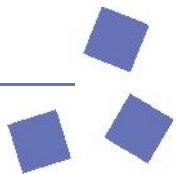


Qualitative Assessment of Visitor and Migrant use of the NHS in England

Observations from the Front Line



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7 October 2013/ Job No. 626/ Version 4

Prepared for:

Department of Health

The views expressed in this report are those of the authors and the respondents taking part in the research, and not necessarily those of the Department of Health (nor do they reflect Government policy).

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Contents

1	INTRODUCTION	1
1.1	Background	1
1.2	Aims and Objectives	2
1.3	Definition of terms	3
2	METHOD AND SAMPLE	5
2.1	Introduction	5
2.2	Methodology	5
2.3	Sample Structure, Recruitment and Sample Achieved	6
2.3.1	Expert briefings	6
2.3.2	Scoping Study: Trusts	7
2.3.3	Scoping study: Border Force/Immigration Enforcement	11
2.3.4	Case studies	12
2.3.5	Diary exercise	15
2.3.6	Timescales	16
2.3.7	Operational issues	16
2.3.8	Quotations	17
2.4	Interpreting the Data	17
3	CATEGORIES OF MIGRANTS AND OVERSEAS VISITORS	19
3.1	Introduction	19
3.2	Awareness and Understanding of Terms	20
3.2.1	Trusts	20
3.2.2	Primary care	22
3.3	Categories of migrants and overseas visitors being seen	24
3.4	EEA Temporary Residents and their Families	25
3.4.1	Trusts	25
3.4.2	Primary care	28
3.5	Non-EEA Temporary residents and their Families	29
3.5.1	Trusts	29
3.5.2	Primary care	30
3.6	Asylum Seekers	30
3.6.1	Trusts	30
3.6.2	Primary Care	31
3.7	Irregular Migrants	31

3.7.1	Trusts	31
3.7.2	Primary Care	32
3.8	British Ex-pats	33
3.8.1	Trusts	33
3.8.2	Primary Care	34
3.9	Visitors who Fall Ill Unexpectedly While Temporarily in the UK	35
3.9.1	Trusts	35
3.9.2	Primary Care	38
3.10	Visitors who ‘Fly In and Fly Out’	38
3.10.1	Trusts	38
3.10.2	Primary Care	41
3.11	Numbers of Chargeable Patients falling into each Category	42
3.12	Clinical Areas being Accessed	44
3.13	Experiences of Immigration Officers	45
4	SYSTEMS AND PROCEDURES WITHIN SECONDARY CARE	50
4.1	Introduction	50
4.2	Overseas Visitor Team	51
4.3	Identifying Potentially Chargeable Patients	55
4.3.1	Systems and procedures	55
4.3.2	Estimates of the number of patients being screened	60
4.4	Establishing Whether the Patient is Exempt or Chargeable	61
4.4.1	Systems and procedures	61
4.4.2	Estimates of the number of patients who are exempt from charging	64
4.5	Advising/Invoicing Chargeable Patients	65
4.5.1	Systems and procedures	65
4.5.2	Estimates of the number of patients being treated who either hold an EHIC or are covered by a reciprocal agreement	68
4.5.3	Estimates of the number of patients identified as directly chargeable and amounts charged	69
4.6	Recovering Charges	70
4.6.1	Systems and procedures	70
4.6.2	Estimates of number of patients who are charged but do not pay	72

4.6.3	The amounts being recovered	72
4.6.4	Levels of debt	73
4.6.5	Written off debt	74
4.7	Chargeable Patients who may not be Identified/Charged	75
5	SEGMENTATION OF TRUSTS	78
5.1	Introduction	78
5.2	Less Engaged Trusts	80
5.3	Reactive Trusts	82
5.4	Trusts with a Clear Sense of Direction	87
5.5	Proactive Trusts	93
5.6	Summary of Good Practice	100
6	IMPACTS AND CHALLENGES WITHIN SECONDARY CARE	102
6.1	Introduction	102
6.2	Financial impacts	102
6.3	Impact on Other Patients	105
6.3.1	Bed availability	105
6.3.2	Increase in waiting lists	106
6.3.3	Giving less time to other patients	107
6.4	Concerns about Professional Standards	107
6.5	Impact on Staff Morale	107
6.6	Impacts on Maternity	108
6.6.1	Communication difficulties	110
6.6.2	Cost of interpreter services	112
6.6.3	Safeguarding	113
6.6.4	Variation in practices and co-management of care	113
6.6.5	Risk management	114
6.6.6	Recovering charges	115
6.7	Impacts on Renal	115
6.7.1	Financial impacts	116
6.7.2	Impact on scarce resources	117
6.7.3	Staff morale	119

7	OBSTACLES TO IDENTIFYING AND CHARGING WITHIN SECONDARY CARE	120
7.1	Introduction	120
7.2	Internal Obstacles	120
7.2.1	Attitudes to the OVO role	120
7.2.2	Resourcing	120
7.2.3	Training	121
7.2.4	Initial screening	122
7.2.5	The attitude of clinicians	123
7.2.6	Other internal obstacles	124
7.3	External Obstacles	125
7.3.1	Pathways into the Trust	125
7.3.2	Dishonesty on the part of patients.	127
7.3.3	Perceived inadequacy of existing guidelines	129
7.3.4	Difficulties sharing information	129
7.3.5	Other external obstacles	130
7.4	Additional Obstacles identified by Border Force/Immigration Enforcement	132
8	SYSTEMS AND PROCEDURES WITHIN PRIMARY CARE	135
8.1	Introduction	135
8.2	Who they Can/Cannot Register and Charge	135
8.3	Registering New Patients	139
8.4	Registering Migrants and Overseas Visitors	140
8.5	Referrals to Secondary Care	143
9	IMPACTS AND CHALLENGES IN PRIMARY CARE	145
9.1	Introduction	145
9.2	Main Challenges within Primary Care	145
9.2.1	Language difficulties	145
9.2.2	Patient expectations	149
9.2.3	Cultural differences	150
9.2.4	Nature of health issues	151
9.2.5	De-registration	152
9.2.6	Use of A&E	152
9.3	Impacts of Migrants and Overseas Visitors on Primary Care	153

9.3.1	Demand for the service	153
9.3.2	Financial impacts	154
9.3.3	Quality of care	155
9.3.4	Impact on staff	156
9.4	The CCG View	156
10	RESPONSE TO THE PROPOSALS	160
10.1	Introduction	160
10.2	Overall	160
10.3	Contributory Principle	161
10.4	Health Levy	162
10.5	Compulsory Insurance	164
10.6	Pre-registration	164
10.7	Extension of Charging	167
10.8	Centralised Invoicing and Recovery	170
10.9	Ex-pats	172
10.10	Legal Gateway	173
10.11	Other Ideas Generated by Respondents	175
10.11.1	Culture change within the NHS	175
10.11.2	Active programme of communication about the possibility of charging	176
10.11.3	Regulatory framework and clarity	177
10.11.4	Systems	178
10.11.5	Border Force/Immigration	178
11	APPENDICES	180
11.1	Sample Details	180
11.1.1	Structuring the Sample of Trusts for the Scoping Study	180
11.1.2	Primary Care Practice profiles	188
11.2	Data	190
11.3	Research Materials	200
11.3.1	Letters of Authority	200
11.3.2	Expert briefing	204
11.3.3	Scoping study materials	207
11.3.4	Case study materials (Secondary Care)	215

11.3.5	Case study materials (Primary Care/CCG)	230
11.3.6	Diary	237
11.4	Approach to Analysis	238
Table 1:	Scoping study Trust sample profile	10
Table 2:	Case study Trust sample profile	13
Table 3:	Profile of respondents working in Primary Care.....	14
Table 4:	Numbers of chargeable patients falling into different categories and sums charged	43
Table 5:	Numbers of patients accessing secondary care within 4 and 13 weeks of arrival in UK.....	44
Table 6:	Full time equivalent size of OV team	53
Table 7:	Distribution of full time equivalent staff across pay bands	54
Table 8:	Establishing 'ordinary residence' status.....	61
Table 9:	Establishing if a patient is exempt from charging.....	65
Table 10:	Details of EHICs and Reciprocal Agreements	69
Table 11:	Number of patients determined to be chargeable.....	70
Table 12:	Number of patients that are charged but do not pay	72
Table 13:	Amounts being recovered	73
Table 14:	Current level of bad debt.....	73
Table 15:	Written off debt.....	74
Table 16:	Profile of segments across key variables	79
Table 17:	Estimates of the number of new patients being registered and indication of what proportion of new patients/patients on their list are migrants/from overseas.....	142
Table 18:	Trusts mapped onto the five key variables	184
Table 19:	Proportion in each cell based on a representative sample of 30 Trusts.....	184
Table 20:	Sample structure for 30 Trusts	186
Table 21:	Primary Care Practice profiles.....	188
Table 22:	Trust Data	191
Table 23:	Number of patients being asked about their exemption status per Trust pa by key variables	192
Table 24:	Number of patients being determined to be exempt per Trust pa by key variables	193
Table 25:	Number of patients being determined to be chargeable per Trust pa by key variables	194
Table 26:	Amount charged per Trust pa by key variables	195
Table 27:	Number of patients that are charged but do not pay per Trust pa by key variables	196
Table 28:	Sums recovered per Trust pa by key variables.....	197
Table 29:	Proportion of charges recovered per Trust pa by key variables.....	198

Table 30: Current level of bad debt per Trust pa by key variables.....	199
Figure 1: Overview of research programme	6
Box 1: Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment	3
Box 2: A segmentation of Trusts	11
Box 3: Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment	19
Box 4: Situations in which a patient may be classified as either OR or exempt and charged to the CCG.....	75
Box 5: Examples of systems and procedures being adopted in Trusts with a clear sense of direction	91
Box 6: Examples of systems and procedures being adopted in proactive Trusts.....	97
Box 7: Examples of good practice	100

The members of the research team would like to express our thanks to everyone who gave up their time to talk to us and share their views, to gather data and to help organise our schedules, often within very tight timescales. We hope that we have represented your views accurately and fairly. It has been a pleasure for us to work on this project and witness at first hand the dedication of everyone we have met.

1 Introduction

1.1 Background

The NHS provides a comprehensive service based on clinical need rather than ability to pay and is free to those who are 'ordinarily resident' in the UK. An overseas visitor and migrant charging system places a statutory duty on NHS bodies to make and recover charges for hospital treatment (only in NHS hospitals for secondary care) from non-residents, where no exemption from charge applies (see section 1.3 for an explanation of 'ordinarily resident' and definition of the terms migrant and overseas visitor). Charging rules do not apply in primary care and GP practices are free to register any person as an NHS patient, although this does not mean NHS hospital treatment is free.

There is widespread recognition that the system for charging those who use the NHS but are not eligible for free care is complicated, inefficient and does not provide the right balance of fairness and affordability.

The residency based nature of the NHS leaves it perhaps more exposed to use by those who should be charged but are not identified (often through no fault of their own) and intentional misuse by those who are able to come to the UK from countries with poorer health systems. Frontline staff are often either unaware that some people are liable for charging, or unwilling to identify them.

The NHS also has some of the most generous rules in the world, for example currently allowing free access to primary care for any visitor to the UK, including tourists, and free access to all NHS care for foreign students and temporary residents. Only NHS hospitals have a statutory duty to charge, and even then, emergency treatment provided in an Accident and Emergency (A&E) unit is free.

As part of the cross-Government work on migrant access to benefits and public services, the Department of Health (DH) is looking at how to address these significant weaknesses and failures in both the rules and their application. A public consultation was recently undertaken on how to do this.¹ The consultation asked for views on who

¹ http://consultations.dh.gov.uk/overseas-healthcare/migrant_access

should be charged in the future, what services they should be charged for, and how to ensure that the system is better able to identify patients who should be charged.

Data on migrants in the UK is limited, and in the area of NHS use, is minimal; that which exists is of very poor quality. Consequently, the NHS has no robust evidence on which either to base estimates of the amount of money spent on those who are not entitled to free treatment or to prioritise action to combat abuse. There is a need to gain an understanding of the extent of the problem, in terms of the numbers of people either accessing free services fraudulently, or because:

- they are not identified as chargeable
- even though identified as chargeable they fail to pay
- they are currently exempt but may not be in the future.

Creative Research was commissioned to conduct a programme of qualitative research to provide a basis on which the DH can work with the NHS to develop firm proposals for change. It will provide DH with a better understanding of how key NHS and other stakeholders perceive the challenges of visitors and migrants in their daily work, in particular, the priority given to them by frontline staff and their willingness to address the issues of identification and recovery of charges. It will also help DH to build a model of the extent of the cost to the NHS which will facilitate discussions with commissioners and providers and help incentivise the change in behaviours which the Government seeks.

1.2 Aims and Objectives

The overall aim of the research was to provide DH with a better understanding of how key NHS stakeholders perceive the issue of migrant and overseas visitor use of the NHS in England, by engaging with a wide range of clinicians in primary and secondary care as well as managers and administration staff across England. Its purpose was to build a detailed picture of current practices and procedures, and reactions to the proposed changes, whilst also looking into the scope of the issues and providing a basis from which DH can estimate the use of the NHS in England by different key groups. The findings, alongside findings from a quantitative modelling study, will feed into the consultation process and form a key component of the DH impact assessment to support policy changes.

1.3 Definition of terms

Legislation permitting persons who are not 'ordinarily resident' (OR) in the UK to be charged for NHS services dates back to 1977, and subsequent regulations, first introduced in 1982, impose a charging regime in respect of hospital treatment for overseas visitors². 'Ordinarily resident' is not defined but is a common law concept, which was the subject of a judgment in the House of Lords in 1982 in the context of the Education Acts, where it was defined as:

living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being, whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as "settled". (Source: see footnote 2)

The situation is complex when it comes to deciding in practice who is and who is not eligible for free NHS hospital treatment. What follows (see Box 1) is a summary of the situation for a number of different categories of people who may be living in the UK at any one time and who may or may not be eligible for free NHS hospital treatment other than emergency care provided within A&E. In practice, these distinctions can be very difficult to make on the ground.

Box 1: Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment

- 1. British nationals who have a right of abode and who live in the UK:** this will include immigrants and/or their descendents who have applied for, and been granted British citizenship.
- 2. Migrants with 'indefinite leave to remain' (ILR)** who are living in the UK on a permanently settled basis.
- 3. European Economic Area (EEA)³ temporary residents:** EEA nationals (and their family members) who are resident in the UK but have not yet acquired permanent residence in the UK. An EEA national has an initial right to reside in the UK for three months. They have an extended right beyond that if exercising 'EU treaty rights' as a worker, a self-employed person, a job-seeker, a student, or a self-sufficient person. Until an EEA national acquires 'ordinarily resident' status, they would be chargeable for their hospital treatment unless covered by an exemption under the charging regulations, e.g. they have an EHIC card or are students. In practice this means that most EEA nationals are entitled to free treatment.

² Source: www.parliament.uk/briefing-papers/SN03051.pdf

³ The European Economic Area (EEA) comprises the member states of the European Union (EU) plus Iceland, Liechtenstein and Norway. Switzerland has not joined the EEA, but has a similar agreement with the EU and as far as NHS services are concerned, Swiss nationals enjoy the same rights as nationals from EEA countries.

4. **EEA permanent residents:** EEA nationals who have been residing in accordance with the above conditions for five continuous years, at which point they acquire a right of permanent residence in the UK, which means they no longer need to exercise treaty rights in order to have a right of residence here.

5. **Non-EEA temporary residents:** people from outside the EEA (and their family members) who have been granted a right of residence for a limited period (usually between six months and five years). They may or may not go on to acquire ILR.

The above groups are all likely to pass the current 'ordinary residence test and therefore be entitled to free NHS hospital treatment.

6. **Asylum seekers:** anyone who has made a formal application with the Home Office to be granted temporary protection, asylum or humanitarian protection which has not yet been determined. Formal applications are those made under the 1951 UN Convention and its 1967 Protocol and also some claims made on protection from serious harm grounds under Article 3 of the European Convention on Human Rights. A person whose application for asylum (or humanitarian/temporary protection) is accepted becomes a refugee.

7. **Irregular migrants:** any non-EEA national who does not have immigration permission to be in the UK.

8. **British ex-pats:** British nationals (or other person not subject to immigration control in the UK) who is a former resident of the UK but who now lives overseas.

9. **Visitors:** those, of any nationality, who live overseas but are visiting the UK.

The above groups (with the possible exception of refugees) will not pass the current OR test, so are chargeable except where exemptions from charge in the Charging Regulations apply.

The focus of this research is on categories 3, and 5 to 9 and, as a group, they are referred to throughout the report as 'migrants and overseas visitors'.

The term 'migrant' is used throughout the report to refer only to 'temporary residents' and not migrants and/or their descendents who have applied for, and been granted British citizenship (category 1), migrants who have ILR (category 2) or EEA permanent residents (category 4). However, it should be noted that for the reason given above, NHS staff are unlikely to be able to differentiate between permanent and temporary EEA residents (categories 3 and 4).

The term 'overseas visitor' is used to refer to people who are visiting the UK on a temporary basis; this includes British ex-pats (unless they are returning to live in the UK on a permanent basis) as well as those of any other nationality who live overseas (categories 8 and 9).

This research is not concerned with private patients from overseas who are in the UK on medical visas for treatment.

2 Method and Sample

2.1 Introduction

This section of the report outlines the research method including how the sample was structured and drawn and the achieved samples.

2.2 Methodology

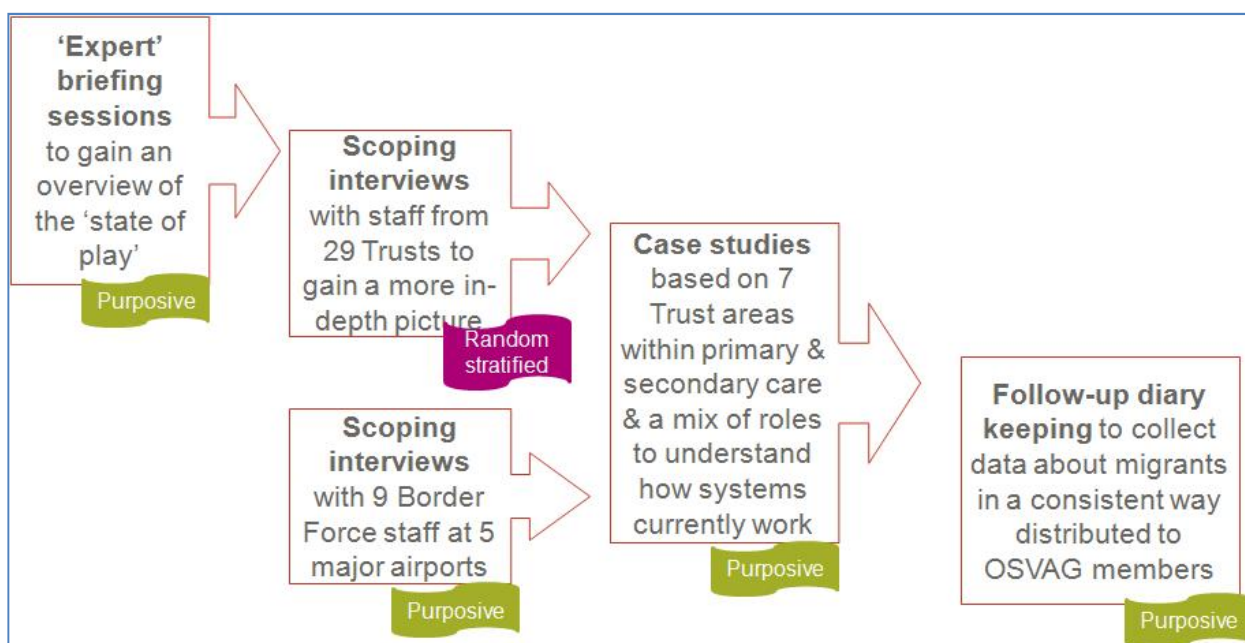
The research involved four components (see Figure 1):

- **expert briefings:** two briefing sessions with members of the Overseas Visitors Advisory Group (OsVAG)⁴ to begin to develop an understanding of where and how migrants and overseas visitors might present in different Trusts and the systems they have in place to identify and charge them
- **scoping study:** to gain a broader and more detailed picture
 - 29 telephone interviews with 36 respondents from a cross-section of Trusts. In each Trust, this involved one or more OVOs or others taking on this role, together, in one or two cases, with a more senior manager
 - five interviews with nine Border Force and Immigration Enforcement officers based at five major airports
- **case studies:** to develop a deeper understanding of the impact of migrants and overseas visitors in both primary and secondary care
 - seven Trusts involved in the scoping study were visited and a cross-section of staff, from clinicians through to front line staff, were interviewed face-to-face

⁴ The Overseas Visitors Advisory Group (OsVAG) is a group formed and run by Overseas Visitor Officers, Overseas Visitor Managers and other NHS staff working in the area of identifying and charging non-UK residents who are not entitled to free NHS hospital treatment. They meet at regular intervals to discuss current issues, exchange examples of good practice and listen to guest speakers. OVOs are members of staff who have the responsibility for implementing the overseas visitor hospital charging regulations. Some individuals fulfilling this role were 'managers' (OVMs) while others were 'officers' (OVOs) on lower pay bands. For consistency, throughout the report, the term OVO has been used.

- in each of these areas, two Primary Care Practices were visited and interviews conducted with a cross-section of staff; the Clinical Commissioning Group⁵ (CCG) was also invited to take part
- **diary exercise:** to collect data about the number of migrants and overseas visitors in a more consistent way; a ‘diary’ was distributed to all OsVAG members inviting them to keep a record of all patients brought to their attention over a two week period⁶.

Figure 1: Overview of research programme



2.3 Sample Structure, Recruitment and Sample Achieved

2.3.1 Expert briefings

Two workshops, each lasting some 2.5 hours, were set up and run at very short notice following the project inception meeting, with the aim of bringing the research team up to speed with the key issues. The sessions involved a purposive sample⁷ of OVOs based on participants in workshops that DH had run in 2012 as part of an initial review of the

⁵ Clinical Commissioning Groups are groups of GPs that are responsible for planning and designing health services in their area to meet local needs.

⁶ At the time of writing, the diary exercise was still on-going and the findings will be incorporated into a supplementary report.

⁷ A purposive sample involves the selection of participants who have knowledge or experience of the area being investigated.

issues. Each participant was emailed an invitation to attend one of two briefing workshops to be held in Leeds or London. Due to the numbers and location preferences of those responding and the need to organise the session at short notice, both workshops were held in London, with 11 OVOs from Trusts in London, the South East and East of England regions taking part. Participants were offered travel costs.

Copies of the research materials used during the Expert briefings can be found at section 11.3.2.

2.3.2 Scoping Study: Trusts

At the project inception meeting, based on what was known about the issues, it was agreed that the sample should take into account seven variables namely:

- Trust expenditure levels of expenditure are likely to correlate with patient numbers as well as the type/cost of treatment
- Specialisms (specifically, cancer, renal, maternity) anecdotal evidence suggested that higher numbers of migrants and overseas visitors may be accessing these types of services
- Proximity to international airport again, anecdotal evidence suggested that visitors who ‘fly in’ with the purpose of accessing NHS services are likely to present at Trusts close to major airports
- Asylum seeker dispersal areas in order to establish whether the presence of higher numbers of asylum seekers was having an impact
- Presence of A&E although emergency treatment in A&E is free of charge to everyone, OVOs had identified this as a potential pathway into a Trust for chargeable patients
- Urban/rural locations in order to establish whether the extent of use of NHS services by migrants and overseas visitors varies according to the type of location
- English regions to ensure the sample was geographically representative.

All 161 Trusts were mapped onto these variables and a random stratified sample⁸ of 30 Trusts was drawn. Details of how this was done are provided in the appendices (see section 11.1).

⁸ A random stratified sample involves the division of a population into smaller groups known as strata. The strata are formed based on members’ shared attributes or characteristics. A random sample from

The findings of a Home Office research project examining migrant composition and impacts at the local level became available shortly after the sample had been selected. It presents a local authority typology, classifying all local authorities within England and Wales into twelve discrete groups, on the basis of key migration and socio-economic indicators, including the different migrant types (e.g. workers, students) and nationalities of migrants they have recently received⁹. The twelve groups can be collapsed into three broader segments:

- **high migration clusters:** local authority areas that have migration rates that are well above the national average
- **moderate migration clusters:** local authority areas that have migration rates that are close to the national average
- **low migration clusters:** local authority areas that have migration rates that are below the national average.

When the selected sample of Trusts was mapped onto this variable, it provided a good approximation to the national profile of 161 Trusts (see Table 1).

