patient was commenced immediately and the agreed asthma protocols followed to stabilise the patient.

• The following day the patient is reviewed and identified as much improved and therefore fit for discharge. The clinical team inform the patient of the treatment they have received, provide a written discharge letter and advise them to contact their local healthcare practitioner as soon as possible on their return to their home country.

• The OVM/patient facing administrative team identifies the patient as chargeable once they have been admitted and are in a fit state to be interviewed. They are presented with an invoice for treatment received; however no decision is required from clinicians as they have already made the decision to discharge the patient.

**Overseas Visitor Regulations: Considerations**

• The necessity for clinical treatment is immediately necessary/urgent so arrangements will be made to treat the patient.

• Only clinicians can make an assessment as to whether a patient’s need for treatment is immediately necessary, urgent or non-urgent.
7. Role of OVMs/patient facing administrative teams

7.1. The success of the charging rules depends on staff at all levels, including senior management and clinicians, being aware of, and supportive of, OVMs/Overseas teams. If a specific OVM/Overseas team is not in place, relevant administrative/patient facing staff in the patient pathway should be provided with the necessary training, resources and support to enable them to fulfil the providers’ legal requirements.

7.2. Frontline administrative staff/receptionists, who are responsible for asking patients the baseline question (see section 5) to help identify whether a patient may be chargeable, should be able to pass on information about a patient’s status to the OVM/patient facing administrative team where the baseline question does not confirm it.

7.3. It is the responsibility of the OVM/patient facing administrative team to establish whether or not the patient is entitled to free NHS treatment. Once this is done they should ask the clinician to complete their section of the Clinician Patient Assessment form when they assess a patient who is or may be required to pay for treatment (see para 7.6 below).

7.4. Once the urgency of treatment a patient requires has been categorised, it is the role of the OVM/patient facing administrative team to discuss with the patient their options depending on:

- if the patient has not paid/refuses to pay/unable to pay upfront and their treatment is not immediately necessary or urgent, inform them they are not entitled to receive treatment.
- if the patient has not paid/refuses to pay/unable to pay and treatment is deemed immediately necessary or urgent they should be informed that they will be provided with treatment but the costs will be required, with any debts pursued where appropriate as per the usual cost recovery process.

7.5. The OVM/patient facing administrative team should act appropriately when requesting payment taking into consideration the particular circumstances of the patient, for example, when dealing with a vulnerable patient who may leave the hospital if it appears they will be charged. If required the OVM/patient facing administrative team will be responsible for generating a referral to the safeguarding of adults team, collaborating with the lead clinician.

The Clinician Patient Assessment form

7.6. The Clinician Patient Assessment form (example letter in Appendix C) records whether a patient requires immediately necessary or urgent treatment. It includes sections for both the OVM/patient facing administrative team and the clinician to complete. The OVM/patient facing administrative team should first complete the below details:

- Name of patient
- Date of birth
- Hospital number

7.7. The OVM/patient facing administrative team should then include the form in the notes for the clinician and ask the clinician to complete their section - which is to mark the box to show whether the patient requires immediately necessary, urgent or non-urgent
treatment, or whether further investigation is required. Once the clinician has completed their section and signed and dated the form, the OVM/patient facing administrative team should collect the form and sign and date it, in the section below the clinician's signature.

7.8. Once the form is fully complete and signed by both the clinician and OVM/patient facing administrative team, the OVM/patient facing administrative team should process the form, updating the data record as appropriate, communicate with the patient (including full, clear sign posting on how they can challenge the provider on any decision they disagree with) and deal with upfront charging decisions as necessary.
8. Estimating cost of treatment

Cost estimates Pricing Schedule

8.1. Alongside this guidance you will find a list of indicative prices, which can be accessed here: https://improvement.nhs.uk/resources/overseas-patient-upfront-tariff. This list has been developed for guidance purposes to support upfront charging. These are not mandatory and not designed to replace existing pricing practice where it is felt that the provider has a system in place that works. This price list will stay under review and NHS Improvement will ensure that any national pricing changes/adjustments are reflected as required.
9. Upfront payments

9.1. Following the categorisation of treatment, the OVM/patient facing administrative team should inform the patient of the estimated costs, which can be calculated using the cost estimates price list (see section 8), explaining how the cost has been estimated based on the expected treatment.