Emails, along with a letter of authority from the DH, were sent to the OVOs at the 30 Trusts inviting them to take part in the research (see section 11.3.1) and were followed up with telephone calls by members of the research team. Ten Trusts, the majority based in the North West, declined to take part. Where possible, they were replaced with other 'like-for-like' Trusts (in terms of the key variables). Where this was not feasible, they were replaced with a Trust that matched on as many of the key variables as possible.

A short questionnaire was completed either during the course of the interview or afterwards although not all Trusts provided data for all questions. This was particularly true for questions about financial data. This information was not always available to OVOs, in some cases, because the invoicing of chargeable patients was outsourced and, in other cases, the data was held by colleagues in finance. Although OVOs were

each stratum is taken in a number proportional to the stratum's size when compared to the population. These subsets of the strata are then pooled to form a random sample.

⁹ Source: <https://www.gov.uk/government/publications/social-and-public-service-impacts-of-international-migration-at-the-local-level>

encouraged to ask colleagues in finance to supply the data, this was not always forthcoming. One Trust completed and returned the questionnaire but declined to take part in an interview; their data has been included in the analysis. Another Trust agreed to take part as a replacement, however, the interview was cancelled on three occasions by which point there was not time to find a replacement. Thus, the final sample was 29 Trusts taking part in the full interview and one Trust providing just the questionnaire data. Although the majority of the interviews involved just the OVO, on occasions, a second respondent was involved, such as another member of the OV team or a member of staff from finance. In total, 36 people took part in these interviews.

The following table (see Table 1) shows how the final sample profile compares to the profile of all Trusts across the variables used to structure the sample. Cells where the profile differs from the national profile by seven or more percentage points¹⁰ are shaded in green. These differences were largely a consequence of a number of Trusts declining to participate as it was not always possible to find a replacement that matched on all variables.

The main differences between the sample and the national profile (highlighted cells) were:

- a smaller proportion of Trusts located in one of the top ten per cent of asylum seeker dispersal areas and a correspondingly higher proportion in other areas
- a higher proportion of Trusts from rural locations
- a higher proportion of foundation and a correspondingly lower proportion of acute Trusts.

¹⁰ For a sample of 30, 6.7 percentage points represents 2 Trusts.

Table 1: Scoping study Trust sample profile						NB Low bases					
Expenditure		total	High	Med	Low						
All Trusts	N	158	53	53	52	Data for 3 Trusts unavailable					
	%	100	34	34	33						
Sample	N	30	9	10	11						
	%	100	30	33	37						
Asylum dispersal		total	top 10%	other							
All Trusts	N	161	44	117							
	%	100	27	73							
Sample	N	30	6	24							
	%	100	20	80							
Airport catchment		total	None	Long Haul	Euro						
All Trusts	N	161	79	47	35						
	%	100	49	29	22						
Sample	N	30	15	10	6	Total sample sums to 31 as one Trust was in the catchment area for both Long Haul and Europe					
	%	100	50	33	20						
Location		total	Metro	Urban	Rural	mixed					
All Trusts	N	161	63	47	36	15					
	%	100	39	29	22	9					
Sample	N	30	12	7	10	1					
	%	100	40	23	33	3					
Region		total	London	South East	East of England	South West	East Mids	West Mids	North West	North East	York & Humber
All Trusts	N	161	27	21	18	18	8	19	28	8	14
	%	100	17	13	11	11	5	12	17	5	9
Sample	N	30	5	4	4	3	2	3	3	2	4
	%	100	17	13	13	10	7	10	10	7	13
Migration Cluster		total	High	Mod	Low						
All Trusts	N	161	104	39	18						
	%	100	65	24	11						
Sample	N	30	18	8	4						
	%	100	60	27	13						
Specialisms		total	Found-ation	A&E	Cancer	Mater-nity	Renal				
All Trusts	N	161	100	145	111	138	97				
	%	100	62	90	69	86	60				
Sample	N	30	21	26	20	25	17				
	%	100	70	87	68	83	57				

A qualitative segmentation of the 29 Trusts taking part in a scoping interview (one Trust completed a questionnaire but did not take part in an interview) was arrived at in the light of the scoping study interviews reflecting differences in attitude and approach to the issue of identifying and charging patients ineligible for free NHS care (see section 5 for further details). This was used, in part, to structure the sample for the case studies (see section 2.3.4). The segments are summarised in Box 2.

Box 2: A segmentation of Trusts	
Segment	Characteristics
Less engaged Trusts	Trusts that either do not recognise the relevance of the issue of charging non-exempt visitors and migrants or have not put in place effective measures to tackle it.
Reactive Trusts	Often at an early stage in developing systems and seem to be waiting for very obvious patients to be flagged by frontline staff rather than reaching out to/training staff in the range of patients who are potentially chargeable. May feel they do not have the resources to respond in a timely fashion or follow up patients who do not respond to enquiries about status. However, they are often keen to have a more dedicated role and training themselves, in order to perform better.
Trusts with a clear sense of direction	Aware of their responsibility to follow the guidelines and keen to do this. While systems might not be fully developed, they are often ambitious in what they are trying to do. They are actively training and monitoring what staff are doing on the front line and responding to their alerts promptly. They are also more rigorous in their checking, and on occasion, blocking treatment if patients have not satisfied them that they are eligible for free treatment.
Proactive Trusts	Some of the most experienced OVOs who are continually developing the systems in their Trusts to make them more effective. A few were also reaching out to primary care to improve relationships.

2.3.3 Scoping study: Border Force/Immigration Enforcement

Interviews were conducted with nine members of Border Force and Immigration Enforcement at five major UK airports; six members of staff were visited at two airports and the remaining three were interviewed over the telephone. Interviews lasted between 45 minutes and two hours. All the airports were international and while not all had long haul flights, incoming flights connected with hubs in Europe for long haul destinations. The main purpose of these discussions was to build some understanding of staff perceptions of 'health tourism' at their port of arrival, any measures for tackling it (including the level of contact with primary and secondary care), responses to the proposals for change and any other ideas that might be helpful.

Copies of the discussion guides, the questionnaire and the stimulus materials used in the scoping interviews can be found at section 11.3.3.

2.3.4 Case studies

The intention behind a qualitative case study design was to select purposively cases of interest and relevance to the research and capture the range and variation of practice within this.

Trusts

Seven of the 30 Trusts were selected as case studies. The aim was to select a purposive sample of Trusts drawing three from the 'proactive' segment and two each from the 'clear direction of travel' and 'reactive' segments. The 'less engaged' were not included as they were doing the least to address the issue and were judged to have very little to offer. In addition to selecting on the basis of the three segments, the aim was for the final sample to provide a good spread across the other variables, such as level of Trust expenditure, geographical location, etc., as far as this was possible (see Table 2).

The OVOs from the nominated Trusts were contacted to obtain the agreement of their Trust to take part. It proved difficult to persuade 'reactive' Trusts to participate and the final sample comprised three 'proactive', three 'clear direction of travel' and one 'reactive' Trust.

Discussions were held with the OVOs within each case study Trust in order to identify the various departments and members of staff who might be involved. The aim was to include a mix of the following categories of staff:

- members of the Overseas Visitor team
- a senior Finance manager
- clinicians
- nurses
- frontline and back office staff responsible for registering patient details.

On the basis that the OVOs were best placed to know what was happening in their Trust, together with the very short time period in which the work had to be completed, the OVOs were asked to nominate staff from a range of different departments including those who were more receptive to their work as well as those that were less receptive. This meant that the departments covered varied from one Trust to the next to reflect

local conditions. OVOs then arranged for one of the research team to meet with the various members of staff during the course of a visit to their Trust.

Table 2: Case study Trust sample profile										NB Very low bases	
Expenditure		total	High	Med	Low						
Sample	N	7	4	1	2						
Asylum dispersal		total	top 10%	other							
Sample	N	7	2	5							
Airport catchment		total	None	Long Haul	Euro						
Sample	N	7	5	1	1						
Location		total	Metro	Urban	Rural	mixed					
Sample	N	7	2	3	1	1					
Region			London	South East	East of England	South West	East Mids	West Mids	North West	North East	York & Humber
Sample	N	7	1	1	1	2	1	-	1	-	-
Migration Cluster		total	High	Mod	Low						
Sample	N	7	5	1	1						
Specialisms		total	Found-ation	A&E	Cancer	Mater-nity	Renal				
Sample	N	7	5	6	5	6	4				

Across the seven Trusts, a total of 69 members of staff took part in the case study interviews:

- 12 members of the OV team
- 13 clinicians
- 18 frontline and back office staff.
- 8 Finance managers
- 18 nurses

Respondents came from a range of departments/clinical areas including:

- Maternity
- Outpatients
- Renal
- Finance.
- A&E
- Trauma/orthopaedics
- Cardiology

The OVOs were sent a more detailed questionnaire in advance of the interview and asked to either complete it in advance or, where this was not possible, return it after the

interview. Copies of the questionnaire and the discussion guides used in the interviews with members of staff are provided at section 11.3.4.

Primary Care Practices

Within the geographical area of each of the seven Trusts, two Primary Care Practices were selected to take part in the research. Apart from a small number of Practices that were suggested by Trusts, the selection was random although a degree of self-selection was involved as not all the practices that were approached agreed to participate.

A researcher visited each practice and respondents were interviewed in whichever way best met the needs of the practice. This meant some staff members were seen individually or in pairs while others were seen in small groups. A small number of interviews were conducted by telephone when a member of staff was unavailable on the day of the visit.

Across the 14 practices, 62 members of staff took part in the research including GPs, practice managers, deputy practice managers, practice nurses, reception managers and reception staff, administration and secretarial staff and, in one case, a family health worker (see Table 3).

Table 3: Profile of respondents working in Primary Care						
base: 14 Primary Care Practices						
GP	Practice Manager/ Deputy	Practice Nurse	Reception staff	Admin/ Records/ Secretarial	Family health worker	Total
16	16	11	16	2	1	62

The practices varied in terms of their size and the profiles of their patients. A summary is provided at 11.1.2. and in Table 21. There was considerable variation between practices, including those from the same case study area. This reflected differences in the demographics of their catchment areas as well as differences in a practice’s registration policy; for example, whether they registered patients of no fixed abode (NFA).

Clinical Commissioning Groups

The Clinical Commissioning Group (CCG) in each case study area was contacted by

email and telephone and invited to nominate someone to take part in an interview. Despite several reminder calls and emails, only three decided to take part¹¹. Of these, one took part in a face-to-face interview and the other two took part in telephone interviews.

Copies of the discussion guides used with Primary Care Practices and CCGs are provided at section 11.3.5.

2.3.5 Diary exercise

It was clear from the 'expert briefings' and the scoping interviews that each Trust was dealing with the issue of chargeable patients in a different way and the data that was being captured also varied. The aim of the diary exercise was to gather data on the numbers of patients being brought to the attention of OVOs in a more systematic and robust manner. It was also clear that not all OVOs had access to financial data concerning the amounts being invoiced and recovered. In some cases, this was because this was handled by colleagues in Finance but also because some Trusts outsource this. Also, as many Trusts were not raising invoices until a patient was discharged, there was often a considerable time delay between a patient being identified as chargeable and an invoice being raised. There may also be a further delay between an invoice being raised and it being paid. For these reasons, the diary focused on the number and type of patients being brought to the OVOs' attention and did not address the question of how much these patients might be charged.

In essence, the diary involved OVOs recording over a two week period in July/August the number of potentially chargeable patients brought to their attention. For each patient, as far as they were able to do so, they were asked to record:

- age and gender
- nationality
- date of entry into the UK
- category of migrant/overseas visitor

¹¹ CCGs only became fully operational on 1st April 2013 and they may have had other priorities.

- whether the patient was, in fact, chargeable
- their pathway into the Trust (e.g. GP referral, Outpatients, etc.)
- which hospital services the patient requires (e.g. Maternity).

A copy of the diary was distributed by OsVAG by email to all of its members inviting them to take part (a copy can be found at section 11.3.6).

2.3.6 Timescales

The timescales for the research were challenging. All of the fieldwork for, and analysis of, the Expert Briefings, Scoping Study and Case Studies were completed in a three month period covering June to August 2013.

2.3.7 Operational issues

As noted in the preceding sections, a number of operational issues were encountered in drawing the sample; specifically:

- the Expert Briefings consisted only of OVOs from London, the South East and East of England
- a lack of cooperation/engagement from some Trusts based in the North West with respect to the Scoping Study
- a lack of cooperation/engagement with some of the 'reactive' Trusts with respect to the Case Studies with the result that there was only one case study for the four regions covering the North of England and the West Midlands and two case studies in the South West.

It is difficult to know what impact these issues had on the findings other than they may not be representative of all Trusts across the whole of England. It is likely that those Trusts who are currently doing least to address the issue of migrants and overseas visitors were underrepresented. Amongst other things, this might suggest there are more 'less engaged' and 'reactive' Trusts than the research findings suggest (see section 5). It is also difficult to know how this might impact on the numbers of chargeable patients being identified and charged. Some Trusts may be doing less simply because their services are accessed less frequently by migrants and overseas

visitors. Alternatively, the reason they currently identify relatively few chargeable patients may reflect the resource and effort they are currently allocating to this task. There is some evidence from this research that where a Trust has increased this resource and effort, larger numbers of chargeable patients have been identified.

2.3.8 Quotations

Verbatim quotes have been used extensively throughout the report to illustrate the findings using respondents' own words. Occasionally, the quotes have been edited to aid comprehension or to bring together related points from different parts of an interview. This is indicated by the use of square brackets. Some of the interviews involved more than a single respondent and where there is a change in speaker, this is shown by the use of '...' at the end of the first speaker's contribution and at the start of the next person's contribution. Questions and comments made by the researcher are shown in bold. Each quote is given an attribution to identify the role of the respondent e.g. OVO, nurse, practice manager etc; the detail of roles including the seniority of individuals has not been included to protect respondents' anonymity. In the case of Trusts, the attribution also includes the segment they have been allocated to (e.g. proactive, clear direction of travel, etc) and a Trust, Primary Care Practice and airport identifier (e.g. *T1, PC2a, airport 3*). The Practice identifier corresponds to the Trust taking part in the case study exercise. Thus, Practice 20a is one of the two Primary Care Practices visited in the locality of Trust 20.

It should be noted that individual Trusts have not been identified where more detail is given about the procedures they have adopted (in 5.4 and 5.5) in order to help protect their anonymity.

The quotes are based on the individual respondents' understanding of the rules and regulations in relation to migrants and overseas visitors; these may not always be correct. They also reflect the individual's perceptions and personal views.

2.4 Interpreting the Data

This is a qualitative study which means the opinions of a relatively small number of people have been explored in considerable depth. The researchers used a topic guide to ensure that the relevant issues were covered, they also followed up particular points to ensure the point being made was understood, and they may also have explored relevant points that were made by the respondent. In some circumstances it may not have been possible to cover everything in the guide; the team had to work around the availability of staff members. The views of different

respondents from the same Trust or Primary Care Practice have also been used to 'triangulate' the findings. With a few exceptions, answers were not recorded in the form of tick boxes or head counts since the aim was to explore the range of opinions expressed rather than to 'measure' how many respondents had expressed a particular view. One reason for this is that people do not always express their answers in such black and white terms. Another reason is that it is not possible to explore every single issue in every single interview. Some issues may only have arisen in certain interviews.

In analysing the data (see section 11.4 for an outline of the analysis procedures followed), one of the things that has been looked for is where there is a consensus of opinion or a similar view on an issue and this is expressed using language such as 'all', 'most', 'widespread', 'widely held', 'many people', etc. However, it is also important to look for the range and variety of opinion that is expressed; these might be opinions offered by just 'a few' respondents as well as those opinions mentioned by 'some' of the sample (i.e. more than a 'few' but less than 'many'). It is also useful to report things that may only be mentioned by one or two people if these seem to offer relevant and insightful observations. This would normally be made clear by stating something along the lines 'one respondent said...'

It should be noted that the use of terms such as 'most' or 'few' etc relate only to the sample under consideration, such as 'most of the OVOs that took part in the scoping interviews', or 'most of the Primary Care Practice staff', and should not be taken to imply 'most of the OVOs or Primary Care Practice staff members in the total population' i.e. across all Trusts/Primary Care Practices.

The report also contains data provided by Trusts during the scoping study and the case study interviews about the numbers of patients being screened and identified as chargeable as well as the amounts being charged and subsequently recovered. Estimates were also provided by Primary Care staff about the number of patients they were registering and what proportion of these might be migrants and overseas visitors. **Although these data are presented in numerical form, they are still qualitative in nature.** In many cases, the numbers are respondents' best 'guesstimates'. Where tables of data have been provided, these display the number of Trusts/Primary Care Practices they are from, the range of values and, where appropriate, the overall total.

Typically, the range of values provided for any measure was very wide. In part, this reflects the fact that each Trust has attempted to tackle the issue in its own way. In the case of financial data, it is also because the cost of a single treatment can vary between a hundred pounds or so, to hundreds of thousands of pounds. Another reason for the variability in the data is that the number of OVOs able to provide answers to particular questions also varied widely. In the case of the Primary Care Practices, the variation often reflected the local demographics of their catchment area.

For the purposes of completeness, the data provided by the Trusts is sometimes shown broken down according to key variables. This means that the base sizes are even smaller and the data should be treated with great care.

The findings in this report should be read as indicative of the broader picture in terms of the range and diversity of practices being adopted across Trusts and Primary Care Practices in England. They also highlight examples of 'good practice' and provide insights into the practices and procedures that differentiate between the 'proactive' Trusts, those with a 'clear direction of travel' and those classed as 'reactive' and 'less engaged'. Nevertheless, great care is needed when trying to generalise to the wider population of Trusts and Primary Care Practices.

3 Categories of Migrants and Overseas Visitors

3.1 Introduction

To facilitate discussion about migrants and overseas visitors accessing NHS services, seven categories were outlined (see Box 3). Five of the main categories were further divided into a number of sub-categories. These groupings were explored and validated during the ‘expert briefing workshops’ and then used in subsequent interviews. They include patients who are eligible for free NHS care and those who are not.

Although there was considerable overlap in the perceptions and experiences of those based in primary and secondary care, of each category of migrant and overseas visitor, their views are summarised in separate sections to ensure a clear picture is provided. The interviews with immigration officers focused specifically on the issue of ‘health tourism’ and their views are set out at the end of this section.

Box 3: Categories of people living in the UK who may or may not be eligible for free NHS hospital treatment

European Economic Area (EEA) temporary residents		
students	workers	self employed
job seekers	economically inactive who do not have a right of residence as a family member	economically inactive who are state pensioners in another country
Non-EEA temporary residents		
students	workers	self employed
resident on another basis e.g. staying with family		
Asylum seekers		
Irregular migrants		
illegal immigrants	failed asylum seekers	overstayers
absconders	those applying for leave to remain	
British ex-pats		
visiting the UK		returning to live in the UK
Visitors who fall ill unexpectedly while temporarily in the UK		
EEA nationals (with and without an EHIC)		Non-EEA nationals
Visitors who ‘fly in and fly out’ (sometimes referred to as ‘health tourists’)		

3.2 Awareness and Understanding of Terms

3.2.1 Trusts

During the case study interviews a number of respondents¹² were asked if they were aware of the difference between a migrant and an overseas visitor, as well as whether they knew which categories were potentially chargeable.

Overall, there was a good appreciation of the difference between a migrant and an overseas visitor but less certainty over who is chargeable.

“An overseas visitor I would assume, was somebody that planned a visit from overseas and they are here for a term. A migrant I would think is somebody who had come to live here. As far as I’m aware anybody who has lived here less than a year we should be charging for them, that is my understanding.” (Nurse, Reactive, T12)

On occasion, members of frontline staff whose job it is to carry out the initial screening were poorly informed. For example, an outpatient receptionist felt that anyone who is not a UK citizen was chargeable.

“Migrants, I’m a bit fuzzy on that, it’s a bit of a grey area whereas overseas visitors, you class it as anyone who’s lived outside the country for the past 12 months, they’ll be classed as overseas visitor. [] Yes I understand that because both England, Scotland, Wales and Ireland we can do that, Northern Ireland and the Isle of Man are exempt for us as well because we always charge them but they’re actually exempt for us, so I understand...”

...So anyone who doesn’t come from those countries?...

...Yeah is chargeable.” (Reception/Administration, Reactive, T12)

Later on in the interview, he described visiting ex-pats as being entitled to free NHS care.

“The British ex-pats, we do see quite a lot of them especially because I’ve been on ECG last year. The pacemaker people, they come back. The pacemaker gets checked every 12 months so they’re coming back for that. They can probably get it checked in Spain but they want to come back and have it done here...”

...So what’s the situation as far as you’re aware with those patients, are they chargeable or not?...

...I don’t think they were but I haven’t been told any different, that’s the only problem.” (Reception/Administration, Reactive, T12)

¹² This was not explored with members of the OVO team or those from finance.

The majority of respondents indicated that they had some appreciation of the issue of eligibility for free healthcare and if they had any concerns about a patient, they would bring it to the attention of the OVO. Some of the clinicians, while aware of the issues, expressed the view that it is not something that they tended to concern themselves with.

“Well, all I can say from my own practice, is that there is quite a large number of overseas people over here, and I suspect a significant proportion of them are not here legitimately. I had a patient, an Eastern European, the other day who gave a false name but, as a person, like I said before, it’s just not on my radar to think of this as an issue for me to look at.” (Consultant, Clear direction, T10)

A widely held view among respondents other than OVOs was that if a patient has an NHS number, they are entitled to free care.

“I think people who have a GP with an NHS number really don’t get questioned at all. [] Most staff will say they’re entitled to treatment.” (Consultant, Proactive, T20)

“It’s interesting actually because I can remember at a bed meeting having a conversation about a particular patient and there was discussions around whether they were eligible for treatment or did they have to pay. Every single person who was there discussing it was of the opinion that if they were registered with a GP and had an NHS number they must be eligible for care...

...So what sort of mix of staff would that be?...

...That would be your Ward Managers, quite Senior Nurses, so quite a senior level were part of that discussion. It was not long ago.” (Matron, Reactive, T12)

A number of other issues around awareness and understanding sometimes arose during the course of an interview including:

- knowing what the boundary was between a dependent of someone who is a non-permanent resident and a family member who is visiting; anecdotally, respondents were often aware of relatives being brought to the UK in order to gain access to free healthcare but when challenged, were being told either by the patient themselves or a member of the resident family, that the relative is living with their family on a permanent basis. There were also examples of British men bringing non-British girl friends/wives into the UK expecting to be able to access treatment, such as maternity

“What we have had quite a few of lately I would say, is men who have married women from abroad, bringing them here thinking that they will get free treatment and they don’t and then the men get very stroppy.” (Midwife, Clear direction, T29)

- issues relating to visas
 - the difficulty of understanding all the different categories of visas and what these mean in terms of entitlements
 - not being sure what the passport stamp, ‘no recourse to public funds’, means; some respondents (including some of those in primary care) assumed the stamp means the individuals are not entitled to free NHS care
 - not always appreciating that there is no requirement for pre-existing conditions (especially pregnancy) to be declared when the patient applies for a visa.

3.2.2 Primary care

While there was a reasonable level of understanding of the terms ‘migrant’ and ‘overseas visitors’ among staff working in primary care, there was limited awareness of which patients are chargeable in secondary care. GPs, Practice Managers and CCG representatives tended to be better informed than other members of staff.

“Migrants are people who live here, who have emigrated to here and the other ones are just visiting.” (Practice partner, practice manager, nurse & receptionists, PC12b)

“I don’t deal with things like that...”

...I wouldn’t feel confident knowing that at all...

...No, I wouldn’t either.” (Practice partner, practice managers, nurse & receptionist, PC20b)

“I think I probably do, but I may be wrong. An overseas visitor is here from overseas, come temporarily, on holiday or on visa, and I would understand migrant being a more permanent term; somebody who is staying in the country longer term.” (CCG representative, 18)

This state of affairs reflects the fact that they do not need to know about a patient’s status, other than to establish if they should register them as a temporary or permanent patient.

“Once they are registered with us, as far as we are concerned, they are NHS patients and we will treat them as such. Our job is to be the clinician, not to do anything else.” (Practice partner, practice manager, nurse & receptionist, PC24a)

Indeed, the view was often expressed by respondents that all the guidance they have received from DH, the Primary Care Trust (PCT)¹³/CCG and from professional bodies, such as the British Medical Association (BMA), was that they should **not** ask the questions that would allow them to classify patients in this way.

“I’m interested to just find out from you whether you feel you’ve got a good understanding of what’s meant by migrant or overseas visitor?...”

...No...

... Probably not necessarily no, because we wouldn’t consider that that would be part of the receptionist job. I know that we are front of line but we have had so many over the years as you know. We’ve had asylum seekers, we’ve had people who have been in the country illegally, and overseas visitors, how do you classify that? We don’t know. But occasionally the girls do say, ‘well, if you’re working here, can we photocopy your work visa?’ But again, it’s not something really we should be asking for...

...Unless there’s a clear guidance that you can ask those questions, if you’ve got the backup and the documentation to say that you’re supposed to, but we’ve actually been told ‘don’t do that.’” (Practice partner, practice managers & reception manager, PC20a)

There was also a degree of resistance on the part of some respondents in terms of getting involved in identifying patients as being migrants or overseas visitors.

“I think as a clinician I do not want to be having to get involved, I think there needs to be clear rules, so we know where we stand. So that we know what we are allowed to do for people and we know what we are not allowed to do for people, according to rules that somebody else says. And then I want to treat the patient, because we don’t have time to be getting involved in the ins and outs of people’s rights and not rights.” (Practice partner, PC13a)

A CCG representative commented that the situation is not helped by the use of different definitions in primary and secondary care.

“The current definition that is used in the NHS Primary Care is ‘normally resident’, which doesn’t quite match those definitions and then there’s a different definition used for secondary care [‘ordinarily resident’], and this, I think, is one of the difficulties the NHS have at the moment. It doesn’t distinguish between what is happening in primary care and what is happening in secondary care.” (CCG Representative, 10)

¹³ On April 1 2013, Primary Care Trusts (PCTs) ceased to exist. Their functions have been taken over by clinical commissioning groups (CCGs) and local area teams.

3.3 Categories of migrants and overseas visitors being seen

When it came to establishing if a patient is 'ordinarily resident', exempt from charges, or chargeable, in most cases Trusts involved in the research were not systematically capturing data at the level of the various categories. Nevertheless, all of the categories were recognisable and respondents reported coming across all or most of the main categories, albeit in varying proportions.

*"I think I've seen somebody in each of those categories in the last seven days."
(OVO, Clear direction, T5)*

In the case of primary care, respondents reported that they were not screening patients other than in terms of their identity and address, so it was difficult for them to know which categories their patients fell into. Nevertheless, respondents recognised the different categories and were able to provide anecdotal evidence about them.

"It's difficult really because we treat everybody the same, they fill in an application form when they join us and as long as we get the right information we don't then question them as to which person they are on a list!" (Receptionist, PC10b)

The numbers of patients seen within each category varied and was dependent upon a range of local factors such as the level of tourism, the opportunities for casual employment, and the demographics including the numbers of minority ethnic residents. Within secondary care, it also varied according to the department/clinical area in which individual respondents were based.

"We do get a lot of Eastern Europeans and that's a regular thing, so every Monday morning, especially after the weekend, we will get inundated with calls from the hand clinic. [] But I think that is just directly connected to the sort of clinic it is, so it's hand injuries. We get a lot of builders, a lot of carpenters, we get a lot of people that do kitchen work. So we have specific trends like that in terms of those injuries." (OVO, Proactive, T20)

Given the lack of data on the numbers of patients falling into each category, what follows is largely based on estimates and experience, although in the case study Trusts, the views of the OVOs were largely backed up by the experiences of colleagues, and in primary care, there was also a consensus across the different members of staff.

3.4 EEA Temporary Residents and their Families

This category includes students, workers, the self-employed, job seekers, economically inactive migrants who do not have a right of residence as a family member, and economically inactive migrants who are state pensioners in another state.

3.4.1 Trusts

For many Trusts in the sample, this category of patients represented a key and growing challenge, in particular, the influx of patients from Eastern European countries. These patients are, in most circumstances, not chargeable; however some Trusts reported that they were struggling to cope with the increasing numbers and see this category as presenting the biggest challenge.

“Well, first of all, it’s the Eastern Europeans have definitely overloaded our antenatal, without a doubt, absolutely crowded with them. Now you probably won’t believe me but there can be a clinic, three or four clinics a week and it is full of Eastern Europeans.” (OVO, Clear direction, T1)

The key sub-categories being seen included students, workers, the self-employed and those seeking work. OVOs reported that those in work often represented a significant challenge when it came to establishing their status as they may be paid cash in hand and either staying with friends or renting a room in a house which meant it could be difficult for them to provide the necessary proof of working status and residency.

“Most of them rent rooms from friends so we can’t establish whether they are, you know. They just get a hand written letter or they get written references from people that they work for, clean their houses.” (OVO, Proactive, T21)

One OVO pointed out that the situation is not made any easier by different bodies having different regulations.

“They are really, really difficult to try to resolve because of the way Immigration runs compared to the regulations in the hospital. It doesn’t run side by side and it doesn’t make sense. You’ve got Immigration that somebody from the EU can be in the UK legally for three months without working, without being sufficient, but for the NHS regulation, you have to be here for a period of time working etc., to exercise your treaty rights. So it doesn’t add up, you know, we are saying one thing and Immigration are saying a completely different thing and they should run side by side and they don’t. So it’s really difficult but they have got three months to sort themselves out for Immigration rules, but not for the NHS.” (OVO, Clear direction, T17)

In at least one Trust, EEA temporary residents may have their treatment charged to their European Health Insurance Card (EHIC)¹⁴ if they have been in the UK under 12 months. The mere fact the patient has presented an EHIC was being taken as an indication that they were not planning on staying long enough to qualify for OR status.

“Right, so even if somebody is ‘ordinarily resident’ so they’re exempt as you say, would you still put it through the portal if they did have an EHIC?”

...Less than 12 months I might, yes, because once they’re 12 months, they’re ‘ordinarily resident’ aren’t they, but I could until then...

...It depends on that bit really, how do you classify ‘ordinarily resident’? If they’ve provided the EHIC, they’re not ‘ordinarily resident’ because they’ve provided the EHIC, so they obviously think that they’re visiting because otherwise you would say, ‘I live here’. And quite often, if you look, as you say, at the amount of time, you know, generally they’ve only been in the country for a month or so and there’s things they’ll put on the form, a leaving date, so you know they are only planning on being here for a few months.” (OVOs, Clear direction, T29)

Some Trusts reported that they would reclaim charges via an EHIC if the patient was having difficulty establishing their OR status, for example, if they were being paid cash in hand.

EEA temporary residents who are economically inactive (and who do not have a right of residence as a family member) are potentially chargeable as they are required to be ‘self-sufficient’. Some Trusts in the sample were endeavouring to identify such cases.

“I think we generally take a bit of a harder line and we say that actually, if you can’t provide evidence for example, that you’re supporting yourself, if you’re over here, if say for example, you’ve come over from the EEA and you are here for longer than three months and you haven’t got a EHIC and it’s not sort of the need for those treatments, then we will ask for documentation.” (OVO, Proactive, T20)

However, this was not a sub-category that was always recognised by OVOs and therefore not something they were looking for.

“I’m not aware of that...”

¹⁴ The European Health Insurance Card (or EHIC) is issued free of charge and allows anyone who is insured by or covered by a statutory social security scheme of the EEA countries and Switzerland to receive medical treatment in another member state for free or at a reduced cost, if that treatment becomes necessary during their visit. It does not cover people who have visited a country for the purpose of obtaining medical care, nor does it cover care which can be delayed until the visitor returns home. It only covers healthcare which is normally covered by a statutory health care system in the visited country, so it does not render travel insurance obsolete.

...No, that's not something we're particularly going into, I've got to say." (OVO, Reactive, T3)

In some cases, there was confusion over the definition of 'economically inactive'; it was sometimes interpreted as non-working spouses of economically active migrants or migrants seeking work and/or claiming benefits.

"I am seeing a lot of patients who are not partaking into the UK economic system but actually drawing from it." (OVO, Clear direction, T15)

When the sub-category was explained, OVOs were sometimes unsure how they would identify them.

"No I don't think we have ever actually come across one of those and I'm not sure how we would identify that..."

... Yes it would be quite hard to identify...

... We might have come across them. It might just be that we've overlooked them because I'm thinking, how would we be aware of that?" (OVO, Clear direction, T23)

Economically inactive migrants who are state pensioners in another state are required to have an S1 form; however, as the following quote illustrates, not all OVOs in the sample were aware of this requirement (the respondent only learned about it from a recent OsVAG meeting), nor are the patients themselves.

"I'd understood about when the UK state pensioner goes to Spain and then they come back, I got that far, but I hadn't appreciated the other way that actually there are European nationals that are coming to live in the UK and that they should then register the S1 with the Department of Work and Pensions. We had three in last year that I'd actually realised that they're here to permanently stay and I've asked for the S1 document. Because of their age, they should be state pensioners in their own country, and they look at me blankly as if they haven't got a clue what I'm talking about so I actually couldn't tell you whether or not they've registered it or not or if they did and just call it something different, I don't know." (OVO, Clear direction, T10)

One OVO commented that the difficulty lies less with the patients and more with the country of origin taking a long time to issue them.

"What I've found is they're happy to go and get this S1, that's not a problem, it's being able to access getting the S1. They find that the countries of origin aren't happy to issue, don't like it, you know." (OVO, Proactive, T21)

It is worth noting that, unlike an EHIC which should be presented every time a patient requires treatment, an S1 would only be presented when the patient first registers with a

GP. This may explain why some OVOs have not come across them (but not why patients appear to be unaware of them).

3.4.2 Primary care

Respondents in primary care tended not to differentiate between EEA and non-EEA temporary residents; anyone residing in the country as opposed to visiting on a temporary basis would be registered as a patient irrespective of their country of origin.

Both EEA and non-EEA temporary residents and their families were being seen by all practices in the sample albeit in varying proportions. One Practice estimated that migrants made up a third of its list, another put it at around 20 per cent while another put it at around seven per cent.

“About 20 per cent of our population at least, if not more, fall into that category, i.e. from different countries who have come over.” (Practice partner, practice managers, nurse & receptionist, PC20b)

Reflecting the situation found in many Trusts, Practices taking part in the research often reported seeing large numbers of patients from Eastern European countries.

The patients can be very transient especially where they are employed in seasonal work. They may move around the country according to the demand for such work, as well as moving backwards and forwards between the UK and other countries. Some practices spoke about workers arriving ‘en masse’, often registering at the same address.

“There’s a lot of Eastern Europeans, [] and at certain times of year, they come and they’re all living in the same house because it’s almost like gang bosses, they bring a certain amount of people over. They transport them to the salad factory and the chicken factory and they come to work and then they go back and then there’s another lot about six months later. So it’s the same address but there’s different people.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

One practice employed a Czech receptionist and, as a result, had registered a large number of Czech patients. In at least two other practices, they had employed a member of a local migrant population to help them meet the challenge of treating the patient group (receptionists from Poland and Somalia).

3.5 Non-EEA Temporary residents and their Families

This category includes students, workers, the self-employed and residents 'on another basis', such as staying with their family.

3.5.1 Trusts

This category was evident in many Trusts in the sample but especially those with diverse local ethnic populations.

Some respondents reported seeing large numbers of students from local schools, colleges and universities accessing a range of services such as A&E, trauma and orthopaedics and general medicine. Students, and partners of students, were also accessing maternity care and, in some cases, IVF treatment.

*“Fertility treatment, we have actually had examples of that where we’ve had patients that have actually requested fertility treatment and then have obviously had to provide evidence to the consultant to see whether they’re entitled to that, given that it’s a non-immediately necessary, so we’ve had a couple of those.”
(Reception/Administration, Proactive, T20)*

Where workers are employed on a casual/cash in hand basis, OVOs reported that they may experience the same difficulties they have with EEA temporary residents in establishing their OR status. They also reported seeing large numbers of family members, including spouses and parents, who may have moved to the UK but equally who may just be visiting. In some cases, such as elderly relatives, they may require extensive/complex treatment because of their age. There were also anecdotes of family members coming to the UK on annual visits and using the occasion to have a check-up or access treatment. These cases were considered by some OVOs difficult to tackle especially where the Trust is based in an ethnically diverse local community. It could be difficult identifying those family members who are not eligible for free treatment because they will claim to be residing permanently at the address of a family member, they may have been registered with a GP and, occasionally, they may present fraudulent documents, such as somebody else’s passport.

“They’re registered with the friendly GP. Friendly GPs are very useful in that situation.” (OVO, Less engaged, T25)

On some occasions, members of NHS staff will try to get access for visiting family members by claiming they are residing with them and entitled to free healthcare.

3.5.2 Primary care

See section 3.4.2.

3.6 Asylum Seekers

It was noticeable that the term ‘asylum seeker’ was often used when, in fact, respondents were talking either about ‘failed asylum seekers’ or ‘refugees’; the former group falls into the ‘irregular migrants’ category (see section 3.7).

3.6.1 Trusts

Overall, respondents did not report seeing very large numbers of asylum seekers and, where they were seeing them, it was often reported that they were relatively easy to deal with once they had ‘leave to remain’ (i.e. they were refugees) because they would be able to provide the necessary documentation.

“Yeah, the legitimate ones bring all the documentation with them. You know, they’ve got it all. And it’s very easy to deal with. The ones which aren’t legitimate are the ones you have to do a bit of digging with and find out.” (OVO, Less engaged, T25)

The difficulty with this category was during the period when their claim was being considered because they should not be working and the documents they provided could be of poor quality; for example, a photocopied A4 sheet provided by UK Border Agency (UKBA)¹⁵ with hand written details. Moreover, while an ARC (application registration card) records the date the application was made, there is nothing to show when it is valid until and the cards were not taken away when the application was unsuccessful. Some OVOs in the sample reported that failed asylum seekers would use their ARC as a means of trying to access free healthcare.

“Well they’re very good at presenting their IND cards [sic] and they are often very outdated so we can even have ones that are still being presented from 2006/2007 so they don’t get updated very frequently. If it’s years old we will check whether it’s still being processed or it’s actually been refused or not...”

...Do you find very many of them are out of date?...

¹⁵ On 1 April 2013 the UK Border Agency was split into two separate units within the Home Office: a visa and immigration service and an immigration law enforcement division. However, most respondents continued to refer to it as the UKBA and this is reflected in the report.

... Yes, yes actually they're still presenting their IND cards [sic] but they've actually been refused asylum and they're actually chargeable." (OVO, Clear direction, T23)

3.6.2 Primary Care

Some respondents reported seeing a few asylum seekers but they were not seen in large numbers even where a practice was located close to an asylum seeker centre.

3.7 Irregular Migrants

This category includes illegal immigrants, failed asylum seekers, overstayers, absconders and those applying for leave to remain.

3.7.1 Trusts

Although they may not represent the largest patient group, for a number of Trusts taking part in the research, irregular migrants represented the greatest challenge in terms of the amount of time it can take trying to establish if they are chargeable and, once this has been established, recovering the cost of treatment.

"I don't think we've ever had payment from a failed asylum seeker and again overstayers, the problem is once they're discharged. For an overstayer, once they're discharged, you're likely to lose contact with them." (OVO, Clear direction, T23)

The numbers being seen varied from Trust to Trust within the sample; the following quote is from a Trust for whom irregular migrants represented the single largest category of chargeable patients; typically men of working age. Others were seeing fewer overall but nevertheless perceived it to be a problem.

"I would probably say, at a guess, if we are looking at a percentage, I would say probably 20 per cent of all the patients that we bill are visiting on holiday for example and don't have insurance. I would say the other 80 per cent are generally here either illegally or overstayers and are now applying for leave to remain.[] Often it's essentially fit healthy males I think that come here for treatment or have been working here and have fallen unwell, the two tend to go hand in hand." (OVO, Proactive, T20)

It can take considerable effort on the part of the OVO to understand their circumstances, especially where there is a language barrier and/or the OVO needs to liaise with UKBA.

"If we have to deal with the UKBA, or Home Office now, sorry. If we deal with them, and have to get clarification from them, it can just take..."

...Is that simply just because they're not very responsive?...

...Yeah. We go through one route and that is to email through the NHS.net the official form asking for information and, you know, it can take up to ten days to get an answer when obviously we haven't got that ten days to wait if a patient says they haven't got their passport or they've lost their passport." (OVO, Proactive, T21)

The patients often lack any medical history; they may have unknown mental health issues and/or require costly treatment for urgent or complex conditions. They are often homeless and it may prove difficult to discharge them, resulting in them living in the Trust and bed-blocking; two Trusts reported having a homeless irregular migrant who had lived in the Trust for months.

There were reports of people overstaying their visitor visa who, when told they will be charged for their treatment, apply for leave to remain. Although they are still chargeable while their application is pending, they often refuse to pay. If they are then granted leave to remain, they argue they are entitled to free healthcare and still refuse to pay. If their application is rejected, they may well appeal, dragging the process out even more.

"I'll tell you one, people come in on a visit visa, they end up having treatment and then while that is ongoing, they apply for leave to remain. This is a big one, this is. They apply for leave to remain, they are still chargeable until they get leave to remain, so quite a few months. All that time they are carrying on with their treatment." (OVO, Clear direction, T1)

Some Trusts involved in the research were also concerned that they may face legal action if they declined to treat such patients.

Moreover, Trusts knew that these patients were not going to be able to afford to pay for their treatment and OVOs will have to spend a lot of time chasing up non-payments. They often will not have an address to which to send an invoice and the patient may leave or be discharged before an invoice has been raised.

"The problem is, a lot of them don't give you an address so you've only got a name so really you haven't got anything to go on. Sometimes they just take up the bed space for about a week or two weeks, they go and you never see them again and you can't invoice them because there's no address to send it to." (OVO, Reactive, T22)

3.7.2 Primary Care

A number of respondents commented that in many situations they would not know whether or not a patient was an irregular migrant.

“I think sometimes it would be hard to know if somebody was an irregular migrant because if they have got a tenancy agreement, private landlords, things like that, they can gain documents that we need to see for evidence of identification. I think that’s quite a hard one really, no one’s going to say, ‘well yeah, I’m not supposed to be here but I need to see a GP’, are they?” (Practice partner, practice manager, nurse & receptionists, PC12b)

“I’ve not seen any irregular migrants. Obviously I don’t think they come clean! So I probably have but I didn’t know!” (Practice partner, practice managers, nurse & receptionist, PC20b)

One Practice had a strict policy whereby they not only insisted on the patient providing documentary proof of both identity and address, they would only register patients who could prove they had been residing in the UK for at least the last six months. As a consequence, they had very few overseas visitors and migrants on their list.

“I think because we’ve not really encouraged false registrations, we don’t really get that many people making enquiries. I think we only had one last year who was turned away, even though he attempted to register several times, but generally we don’t get them.” (Practice manager, PC10b)

In contrast, some Practices in the sample were willing to accept patients of no fixed abode (NFA) and may not insist on patients providing any form of identity. One Practice spoke about accepting referrals from asylum seeker and refugee support groups. Another spoke about pressure being brought to bear to register such patients by local inclusion groups.

“She came under a lot of pressure from something called the social inclusion team who we have in [town], who are responsible or who support a lot of immigrants, migrants, asylum seekers. They put a lot of pressure on the Practice to register the patients, even though we knew that they were registering with a false date of birth, the Home Office had said that this wasn’t this person. So it’s not just the patients, it’s other organisations who are putting pressure on primary care, social organisations, to register patients who may not be entitled to care.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

3.8 British Ex-pats

This category includes those who are visiting the UK (and are currently chargeable) and those who are returning to live in the UK (for whom NHS care is free).

3.8.1 Trusts

Ex-pats were seen by most Trusts taking part in the research. Some may be coming to the UK to access healthcare for chronic conditions and/or costly treatments while younger ones may come over to access maternity services. While some claim to be

returning to live in the UK, the suspicion is that many return overseas once they have accessed the treatment. It can be difficult to identify those who are non-returners as they are often still registered with a GP, have an NHS number and use the UK address of a relative and it may only be a chance remark that leads to further investigation.

“With the ex-pats obviously, because they’re probably registered and have quite an old NHS number, and we do have quite a few people who live either in France or in Spain and they can pop backwards and forwards and that’s quite difficult because if there is an address here and they have, as I said, an old NHS number and an old hospital number as well, and still register with the same GP then that is, you know, that is quite difficult to pick up.” (OVO, Proactive, T28)

Moreover, the patients themselves are often unaware that they are chargeable, and can strongly resent the idea when it is brought to their attention.

“One of the issues that I do have is people who class themselves as British nationals and they’ve been out of the country, or if they are in the Forces, and they do take great exception to being asked the question, to having to provide evidence because they can’t get over the fact that they are British nationals and they have a British passport.” (OVO, Clear direction, T15)

Simply asking basic screening questions can therefore cause problems and some staff preferred to avoid it.

3.8.2 Primary Care

The situation in the Primary Care Practices largely mirrored that in Trusts; respondents recognised this as a category but found it very difficult to prove that a patient was visiting as opposed to returning. Indeed, it could be difficult to even identify them as ex-pats.

“They’re on our list and they kind of turn up, not always quite at the right time for their reviews but vaguely, and come in and have their review and all these other bits and pieces, and they vaguely mention that they’re going on holiday again and they kind of talk about that they’re retired and they have six week holidays but they don’t really talk about the fact that they live there. That’s a huge problem because it’s really, really hard to find that out.” (Practice manager & receptionist, PC18a)

Examples were given of family members coming in with repeat prescriptions and, when told the patient needs to be seen (for example, for a review), being told they are ‘on holiday’.

“Then they go back to their own country and then the daughter will come, bring the prescription and repeat it and send it back to the father. When you ask, ‘I want to see your father’, ‘he’s gone on holiday, he’ll back in two months’ time’

and then you find out they're still not back because they've gone to stay in their own place.” (Practice partner, practice managers, nurse & receptionist, PC20b)

“It's quite common for people to ring up and request their medication from abroad as well. People that say they're out of the country and can they have their medication? I've had that quite a few times downstairs....

...Or they just request a medication, the family drop in a request. They're abroad and then eventually they catch us up because we have a medicines review and that's when you catch them up. They'll turn up for their medication.” (Practice partner, practice managers & reception manager, PC20a)

3.9 Visitors who Fall Ill Unexpectedly While Temporarily in the UK

This category includes visitors from EEA countries, with and without an EHIC, as well as visitors from non-EEA countries.

3.9.1 Trusts

Most Trusts in the sample reported seeing a proportion of tourists and holiday makers with and without various types of cover.

“More often than not, they don't travel with insurance and then they get a huge shock when there is a bill for £2,000 to £5,000 and then it's, 'I'm sorry, I can't pay!'” (OVO, Reactive, T11)

It was perceived by some respondents that visitors from the EEA sometimes believe that freedom of movement equates to free access to NHS services.

“There seems to be this real lack of understanding and communication around this European Health Insurance thing. We go abroad from the UK, we wouldn't dare go without your EHIC card, 'yeah, you've got your EHIC card, you'll be fine'. People coming into the UK don't seem, and I mean from my experience over recent years, hardly any of them have an EHIC card.” (OVO, Clear direction, T5)

“I find quite a lot of the European ones will say, 'oh, I haven't got a European Health Insurance Card because my friend told me that the NHS is free', and I get quite a lot of 'the NHS is free'.” (OVO, Reactive, T14)

Where a patient does not have an EHIC, it may be possible for them to apply for a Provisional Replacement Certificate (PRC)¹⁶; however it can take several weeks for the card to arrive.

“When somebody is here just visiting family and they've been absolutely upfront, 'I'm from wherever, and I've come to visit my son for six months', they have

¹⁶ A Provisional Replacement Certificate (PRC) provides the same access to free healthcare as a European Health Insurance Card (EHIC).

absolutely no idea about an EHIC card. Then you have to give them details of the provisional replacement card which then takes another 28 days to come through, it takes absolutely ages.” (OVO, Clear direction, T17)

Some OVOs reported taking steps to help such patients apply for a PRC.

“What I normally do, I’ve got a best practice where I’ve got printouts of every country’s European Health Insurance Card because if there’s a language barrier and I don’t always have time to wait until the interpreter comes, I normally go and see them. And, if a nurse in charge allows me to go and visit them if they are well enough, I’ll just like show them a printout and say, ‘from Finland’ and normally they’ll recognise the card and they’ll point to the badge or whatever or the wallet and I’ll be able to get the card out and get the details then. If not, I’ve also got printouts of all the provisional replacements, if they give addresses. So say for example, someone is from Belgium, [] we have all different areas and it will have like the addresses and this is where a patient can get the EHIC from. So what I do is, I get them to point out the actual address where they live so I can marry them up where their district is and then I contact that district straightaway. So I contact Belgium direct, even though the patient is supposed to do it, I just take it upon myself to do this, I’ll email the details and they send a provisional replacement certificate straight out.” (OVO, Reactive, T12)

One OVO reported that patients from Eastern Europe often have never heard of EHICs. She estimated that the proportion of A2 and A8¹⁷ patients she comes across with an EHIC card is very low; five to ten per cent at most.