9.2. The OVM/patient facing administrative team should explain that the charge at this point is an estimate, based on the national tariff (see section 10), and that the final invoice may be adjusted with either a refund provided if the estimate is higher than the final cost, or further payment taken if the estimate is lower than the actual cost, which is dependent on a number of factors including the condition of the patient, any additional treatment required or an extended length of stay.

Requesting payment

Routine treatment (i.e. not urgent or immediately necessary)

9.3. If the patient is not eligible for free NHS care the OVM/patient facing administrative team should advise the patient that they are liable and need to pay for treatment upfront and in full.

9.4. OVMs/patient facing administrative teams can use the tool outlined in section 8 or locally-determined tariffs to estimate the cost of treatment in advance.

Immediately necessary or urgent treatment

9.5. Where the patient is found to be liable the OVM/patient facing administrative team should advise the patient of estimated costs at the earliest opportunity after the initial clinician's assessment (establishing whether the patient does or does not require immediately necessary/urgent treatment), ensuring the patient's clinicians are also aware.

Methods of payment

9.6. Each provider should ensure they can take payment using:
   - Credit/Debit card payments (in person and over the telephone)
   - Bank Transfers
   - Cash (ensuring appropriate cash handling processes are in place and adhered to)
   - Direct Debit or standing order options for payment plans (direct debit is preferred)

9.7. In cases where the patient has medical health insurance and does not require immediately necessary or urgent treatment, direct payment should be taken either from the patient or the insurance company prior to any treatment.

Withholding treatment for non-payment

9.8. If a patient refuses to pay, the OVM/patient facing administrative team should inform them that they will not receive treatment as their condition has been assessed by the clinician as not being immediately necessary or urgent.

9.9. For elective treatment that is not immediately necessary or urgent, where they have been referred for treatment by a GP, the OVM/patient facing administrative team should
send the patient the Patient Chargeable letter and send their GP the Advice to Doctors or Dentists letter, informing them that the patient is not eligible for free treatment.

9.10. Patients who are unable to pay for care deemed non-urgent or immediately necessary, such as those on low incomes, should be signposted to support groups such as the British Red Cross, their Embassy, Home Office (voluntary return), Citizens Advice Bureau or other local support group.

9.11. Providers must also ensure they have in place clear, robust and accessible processes for patients who wish to make a complaint or challenge the decision made by the clinician that their condition is not immediately necessary or non-urgent. OVMs/patient facing administrative teams need to ensure that they and patients charged for NHS services are aware of these procedures and that they are communicated and followed at all times.
10. Final costs and invoicing

Invoicing and payment arrangements

10.1. The upfront charge should be calculated, using the NHSI Overseas Visitor pricing schedule (see section 8) or the provider's own pricing method.

10.2. The OVM/patient facing administrative team should raise the invoice prior to commencement of treatment. The invoice should clearly set out the reasons for the charge.

10.3. The invoice should also set out a high level explanation of the charge.

10.4. The invoice should then be issued to the patient as soon as possible, and the patient informed that treatment will not progress until payment is received.

10.5. Chargeable patients should be informed that a post discharge adjustment will be made if necessary (further invoice or refund) once the full price related to the fully coded treatment(s) has been calculated, based on the NHS national tariff.

10.6. Payment can be taken using credit/debit card payments, bank transfers, cash or through direct debit or standing orders (see para 9.6). Where a patient has personal insurance cover the provider may prefer to leave the patient to deal with the insurance company themselves, providing the patient with sufficient paperwork to pursue their claim.

Post discharge adjustment charge

10.7. The finance team should finalise the invoice by completing the requisite actions (which will include but not be limited to the reconciliation between the estimated invoice and the fully coded invoice). This action can be fulfilled by OVMs/patient facing teams if they have the capability and resources to do so.

10.8. The clinical coding of the overseas visitor's patient record should be completed in a timely way to ensure any adjustment invoice can be issued as soon as possible after discharge to increase the chances of payment.

10.9. Once coding is complete, the fully coded charge can be established. It can then be compared with the up-front invoice raised previously. The adjustment invoice or credit note should clearly set out this calculation, setting out details of final charge on the face of the invoice, together with the original invoice value. It is important that references are included on the invoice that links it back to the original up-front invoice.

10.10. If a credit is required the invoice and the payment on the provider debtors system should be un-matched so that they become visible again on the sales ledger. A credit note/journal for the adjustment amount should be raised and processed against the original invoice/payment. The process is set out in the NHS Debtors Return Process Instruction.
Payment terms, chasing unpaid invoices and debt collection process

10.11. On all invoices raised, payment terms should be clearly stated and should maximise the chances of debt recovery, together with clear information related to methods of payment (which should be as simple and flexible as possible). Additional information on the escalation process in relation to debt collection should also be included.