“I interview a lot of Eastern Europeans, Latvian, Lithuanian, Poland and as I said to you last week, I got my first Lithuanian EHIC and I’ve been here nearly three years. Most patients haven’t even heard of it or if they have, they are telling me that they haven’t heard of it.” (OVO, Proactive, T13)

One of the issues in relation to EHICs was when a person was not entitled to an EHIC in the home state as they had not paid a sufficient contribution. One OVO reported that if they try to get a PRC, they often get a letter back saying that the patient cannot have one because they are not insured in their country.

“I had a Polish lady today who told me that she’s only been here four weeks and I said, ‘you need your EHIC’ and she goes, ‘to get my EHIC I have to go back to Poland and start paying into the health system there which I didn’t pay for before and then come back with it’.” (OVO, Proactive, T24)

Several OVOs in the sample commented that visitors from EEA countries sometimes present a UK EHIC and they were concerned that this might mean the card had been

¹⁷ A8 countries: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia.
A2 countries: Bulgaria, Romania.

obtained under false pretences and that the people concerned would then return home and access healthcare which they previously would not be eligible for, with the cost being met by the UK taxpayer.

“We’ve had people who have come in the country one day, GP appointment the next day, been referred to hospital on the third day and they have even come in and supplied a UK EHIC on the fourth day. [] The rest of Europe have to pay into their own country’s insurance policy which is what generates their EHIC card, if you don’t pay into it, you don’t get one. In this country, all you need is an NHS number or a national insurance number. Well, as soon as you go and see a GP, you will automatically get an NHS number within 24 hours. So you’ve got that number, you type that in online and within a week you’ve got your UK EHIC and you have not even lived here two weeks and you’ve got it already. So even if you can’t get free treatment here because you can’t prove it, you can go off to Spain or just get on the ferry and go to France and have as much treatment as you like and we’ll have to foot the bill.” (OVO, Proactive, T24)

“We have a lot of situations where people who are not entitled to free NHS treatment because they can’t provide the documentation to show they are resident here, are providing me with a UK EHIC card. From my understanding, they can use that in any other EU country and charge the UK back for treatment, but they can’t have treatment in the UK. How do you explain to somebody that that is our system at the moment and we allow that to happen?” (OVO, Proactive, T27)

It was also reported by some respondents that they have come across visitors from EEA countries without EHICs who, when they are told they are chargeable, may ‘change their story’ and claim they have come to live/work in the UK.

“And so we had the whole thing about they’ll bring their EHIC and that’s fine but actually, if they’re not entitled to an EHIC or they haven’t got one, then it makes it quite difficult for them...”

... Yes. So what do you do?...

... Well, in the past we couldn’t do anything because they were still automatically eligible because they came from Europe. We now do say to them they may well be charged and this is where it does become quite difficult because suddenly their status will change because they’ll then say they’re working or they’re doing something else.” (OVO, Clear direction, T29)

“Their family all come to stay with them for a holiday and as soon as you have someone who doesn’t have an EHIC card who, you know, it tends to be a right saga every time. They don’t want to pay the bill, ‘well, why should they pay the bill, we’re living here?’ And all of a sudden, when they come into hospital they say, ‘I’m just here visiting my family for a holiday’. By the time they’ve left, they know they’re going to get a bill, ‘oh well, I’m living here’. And we’ve then got to go through the whole saga of ‘prove it’ and then they can’t prove it and it all ends up getting messy, there’s letters flying back and forward and we’re billing them, and they refuse to pay.” (OVO, Clear direction, T5)

Another reported issue that could result in confusion and/or difficulties for OVOs was where visitors have EEA country passports but are resident in non-EEA countries; they may not have travelled to the EEA country and therefore not got an EHIC. For example, one OVO reported an issue with patients on a Portuguese passport who were in fact from Goa; another example was someone from Somalia travelling on a passport from the Netherlands. Similarly, another Trust had to deal with a patient from the United States with dual nationality claiming to be an EEA national.

There were also examples of visitors from non-EEA countries travelling to the UK without health insurance because they had heard that the NHS 'was free'. The following quote relates to an American tourist who was trying to access healthcare without insurance.

"I said, 'in your system you need insurance and things so you should be aware of charges for healthcare'. And they said, 'oh, but our system's really unfriendly'. 'So's ours when you're not eligible!' And yeah, then they were really very disgruntled, very unhappy and both my colleague who was with me at the time, and myself were sworn at and given quite a lot of abuse because we suggested that he pay." (OVO, Clear direction, T29)

3.9.2 Primary Care

Depending on their location and/or the local demographics, some Practices taking part in the research were seeing large numbers of tourists and/or people coming from abroad to visit families. For example, a London Practice had developed a relationship with a number of hotels and as a result received lots of visits from tourists. They had developed a walk-in system for emergency cover for their registered patients and had been horrified when they were told by the PCT/CCG that they had to offer this service to anyone visiting their Practice. As a result, they are inundated with demands from overseas visitors. They often have arguments with such patients as to what constitutes an emergency (e.g. patients who forget to bring medication with them) but since reception staff cannot assess what is and is not an urgent case, this takes up a large proportion of the GPs' time.

3.10 Visitors who 'Fly In and Fly Out'

3.10.1 Trusts

Although widely recognised, this was not a discrete category as it was perceived to overlap with most of the other categories. It was seen as including relatives of EEA and

non-EEA temporary residents, self-sufficient EEA temporary residents, ex-pats and people travelling on visitor visas. In many cases where OVOs had suspicions, it was difficult for them to prove that the patient was coming to the UK with the express intent of accessing healthcare.

Occasional examples were provided of non-EEA visitors who will attempt to access free treatment but when challenged, have the means to pay for their treatment.

“Well, they come prepared because they know if they can get away with it they will, but if they’ve got to pay then they have got the money or the cash or the card.” (OVO, Clear direction, T1)

Many OVOs in the sample were able to cite examples of cases where they felt the patient had travelled to the UK with the explicit intention of accessing free healthcare for a pre-existing condition:

- patients arriving with serious pre-existing conditions who claim they have ‘suddenly fallen ill’

“The person involved was wanting to have an elective procedure and she’d only been in the country four weeks and it related to something that was a condition that was before she applied, before she’d arrived in the country but she hadn’t divulged it when she’d applied for a visa.” (OVO, Clear direction, T5)

“Again it’s that timing thing. But that’s quite a big thing, it’s quite a difficult one to prove. But yes, to be honest we’re actually investigating one at the moment that just came up. They arrived in the country and then went to a walk-in centre within two to three days and has been sent for bowel cancer screening. So it just seems a bit strange.” (OVOs, Clear direction, T29)

This led some OVOs to question why such individuals were not identified at the point of applying for their visa.

“The cases we had, the mother’s come here on a visitor’s visa and my question is how the visa was given and they were allowed to come to the UK, knowing that they were pregnant and had a scan that the child would be born with a certain condition that would require a very expensive treatment because it’s not available within their country. So how can the Home Office fail to recognise that that mother came automatically to receive NHS care?” (OVO, Proactive, T6)

- pregnant women who claim to be residing in the country who, when challenged, have travelled on a visitor visa

“So you’ll get somebody coming to Maternity, this is a good example, this happens quite frequently, so they’ll say ‘oh yeah, I’m living here’ and we’ll say ‘how long have you been in the country?’ They’ll say, ‘oh six weeks’. And we’ll go

then and check them out and they're here on a visit visa, so they're here on a six month visit visa, no recourse to public funds, no right to NHS treatment. And then we'll go back and if the treatment hasn't started we'll bill them upfront, before their treatment starts they'll have to pay that bill." (OVO, Clear direction, T5)

- patients who have travelled to the UK on numerous occasions to access healthcare

"Some people we've captured that they may have had their baby here say twice, in two years and we have caught them on the third time and we've made them pay...

...Because they are going home in between times?...

...Yeah. Well when you get their passport you can see their pattern. So we always ask them to bring in their passport rather than them sending like a copy, we ask them to bring in the passport." (OVO, Clear direction, T4)

- family members living overseas who regularly visit relatives in the UK and use the opportunity to access free healthcare

"People who are living here who are from different countries who actually have a British passport now but their family are based abroad. Their family comes in here to have different procedures or outpatients appointments mainly, but because they are family, they think that they can come in and have that treatment if their son or daughter is based here." (OVO, Reactive, T7)

"What they would do was come over on a six month visit visa every year, stay with their sons, daughters. They'd already registered with the GP locally, had an address, had an NHS card and what they would do was come in and go to the diabetic clinic, go to the podiatrist, get everything sorted out and then make a new appointment for 12 months time when they came back. And they were literally going through the systems as NHS patients because they were registered with the local GP, with the local NHS, had an NHS card and, you know, the question was never asked and we sort of came about this by accident more than anything else but we don't get any of those people coming in now...

...Because you've put a stop to it?...

...Because we started charging them." (OVO, Clear direction, T5)

- patients on student visas who are not attending college

"And so we have had a few cases where we've gone back to the college they're supposedly attending to say 'does this person actually attend?' And they've registered but they don't actually go. So we've had a few of those..."

...And what are they doing here, are they working?...

...Probably getting pregnant. Because that's the sort of background of the story, 'I've got this visa but I'm now seeking maternity care', and then you look into it

and actually they weren't attending the college in the first place." (OVO, Clear direction, T29)

"Yeah, I think there're a number of people coming on student visas who aren't actually a student. And if we asked them to provide evidence that they are actually studying, regardless of the NHS number, if we were doing it legitimately and properly, I think you would find there is a lot of people using maternity services while on a student visa and aren't actually studying. So they've used the visa to get over here and the entitlement for free treatment, but the reality is they've come to have the child." (OVO, Less engaged, T25)

- patients who are brought in by NHS staff members; for example, a clinician had been involved in a case where the father was being treated for cancer in his own country and the son (an NHS employee) arranged for him to come to the UK and present at A&E. Although they tried to claim he had suddenly taken ill, the patient had significant pressure sores and was clearly seriously ill. It took a lot of work to resolve the situation as the son tried to argue that his father was entitled to NHS treatment. Various respondents raised this as an issue; two examples are provided below.

"We are net importers of doctors these days, we import a lot of doctors from abroad. If I was a doctor from abroad and my parent needed treating, yes, 'come and stay with me and register with the local GP, we'll get you a number, we'll sit it out for a bit and then we'll get you some treatment, get you the heart surgery you need' or whatever." (Consultant, Reactive, T12)

"The one thing we do experience and we are trying to put a stop to, is we get doctors bringing relatives in. And that sometimes can cause a little bit of a problem..."

...Are these hospital doctors or GP's?...

... Yes, hospital doctors...

... Yes three or four times we've had that, yes. They can just bring them in the back door sometimes...

...Yes, so they're aware that strictly speaking they shouldn't be doing this are they, the doctors?...

...I don't know if they're aware of it, I don't know if they think it's a perk but, you know, we always do catch them." (OVO, Reactive, T3)

3.10.2 Primary Care

Just as in secondary care, respondents recognised this category of visitor but felt that there was nothing they could do about them other than provide emergency care or register them as temporary patients. Similar examples were cited including women who

are 36 weeks pregnant when they arrive in the UK or those who are here 'on holiday' only to 'suddenly' develop renal failure.

"I had one yesterday that had had an ear infection, been seen abroad and the doctor said that she needed an operation. She wasn't willing to pay over there, so came back and came in and asked me to do a referral for it." (Practice partner, practice manager, nurse & receptionist, PC24a)

"Although I do have a background suspicion about the numbers who, looking at the names of our patients who are currently pregnant, there's a very heavy non-English name dominance. So whether there is some maternity tourism and 'come and get a job so I can have my babies and then go back home', I don't know, but I wouldn't be at all surprised." (CCG representative, 29)

3.11 Numbers of Chargeable Patients falling into each Category

Most Trusts taking part in the research were not collecting data by these categories. For this reason, the case study Trusts were asked if they could provide a breakdown of their chargeable patients according to whether they were:

- visitors from the EEA (e.g. those without an EHIC)
- visitors from non-EEA countries
- British ex-pats
- visitors who 'fly in' and 'fly out' (so called 'health tourists')
- irregular migrants

They were also asked if it was possible to provide a breakdown of the total amount of money their Trust had charged these patients. Four of the seven Trusts were able to provide a breakdown for the last three financial years and the data are set out in Table 4.

For these four Trusts between 2010/11 and 2012/13, visitors from non-EEA countries accounted for nearly two-thirds (512/816; 63%) of chargeable patients and three-quarters (£1,209,316/£1,611,165; 75%) of the sums charged. Visitors from the EEA represented almost a quarter (188/816; 23%) of all chargeable patients, although they only accounted for 14 per cent of the sums charged (£226,924/£1,611,165). In contrast, 'irregular migrants' and 'ex-pats' represented small numbers. Visitors who 'fly in and fly out' were, in most cases, not being identified for the reasons given above (see section 3.10.1). The 'other' category was made up of chargeable patients that OVOs were unable to classify.

Table 4: Numbers of chargeable patients falling into different categories and sums charged						NB Very Low Bases
base: case study Trusts able to provide data						
	Year	n	total no. of patients	range	total amount charged (£k)	range
Visitors from EEA	12/13	4	62	0 to 55	£47,491	£0 to £33,415
	11/12	4	60	0 to 55	£111,690	£0 to £103,587
	10/11	4	66	2 to 48	£67,743	£8,555 to £32,931
Visitors from non-EEA	12/13	4	166	2 to 81	£365,705	£9,316 to £213,121
	11/12	4	166	3 to 90	£329,789	£27,401 to £172,978
	10/11	4	180	4 to 107	£513,822	£16,374 to £276,907
British ex-pats	12/13	4	7	0 to 5	£5,674	£0 to £3,326
	11/12	4	9	0 to 5	£7,253	£0 to £5,583
	10/11	4	6	0 to 5	£3,574	£0 to £2,758
Irregular migrants	12/13	4	12	0 to 12	£8,682	£0 to £8,682
	11/12	4	13	0 to 12	£20,511	£0 to £20,216
	10/11	4	31	0 to 26	£42,030	£0 to £34,472
Visitors who 'fly in & fly out'	12/13	4	0	-	£0	-
	11/12	4	0	-	£0	-
	10/11	4	4	0 to 4	£43,765	£0 to £43,765
Others	12/13	4	9	0 to 5	£7,583	£0 to £5,728
	11/12	4	16	0 to 12	£14,227	£0 to £8,473
	10/11	4	9	0 to 5	£21,626	£0 to £17,355
Total	10/11 – 12/13	4	816	0 to 107	£1,611,165	£0 to £276,907

As noted above, anecdotally, OVOs were very aware that some patients are 'flying in and flying out' after accessing healthcare, however, this can be very difficult to prove. Conversely, OVOs were often unaware that economically inactive EEA migrants may be chargeable and felt this was also something that was difficult to prove. Another way of exploring the question of how many patients might fall into the category of visitors who 'fly in and fly out' is to look to see how many patients access secondary care services shortly after arriving in the UK. One of the case study Trusts had started to collect data about when patients arrived in the UK. This revealed that in 2012/13, out of 157 patients charged, the date of arrival was recorded for 116 of them and was unknown in 41 cases. Out of the 116 patients, 69 (59%) had accessed treatment within three months of arrival and, of these, 43 (37%) had accessed treatment within four weeks of their

arrival¹⁸. The largest category of patients accessing secondary care within four weeks of their arrival in the UK was non-EEA nationals (26% of all chargeable patients; see Table 5).

Table 5: Numbers of patients accessing secondary care within 4 and 13 weeks of arrival in UK								NB Very Low Base			
base: a single case study Trust											
	All patients		EEA		non-EEA		Ex-pats		Irregular migrants		
	n	%	n	%	n	%	n	%	n	%	
within 4 wks	43	37	12	10	30	26	1	1	0	0	
within 13 wks	26	22	8	7	16	14	1	1	1	1	
after 13 wks	47	41	20	17	18	16	0	0	9	8	
total	116	100	40	34	64	55	2	2	10	9	

3.12 Clinical Areas being Accessed

During the scoping study, OVOs were asked if they could identify any key clinical areas where migrants and overseas visitors were more likely to be found. Not all Trusts were able to break down their data in this way although most were able to provide an indication of the more frequently accessed areas. Not surprisingly, this covered a wide range of clinical areas, although three tended to be mentioned more frequently, namely Maternity, A&E, and Trauma and Orthopaedics. Other clinical areas mentioned included the following but this is by no means an exhaustive list:

- cardiology
- oncology
- stroke
- general medicine
- ophthalmology
- termination of pregnancy
- gynaecology
- renal
- transplant

The point was made that for some clinical areas, such as dialysis or transplant, the issue is not the number of chargeable patients who may be accessing a clinical area and not being identified because the cost of treating just a single patient can be very high, for example, the cost of a transplant could be £200,000 to £300,000. One Trust had had two instances of chargeable patients being given transplants. In the first case, the patient was an emergency referral from another Trust who, at the time of referral was confused and unable to communicate. His condition meant a transplant was needed within 72 hours of admission. Only subsequently did the Trust discover he was

¹⁸ These values need to be viewed in context; the majority of overseas visitors will be staying for no more than six months.

an 'overstayer' and the patient did not have the means to pay for his treatment. The second case was known to be ineligible however, the clinician decided to operate anyway and the patient then left the country and the cost was never recovered.

Case study Trusts were asked if they could provide a breakdown of their chargeable patients according to which services were accessed most frequently, as well as the amounts being charged. Three of the seven Trusts reported that they were unable to do so. The other four Trusts provided data but there was little overlap in the most frequently accessed clinical areas. The exception to this was for maternity care where all four Trusts provided data on the sums charged during 2012/13. The total amounts being charged and the proportion this represents of all charges raised in the Trust to chargeable patients across all areas are shown below:

- £166,762 out of £230,383 (72%)
- £248,555 out of £835,215 (30%)
- £3,477 out of £24,280 (14%)
- £20,241 out of £171,156 (12%).

Once again, one of the most striking things is the variability between these four Trusts.

3.13 Experiences of Immigration Officers

'Health tourism' is not currently one of the priorities for immigration officers at UK airports and its investigation relies a great deal on the personal interest of individuals and teams. Some years ago the issue was given greater focus after recognition of the large numbers of women from West Africa in particular, who were flying into the UK heavily pregnant with the aim of delivering their babies here but other issues, such as drugs and people trafficking, have pushed it down the list. Any data gathered as part of one-off exercises to assess the extent of the challenge is now some years old.

However, one officer estimated that 50-60 per cent of passengers coming through a particular non-EEA control where passengers are processed more quickly are likely to use the NHS whilst in the UK because of the apparent state of their health and the length of their planned stay.

In the absence of recent data, much of the information provided by these participants was based on anecdote but those anecdotes were based on experience and there was a high level of consistency between officers' accounts, and with those of OVOs. What follows summarises the range of cases that are seen but does not provide any indication of the volume of such cases.

Bearing in mind that immigration officers are only able to question non-EEA passengers, the main examples of migrants and overseas visitors identified are:

- Pregnant women, sometimes with health conditions themselves (e.g. sickle cell anaemia) or with other complications, typically claiming to be at an earlier stage in their pregnancy than is the case. They may come to the UK for successive pregnancies.

"We get people in the height of summer wearing a big coat, or holding a coat in front of their tummy and they are just coming for a week's shopping apparently. Clearly at 33 weeks that's what you want to do, isn't it? Jump off a plane and then go down Kensington High Street." (Border Force/Immigration, airport 3)

"Now I've had referrals from our front line saying 'I have got this pregnant woman here, she's eight months pregnant'. Ideally, what we are told is the airlines won't carry a woman over six months unless she has a doctor's certificate. So they conceal it. So the officer says 'I have this seven to eight month pregnant woman here'. So I go back and I check the visa application. She was obviously three, four, five months pregnant when she applied for the visa. So I contact the visa office and I say 'this woman here is very pregnant. She was four or five months pregnant when she applied for the visa. Do you not ask her if she is pregnant, or has any medical condition?' 'No, we are not allowed to ask that question'." (Border Force/Immigration, airport 5)

"Sometimes they will come back for their second and third baby. Sometimes they will quite blatantly say 'I'm coming because the care is better. I'm having twins, triplets, blah, blah, blah'. And once they are here, if they are assessed to be a certain gestation, then we are stuck really." (Border Force/Immigration, airport 3)

- Pregnant women with a British partner or whose partner is resident in the UK
- Women returning with babies/children for routine inoculations/other NHS treatment
- Students and ex-students who have retained their NHS card; they or their dependents may have chronic health conditions and once receiving treatment in the UK may claim they cannot return home. The former would be exempt from charges.

“But then they’ll say, ‘hang on, I can’t go back to my country because I’m having treatment here, I’m continuing treatment’. So their leave gets extended because they’re having treatment here. But they’re only having treatment because they needed it because they’re here as a student.” (Border Force/Immigration, airport 1)

“We might have a 28 week pregnant student who has come in to study, with twins, and quite clearly isn’t going to do that either, so it’s a bit of a loophole. The dependents as well. You could have a genuine student with a wife and child, or husband and child with medical problems travelling on a dependent visa, and they can access it that way.” (Border Force/Immigration, airport 3)

- Elderly non-EEA relatives of people resident in the UK who may be in the UK on visas that can last up to five or even ten years; it was noted that when asked, they may mention their son or daughter works for the NHS. Immigration officers may look more carefully at such visitors who stay in the UK for nearly six months, leave the country for a short time (e.g. a day trip to France) and re-enter for a further period of 180 days.

“If they say, ‘oh yes, I’ve got high blood pressure’, ‘okay, do you have blood pressure tablets to cover the period that you’re staying here?’ ‘Oh my son will pay if I need more, my daughter will pay if I need more’. Sometimes you go on and ask, ‘what does your son or daughter do in the UK?’ ‘They’re a doctor, they’re a nurse’. You do find that a lot.” (Border Force/Immigration, airport 1)

“Then of course we get the older people that we encounter. We had a woman coming back, ‘I’m here to have my hearing aids fitted. I’ve had my teeth done on the NHS, I’m here to pick up my hearing aid now’. You get a mixture of people coming in who have availed themselves of NHS services as someone ‘ordinarily resident’ in the UK and it just goes on from there.” (Border Force/Immigration, airport 5)

“If someone is here for six months and only spends a week out of the country and then they’re here for another six months, nothing to say that they can’t do that but they’re obviously needing medical treatment. If you’re a pensioner you’re more likely to need support.” (Border Force/Immigration, airport 4)

- People who lived and worked in the UK in the ‘50’s and ‘60’s but are based back in their country of origin now, visiting family still resident in the UK.

“It could be somebody coming on a family visit who is a regular traveller. They always comply; they always come for three months, four months, five months and leave and that’s what the entry clearance office will look at. On issuing a visa they will say they are travelling, they have complied with the terms of their visa, so we don’t have problem there, so we are okay. But we might look at somebody coming, they might come regularly twice a year for a three month period each time but they are of an age where they might have something wrong with them.” (Border Force/Immigration, airport 3)

“They might be on a buggy, so they might have health issues which would alert us. They are coming for six months, ‘do you have enough medication with you?’; ‘No’; ‘Okay, what will you do?’; ‘I’ll go to the doctor.’; ‘Okay; have you...?’; ‘Yes, I had my knee done last time I was here’. (Border Force/Immigration, airport 3)

- People on visitor visas who decide/need to access treatment while in the UK (not necessarily the elderly); they may be from countries with very good health systems but which are costlier to access

“Most of the others are probably visitors, as in not elderly particularly, could be any age who come as visitors and just, like I say, turn up and think they’ll have their cataracts done or whatever. I don’t know, it’s really difficult to say whether there’s any premeditation about it, whether they might have got a visit visa as a visitor on the face of it legitimately and then something’s come up afterwards. Or whether or not they apply for the visa in the full knowledge that really what they’re coming for is treatment. It’s impossible to tell really.” (Border Force/Immigration, airport 2)

“I just think that it’s affordability really. Anywhere where you’re having to basically pay up front and even that doesn’t necessarily provide a wonderful system for, depending on what level you’re paying in, then to buy a £400 round ticket to the UK, it’s not a bad deal.” (Border Force/Immigration, airport 2)

“We have had Americans who come in because it’s cheaper to pay for a flight and have chemotherapy here than it is to have in America. It’s not just visa nationals, it’s widespread really.” (Border Force/Immigration, airport 3)

- People with medical visas who are due to have private medical treatment but they take a diversion to an NHS hospital and present in A&E.

“And that is seen as quite a high level of potential abuse as well. They have the consultant treatment or consultation and then they go to the next hospital and say ‘I’ve seen my doctor and I need this and this and this’. And they get admitted through A&E. Or they don’t go to the hospital where they’ve got the consultant and the agreement, they go to another hospital. And then they’re just like, ‘yeah I’ve got this’.” (Border Force/Immigration, airport 1)

- People wishing to gain access to treatment for HIV which is free in the UK

“And there is a concern that that will be a draw to the UK for people that can come and have HIV treatment. However a lot of that was you don’t have to give your true name to have treatment, so who are you?” (Border Force/Immigration, airport 1)

“They come across to the United Kingdom because there is medical treatment that they can get here for free that in their own country is no longer a provision under their health system because their health system cannot afford the basics. So they can’t afford to maintain prescriptions and things like that so they migrate across here and as long as they’re here for a certain period of time, get their prescription and then go back. The trouble is they then pass this onto their friends. Four friends followed with similar conditions and they’re now all being

supported by the NHS for an extraordinarily expensive kind of treatment which they should be able to get in their European country but they can't because it's no longer available but we have to offer it because they're European...

...Which country is this?...

...Greece, Spain, Italy, Greece primarily. This is the thing, we're going to have a lot of this but you only have to look at the flights we get in and the vast majority of people who are coming in are poor Europeans." (Border Force/Immigration, airport 4)

- Abuse can also take other forms than accessing treatment such as accumulating large amounts of prescription drugs and taking them out of the country, presumably, it was felt, to sell them.

Irregular migrants are an issue for Immigration Enforcement officers especially when they are receiving prolonged courses of treatment. Situations were described both in which migrants might use treatment as a reason to stay and in which they are willing to return home but clinicians are concerned about the standard of care they will receive and prevent their return. Since families with children entering the UK illegally can no longer be detained, it was noted that immigrants seem to become pregnant quickly after arriving.

"I've got somebody who's completely different whose actually got a medical condition but he's actually being supported by his family and his family don't want to go home because at the moment the medical condition is being managed. He will get treatment in his home country but either he'll have to pay or it's not to the standard offered. So he's actually now being supported by his family and the treatment is costing us thousands." (Border Force/Immigration, airport 4)

Officers also confirmed OVO views that the most common referrals that they received from Trusts to check on patients' status concerned asylum seekers (some of whom have failed in their application or are appealing the decision), visitors, (some of whom will be overstayers), and others who have been given indefinite leave to remain such as work permit holders.

4 Systems and Procedures within Secondary Care

4.1 Introduction

This section of the report considers:

- the variation in the composition of the OV ‘team’
- the processes and procedures involved in identifying, charging and recovering charges from chargeable patients, along with estimates of the numbers being identified and the amounts being charged
- the main reasons why chargeable patients may not be identified and/or charged.

Of the thirty Trusts involved in the main part of the research (scoping and case study strands), and those taking part in the briefing sessions, no two approached the issue of migrants and overseas visitors in the same way, and there was wide variation in the priority they gave it, the systems they had in place and the robustness of these systems in identifying and charging overseas visitors.

During the scoping study interviews, respondents were asked to describe the processes and procedures in place in their Trust for identifying chargeable patients and to estimate the numbers involved. Following the DH Guidance¹⁹, this was discussed in three steps:

- establishing if a patient is not ‘ordinarily resident’ (OR) including providing estimates of how many patients are being screened and what proportion of these prove not to be OR
- if not ‘ordinarily resident’, establishing if a patient is exempt from charging including providing estimates of how many are determined to be exempt
- providing estimates of the numbers of patients determined to be chargeable, how much they are being charged and how much is being recovered.

For the scoping interviews, a short questionnaire was used to collect numerical data about numbers of patients and amounts being charged (see 11.3.3). This was provided

¹⁹ Source: <https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations>

in advance of the interview and either discussed during the interview or, in some cases, forwarded afterwards (for example, where an OVO needed to obtain information from colleagues). OVOs were invited to give an estimate of the numbers of patients/sums being charged over whatever time period made most sense to them. The resulting values were then translated into an estimate of the number of patients/sums being charged or recovered per year. A more detailed questionnaire was used as part of the case study interviews (see 11.3.4).

The findings reported in this section are based, in part, on the information provided in response to these two questionnaires. A complete set of the data is provided in the appendices (see Table 22, p191). It should be noted that these data were often based on respondents' estimates of the numbers of patients/sums involved; moreover, there is considerable variability in the data and not all questions were answered by all respondents. The data should be interpreted qualitatively; they demonstrate the considerable variability between Trusts in the numbers of patients being screened and, where appropriate, charged, as well as the extent to which the Trusts taking part in the research were recovering these charges. However, given that the data is qualitative, they cannot be used to derive estimates of what may be happening across the population of all 161 Trusts in England and considerable care is needed in interpreting these data (see section 2.4 for guidance).

4.2 Overseas Visitor Team

In 2004, the Department of Health strongly recommended all Trusts to appoint a staff member to put into effect the guidance on implementing the overseas visitor hospital charging regulations. Included among those in this role contributing to the research, were those who were doing it alone and others who worked in a small team, sometimes a mix of OVOs and supporting administration staff. The 'team' typically, but not always, 'sat' within the Finance department and OVOs had a range of titles depending on the main thrust of their role. A selection of job titles are given below which illustrates how OV responsibilities were often combined with Private Patients, Medical Records and Finance.

Overseas Visitor Manager/Co-ordinator/Supervisor

Head of Private Patients/Private Patient and OV Manager/OVO and PP Co-ordinator/
Private Patient Co-ordinator

Health Records Manager/Supervisor Medical Records/ Assistant Appointments and
Health Records Services Manager

Interim Head of Contracts/Contracts Officer

Finance and Capital Accounts/Head of Accounts Receivable and Overseas Visitors/
Finance Manager

System Income and Costing

NHS Eligibility Manager

The OVOs in the sample were on a salary scale of anywhere between band 2 and 8c. In the briefing and scoping discussions, some OVOs were the main 'hands on' person while others were in a more senior position with a team that went out and about interacting with staff and patients; in the case studies, where possible, those in both these roles were interviewed.

Those OVOs who were able to work full-time on the role were in the minority; most had to combine the role with at least one other and sometimes, more roles. Some supporting administration staff took on OV roles 'as needed'. Those OVOs juggling with multiple responsibilities were having to fit in their OV duties as and when they could, rather than being able to work at the task systematically. Moreover, certain OVOs might be under pressure to prioritise the parts of their job that resulted in more certain income such as private patients and charging other CCGs.

Information about the size of the Overseas Visitor team, job titles, pay bands and the proportion of staff time spent dealing with overseas visitors was provided by 27 trusts. In these trusts, the Overseas Visitor team varied in size from one to six members of staff; however, the full time equivalent (fte) team size ranged from 0.01 to 3.5. The average was just over one full time member of staff (the mean was 1.3 and the median was 1.0).

The largest teams tended to be found in Trusts that were:

- 'proactive' (2.7 fte)²⁰
- 'high spenders' (2.1 fte)
- located in a 'top 10%' asylum dispersal area (1.9 fte)
- located in 'high' migration clusters (1.7 fte)
- located within the catchment area of an airport serving long haul destinations (1.7 fte)

Conversely, the smallest teams tended to be found in Trusts that were:

- 'reactive' (0.7 fte) and 'less engaged' (<0.01 fte)
- 'low spenders' (0.5 fte)
- located in rural areas (0.9 fte)
- located in 'low' (0.6 fte) and 'moderate' (0.8 fte) migration clusters
- located within the catchment area of an airport serving mainly European destinations (0.5 fte)

See Table 6 (see section 2.4 for guidance on interpreting the data).

Table 6: Full time equivalent size of OV team				NB Very low bases	
Base: 27 Trusts					
Segment	n	average full time equivalent	Location	n	average full time equivalent
Proactive	7	2.7	Metro	12	1.4
Clear direction of travel	8	1.2	Urban	5	1.5
Reactive	9	0.7	Rural	9	0.9
Less engaged	3	<0.01	Mixed	1	2.6
Total	27	1.3	Total	27	1.3
Expenditure	n	average full time equivalent	Migration Cluster	n	average full time equivalent
High	8	2.1	High	16	1.7
Medium	9	1.5	Moderate	7	0.8
Low	10	0.5	Low	4	0.6
Total	27	1.3	Total	27	1.3
Asylum dispersal	n	average full time equivalent	Airport catchment*	n	average full time equivalent
Top 10%	6	1.9	None	12	1.4
Other	21	1.1	Long haul	10	1.7
			Euro	6	0.5
Total	27	1.3	Total	27	1.3
*sums to 28 because one Trust was in the catchment area of airports serving both long haul and European destinations					

²⁰ See section 5 for details of the segmentation of Trusts

Between them, the 27 trusts employed the full-time equivalent of 35 staff who were involved in identifying chargeable patients. The distribution of these across the pay bands is shown in Table 7.

Table 7: Distribution of full time equivalent staff across pay bands								NB Very low bases		
Base: 27 Trusts										
No. FTE staff	not given	band 2	band 3	band 4	band 5	band 6	band 7	band 8a	band 8b	
35	1.5	2.8	6.5	11.1	9.2	1.6	2.2	0.1	0.1	

While the seniority of OVOs varied, this was not an indication of their experience in the role. A number of OVOs in the sample, sometimes on lower bands, had been doing the job for many years, had largely learned ‘on the job’ and were both very knowledgeable and committed to their role.

“I first of all started off as Private Patient Officer and the person who handed the job over to me just said, ‘oh, occasionally you get somebody from overseas and fill that form in, copy it, send one upstairs and if they’re chargeable, charge them.’ I didn’t know a thing about it, everything I’ve learned is from my own knowledge, my own delving. The meetings that we go to are very useful and talking to other people. And now I know, I think I’m very knowledgeable after 14 years.” (OVO, Clear direction, T1)

They were extremely positive about its value in the context of what they saw as the increasing impact of migrants and overseas visitors on NHS services despite sometimes coming under great pressure from heavy workloads, the demands of a complex job that requires great interpersonal skills and technical judgements, and conflicting attitudes. The support given to OVOs in their role varied, with some speaking about the positive support they receive from their managers, others feeling that that they are neither encouraged nor discouraged in their efforts and yet others referring to not being given free rein to do their job as they felt it should be done. Occasional anecdotal comments were made about one or more OVOs facing disciplinary action for trying to ensure chargeable patients were correctly identified and charged, as well as limits being placed on how much they were allowed to invoice.

The OVO, working alone or as part of a team, plays a key role in screening patients to check their eligibility for free NHS treatment. They may also be involved in organising the invoicing of the patient and less often, chasing payment. The main stages of the process are as follows.

4.3 Identifying Potentially Chargeable Patients

4.3.1 Systems and procedures

The OVO would not typically be involved at this point but rather would use the ‘eyes and ears’ of other staff on the frontline with patients and in the back office, to identify those patients who should be screened to see if they are eligible for free treatment or chargeable. These staff include reception and administration staff, as well as some nurses and clinicians who feel that it is important to do this. A patient’s potentially chargeable status might be picked up at several points and in various departments and not always when he/she first arrives in the Trust.

It was reported that the central question that is commonly asked of patients when they arrive in a Trust hospital is whether he/she has been resident in the UK for 12 months. While many OVOs in the sample had instructed staff and hoped that this was being asked of all patients in order not to be discriminatory, few claimed that baseline residency questions were asked routinely in every department. It was often the case that they simply did not know what was happening on a day by day, shift by shift basis; they were also aware that often it came down to individual members of staff and their awareness of the importance of the issue.

“It should be everybody. Because that is the criteria of the clerks to ask these questions. But to actually monitor that is impossible. I mean obviously when [name of OVO] goes round and does the education part, obviously she reminds them that that’s what they should be doing but she asks, ‘are you asking these questions?’, and they turn around and say ‘yes’.” (Midwife, Clear direction, T29)

Some OVOs taking part in the research were aware that staff may have tried to ask the question but in some departments had given up or did not do it consistently. This was confirmed by a few staff on the frontline who reported that they do not have the time to ask all patients the 12 month residency question as it means that queues build up.

“So do you ask every new patient?...”

...Well, we are meant to but I don’t really, I can’t say 100 per cent we do that with every patient...

...What would determine whether you did or you didn’t?...

...Obviously it’s how busy you are (laughs). Sometimes you can spend more time with them and other times you’ve got 20 people waiting so it does depend. I know we should ask every single patient, every new patient, but I can say we ask about 75 per cent of people.” (Reception/Administration, Reactive, T12)

In other departments, the question might not be asked at all; for example, a Maternity department seeing a large number of women from overseas and asking about their ethnicity and social circumstances but not how long they have been in the UK.

While OVOs tried to bring home to staff the importance of asking the baseline question of everyone, it seemed that some staff found it difficult because of the response it could provoke (from UK nationals as well as those from overseas) and the time taken to follow up with additional questions if necessary.

“Well if they were not British nationals. I’m not sure, I think probably the only thing that would make me ask the question is if they were like non-English speaking, not British.” (Nurse, Reactive, T12)

“Some people take offence at that, you know, especially people who are sort of born and bred in the UK, they think it’s an offence to come and start asking them questions like that.” (OVO, Proactive, T20)

“If we’ve got to ask the patient downstairs, ‘have you lived in the country for the past 12 months?’, that patient says ‘yes’, we’ve got to take that as gospel. We can’t say, ‘oh no, we think you’ve’, we can’t challenge the patient. We don’t want to do it anyway because we’re in the middle of Outpatients Department, it’s a bit embarrassing for us and it’s a bit embarrassing for the patients.” (Reception/Administration, Reactive, T12)

While feedback from the case studies suggests that some staff are formally asking basic questions, it also seems that some prefer to look out for other signs of ‘foreignness’ (often based on name/language/accent/nationality) and might alert the OVO based on these. This meant that they were unwittingly discriminating by using proxies that could be misleading and which meant that migrants and overseas visitors who may be chargeable were not being identified. OVOs were sometimes aware of the discomfort felt by staff and accepted that a degree of latitude was necessary in order that they were made aware of potentially chargeable patients.

“So we leave it, if you like, to their judgement. If they think, ‘oh, so it’s do you live permanently in the UK or something’, quite apart from having the GP and NHS number. Like I said, a few of them are not going to be asking questions like that because they think it’s not for them to do.” (OVO, Proactive, T20)

“I know other departments attempted to ask and people were looking at them blank. You have to ask everybody you see, you can’t be seen to be prejudiced and they weren’t comfortable with doing that. So that kind of went to the wall in a way unfortunately but that department, having said that, if they suspect, I will get a ring, I will get a call.” (OVO, Reactive, T26)

Staff also reported how other suspicious behaviours might suggest that a patient should be looked into further; they might appear agitated, hesitant (even over routine details such as date of birth), or if further questions are asked, their story might not quite ‘add up’.

“And body language, isn’t it? That’s what does it sometimes, it’s the body language. Remember you had the guy that came in and he was very agitated and he wanted to be seen quickly and you kind of picked up on that, didn’t you?” (Reception/Administration, Proactive, T20)

“It’s quite subjective, isn’t it? If, in clinic, I feel that someone is evading certain questions, not being very forthcoming, not wanting to bring in documentation, then that would usually be a trigger to contact the team.” (Administration, Proactive, T20)

In some Trusts in the sample, staff might take the view that certain groups of people did not merit attention because they were eligible for free treatment. It might be assumed for example, that patients from EEA countries are OR unless there is a reason to think otherwise or, more widely reported was the view that if a patient is registered with a GP and has an NHS number, they are eligible for free NHS care. The ease with which NHS numbers could be obtained and the lack of screening within primary care were not generally appreciated.

“We can only go on instinct or an NHS number...”

...So if someone’s got an NHS number?...

...We wouldn’t challenge them.” (Reception/Administration, Proactive, T20)

...So if someone presents and they’ve got an NHS number and they’re registered with a GP?...

...We would assume that we wouldn’t need to be charging for that patient.” (Nurse, Reactive, T12)

With or without the 12 month residency question, and notwithstanding the informal proxies used, other indicators might prompt a request for further information from the patient or the need for the OVO to become involved. These were:

- an overseas address (the obvious one)
- no NHS number
- tests conducted overseas.
- not registered with a GP
- a recent NHS number (070, 080)

It was reported that occasionally, a GP might flag up in a referral letter the fact that a patient was a visitor from overseas or had 'been in the UK for x weeks' but this was not regarded as the norm (this was confirmed by the Primary Care Practices; see section 8.5.)

The chargeable status of some patients was sometimes not called into question until their treatment had begun or even after several episodes of treatment or they were on a ward recovering. Questions might arise from comments made in conversation about 'going home' or when questions that should have been asked earlier were finally put to patients.

"The chappie said he couldn't speak English. He did have a family that were living around, quite a large family and nothing was ever mentioned about him being a visitor or whatever. He had his procedure done, he needed a by-pass also after the procedures we'd done here and it was only because we said, 'who is your GP?' and he goes, 'I haven't got one'. Then that sends a light off."
Reception/Administration, Reactive, T12)

While some doctors/consultants took an interest in whether chargeable patients were identified and charged for treatment, reports from staff suggested that they were in a minority and certainly, it was felt that clinicians expected any screening to be done elsewhere so that they could focus on treatment.

"I think that there is an issue, there are quite a lot of patients coming, especially through the emergency department, but doctors would rather not focus on searching who is who. It is up to, in my opinion, the administration to approach or tackle these problems." (Consultant, Clear direction, T10)

"It's important, from a medical perspective, you don't get caught up in the financial part of their treatment and I think you need to be impartial and let another team deal with the financial side, because what you don't want to do is have the patients feel threatened by you because of the financial issue. You want to be treating their medical condition." (Consultant, Proactive, T20)

Pre-attendance forms (PAF) were used in many Trusts involved in the research, either the version suggested by DH or in an adapted form; alternatively, key questions from the form might be incorporated into other forms used by different departments. They might be sent out to all new patients before an appointment or might be given to the patient to complete while in the Trust (maybe as well as sending it out in advance). While some OVOs were very supportive of the PAF and used it to gather information from patients who had been passed to them to follow up, others felt it would create too much work if it was routinely sent out.

“Because of the amount of patients that come through in Maternity, we’ve only been able to do that (use the PAF) in that department. If we did that in every department, I’d need about 30 overseas officers.” (OVO, Clear direction, T4)

“We don’t send them out in advance with every appointment. (1) because the cost of sending them out and (2) because we wouldn’t have, again as I explained to you, the limited resource we have, we wouldn’t have anybody to vet them all. So we would literally have thousands every week to go through and we wouldn’t be able to manage that as in filtering them as they come back with one for every patient.” (OVO, Clear direction, T23)

The view was also expressed that ‘better quality’ information could be collected if patients are not pre-warned about the questions they may be asked.

Another tool used in identifying patients who merited further investigation for their chargeable status was the Spine²¹ which might be consulted by back office staff before alerting the OVO, or by the OVO him/herself. This enabled them to look at the history and pattern of interaction that patients had had with the NHS over the years. A couple of the reactive Trusts seemed to like this approach, in part, because it was seen as less discriminatory.

“Okay, and what do you do with that? What are you looking for there to reassure you?...”

...Well, it’s a bit of a detective really. I mean you can actually on Summary Care Record get the history of where the patient was, which GP he was registered with, which also gives you a clue as to how long he’s been in the country.” (OVO, Clear direction, T18)

“Well for example, if somebody who’s on the computer screen and they’re a new registration, there’s no NHS number, there’s no GP, if in fact they’re an adult and they’ve never been seen before, then that’s worth investigating.” (OVO, Reactive, T3)

It appeared that a variety of patient information systems were being used in Trusts, with varying facilities to post alerts against patients (for whatever reason). Systems used for recording information provided by patients might include the central residency question as a mandatory field while in some Trusts, it could be passed over.

“Every patient that is booked in is asked the question ‘have they lived in the UK for the last 12 months?’ It’s a mandatory field, that’s what’s on our system, it has to be or else we can’t go any further.” (Reception/Administration, Clear direction, T29)

²¹ Information about the Spine can be found at <http://systems.hscic.gov.uk/spine>

Similarly, some systems allowed anybody to alter information about a patient's chargeable status (e.g. by putting in a UK address in place of one overseas). Several Trusts in the sample were using automated kiosks for patients to log their arrival and provide certain information. It was felt that it was very easy to lie in response to the 12 month residency question asked in this way.

A few Trusts taking part in the research reported that they receive telephone enquiries about the possibility of being treated at their hospital, often for more serious conditions such as breast cancer or kidney disease. They advise callers according to their eligibility and may log their names in case they present in person and are chargeable.

4.3.2 Estimates of the number of patients being screened

OVOs were invited to give an estimate of the numbers of patients that are being screened in their Trusts. In many cases, this was unknown although some respondents (n=15) provided an estimate. Across all of the 15 Trusts in question, it was estimated that a total of just under 1m patients (975,057) were being screened in a twelve month period to establish their OR status. This ranged from 'none at all' in two Trusts, up to 0.5 million in one Trust. This latter response was based on an estimate of up to 50 per cent of patients actually being asked the question by frontline staff.

"I have no evidence, I think that I wouldn't even say it's 50 per cent if I'm honest because the ward clerks and the clinic coordinators, the people who are actually there at that time, are quite scared of what they're going to get back from the patient, they don't all ask those questions." (OVO, Proactive, T24)

Where an estimate of the number being screened was provided, OVOs were asked if they could also estimate what proportion of such patients were, in fact, determined to be eligible for free NHS care. Not all were able to do so, for example, the Trust where an estimated 0.5 million patients were said to be asked about their status, was unable to estimate what proportion of these were determined to be eligible. 11 OVOs provided an estimate of the number of patients who were screened and determined to be OR each year. This ranged from just over 30 to over 140,000. Taking the 11 Trusts where estimates were provided for both the number of patients being asked about their OR status and the number that are determined to be OR, the proportion that were being determined to be OR ranged from 0.4 up to 98 per cent. These data are summarised in Table 8.

Table 8: Establishing 'ordinary residence' status					NB very low bases
base: no. of Trusts providing an estimate					
No. of patients being asked about their OR status		No. of patients determined to be OR		Proportion of patients determined to be OR	
	no. of Trusts = 15		no. of Trusts = 11		no. of Trusts = 11
range	0 to 500,000 pa	range	32 to 142,255 pa	range	0.4% to 98%
total	975,057 pa	total	164,010 pa		

It is clear from both the number of OVOs who were unable to provide an estimate, as well as the enormous variation in the numbers where such estimates have been given, that:

- in many of the Trusts taking part in the research, the extent to which patients are being screened is largely an unknown
- while in other Trusts in the sample where estimates were provided, there is wide variation in terms of the proportion of patients who are being screened.

4.4 Establishing Whether the Patient is Exempt or Chargeable

4.4.1 Systems and procedures

This is the point at which the OVO takes over and follows up the questions raised about a patient's chargeable status. Next steps depend on the information provided to the OVO by staff but typically, they will make contact with the patients by phone, letter or email, or in person if they meet them at their appointment or on the ward. They will ask questions (in person or using the PAF) to identify whether they are OR or whether another exemption applies which means they are eligible for free treatment.

Documentary proof will generally (but not always) be sought from the patient to substantiate their status.

Responses to these questions and production of the necessary documentary proof may or may not be forthcoming and the conclusion may be drawn that reluctance or inability to provide it is more likely to suggest somebody is chargeable. At this point, some OVOs involved in the research may tell patients they are chargeable (and raise an invoice) while some may decide it is too difficult to pursue and not charge.

“The people that I’ve assessed, they have brought in their documentation and we are finding that if people are eligible they’re more likely to bring in the documentation to get it all sorted out than those that don’t reply. And if you have

to send them lots of letters, or they don't phone back, we have to chase them, they're more likely to be not eligible." (OVO, Reactive, T7)

"So we might have a vague suspicion but actually we've got no evidence, nothing that we could actually take any further. We've asked questions and we can only go on the information we've got and so then, we will just put those through the system." (OVO, Clear direction, T29)

OVOs often reported the time consuming nature and difficulty of deciding whether a patient is exempt or chargeable both in terms of negotiating/understanding the DH guidelines and then requesting/obtaining the relevant documents. Depending on the complexity of the case and the OVO's level of experience, some might consult the DH team via the 'helpline' or seek the advice of more senior staff in the Trust or more experienced counterparts in other Trusts. In the case of elective treatment, while there may be a considerable period of time between the initial referral and a patient being seen either as an Outpatient or admitted as an Inpatient, nevertheless it can be a challenge for OVOs to complete all the necessary screening in a timely manner. In some cases, this is because the patient may only be identified as potentially chargeable once they arrive at an Outpatient clinic or when they are admitted onto a ward; indeed, in some cases, they may not be identified until after treatment has commenced and/or been completed.