10.12. Payment of the invoice should be requested as soon as possible (according to provider policy). Where payment has not been made in the appropriate timescale, the unpaid invoice should be referred to the appropriate debt-collection agency.

10.13. Where payment plans are entered into, providers should ensure that they are set at a level that maximises the chance of a reasonable return within a reasonable time frame.

10.14. For non-EEA patients, if the debt is over £500 and outstanding for two months or more the patient must be referred to the Home Office via the Department of Health. The Home Office input the patient details into their systems to ensure that the patients’ status is recorded. The Home Office can then use that data to deny any future application to enter or remain in the UK that the person with the debt might make.

10.15. It is therefore important to ensure that any arrangements for staggered payments are realistic to reduce the need for the patient being placed on the Home Office record.

Risk share arrangements with commissioners

10.16. Risk-share arrangements with commissioners should only be used in the case of treatment deemed by clinicians to be immediately necessary or urgent (category D and F patients) i.e. those cases where payment is not received upfront and in full in advance of treatment (see https://www.england.nhs.uk/resources/resources-for-ccgs/).

10.17. The provider may find it useful to agree a protocol for managing risk-share arrangements with commissioners (including CCGs and NHS England).
11. Performance Management

Capturing key data

11.1. Although there are no new national data requirements as a result of the updated Charging Regulations, we would recommend providers record:

- number of chargeable patients treated, both elective and non-elective;
- number of patients identified as not-eligible for free NHS services whose non-urgent or immediately necessary treatment did not go ahead as payment was not received or who have decided not to seek treatment following being identified as chargeable;
- how much income has been received through upfront charging;
- the level of debt from chargeable patients;
- how much has been written off (for immediately necessary or urgent treatment only).

11.2. This information, if it can be collected, should be used by providers to assess how effectively they are implementing upfront charging.
Appendix A

Statutory provisions and the Charging Regulations

11.3. **Section 175 of the National Health Service Act 2006** (the 2006 Act) allows the Secretary of State for Health to make regulations for the making and recovery of charges in relation to any services provided under that Act to any person who is not ordinarily resident in Great Britain. It also gives the Secretary of State the power to calculate charges on any appropriate commercial basis.

11.4. The National Health Service (Charges to Overseas Visitors) Regulations 2015 (the Charging Regulations) came into force on 6 April 2015 and apply to all courses of treatment commenced on or after that date. The Charging Regulations have subsequently been amended, most recently on 23 October 2017 by the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations ("the 2017 Amendment Regulations").

11.5. The Charging Regulations apply to England only, and replace previous regulations on charges to overseas visitors. A relevant body must only make and recover charges from an overseas visitor where it determined that neither the person nor the service is exempt under the Charging Regulations.

Exempt services and individuals

11.6. The following services are free at the point of use for all patients. A charge cannot be made or recovered from any overseas visitor for:

- accident and emergency (A&E) services, this includes all A&E services provided at an NHS hospital, e.g. those provided at an accident & emergency department, walk-in centre, minor injuries unit or urgent care centre. This does not include those emergency services provided after the overseas visitor has been accepted as an inpatient, or at a follow-up outpatient appointment, for which charges must be levied unless the overseas visitor is exempt from charge in their own right;

- family planning services (does not include termination of pregnancy);

- diagnosis and treatment of specified infectious diseases;

- diagnosis and treatment of sexually transmitted infections;

- from 23 October 2017, palliative care services provided by a registered palliative care charity or a community interest company;

- services that are provided as part of the NHS111 telephone advice line;

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1 Making a fair contribution: Government response to the consultation on the extension of charging overseas visitors and migrants using the NHS in England (published 6 February 2017) stated that the Government is still considering its proposal to extend charging for overseas visitors to services provided at an A&E unit or similar, with an intention to respond later in the year.
treatment required for a physical or mental condition caused by:
- torture;
- female genital mutilation;
- domestic violence; or
- sexual violence,
except where the overseas visitor has travelled to the UK for the purpose of seeking that treatment.