Many Trusts taking part in the research were also calling on the help of UKBA (as was) in establishing certain patients' immigration status especially where documents were not provided or it was claimed they were lost. Patients gave their consent for this to happen, often on the PAF. It appeared that changes had taken place in terms of which office OVOs should contact for this help and OVOs frequently voiced frustration with the turnaround times of up to ten days that were now operating in what was a centralised resource; this meant that there were delays in informing a patient that they were chargeable and therefore treatment may have been provided and/or the patient may have left the hospital by then. The preference was to use their often much appreciated relationship with local Immigration offices for guidance on regulations and information about patients. This saved time all round: for example, if they were told that someone had indefinite leave to remain, they knew not to spend any more time checking or chasing them, and if the patient was not entitled to free healthcare, they were able to tell them straightaway. It also could make it easier for the doctor, who may need to make decisions about whether the treatment is immediately necessary and whether to limit it.

“It’s got to be with your local Immigration teams because they can give you an instant answer there and then. What I was doing was getting the Immigration consent form signed or the pre-attendance form signed there and then with the patient, going into a quiet office, phoning them up, ‘can you check the details on this patient?’ They were able to tell me there and then, this patient actually wasn’t entitled, they were an illegal, they never had legal status to be here, or they couldn’t find them on the system, or they were an absconder or whatever, failed asylum seeker, all appeal rights exhausted. But you need to know that then because that person needs to know there and then where they stand.” (OVO, Proactive, T13)

“For the patients who are non-EU, if they’ve signed the bottom of that pre-attendance, given us consent, we can find out straightaway, a quick email and they can let us know whether or not that patient is liable or exempt from charges. It can save weeks, months you know of chasing and chasing and chasing because you know what you’re dealing with from the beginning.” (OVO, Proactive, T24)

“Earlier in the year we had a guy in who was really, really very aggressive and very abusive. And there was a suspicion that he wasn’t an OR but we were more concerned about his behaviour rather than anything else. When we checked him out with the Border Agency he was reporting to them and he was flagged up on their system as being dangerous. He had actually been convicted with carrying an offensive weapon.” (OVO, Clear direction, T5)

Some frustration was voiced about the time taken to establish that a patient is exempt and indeed, the high proportion of overseas visitors that prove to be exempt. For some OVOs seeing smaller numbers of overseas visitors, the effort (and outcome) could seem like a waste of resource.

“Proportionally speaking, they’re quite small, even though we’ve had more than we’d originally thought, it is quite a small number compared to our total number of patients that we see. I suppose for me, the biggest impact is on my colleague and myself, we’re looking into all of these ones and it almost seems a bit wasted time. Because actually, if they are entitled, it would be so much easier to know they were entitled and treating them rather than spending lots of time proving that they’re entitled, if you see what I mean. If the regulations were clearer and there were fewer exemptions, then actually we would be able to charge more and then put that resource back into the health service.” (OVO, Clear direction, T29)

With respect to EEA patients, EHICs were routinely sought including occasionally where the patient was found to be OR but had not been resident for 12 months. In the common situation where patients did not have an EHIC, OVOs would frequently help them obtain a PRC either by simply telling them where to obtain one or by pursuing it themselves.

In the case of one specialist Trust, they might also help patients obtain E112s²² from their country. This task can, it was reported, be very time-consuming but in some cases where very costly emergency treatment has been given and the patient has no means to pay for it, it is the only way that a Trust feels able to recover its costs.

“Those E112 forms that I don’t get to have a copy of or don’t get the health boards to issue retrospectively and then I have no option but to invoice for the treatment provided but I try to help the families in obtaining the form.” (OVO, Proactive, T6)

4.4.2 Estimates of the number of patients who are exempt from charging

OVOs were asked if they could provide an estimate of the number of patients they screen each year to determine whether they are exempt from charging. Given that this is the point in the process where OVOs typically get involved most respondents (n=27) were able to provide an estimate. They were then asked to give an estimate of the number of patients who were established to be exempt from charging. 22 OVOs were able to do so.

Across the 27 Trusts providing an estimate, the total number of patients being asked about their exemption status was just over 10,000 per annum; estimates ranged from 1 to just over 1,800 patients a year.

For the 22 Trusts that were able to provide an estimate of the number of patients that were determined to be exempt, this ranged from 0 to just over 1,500 patients, with an overall total of 6,320 patients per annum.

Taking the 22 Trusts that provided an estimate of both the number of patients being asked about their exemption status and the number that were subsequently determined to be exempt, the proportion of patients being screened and determined to be exempt ranged from 0 per cent in one case, and 100 per cent in one other case; 17 of the 22 Trusts provided estimates of between 50 per cent and 90 per cent. In other words, for most of the Trusts that were able to provide an estimate, the majority of patients they were screening were determined to be exempt from charging. These data are summarised in Table 9.

²² The S2 or E112 entitles patients to travel abroad to receive state funded medical treatment in any EEA country and Switzerland. Patients going abroad to these destinations will be entitled to the same care and payment conditions as the residents of that country.

Table 9: Establishing if a patient is exempt from charging				NB very low bases	
base: no. of Trusts providing an estimate					
No. of patients being asked about their exemption status		No. of patients determined to be exempt		Proportion of patients determined to be exempt	
	no. of Trusts = 27		no. of Trusts = 22		no. of Trusts = 22
range	1 to 1,820 pa	range	0 to 1,560 pa	range	0% to 100%
total	10,241 pa	total	6,362 pa		

Variations in the number of patients being asked about their exemption status according to the key sample variables are summarised in Table 23 (p192) in the appendices.

Variations in the number of patients being determined to be exempt according to the key sample variables are summarised in Table 24 (p193).

4.5 Advising/Invoicing Chargeable Patients

4.5.1 Systems and procedures

The Trusts involved in the research generally recognised the importance of giving timely advice to patients about the fact that they are not eligible for free NHS treatment and about the amount they might be liable for because of the resentment caused and resistance to paying if they find out only after treatment has begun. Moreover, many of the OVOs in the sample believe this is the fair way to deal with such patients. Some of the Trusts have put in place procedures to enable patients to be invoiced up-front with the understanding that a follow-up invoice will adjust the amount to reflect the cost of the actual treatment provided. This was sometimes easiest to do in departments such as Maternity where Trusts had a good idea of what different packages of care could cost.

“Again, making people aware at the point of contact if we are aware that they will have to pay, then we try and quote the cost approximately, also bearing in mind that we generally try and quote the special care fees just on the off chance that the baby has to go into special care. So they are aware in advance.” (OVO, Reactive, T9)

However, the inadequacy of current systems/processes often meant there was a delay; for example, as observed above, a patient’s status may only be questioned because of a chance remark while being treated or in some Trusts, the OVO is only made aware of a potentially chargeable patient through reports that are sent to them ‘after the event’.

“So I’ve got half a dozen of those from April/May. I think 4 from May, 2 from April; I then look into the notes retrospectively. So Monday, Tuesday, Wednesday I’ll

be getting a few hours between reading the notes, deciding where they came from, what they've had done, maybe having to write to them saying 'have you got insurance? Have you got an EHIC?' And then deciding at some point to bill them." (OVO, Reactive, T8)

One Trust explained how coding for overseas visitor discharges was dealt with along with all other discharges and could take 24-48 hours to complete; the OVO may only find out the amount charged a month later.

"The coding can be done, like, a week after the discharge, you know it's quite a long delay depending upon which area, which specialty. We only run our monthly reports, well, monthly! So there could be a month's delay before I've seen a patient come through with the cost next to them, but obviously, we try." (OVO, Clear direction, T29)

Patients who come onto a ward over a weekend who have not been screened in advance may be taken aback by being told on Monday that they are to be billed.

"Or sometimes, if they are still on the ward, Monday through Tuesday or whatever, sometimes the ward does contact us that this person came Friday night maybe, Saturday morning and we need to come and have a look, see what's the situation. I'll be honest with you, by that time the bill has already risen by about what - £600, £700 and they're like, 'what, you're telling us now that we're going to have to pay?'" (OVO, Reactive, T22)

Once informed they are chargeable and patients indicate they wish to go ahead with treatment, they are asked to sign an 'undertaking to pay' form and, in some Trusts taking part in the research, a deposit or large part-payment is sought in advance. With regard to Inpatients, an interim invoice, sometimes every few days, may be issued. If someone is undergoing a lengthy period of treatment, they may be asked to pay in instalments as each course of treatment is completed.

"Obviously if they're an Inpatient, it depends how long the admission is. If they're in quite a long time we will do interim invoices every few days." (OVO, Clear direction, T23)

However, in other Trusts in the sample, an invoice is only raised after treatment is completed and sometimes following discharge; they are aware that in this situation, despite getting contact details from patients, it is less likely that the invoice will be paid. Even if Trusts secure a large part of the cost up-front, they may then find that the follow-up invoice after treatment is unpaid.

"To be honest, if I've ever seen any difficulty, it's with the follow-up invoices because they've already paid a significant chunk and then nobody likes to have

an after bill and think, 'I've got to pay some more, have I?'" (Finance, Reactive, T12)

In cases where patients say they are unable to pay, OVOs may be involved in setting up a payment plan (sometimes in advance of treatment if they can arrive at an estimate of the cost) but it was widely evinced that payment plans are often not followed through to clear the debt.

"My feeling is that after a period of time I would suggest a high number of people, if they're paying small amounts, would soon stop paying anyway." (Finance, Proactive, T20)

Patients who were not eligible for free NHS care were always treated where immediately necessary but where they were unable to pay for elective treatment, the picture varied. Clinicians might take the decision to treat regardless or the decision whether to treat might be escalated within the Trust's hierarchy especially where more expensive/difficult/questionable cases were involved; these could involve the contracting team, clinical team etc.

"Yeah I think the normal route then, they would need to sign off to say that they want to treat the patient so I think, yeah it then gets processed at Medical Director level and Board level as to whether or not we would then be prepared to accept the patient. We could not just have clinicians deciding for themselves as they could get any Trust into financial ruin." (Finance, Proactive, T20)

However, cases were cited where patients were refused treatment when they were unable to pay and it was not immediately necessary.

"We've had a few, they've come over, pretty sure they've got cancer, come over to the UK to be treated free as they see it and we have turned a few away saying, 'no, you have got cancer but it's not life threatening enough for you not to get back to your own country to receive treatment'." (OVO, Reactive, T9)

While the process of raising an invoice is straightforward for many (some, handing it over to another department or out-sourcing it), for a few taking on this task themselves, it was more complex and time-consuming as they liaised with different departments to arrive at a final invoice. Most OVOs in the sample thought patients were charged based on the NHS tariff although some felt this did not take into account either all the additional time involved in treating patients from overseas or all the associated costs. In parallel with this research, the DH ran two workshops with OVOs from 23 Trusts, of these about half were charging the NHS tariff and a third, the NHS tariff plus a standard

overhead to cover administration and other costs. A small number were charging the private treatment or some other rate.

Where insurance companies are involved, the majority of Trusts in the sample prefer to invoice the patient who can then reclaim the money from their insurer; this is especially the case where North American insurers are concerned because of the demands they make in how the invoice is presented.

“In the past, I’ve struggled with the insurance companies so we now ask our Finance Department to invoice the patient. So I would expect them to pay and then to claim it back from the insurance because you’d think it would be easier the other way round but from experience it hasn’t been. We do struggle to get it back from the insurance companies.” (OVO, Reactive, T3)

Again, some Trusts in the sample may help patients negotiate with their insurance company and this can take up significant amounts of time to sort out.

“And then they want things faxed through to their insurance company, they want medical reports, we spend time chasing the consultants, so we can get them faxed to their insurance company. So it’s very time consuming sometimes with the paper work and the phone calls. Although I had one recently, I didn’t do the phone calls but she was in my office for a good hour and a half on the phone trying to sort out her insurance for her mother. And then, of course, we’re sort of a go-between because then the insurance companies email us to keep us updated and we have to email them to keep them updated, that’s on a daily basis. Getting hold of the consultants, saying ‘right what’s the state of play today, are you operating, are you not? Their insurance company wants to know the estimated time’. It’s time consuming.” (OVO, Clear direction, T18)

Some OVOs taking part in the workshops run by DH commented that they may have some dialogue with insurers to find out if they will provide pre-authorisation and/or issue a certificate of guarantee of payment. In this case they may be prepared to invoice the company rather than the patient but some Trusts would then want payment up-front.

4.5.2 Estimates of the number of patients being treated who either hold an EHIC or are covered by a reciprocal agreement

As part of the case study exercise, respondents were asked if they could provide data concerning the number of patients who had been treated and either held an EHIC or were covered by a reciprocal agreement. They were also asked to provide details of the amount of money that had been charged. Six of the seven Trusts were able to provide EHIC data for the last three years while four were able to provide data on reciprocal agreements. The data are summarised in Table 10.

Table 10: Details of EHICs and Reciprocal Agreements						NB very low bases
base: case study Trusts able to provide data						
	Year	n	total no. of patients	range	total amount charged (£)	range
EHICs	12/13	6	234	4 to 121	£485,238	£856 to £281,440
	11/12	6	239	8 to 121	£375,814	£7,986 to £90,997
	10/12	6	207	8 to 67	£324,735	£14,287 to £111,459
Reciprocals	12/13	4	46	4 to 22	£233,368	£15,783 to £98,891
	11/12	4	45	1 to 22	£253,542	£9,906 to £99,449
	10/12	4	44	3 to 21	£104,269	£2,280 to £38,293

On average, the four Trusts between them were identifying 227 patients who held an EHIC and charging a total of £395,262 per year, as well as 45 patients covered by a reciprocal agreement and charging a total of £197,060 per year.

4.5.3 Estimates of the number of patients identified as directly chargeable and amounts charged

OVOs were asked to provide an estimate of the number of patients being identified as directly chargeable (i.e. excluding those that were exempt or were visitors from the EEA and held an EHIC). The number of chargeable patients being identified in a twelve month period across the sample varied from 0 to 720 across the 29 Trusts providing an estimate. The total number of such patients across the sample was 3,387 per year.

Estimates of the total amount charged to such patients were provided by 26 of the Trusts. The total amount being charged by these Trusts came to just over £4.5m per annum with a range from just under £3,800 to over £900,000 per annum.

Complete data were provided by 24 of the Trusts and this reveals that the average amount being charged per patient ranged from £250 to over £43,000; this latter amount was for a specialist Trust. In between this two extremes, the average per patient charge was less than £1,000 in the case of seven Trusts, between £1,000 and £2,000 in the case of a further seven trusts, and between £2,001 and £4,658 for the remaining seven Trusts. These data are summarised in Table 11.

Variations in the number of patients being identified as chargeable and the amount

charged according to the key sample variables are summarised in Table 25 (p194) and Table 26 (p195) in the appendices (see section 2.4 for guidance on interpreting the data).

Table 11: Number of patients determined to be chargeable					NB low base
base: no. of Trusts providing an estimate					
No. of patients determined to be chargeable		Total amount charged		Amount charged per patient	
	no. of Trusts = 29		no. of Trusts = 26		no. of Trusts = 24
range	0 to 720 pa	range	£3,794 to £912,718 pa	range	£250 to £42,461 pa
total	3,387 pa	total	£4,561,950 pa		

4.6 Recovering Charges

4.6.1 Systems and procedures

The recovery of charges is a significant problem for most Trusts involved in the research and many are aware that in certain cases payment is unlikely. While many are rigorous in charging wherever justified, others may be more reticent and in some cases, charge the PCT/CCG if the patient is registered with a GP/has an NHS number. Some OVOs in the sample readily admitted that where they cannot get the information they need about a patient or the patient has no fixed abode (NFA), they may not pursue the matter and put the patient through as exempt.

“As I say, there are some that we know we have to put as exempt, the ones who are no fixed abode, and things like that, because we have nothing to go on, we can’t do anything but put them down as no fixed abode and they’d go through whatever route it is, the same as UK no fixed abodes, because, you know, there’s nothing, nothing you can do about it. You know they don’t speak any English, you know they haven’t got a home, you know they’ve got no money, but you have nothing else at all, so, you know, those ones we don’t have a choice.” (OVO, Clear direction, T29)

“Otherwise than that, the ones that we’ve put as ‘ordinarily resident’ is because actually we can’t get any information to prove otherwise. Strictly speaking, if they can’t immediately give me anything, I suppose, you know, we can really charge them but the thing is, what you’ve got to think about there is, you’re going to create more debt and who is going to chase that debt, who has got the time to chase that debt? Do you know what I mean? It’s going to be a bad debt.” (OVO, Reactive, T26)

This same Trust, faced with an EEA patient who had just arrived in the UK without an EHIC and needing surgery, was sending the referral back to the referring dentist

suggesting that one solution was for the patient to register with a GP so that the CCG could be charged.

“And I said, ‘we are not going to get paid for that, no one is going to fund that, so I suggest that we send it back to the dentist and say, do they want to be seen on a private basis or is there a GP we can invoice for the treatment?’ [] I’ve asked the lady to send the referral back.” (OVO, Reactive, T26)

A number of the Trusts in the sample outsourced the raising and processing of invoices to SBS²³ who automatically sent out reminder letters at set periods but appeared to do little else. This was not generally seen as an effective means of recovering debt, especially from overseas, and frequently the debt was returned to the Trust for it to do any further chasing. The Trust then needed to take a decision about whether and how to do this based on the size of the debt and such factors as the cost of using debt collection agencies (quoted at 25 per cent of the invoice value by one Trust and as a small retainer plus a percentage of the invoice value, thought to be between 10-15 per cent, by another Trust) or the likely result of pursuing the debt through the courts. In the latter case, where patients claimed they could not pay, it might lead to a payment plan based on what could be seen as very small sums.

Threats to report an unpaid bill to UKBA with the consequences for future visa applications, were generally seen as helpful in recovering debts from non-EEA patients, especially those with family in the UK who have reason to travel back and forth on a regular basis²⁴. Conversely, a couple of Trusts reported being contacted by UKBA who wished to find out whether an individual had paid for previous treatments; and an immigration officer cited an example of helping to identify a chargeable patient and recover a debt.

“I think probably from our point of view, it’s a little bit of a back-up for us, because we can actually say to them, ‘well, if you don’t pay it, this will go to the Border Agency’. I had a lady that for two years she didn’t pay, she was American, I did actually fill this in and [told her] ‘we can, you know, let the Border Agency know’ and she paid up straightaway. It’s a tool for us.” (OVO, Reactive, T3)

“We had a gentleman that had arrived; we suspected that he was a health tourist. He was refused entry but granted temporary admission because of his age and

²³ For details, see <http://www.sbs.nhs.uk/>

²⁴ If a migrant or overseas visitor owes £1000 or more to the NHS for treatment from a previous trip to the UK, visa applications can be refused until the debt is repaid.

because of the nature of his illness. Contacted the hospital and just said 'are you aware that this person is an overseas visitor?' and they said, 'no we're not.' They then made contact with that person and he paid the debt over the phone with his credit card. It was that easy." (Border Force/Immigration, airport 1)

However, there was no such recourse for chargeable EEA patients who refuse to pay.

"They know there is no come-back for them. They are not going to get deported, they are not going to get anything happen to them, you can put it through and send them three letters, send it to the solicitors, send it to the debt collector, go through all the motions, but they ignore it, ignore it, ignore it, they know nothing is going to happen." (OVO, Proactive, T24)

4.6.2 Estimates of number of patients who are charged but do not pay

OVOs were asked to provide an estimate of the number of patients who are charged by their Trust but who do not pay. Not all were able to do so. Among those that did (n=21), it ranged from 0 to 335 patients, with a total

Table 12: Number of patients that are charged but do not pay		NB low base
base: no. of Trusts providing an estimate		
NB low bases	No. of patients charged but not paying	% of all patients who are charged
	no. of Trust = 21	no. of Trust = 20
range	0 to 335 pa	0% to 100% pa
total	1,308 pa	

across the 21 Trusts of just over 1,300 patients per year. When this is expressed as a percentage of all the patients charged by each Trust, the range was 0 to 100 per cent of patients; half the sample estimated that less than 50 per cent of the patients who were charged did not pay, while the other half estimated that more than 50 per cent did not pay (see Table 12).

Variations in the number of patients being identified as chargeable but who do not pay according to the key sample variables are presented in Table 27 (p196) in the appendices (see section 2.4 for guidance on interpreting the data).

4.6.3 The amounts being recovered

23 Trusts provided an estimate of the amounts of money recovered from chargeable patients. The estimated annual amounts ranged from £1,581 to £261,495 with a total amount across the 23 Trusts of just over £1.2m. When expressed as the amount recovered per patient charged, this ranged from £25 to over £5,000; 16 of the 22 Trusts reported that they recovered between £100 and £1,000 per patient charged. When expressed as a proportion of the total amount charged to chargeable patients, the

amounts being recovered ranged from less than 1 per cent in one case, to 100 per cent in the case of a Trust that had only charged two patients in 2012/13. 14 of the 23 Trusts reported recovering less than 50 per cent of the amounts that had been charged, while 9 reported recovering between 50 and 100 per cent of the sums in question (the data are summarised in Table 13). These figures do not include outstanding invoices where a payment plan has been put in place; however, as noted above, Trusts in the sample reported that they often failed to collect the full amount due in these circumstances.

Table 13: Amounts being recovered					NB low base
base: no. of Trusts providing an estimate					
Amounts recovered from chargeable patients		Amount recovered per patient charged		Proportion of charges recovered	
	No. of Trusts =23		No. of Trusts =22		No. of Trusts =23
range	£1,581 to £261,495 pa	range	£25 to £5,326 pa	range	0.73% to 100% pa
total	£1,216,228 pa	total			

Variations in the amounts being recovered and the proportion of charges being recovered according to the key sample variables are presented in Table 28 (p197) and Table 29 (p198) in the appendices; see section 2.4 for guidance on interpreting the data.

4.6.4 Levels of debt

For the 22 Trusts providing the information, estimates of current levels of bad debt ranged between £0 and £0.7m pa and, in total, amounted to more than £3m.

Table 14: Current level of bad debt			NB low bases
base: no. of Trusts providing an estimate			
Level of bad debt		bad debt per patient charged	
	No. of Trusts =22		No. of Trusts =20
range	£0 to £706,687 pa		£0 to £111,404 pa
total	£3,175,823 pa		

The estimated level of bad debt per patient charged in a twelve month period ranged from £0 to over £100,000 (see Table 14). **NB** the reported levels of bad debt are likely to be an underestimate as they do not include any debt carried over from previous years; they also include outstanding sums where a payment plan is in place but as noted above, these sums may not be recovered.

Variations in the level of bad debt according to the key sample variables are set out in Table 30 (p199) (see section 2.4 for guidance on interpreting the data).

Eight Trusts reported bad debts in excess of £100,000. Of these, one was classed as 'reactive', two as 'clear sense of direction' and five as 'proactive'; in other words, the highest levels of debt were often to be found among those Trusts judged to be doing the most to identify and charge patients. It seemed that their diligence was often rewarded with higher levels of bad debt which could lead to feelings of resentment and injustice.

“At the moment, the more patients you identify, the more the Trust is penalised and that shouldn't be the way. That absolutely shouldn't be the way. There should be a way of making this mandatory and supported and not a negative to the Trust.” (OVO, Proactive, T13)

“When you look at the amount of debt, you do think, ‘well actually, because of the very nature of overseas visitors, are we really going to recoup all that?’ In fairness, I feel you can go to debt collection but at the end of the day if you don't get the money, you don't get the money. It is the Trust that will suffer because the Trust don't get that income from the Government, so it's obviously loss of income because we don't charge the commissioners, so financially, that is the biggest impact.” (OVO, Clear direction, T15)

“That's what the guidance says and that is what we have to do. I mean there are times when we really don't want to, I have to say. I mean at the moment, we've got one that is like £250,000 and we really don't want to raise it, but we are going to have to because they are liable. The standard is we will always bill because that is what the guidance says and there's never been any question that we won't do that. I don't understand why [some other] Trusts don't.” (OVO, Proactive, T24)

4.6.5 Written off debt

20 of the Trusts provided data about write-offs; however, the time period that the figures relate to varied from, in one case, 2006 to 2013, to, in five cases, the last twelve months. In some other cases, the time period was not provided. The amounts in question varied between £0 and £1m, with a total bad debt in excess of £2.25m across the 20 Trusts (see Table 15).

Table 15: Written off debt		NB low base
base: no. of Trusts providing an estimate		
Written off debt (£)		
time period	No of Trusts =20	
2006/13	£5,986	
2007/11	£15,804	
2008/13	£1,020,009	
2008/13	£83,015	
2010/13	£427,045	
2011/13	£385,000	
2012/13	£2,317	
2012/13	£3,482	
2012/13	£5,700	
2012/13	£8,000	
2012/13	£60,000	
not stated	£11,000	
not stated	£11,191	
not stated	£52,709	
not stated	£172,900	
	£0	
	£0	
	£0	
	£0	
	£0	
range	£0 to £1,020,009	
total	£2,264,158	

Ten Trusts had written off in excess of £10,000; of these, five were judged to be ‘proactive’, four as having a ‘clear direction of travel’, and one was classed as ‘reactive’. In other words, those Trusts judged to be engaging most with the issue, and putting more effective systems and procedures in place, were more likely to have written off larger debts.

4.7 Chargeable Patients who may not be Identified/Charged

OVOs acknowledged that whatever system their Trust had in place to identify potentially chargeable patients, it was by no means foolproof and that a sizeable number of patients who should be charged were not being identified. This was true across all of the Trusts taking part in the research, from those who were currently identifying the largest numbers of such patients, to those who were identifying very few.

The research has highlighted the fact that there are opportunities throughout the process where patients may not be identified or, having been identified as potentially chargeable, may not be invoiced. To sum up, the sorts of situations in which a patient may be classified as either OR or exempt and charged to the CCG are summarised in Box 4.

Box 4: Situations in which a patient may be classified as either OR or exempt and charged to the CCG

- First and foremost, non-exempt patients who have already accessed NHS services and do not figure as new patients may not be challenged
“There are so many people in the system now that don’t have entitlement and quite often you will get somebody from a hospital – they would say before they have an old NHS number, so that suggests they are fine but their attendance is sporadic so it could be they are not living here, so they have to find them that way.” (Border Force/Immigration, airport 3)
- It is commonly accepted that having an NHS number means that someone is eligible; all the more so if someone has a GP
- Where GPs or other clinicians have identified a patient as exempt (although they may not be), this may simply be accepted; similarly, referrals made using Choose and Book may be subject to less scrutiny
- Use of self check-in points make it easier for patients to give answers that will gain them free treatment without being questioned further
- If patients are asked about their residence as a precursor to finding out whether they are OR, the staff member may accept their answer unless there are any other clues to alert them. Moreover, the patient may not be entirely honest and may provide information that ostensibly suggests they are OR
- If there are clues to suggest someone may not be OR, these may/may not be followed up. Even where Trusts follow up as routine to seek evidence, if the patient is not forthcoming

with further information/documentary proof, some Trusts may give up and charge to the CCG
<ul style="list-style-type: none"> • If patients respond in a confrontational manner, possibly threatening legal action, or refuse to provide answers, a Trust may choose not to pursue the matter
<ul style="list-style-type: none"> • Given the multitude of exemptions and the lack of clarity surrounding them, a patient could be misidentified as exempt
<ul style="list-style-type: none"> • Details about a patient's status may be incorrectly entered on the patient information system or may be altered to make him/her exempt
<ul style="list-style-type: none"> • Having identified a patient as someone who merits further investigation by the OVO, staff may not inform the OVO
<ul style="list-style-type: none"> • Even though the OVO has been informed, he/she may not have the time to follow up or follow up in an effective way
<ul style="list-style-type: none"> • A patient may be deemed too difficult to classify or to pursue payment, for example, if of no fixed abode
<ul style="list-style-type: none"> • If patients insist they will not pay or the Trust knows they lack the funds to pay
<ul style="list-style-type: none"> • Trusts may not want to risk not being compensated if the patient provides the necessary documentary proof outside the window for charging to the CCG or may not wish to risk double charging (the patient and the CCG)
<ul style="list-style-type: none"> • If Trusts are invoicing chargeable patients but as a result of non-recovery of the debt, the amount they are writing off is increasing, they may decide to be more selective about those they pursue.

It was not unusual for OVOs and other members of staff taking part in the research to suggest that they may only be identifying 50 per cent of chargeable patients. The following quotes provide a few examples (with estimates of how many patients they are capturing and/or might be chargeable underlined).

"I think there are still people slipping through. I think that would be in any Trust..."

...Yes I'm sure...

...Maybe we're capturing 50 to 60 per cent." (OVO, Clear direction, T4)

"We don't have a fantastic system to record overseas visitors because, unfortunately, the patient admin system doesn't record them in the categories. The number that we charge compared to the number that goes through is probably significantly, you know. I think in 11/12 we raised invoices for about £80,000 which is probably just the tip of the iceberg to be honest..."

...And can you give me an idea what the iceberg is? When you say it's just the tip of the iceberg...?

...I fear if we pick up, we probably only pick up between 10 and 20 per cent." (OVO, Clear direction, T5)

“So do you have a gut feel in terms of if you were putting in very rigorous screening?...”

...I think it would show a lot more...

...10 per cent more, 20 per cent more?...

...Probably, maybe.” (Matron, Proactive, T20)

“Huge - I think it would open everybody’s eyes and it would be then apparent. I think it needs to be done because then it would be apparent just how many overseas you know, well how many are here basically.” (OVO, Proactive, T24)

Where resources have been increased/systems improved, the number of chargeable patients being identified had invariably increased and, in some cases, larger amounts were being recovered. Some examples include:

- a Trust that has doubled the size of its OV team and developed more effective systems and, as a result, has doubled the number of chargeable patients being identified and increased the level of debt recovered to 87 per cent
- a second Trust reported that the numbers of chargeable patients being identified tripled after they tightened up their procedures
- yet another Trust, that had started invoicing chargeable patients in advance of treatment wherever possible, was recovering more money

“It’s been completely successful, totally successful. Last year we only got £21,000 paid in advance. This financial year we are only what, eight weeks in and we’ve already had £23,000 paid in advance. And it gives the patients the option to change their mind should they decide not to go ahead because of payment.” (OVO, Proactive, T13)

Taking all of the above into account, it would not be unreasonable to assume the numbers being identified and the sums being charged and recovered could easily double if more systematic procedures were introduced. External corroboration of this assumption can be found in feedback from the two workshops run by DH in parallel to the current research among OVOs from 23 Trusts. OVOs were asked ‘what proportion of chargeable foreign nationals receiving treatment in your Trust do you think you identify?’ 18 out of the 23 provided an estimate which ranged from ‘less than 1 per cent’ to ‘90 per cent’. The average was 55 per cent.

5 Segmentation of Trusts

5.1 Introduction

Based on the scoping interviews and the responses from the OVOs involved in these, the research team felt that Trusts could be grouped according to their attitude and experience of identifying and charging patients ineligible for free NHS treatment, and most critically, the systems they either had in place or were putting in place to tackle the challenge. Four loose groupings were identified; these should be seen as a continuum rather than discrete entities. It should be noted that even the most proactive Trusts were aware of areas of their operation that were vulnerable to overseas visitors not being identified or other ways in which their systems could be improved. The segments are as follows:

- Less engaged Trusts
- Reactive Trusts
- Trusts with a clear sense of direction
- Proactive Trusts.

The profile of each segment across the key variables is shown in Table 16. Details of the size of OV teams can be found at section 4.2. The base sizes are very small which makes it difficult to draw any firm conclusions (see section 2.4 for guidance on how to interpret the data) however, there is some suggestion that:

- the Proactive segment was more likely to include 'high expenditure' Trusts based in London, the South East and the East; Trusts in this segment had the largest OV teams (2.7 full-time equivalent)
- the Clear Direction of Travel segment was more likely to include 'medium and low expenditure' Trusts; Trusts in this segment had larger OV teams than the Reactive and Less engaged Trusts (1.2 fte)
- the Reactive segment was more likely to include 'medium and low expenditure' Trusts based in rural locations; these Trusts had smaller OV teams (0.7 fte)
- the Less Engaged segment included Trusts with the smallest OV teams (0.04 fte).

Table 16: Profile of segments across key variables					NB Low bases	
base: 29 Trusts taking part in a scoping interview						
Expenditure	total	Proactive	Clear direction	Reactive	Less engaged	
Total sample	29	8	9	9	3	
High	9	4	2	2	1	
Medium	10	2	4	3	1	
Low	10	2	3	4	1	
Asylum dispersal						
Total sample	29	8	9	9	3	
Top 10%	6	1	2	3	-	
Other	23	7	7	6	3	
Airport catchment						
Total sample	29	8	9	9	3	
None	14	4	6	3	1	
Long haul	10	4	2	4	-	
Euro	6	-	1	3	2	
Location						
Total sample	29	8	9	9	3	
Metro	12	3	4	3	2	
Urban	7	2	4	1	-	
Rural	9	2	1	5	1	
Mixed	1	1	-	-	-	
Region						
Total sample	29	8	9	9	3	
London	5	3	2	-	-	
South East	4	2	1	1	-	
East of England	3	2	1	-	-	
South West	3	-	2	1	-	
East Midlands	2	1	-	1	-	
West Midlands	3	-	-	1	2	
North West	3	-	1	2	-	
North East	2	-	1	-	1	
York & Humber	4	-	1	3	-	
Migration Cluster						
Total sample	29	8	9	9	3	
High	17	5	6	5	1	
Moderate	8	2	1	4	1	
Low	4	1	2	-	1	
Specialisms						
Total sample	29	8	9	9	3	
Foundation	20	5	7	6	2	
A&E	25	6	9	8	2	
Cancer	19	6	6	5	2	
Maternity	24	6	8	8	2	
Renal	16	5	5	5	1	

Although the first three segments contained a similar number of Trusts, it should be kept in mind that there was a degree of self-selection in terms of which Trusts agreed to take part in the research and that 25 per cent of the Trusts approached declined to do so. There is a possibility that refusal rates were higher among the Less Engaged and Reactive Trusts.

The principal characteristics of each segment are described in the following sections and examples are provided from a small number of Trusts (both from the scoping interviews and case studies); we have confined these to the Trusts with a clear sense of direction and proactive Trusts because they illustrate some of the types of good practice that they have adopted.

5.2 Less Engaged Trusts

Only three Trusts were identified in this grouping; each was very different in terms of the reasons for their apparent lack of engagement with the issue of overseas visitors.

The first was a specialist Trust that explained that because they have so few migrants and overseas visitors, there is nobody assigned to the role of identifying such patients. They have only identified one patient as chargeable in the last few years and this ex-pat refused to pay because she was invited by a consultant to have treatment at the hospital and was only told about being charged afterwards. However, when the different categories of migrants and overseas visitors were discussed, it became clear that the patient population might indeed, include more than the Trust at first thought.

“There is a growing Polish [community], I suppose, that will present a risk which I hadn’t really thought through before.” (OVO, Less engaged, T19)

The manager who was interviewed suspected that no basic screening questions were being asked routinely and that it was assumed that checks for eligibility would have been done by GPs or Trusts referring patients.

The second was a large Trust with widely dispersed sites so that it is not feasible for the OVO to go out (on public transport) and interview patients. Instead, she relies on frontline staff (possibly nurses, she suggested) to identify migrants and overseas visitors. They then notify her and provide her with the procedure codes; she lets them know the estimated cost of treatment and sends the ‘undertake to pay’ form. She is

unsure on what grounds this is done but assumes it is if the patient gives an overseas address.

“Simply because we don’t interview, or I’ve never been asked to and the previous person wasn’t asked, so I wouldn’t know people coming through the door what their status is to ask them...”

...And does nobody ask that as a matter of course?...

...I have absolutely no idea, I have no idea. Because literally we’re based here in an office and I don’t leave it.” (OVO, Less engaged, T16)

Moreover, the idea of challenging patients and asking to see documentary proof seems to be something she could not imagine happening.

“So if somebody wanted to deceive and pretend they were OR, they would just give a local address and say they were working here and that would be accepted?...”

...As far as I’m aware, yes. To be fair, I think if somebody told me that, I would accept that. Because at what point do you challenge and how much do you challenge each individual person?” (OVO, Less engaged, T16)

Her main responsibility was to code, invoice and chase payment but she was having to do this on the basis of reports that were several weeks old.

“But I’m just looking at April’s [in June] and there’s already people on there that I haven’t been told about. So they’re now being billed retrospectively for the treatment. And I think with any large organisation, there’s so many things to remember to do and of course patient care, if that’s your first priority, which is exactly right, you’re not going to think ‘oh gracious, I best ring Finance because we need to bill them’.”(OVO, Less engaged, T16)

The last of the less engaged Trusts was in an ethnically diverse and economically deprived area with potentially many migrants and overseas visitors. It follows its own policy whereby all patients with an NHS number are considered eligible for free treatment, regarding the DH guidance as guidance rather than mandatory.

“As the DH guidance is only guidance, it isn’t legislation, the Trust chooses not to follow it. So we actually identify very few overseas visitors...”

... [] So you don’t allow them to be a major issue in a sense?...

...No, because if we follow the DH guidance, we would have an issue. If we followed the DH guidance, having an NHS number means nothing and we’d have to interview, you know, we would then need an overseas visitor department as opposed to a bolt-on to my job.” (OVO, Less engaged, T25)

She recognised that the main reason for the Trust adopting its own policy was that it meant they would be paid for the treatment provided regardless of a patient's chargeable status.

"I think it's to do with payment because if they've got an NHS number, then the commissioners will still pay us if we don't flag them as an overseas visitor."
(OVO, Less engaged, T25)

The person responsible for the area spends very little time on this small part of her role (sometimes nothing in a week) but estimated that she would need to spend possibly two days a week if they followed DH policy. She thought she interviewed less than 12 patients each year to check their eligibility and was able to describe specific patients who have been charged; indeed, the Trust seemed to take a 'tough' line on those without NHS numbers who were not exempt or could not prove they were exempt. However, she was also aware that many of the women in Maternity should be being charged as should visiting relatives of the local population. Since they were registered with a local 'friendly' GP and had an NHS number, they were not being identified.

"Yeah, I think there're a number of people coming on student visas who aren't actually a student. And if we asked them to provide evidence that they are actually studying, regardless of the NHS number, if we were doing it legitimately and properly, I think you would find there is a lot of people using maternity services while on a student visa and aren't actually studying. So they've used the visa to get over here and the entitlement for free treatment, but the reality is they've come to have the child..."

...But you would never be able to check up because that just doesn't come on your radar?...

...No, we wouldn't check purely because of our policy. But if we had the policy, I would look to use our Fraud Department to look into that, and I would ask the patient to provide evidence that they are studying." (OVO, Less engaged, T25)

5.3 Reactive Trusts

About a third of those sampled in the scoping interviews (nine Trusts) could be described as taking a more reactive approach, that is, rather than questioning the systems in place and trying to improve them, especially with respect to identifying chargeable patients, they tended to work within what they were given. This generally meant waiting until they were told about a potentially chargeable patient. Such alerts tended to be based on very obvious signals such as an overseas address or a patient not having an NHS number. The starting point was therefore often that OR status was taken for granted unless there was reason to think otherwise.

“To be honest with you, it’s just the NHS numbers they get in contact with us. If they haven’t got one, they’ll get in contact with us, this is for every department really...

...But for example, if they’ve got an NHS number and they’ve got a doctor and they have given answers to the questions even if they haven’t given truthful answers, they might well slip through?...

... Yes, they do.” (OVO, Reactive, T22)

“We don’t routinely ask everybody that comes through the door, you know. We are reliant on people saying they’ve come from certain places or we only do tend to ask the question to those that have been identified to us.” (OVO, Reactive, T3)

“I mean it depends. The problem is, if they give where they’re staying as an English address and they’ve gone to see a GP as a temporary resident and it’s put on our system you know, their English address and that GP’s a temporary GP, we wouldn’t pick it up anyway so...

...Okay, even if it was a temporary GP?...

... Yes, I mean they could be from any of those categories and they just wouldn’t be picked up unless one of the members of staff that’s treating them think ‘oh maybe’ but other than that, no.” (OVO, Reactive, T14)

These Trusts often seemed to be at an early stage in developing their response to the challenge of migrants and overseas visitors and some OVOs were on lower salary bands than those in other groupings which may, in part, explain the difficulties of driving improvements. Some also seemed to be experiencing a period of change with new systems and structures being put in place but less positively in one case, where an OVO’s position had been downgraded.

The OVOs in many of the reactive Trusts sometimes seemed to lack confidence in identifying those who are chargeable because of a lack of experience/knowledge and in talking to patients about their status.

“‘Ordinarily resident’, it’s a bit difficult because you’ve often got to take people at their word, even if you say, for example you’ve got a patient that’s never registered with a GP. That is the really difficult bit because you’re looking at that, if they’ve not been registered with a GP you’re thinking, ‘well are you an ‘ordinary resident?’” (OVO, Reactive, T9)

“Yep, this is where the system falls down in a way, isn’t it? We are at the mercy of whatever they are telling us, do you know what I mean. If they are here for some treatment, they are going to say yes. So it kind of falls down in that respect and I don’t know where, I don’t know if there is an immigration thing maybe at the airport with checks on it, I don’t know.” (OVO, Reactive, T26)

“It’s challenging the patient as well, isn’t it? It’s quite an uncomfortable thing to have to actually go and do, to say, ‘excuse me, can you prove something?’” (OVO, Reactive, T14)

There was little evidence that these OVOs were trying to reach out and influence what happens on the frontline and in individual departments with the result in the reactive Trust that took part as a case study, most staff, irrespective of their role or department, assumed that screening had taken place by the time they got to see the patient.

“I would think, well I would assume, that the staff would think that by the time the patient has got to us, it has already been highlighted to the right department.” (Nurse, Reactive, T12)

More generally, reactive OVOs seem to do little staff training on the issue, and while some might like to, others do not seem to see it as their role. In one Trust, the assumption was that emailed information was sufficient and that one staff member would pass on their knowledge to their successor if they moved on.

“Well, not so much training, you know, there’s been plenty of emails. They know what to look out for, any types of overseas patients and people are quite savvy now because of all the television programmes.” (OVO, Reactive, T12)

“We do flag it but it’s one of those things that you know, I’ve offered to go to induction days and give a little talk on overseas patients and everything but I think they think it’s so small in comparison to everything else that goes on, that it’s not worth it.” (OVO, Reactive, T14)

It was notable that other staff interviewed in the reactive case study Trust were keen to have clear guidance to help them rather than relying on ‘a feeling’ to suggest someone might be chargeable.

“Yeah, if we had a proper guideline on, yeah it would be more helpful. Sometimes it’s just the feeling, isn’t it?” (Nurse, Reactive, T12)

“I do think there should be proper training and a bit more in-depth into it.” (Reception/Administration, Reactive, T12)

Other signs of a lack of follow-through were seen in relation to information that the OVOs ask patients to bring in; in at least two reactive Trusts, outpatients are sent a letter asking them to tell reception staff if they have not lived in the country for the last 12 months and to bring in certain documents/information but the OVOs both acknowledged this almost never happens.

“So how many people do bring in that information?...”

...Not very many at all. I've been here six years and I've only seen three people. I've seen two people who have said to me, 'I've not lived here 12 months, here's my information', and someone else when they saw the doctor, they told the doctor, so it was the doctor that gave the information, so that's three people in six years." (Reception/Administration, Reactive, T12)

"But if we were informed say, by a medical secretary that this patient will be coming and they may be an overseas patient, I normally send out a letter to the patient just stating could they bring in their documentation either before their appointment or on the appointment date and just tell them that they may have to pay. Sometimes we do get that but that happens very rarely as well." (OVO, Reactive, T22)

A few of the OVOs in question felt that they did not face a significant issue with migrants and overseas visitors and they were sufficiently on top of it; moreover, the amount of input (the work they have to do) was felt to outweigh the output (income generated). They perceived that more resource would not necessarily yield more income and is more likely to increase their debt.

"There is a new directive out that suggests we should be asking every patient to demonstrate their residency. It's just not going to happen and when you weigh the administration burden of that against the small number of overseas visitors for a Trust this size, we didn't deem that to be worthwhile." (Finance, Reactive, T12)

More common however, were OVOs who were very aware that they could be doing more to identify and invoice chargeable patients but lacked the resource to do it as well as they would like. They often had a good sense of what they should be doing to make a difference but felt held back and some were very keen to have a more dedicated role and training so they could perform better.

"So as I got more into it and more involved, it's an area that I'm very conscious, I don't think it has the attention that it needs. So I've been trying to chivvy A&E along and various departments of what they should be asking, should be letting us know. But I do think that people are missed so I think that it should be, not a large percentage of my work, but I do think it should be more than it is. I do tend to do back tracking as opposed to seeing people at the point of time I should." (OVO, Reactive, T8)

"It's not ideal. Often people ring me, 'I've got an overseas visitor'. 'I'm ever so sorry I haven't got time to come and see them, give me the details and I'll send them a letter'. Where ideally, I should be able to go directly up to the ward and say, 'right, I know you probably won't have these documents with you but can I ask you some questions, how long you've been in the UK?' Just establish some very basic facts. But I'm not able to do that because of the workload here." (OVO, Reactive, T9)

The OVO in one reactive Trust was trying to bring about change because they were aware that they needed to shift their attention towards establishing eligibility before treatment rather than retrospectively and were about to introduce various measures to enable this. These included clarifying the questions that staff were expected to ask all patients, sending out their own version of the PAF with appointments and having it available for use by staff, and specifying the documents that needed to be copied as proof of status.

“With the new processes in place, I think we’ll pick up more people and we’ll be able to assess their eligibility but at the moment it’s kind of work in progress. [] I think we’ll see that going forward as more people contact me and more awareness is developed throughout the Trust. I think at the moment it’s definitely an underlying issue that patients are just put through the system but they are there and they are accessing the services so that’s why this post has been put in place to find all the different patients that may be overseas and make sure that we are collecting that data and we are charging the patients that need to be charged that are not eligible.” (OVO, Reactive, T7)

While OVOs from reactive Trusts may have little idea of how effective their systems are, they are often certain that their Trust cannot offer any examples of good practice. They have sometimes called on the help of neighbouring larger Trusts for advice and are often both interested in and impressed by what other Trusts are doing.

“From what I’ve heard and also from some of the staff, their frontline, they all ask questions. Because I’ve actually been over there myself as a patient and they do ask you the questions. Whoever it is who comes through the door, they ask questions. And if they think that they’re an overseas patient, they tell them then and there they may have to pay, the situation. And I’ve got a feeling, I’m not quite sure, the overseas managers over there, I think they only deal with overseas stuff and private patients. I don’t think they have any ad hoc duties like the way we do.” (OVO, Reactive, T22)

“She has a system in place there where again, everybody in A&E is completely clued up. She had an ‘over the line’ letter, so if the patient were to cross the line, i.e. be admitted, that they got a letter that explained ‘you must now understand from this point you may become chargeable’. It’s down to them to make sure before they have any treatments that they are entitled to it or they will have to pay. I think that was a really good idea. But I need to whisk A&E into shape, ask the questions, before we start handing letters out.” (OVO, Reactive, T8)

Most reactive Trusts who were approached were reluctant to participate as a case study. While the OVO interviewed as part of the scoping exercise might be interested, in part because they hoped it would raise the profile of the issue within their Trust, others in the Trust were unsupportive of the idea; sometimes explicitly because of staff shortages but sometimes without any reason being given.

5.4 Trusts with a Clear Sense of Direction

About a third of the Trusts sampled in the scoping interviews (n=9) were felt to come into this grouping. They were very aware of their responsibility to identify and charge patients ineligible for free NHS care and the need to follow DH guidelines as best they could. They accepted that being more effective at identifying chargeable patients will lead to higher debt but felt it is necessary to do this, in part, because they have a statutory obligation to do so.

“The main difficulty is, if we don’t follow the guidelines, it’s murky enough when we do, so if you don’t, you’ve instantly got the challenge from the patient of, ‘well, you’re not following the guidelines’. And, you know, we get that challenge anyway when we’re trying to manoeuvre our way through the guidelines. Some people know bits of the guidelines and say, ‘ah, but I’m part of this money’, but you’re not part of that and that doesn’t apply! And, you know, we’ve got far too many bits to weigh up. If actually you’re doing your own thing and they choose to challenge you, I mean, no solicitor would stand up on our behalf if we’re not following the Department of Health guidelines, so, I don’t know, I mean, that’s us, got no choice really.” (OVO, Clear direction, T29)

Like the more reactive Trusts, they were often in the process of putting staff and/or systems in place but their plans were often more ambitious and started from a more developed base; once implemented, they would be included among the proactive Trusts. They readily acknowledged that there is lots to do and were often aware (especially in the larger, busier Trusts) that currently, they may only be picking up a fraction of chargeable patients. Improved systems to identify more chargeable patients and more resource enabling them to focus on the task were key themes in these discussions. While they often exploited OVO networks for advice and support, they may not feel they have the full support of their Trust; sometimes seeing it in ‘neutral’ terms and they were aware that they may not have persuaded all departments in their Trusts to ‘come on board’.

“We’ve certainly never tried to disincentivise it, I don’t think, but, you know...

...No, I mean, I think you’re right, we send it through to you and you do whatever we ask you to do with it really. I mean, no barriers have been put in our way, I should say. I wouldn’t say there’s open support, but there’s no disincentive to do it either.” (Finance and OVO, Clear direction, T29)

In terms of the procedures that they follow, the starting point for these Trusts is often not so different to the reactive Trusts; they are waiting for staff or reports to flag up potentially chargeable patients and will then investigate them further. The key

difference is that they were reaching out to, and engaging with, staff to make them aware of the range of indicators for chargeable patients and they were more confident that screening questions were being asked. They may also be trying to put in place systems that will enable potentially chargeable patients to be identified earlier. On the case study visits, the research team witnessed how active the OVOs were; regularly receiving email or telephone alerts to a possible overseas visitor and responding, often by visiting departments and going to see patients.