Exempt categories of person

11.7. The following categories of overseas visitor are exempt from charge:

- Non-EEA nationals, who are subject to immigration control, are exempt from charge (see below) if one of the following applies to them while their leave to enter/remain is valid:
  - they have paid the surcharge or are covered by transitional arrangements; or
  - they are exempt from payment of the surcharge or have had the requirement waived or reduced, or have had part (but not all) of the surcharge refunded to them; or
  - they would have been covered under one of the above, but for the fact that they applied for leave to enter or remain in the UK before the start of the surcharge (this will include some people already resident here without indefinite leave to remain, and a small number of people arriving after 6 April 2015 who applied for leave before that date).

- A child born in the UK to an above mentioned exempt person is also exempt from charge up to the age of three months provided that the child has not left the UK since birth.

Vulnerable patients and those detained

- Refugees (those granted asylum, humanitarian protection or temporary protection under the immigration rules) and their dependents.

- Asylum seekers (those applying for asylum, humanitarian protection or temporary protection whose claims, including appeals, have not yet been determined), and their dependents.

- Individuals receiving support under section 95 of the Immigration and Asylum Act 1999 (the 1999 Act).

- Failed asylum seekers, and their dependents, receiving support under section 4(2) of the 1999 Act or those receiving support from a local authority under Part 1 (care and support) of the Care Act 2014 or section 35 or 36 of the Social Services and Well-being (Wales) Act 2014, by the provision of accommodation.

- Children who are looked after by a local authority.

- Victims, and suspected victims, of modern slavery as determined by a designated competent authority, such as the UK Human Trafficking Centre or the Home Office. This includes their spouse/civil partner and any children under 18, provided they are lawfully present in the UK.
• An overseas visitor who has been granted leave to enter the UK outside the immigration rules, in whose case the Secretary of State for Health determines there to be exceptional humanitarian reasons to provide a free course of treatment.

• Anyone receiving compulsory treatment under a court order or who is detained in an NHS hospital or deprived of their liberty (e.g. under the Mental Health Act 1983 or the Mental Capacity Act 2005) is exempt from charge for all treatment provided, in accordance with the court order, or for the duration of the detention.

• Prisoners and certain immigration detainees.

**UK Government employees and war pensioners**

• UK armed forces members, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK (even if they are on a visit visa).

• UK Crown servants who are in the UK in the course of their employment, or who were ordinarily resident prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.

• Employees of the British Council or Commonwealth War Graves Commission who are in the UK in the course of their employment, or who were ordinarily resident in the UK prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.

• Those working or volunteering in employment overseas that is financed in part by the UK Government who are in the UK in the course of their employment, or who were ordinarily resident in the UK prior to being posted overseas, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.

• Those receiving war pensions, war widows’ pensions or armed forces compensation scheme payments, plus their spouse/civil partner and children under 18 when these family members are lawfully visiting the UK with the recipient of this pension/payment.

Those covered by reciprocal healthcare agreements (as listed in Schedule 2 of the Regulations) and other international obligations

• Anyone entitled to free healthcare in the UK under the terms of a reciprocal healthcare agreement with a country outside the EEA (usually limited to immediate medical treatment); see Chapter 10 of Guidance for more details.

• Nationals of states that are contracting parties to the European Convention on Social and Medical Assistance or the European Social Charter and who are lawfully present here and without sufficient resources to pay.

• NATO personnel, when the services required cannot readily be provided by armed forces medical services, plus their spouse/civil partner and children under 18 provided they are lawfully present in the UK.
Immediately necessary and urgent treatment

The concept of immediately necessary, urgent and non-urgent treatment, and when to require payment from chargeable overseas visitors for their healthcare, is long-standing and has previously been developed with the assistance of the BMA and NHS operational staff.

Immediately necessary treatment is that which a patient needs promptly:

- to save their life; or
- to prevent a condition from becoming immediately life-threatening; or
- to prevent permanent serious damage from occurring.

Relevant providers must always provide treatment which is classed as immediately necessary by the treating clinician irrespective of whether or not the patient has been informed of, or agreed to pay, charges, and it must not be delayed or withheld to establish the patient’s chargeable status or seek payment. It must be provided even when the patient has indicated that they cannot afford to pay.

Urgent treatment is that which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to leave the UK. Clinicians may base their decision on a range of factors, including the pain or disability a particular condition is causing, the risk that delay might mean a more involved or expensive medical intervention being required, or the likelihood of a substantial and potentially life-threatening deterioration occurring in the patient’s condition if treatment is delayed until they return to their own country.

For urgent treatment, relevant bodies are strongly advised to make every effort, taking account of the individual’s circumstances, to secure payment in the time before treatment is scheduled. However, if that proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment.

Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and if payment is not obtained before treatment then every effort must be made to recover it after treatment has been provided.

Examples of clinical conditions that may assessed as requiring urgent or immediately necessary treatment, possible examples as follows:

- Acute chest pain
- Acute breathing difficulties
- Major Trauma
- Abdominal pain
- Pregnancy related problems
- Allergic reactions
- Overdoses
- Clinical conditions likely to require acute in-patient hospital admission

It should be noted that non-medical termination of pregnancy is not an exemption under the immediately necessary or urgent clinical category.
Non-urgent treatment

Non-urgent treatment is routine elective treatment that could wait until the patient leaves the UK. Relevant bodies do not have to provide non-urgent treatment if the patient does not pay in advance and should not do so until the estimated full cost of treatment has been received.

Examples of clinical conditions that may be assessed as requiring non-urgent treatment may include:

- Hip replacement
- Gall Bladder Surgery
- Hysterectomy
- Haemorrhoids

How to determine when an overseas visitor patient can reasonably be expected to return home

The general principle is that overseas visitors should either return home for treatment that is not immediately necessary or urgent, or pay in advance of receiving it. However, in some cases it may not be possible or reasonable to expect a person to return home quickly enough for treatment. Clinicians will need to know when a patient can reasonably be expected to return home in order to decide if their need for NHS-funded community or secondary care is urgent or if it can safely await their return.

As a condition of their entry to the UK, general visitors are required to have sufficient funds available to finance their stay, and that of any dependants, as well as the onward or return journey. Many documented migrants have return journeys booked when they enter the UK. If they need treatment before that return date but claim that they cannot pay for it in advance, they should arrange an earlier journey home before the treatment would be necessary in the opinion of a clinician. If an earlier journey home would not be reasonable, and treatment is urgent, care should be provided and debts recovered when clinically appropriate.

Those without return journeys booked are expected to return home for the treatment needed, again, unless it would not be reasonable to do so. As a final resort, the date at which their visa requires them to leave the UK should be used as the date of return.

For undocumented migrant patients, including failed asylum seekers, the likely date of return may be unclear, and will have to be assessed on a case-by-case basis, including their ability to return home. Some may be prevented by travel or entry clearance restrictions in their country of origin, or by other conditions beyond their control.

For some cases relating to undocumented migrants, it will be particularly difficult to estimate their return date. Relevant bodies may wish to estimate that such patients will remain in the UK initially for six months, and the clinician can then consider if treatment can or cannot wait for six months, bearing in mind the definitions of urgent and non-urgent treatment given above. However, there may be circumstances when the patient is likely to remain in the UK longer than six months, in which case a longer estimate of return can be used.

Where a clinician has decided that the need for treatment is non-urgent and can wait until the patient returns home, this should be reassessed if the patient informs the relevant body that their return date has been postponed for valid reasons. It should also be reassessed if the patient’s medical condition unexpectedly changes. On being told that their need for treatment has been found to be non-urgent, and will therefore not proceed without advance payment, patients should be informed that they should present again for a reassessment of the urgency of their treatment if their condition changes. Alternatively, patients’ circumstances may require regular follow-up by clinicians.
Appendix C - Clinician Patient Assessment form

NAME OF PATIENT ...........................................................................................................

Date of birth ………/………/………… Hospital number ……………………………………….

You are asked to provide your considered clinical opinion and tick one of the below declarations:

☐ Having made the appropriate diagnostic investigations, I intend to give treatment which is immediately necessary to save the patient’s life/prevent a condition from becoming immediately life-threatening or needed promptly to prevent permanent serious damage occurring. All maternity treatment is considered immediately necessary.

☐ Having made the appropriate diagnostic investigations, I intend to give urgent treatment which is not immediately necessary to save the patient’s life but cannot wait until the patient returns home.

If the patient’s ability to return changes I will reconsider my opinion.

☐ Having made the appropriate diagnostic investigations, I do not intend to provide treatment unless payment is made in advance, since the patient’s need is non-urgent and it can wait until they return home. If the patient’s ability to return changes I will reconsider my opinion.

☐ I must make further investigations before I can assess urgency.

Date ………/………/…….. Signed .......................................................... (Doctor)

Date ………/………/…….. Signed .......................................................... (Overseas Visitors Manager/Administrator)