Also during the case study interviews, other staff confirmed this level of engagement and how the OVO had raised the profile of the issue within the Trust. The OVO was often greeted by name in the corridors as we accompanied them.

“There is a heightened awareness of the cost of patients who should be being charged for the care that we provide. We don’t have an infinite budget. We have to manage our resources appropriately. So there has been a huge increase in raising the profile, you know, the work of [name of OVO] for instance.” (Matron, Clear direction, T10)

“[Name of OVO]’s been to the Senior Sisters’ meetings and has discussed it with us. Last year she came and did it and I’m sure she’ll be back again this year and discuss where the Trust’s at, how we should be approaching people, and the simple process that we’ve got in place.” (Nurse, Clear direction, T10)

As part of this, they may also be emphasising the importance of not making judgements about patients based on name, accent, ability to speak English etc.

“I don’t think that a lot of people understand that actually it’s not about being British, it’s not about having an NHS number and it’s not about being Black or foreign, or not speaking English, it’s about making sure that we are treating all of our patients fairly.” (OVO, Clear direction, T10)

“Also, you’ve got to make them aware, just because somebody has got a foreign accent, it doesn’t mean they’re an overseas visitor.” (OVO, Clear direction, T4)

In one Trust with a clear sense of direction, they had tripled the number of migrants and overseas visitors being identified simply by bringing home to all staff that they should ask all new patients the 12 month residency question; interestingly however, the OVO in question was receiving a report on a weekly, rather than a daily basis.

“All the staff have been made aware that every patient who comes in for a new episode, as part of the patient demographic details, and checking that those details are correct, as part of that data capture, staff ask every new patient, or a patient for a new episode, the question, ‘have they resided in the UK for the last 12 months?’ And from that, if a patient answers no, then they update the system with a query and I get a report from that query every Monday. Obviously

sometimes you do have these language barriers and they don't understand or sometimes because people are ill as well, there is that confusion element of that. If there is any confusion again, the staff will put that answer to that question in query on the hospital system.” (OVO, Clear direction, T15)

They may also have targeted key areas in the hospital where they felt they could have most impact, for example, Maternity, A&E, and Outpatients, and some had recognised the importance of A&E as a critical gateway into the hospital and put in place procedures there. In one case study Trust for example, the reception staff in A&E confirmed this by describing how they ask the 12 month residency question, fill out a form if the patient has been in the UK for less than this, photocopy any documents they are given and send it to the OVO. In another, they alert the OV team to anyone coming in who might be a migrant or overseas visitor and leave it to them to check whether they have been admitted or been referred to Outpatients. Yet another OVO was aware that A&E might find it difficult to keep them informed and so was calling everyday to see if a patient had been referred on to Out or Inpatients; their notes were kept to one side.

“But if they have any suspicion about anybody or they're not happy about anybody, they'll also inform us but certainly what they will do, if somebody is not OR, they'll send us, they'll fill in what we call our form A, they'll fill that in and send that down. And if that person is admitted, we've already got a bit of a head start because we can pick that up straightaway and get somebody out to visit them to sign form B, which states that they'll pay for any treatment that they need to pay for.” (OVO, Clear direction, T5)

“Because A&E is free, A&E are very busy but I have a system whereby I ring them every other day and hopefully that'll now be daily, just for them to tell me if they have any overseas visitors that have gone on for an outpatient appointment or have actually gone to a ward. And we follow up a lot that way as well. It's an additional way of pursuing them if you like.” (OVO, Clear direction, T18)

These OVOs were often aware of, and more prepared than their reactive counterparts, to identify and interview categories of patient that went beyond the obvious indicators, often picking up patients without GPs/NHS numbers or other signs of recent arrival or tackling other groups of migrants and overseas visitors that might typically be missed.

“I think it is because they come backwards and forwards and keep using us and go back home and take the benefits, because their partners are here. I'm now acting on the premise that if you are not married, I talk to you in your status and not your boyfriend. The boyfriend could be a one month boyfriend, two month boyfriend, I say ‘if you can't show me that you have the right to be here and have free treatment, I will charge you' and that's what I'm doing now.” (OVO, Clear direction, T1)

They were often checking documents in a more rigorous way, scanning and retaining the records, and were actively checking and/or following up documents, where relevant, with Local Counter Fraud Officers and UKBA. Some were keeping their own spreadsheets that they updated daily/frequently and were using patient information systems to alert staff and their own team to chargeable patients who may re-present.

“Because we’ve got an alert on there and if the patient is an overseas visitor and they come back again, I tend to find that people do see that alert and they’ll ring me up again and will say, ‘oh I’ve seen your alert’, and I’ll say, ‘oh I do know about this patient’, and then I can up the costs when I know he’s coming in again...”

...So this might be somebody who hasn’t paid, that’s got an outstanding bill, is that what you’re saying?...

...Yeah, it’s another way of constantly tracking and keeping an eye on that patient and making sure that you’ve captured all the funding for him or if we have his EHIC, that we’ve captured all the costs that we can reclaim for him.” (OVO, Clear direction, T18)

“Because obviously, this is the system that alerts, so if I think someone is chargeable, I put it on the system and then everybody in the Trust that accesses that patient immediately knows that they need to contact me if the patient attends.” (OVO, Clear direction, T23)

Some of these OVOs were invoicing patients up-front if proof of eligibility was not forthcoming to try and encourage them to produce the necessary documents, and then if necessary, and approved by the consultant, blocking treatment.

“If ultimately, they refuse to provide them and they refuse to obviously sign for us to contact UK Border Agency then yes, we would raise them an invoice and then often they tend to provide it then once they receive an invoice.” (OVO, Clear direction, T23)

“We haven’t had to do that very often and the points at which we’ve done that have been based on the information we’ve had at the time which means that it was quite clear that the patient would be chargeable. And it had already been established, if you like, from our point of view but we hadn’t had anything from the patient to kind of contradict us. We tried asking for information and they were obviously withholding information from us, and so we would only, we would go ahead and do that on the basis of speaking to the clinician and saying, you know, ‘how essential do you need to see this patient?’” (OVOs, Clear direction, T29)

Others were frustrated by the problem created by the late invoicing of Inpatients and systems that make it difficult to give even an estimate to patients. One Trust was trying to expedite the process of coding and invoicing where a chargeable patient might be near to discharge.

“But the problem is the coding happens, usually after they’ve been discharged. If you don’t get it to them promptly, you’re not going to be able to track them down...”

...If I know they’re leaving the country, then I would, you know....

...We’ll try and take the notes off and get them coded and get an invoice straightaway.” (OVOs, Clear direction, T29)

“With Inpatients, because the final cost is based on diagnosis and procedure carried out, it’s based on contracting issues and HRGs, we won’t know what to charge the inpatient until after they’ve left the hospital. So that is ridiculous really because you should have a way of identifying what treatment they are having and what the cost could be.” (OVO, Clear direction, T10)

Box 5 sets out some examples taken from a mix of the scoping interviews and case studies which give a fuller picture of what is happening in three Trusts with a clear sense of direction.

Box 5: Examples of systems and procedures being adopted in Trusts with a clear sense of direction

Example 1

- A newly appointed OVO who is taking up the challenge of putting in place processes in a Trust in a very large multi-cultural area
- The Trust no longer accepts 12 month residency as sufficient proof that someone is OR; they have to establish their right to reside and demonstrate they are resident in the UK
- As a first stage, all patients are asked to bring in key documents (these will vary according to the patient’s circumstances but are likely to include proof of identity, address, working status, etc.) to their In or Outpatient appointment for screening as OR
- If admissions/reception staff are not satisfied or documents have not been offered, the patient is interviewed as a second stage, by a senior nurse/ administrator nominated by each clinical directorate; these staff also deal with the administration for any EHICs. They will contact Finance to find out how much the treatment is going to cost for any chargeable patients and if the patient is not willing to pay, will cancel the appointment
- These staff then notify the OVO if there are any issues
- If patients have not been through the process and have another appointment, they are sent a PAF with an SAE and asked to return it before their next appointment; this also asks for consent to contact UKBA about their status if necessary
- The OVO may carry out checks on ex-pats with DWP and may put a stop to elective treatment if necessary
- She has initiated a training programme covering all clinical areas, both among frontline staff involved in the first stage and those nominated to carry out the second stage.

“I think it’s quite important for them to know why it’s important for them to identify in the first instance. If they understand a bit more about the regulations, then they’ll understand what they are supposed to be looking at.” (OVO, Clear direction)

Example 2

- This OVO is committed to staff engagement (e-training and ad hoc training among senior staff); however, Human Resources have stopped her presenting as part of the induction programme because of lack of time

“I’m continually revising my training, continually talking to people and revising the e-learning package at every opportunity. [] So every month I pick a ward and I go to a ward and go, ‘right you’ve had this, you’ve got this new patient on your ward at the moment’, because it’s new and that’s the process we are following and that seems to be working.” (OVO, Clear direction)

Interestingly, those who have not received formal training sometimes commented on how they felt they would have benefitted from this.

“I do feel that some sort of training might have been good, so we’ve got definite things to follow. I’m a bit like that I’m afraid, I like to know where I am and I like to know exactly what I need to do.” (Reception/Administration, Clear direction)

- The OVO has developed an information leaflet for patients which is available in departments and which she uses during interviews and for staff, has put up posters around departments and developed a screen saver as a constant reminder
- All staff responsible for booking patients in for care are required to ask all new patients whether they have lived in the UK for less than 12 months. If they have, the patients are asked to fill in a UK/Non-UK resident information form, and the staff member contacts the OVO. She has devised a flowchart to help staff work out whether to ask the patient to complete the registration form, and to determine whether further investigation is required
- Co-operative departments include A&E, Outpatients, Maternity, Surgical Assessment and Acute Medical units, Imaging, and some wards. In Maternity, new patients are asked to sign a declaration of status at booking. If they present for the first time well into their pregnancy, the case is referred to the OVO

“I do believe in this organisation we have a very robust process in place, so at the very first encounter with a woman who may fall into either of those categories, we would ask her to sign a declaration of her status in the UK in terms of overseas visitor or migrant or permanent resident or whatever the case may be, and we ask her to actually sign that right at the outset of the relationship with her. [] Somebody coming in, in advanced pregnancy, has arrived from overseas and presented themselves in need of care, potentially specifically has come to the UK for that purpose, I would imagine. So the likelihood of that person being eligible for payment is higher, so we want to flag that.” (Matron, Clear direction)

- Relevant documents provided by migrants and overseas visitors are copied and if necessary, she proactively helps EEA patients obtain a PRC if they do not have an EHIC.
- She would like to be able to advise in-patients of the likely cost of treatment as early as possible but usually has to wait and then arrive at a plan to pay the bill. Maternity services are invoiced upfront and patients are expected to pay a good proportion of the bill before delivery. Smaller amounts may be collected using a credit card machine at Outpatient appointments.
- She maintains her own database which she updates daily with patient and invoicing details.

Example 3

- Small OV team whose OVM has put processes in place in A&E (residency question plus when the patient arrived in the UK) and in Maternity (PAFs used at first appointment). She receives reports four times a day from Inpatients about potentially chargeable patients
- While Outpatients’ systems are not set up for picking up migrants and overseas visitors, the

appointments office will alert the team

“As I said, at the moment our appointments office and referrals department are very good because as soon as they’ve read a letter and it’s said something, ‘somebody has arrived in the country two months’, they contact us straightaway to say, ‘can we make this booking?’” (OVO, Clear direction)

- They look for patients without a GP or NHS number, or with a recent NHS number, checking on Spine if necessary. If an overseas address is given, this cannot be changed to a UK address without the OVO doing it
- She is putting up posters and making leaflets available in various departments to make patients aware of the possibility of being asked questions about whether they are chargeable
- She will invoice regardless if patients refuse to co-operate

“My teams can deal with some really difficult patients. They become very shady, they don’t want to fill out the pre-attendance forms, they don’t want to answer questions, they refuse to answer questions. So it can be very difficult for my team...”

...And what do you do in that situation where somebody is refusing?...

..Well we say, ‘Sir/Madam, we will just have to invoice you because you have refused to give us the documentation so we have no choice but to invoice you.’” (OVO, Clear direction)

5.5 Proactive Trusts

A further third of those sampled (n=8) could be described as proactive in their approach. They were frequently the most ‘dedicated’ OVOs in the sample, being both very enthusiastic and committed to their role and also able to focus on the task, perhaps as part of a larger team. They mostly seemed to have the support of senior management, and Finance in particular, but they acknowledged that they may not have yet persuaded all departments to ‘come on board’ and therefore were conscious that not all patients were being screened and not all chargeable patients were being identified.

“Fundamentally, it is wrong to allow somebody to access NHS services free of charge if they’re not entitled to. You know that’s misuse of NHS money, funding etc. and I think that’s something that we do feel quite passionate about is getting this right. So from a sort of finance point of view, it’s small beer, but from a principle kind of view, that kind of pushes it up the radar if you like.” (OVO, Proactive, T2)

They are very aware of the impact of their work on the Trust because, although the sums involved might be small compared to the activity of the Trust as a whole, the high levels of debt that often follow more active identification and invoicing of chargeable migrants and overseas visitors may attract a lot of attention; these were sometimes caused by a small number of very costly treatments or patients from whom it was not possible to collect payment. They were very aware of their obligation to charge those

migrants and overseas visitors who are ineligible for free treatment and of persuading others in their Trust to understand this.

“It’s making clinical staff understand that we have an obligation. We don’t have an option, we have to comply with the regulations.” (OVO, Proactive, T6)

“It’s not just about recovering debt, it’s about avoiding the cost in the first place and so only treating where absolutely necessary and getting as much income in upfront and refusing treatment. It’s a hard decision to make, it’s a new thing really for a lot of the consultants, because of the whole ethical side to it as well.” (Finance, Proactive, T24)

They have well developed and often evolving systems and procedures, and are confident that they are constantly looking to improve these. In many of the larger Trusts, they sometimes expressed the view that they could achieve even more with more resource.

“We do have a good working relationship with all the departments within the Trust to highlight it so yes, I would say we were 90 per cent effective but saying that, if we do talk to other Trusts that have a different method, we are always happy to change our systems and adapt to something that could be more positive as well.” (OVO, Proactive, T28)

Like the Trusts with a clear sense of direction, the proactive OVOs are reaching out and educating other parts of the Trust to initiate the screening process. Case study interviews confirmed that staff were playing a role in identifying potentially chargeable patients and that communications between reception/administration staff and the OV team were often frequent.

“They would be flagged by either myself, the ward, whoever has entered the patient information into the patient centre and we literally hand them over to [name of OVO] and I keep her informed of, ‘are you aware they are actually having their operation today, were you aware that we are actually looking to discharge them tomorrow, have you had a chance to go and do your interview? Is it okay for us to discharge them, do you need to issue a bill and do they need to pay?’ So it’s that sort of thing. Because we are all on the same level and because I fly between all three wards, I pass [name of OVO’s] door numerous times during the day and I’ll just stick my head in and if it’s after a multidisciplinary team meeting where we have an update on how the patient is doing, what the plans are, I can come straight from that meeting and go straight to her. If she is not there, then I will email.” (Nurse, Proactive, T24)

In one Trust based across eight sites, all sites had adopted a mandatory screening process requiring them to ask patients the 12 month residency question; if this is answered in the affirmative, other cues will be also used to alert the OV team including the lack of a GP or NHS number.

There were also examples of Trusts that had tried to have a dialogue with GPs where perhaps the GP had made a referral but the patient had not responded to requests for documents to prove eligibility for free care. Occasionally, a Trust may be forewarned by a GP that a patient they are referring may be chargeable (although as noted elsewhere in the report, this was not the norm).

“We do quite often get phone calls from GP practices to say, ‘we have got a patient, we are going to refer them but we’re not sure’. Whether they charge them or not is entirely up to them, which of course they don’t have to. But we do get quite a few phone calls from GP’s giving us the heads up about patients that they’re referring. Not always, but they’re fairly good about it and some of them will charge because it’s their choice.” (OVO, Proactive, T2)

Some of the proactive OVOs were engaging with clinicians to understand the issues and encourage them to stabilise patients rather than fully treating them if they were chargeable but unable and/or unwilling to pay for treatment. In one Trust, they were putting a statement on chargeable patients’ files that they should be treated only until they are stable.

“I think in the past and not so much that I’m aware of recently, we had issues with, because we have to treat the patient to the state of being stable. Some of the doctors wouldn’t stop there and took it as far as if they were an NHS patient resident here. The doctors might deem ‘well, I will do that extra test just in case’ or whatever, whereas technically, they only have to stabilise the patient and really not look any further and it was in the past we did have issues with doctors not wanting to stop there, if that makes sense.” (OVO, Proactive, T28)

These OVOs generally aimed to gather information in a timely fashion and often this was done before the patient came into the system, thus saving time investigating patients once they were in the hospital receiving treatment. This pre-attendance screening might be done through writing to them or telephoning them. OVOs might also meet patients at their appointments if they had been unable to resolve matters in advance.

“We just explain to them who we are, the reason why it’s been flagged up and we just need to check that if they are a permanent resident of the UK and they’re fine actually and just ask them what their situation is and then they just tell us their situation. We would ask for documentation surrounding that, you know, depending on their situation.” (OVO, Proactive, T21)

“I thought that then catches them, rather than go round to all the different Outpatient departments, try and catch the people before they actually come into the hospital.” (OVO, Proactive, T27)

In a specialist Trust, the central referrals office has recently started sending every patient a pre-attendance form and patients are not allowed to register without completing this; the impact of this has yet to be seen but it was felt that this means that every patient is treated in the same way and it should be much easier to identify potentially chargeable patients. The Trust will allow those who may be chargeable to attend for assessment to see if treatment is immediately necessary.

In general, these OVOs were more likely to take an approach that meant the patient had to prove they were exempt from charging rather than starting from the viewpoint that they were eligible for free treatment unless there was some obvious reason that they were not. This might entail asking questions other than the 12 month residency question, invoicing if documents are not produced and blocking treatment if not urgent.

“You find that people know perhaps they’ve got to be here for 12 months so you’re working to establish residency so the thing to do is to ask ‘when did you arrive?’ rather than, ‘how long have you been here?’ because you know they are going to say ‘oh, 12 months’. They’ve got that off pat, so again, you need to see the documentation but nothing is 100 per cent full proof.” (OVO, Proactive, T28)

“In some cases the patient will respond to the letter. More than 50 per cent of the time I would say they don’t respond to the letter but they do then respond when they get the invoice. It sort of forces their minds really.” (OVO, Proactive, T2)

These OVOs were often stricter about the forms of documentary proof that were acceptable and more likely to scrutinise and follow these up where necessary, for example, to find out whether a student is attending their course. One Trust described looking for proof of residency for EEA patients claiming to be resident in the form of tenancy agreements, council tax bills and proof of employment extending 12 months. OVOs might not accept utility bills because they were aware these could be printed from the internet with the patient’s details inserted fraudulently. Ex-pats might be checked on the electoral register, and if they claim to have re-located, through proof of having given up residency elsewhere e.g. sale of property, shipping of goods. Non-working spouses might be asked for marriage certificates, proof of children being enrolled in school, bank statements. Where such evidence was not available, for example, if an EEA citizen was paid cash in hand or rented a room in a house, they might then be deemed chargeable.

Examples of the approach being adopted by three proactive Trusts are summarised in Box 6.

Box 6: Examples of systems and procedures being adopted in proactive Trusts

Example 4

- Part-time OVO who, with the addition of a part-time assistant, has succeeded in doubling the number of enquiries handled, the number of chargeable patients identified and increasing the level of debt recovered – last year this stood at 87 per cent.
- She has put in place various processes at different entry points to identify chargeable patients, invoice them in a timely manner and pursue payment in advance. This has been accompanied by training in the main clinical areas. These include:
 - GP referrals: telephone appointments team check the referral letter, NHS number etc and pass it on to her if unsure; she then sends a letter and PAF to the patient pointing out that they may not be eligible for free treatment and requesting the relevant documents; if she cannot contact the patient and the patient does not pursue the appointment, she lets the GP know.
 - Maternity: community midwives fill out a PAF at the booking-in appointment with all women and discuss how long they have been in the UK; will refer to the OVO if unsure about the patient's eligibility and the OVO will follow up, requesting documents. If not provided, she meets the patient at the first scan to explain, if relevant, that treatment is not being refused but she will be charged.

“So I get a pre-attendance form and it may say that this person has been in the UK since June 2013, and they are maybe 20 weeks pregnant. I will then call the patient, talk to them about their circumstances, talk to them about what documents I would need and whether they are chargeable. If I can't get a reply or an answer to that, I will then go up for their scan appointment and I will interview them and talk to them. And I know that the regulation is that we can't refuse immediately necessary treatment, but I will speak to the patient and say we are not refusing treatment today, but if you have your appointment, we will be looking to charge and I will talk to them about the cost of care and I will try and obtain an 'agreement to pay' form, and payment for that appointment.” (OVO, Proactive)
- If the patient says they cannot pay for an appointment, she will try and get their credit card details or a deposit; if they say they will not pay, the patient is asked to sign to the effect that they are refusing treatment, rather than the Trust refusing to give it
- She is setting up processes in A&E to ask all patients how long they have been resident in the UK, whether they are a UK national and whether they have a right to reside
- Patients on the waiting list complete a PAF when they come in for their pre-admission appointment; she would ideally like to see these questions also included in the nursing assessment form when the patient is admitted
- She is looking at each department's existing processes and trying to include the residency question in these rather than creating a separate form
- If, after checking documents, she is satisfied, she will send the patient a letter of entitlement
- Where a patient is chargeable, she tries to give patients an accurate idea of the cost of treatment as early as possible so they can decide whether to go ahead; e.g. she will take someone from the coding team to the ward to find out the treatment details and arrive at an HRG²⁵; the patient then knows how much their bill is likely to be as well as being told that it will need to be settled before being discharged. If the patient then decides not to go ahead, they complete a self discharge form

²⁵ Healthcare Resource Group (HRG) is a grouping consisting of patient events that have been judged to consume a similar level of resource.

“I’ve had a patient that has been in and they had been in the UK for two days. They had come literally pretty much from the airport, one day stay at somebody’s house, straight into the hospital for treatment. I said to them that their bill was going to be, I don’t know, say £1200. They had been in less than 48 hours and I said, ‘at the moment your bill stands at 400 and something pounds’. I said, ‘if you are still in tomorrow and you require further treatment then your bill will be £1200. I can’t talk to you about discharge, you need to make your choice on how well you feel that you are, but I am just letting you know what the financial figures are’, and the patient said, ‘well, it’s cheaper for me to go back and have my treatment. I want to self-discharge’, and they went.” (OVO, Proactive)

Example 5

- OVM with small team that includes part-time administrative staff on different sites who interview patients and invoice/do administration. Staff confirm that having one of the OV administration team in their department means that more chargeable patients are identified than they would have been
- Have improved identification of chargeable patients but not getting paid in advance especially with respect to irregular migrants due to difficulties of estimating costs; would like to be able to tell patients their estimated bill before admission. Have started requesting payment up-front for Outpatient appointments
- PAF sent with Outpatient appointments as part of demographic form asking about residence, date of entering UK, any visas; follow-up telephone interview is conducted if the patient has been in the UK for less than 12 months; similar process with Choose and Book appointments
- Inpatients interviewed if in UK less than 12 months, if do not have legal right to be in the UK or if do not have GP/NHS number
- In Maternity, interviewing everyone and investigating documents; have identified overstayers and patients who are coming and going from the UK
- Receive daily reports from across the Trust of potential migrants and overseas visitors based on overseas address, no GP or NHS number. This enables the OV team to identify those who have been admitted ‘out of hours’. Using the reports, have focused staff training on departments seeing more migrants and overseas visitors; maternity, gynaecology, cancer, cardiology, renal/dialysis and orthopaedic/trauma and have seen an increase in patients interviewed
- The data quality team alert OVO to changes in records that make someone no longer chargeable and if a patient newly registered with the Trust does not have an NHS number
- Is aware that staff may not feel comfortable asking all the questions so carries out training and wants to create an expectation among patients and local communities that they will be asked

“We’re looking to do an awareness campaign to make it really clear to everybody within each waiting room, within A&E and all the ward clerks etc., so they know what they need to be asking and patients are aware that they are going to be asked those questions. I think that is the problem, the patient doesn’t like being asked the questions but we need to make them aware that they are going to be asked those questions and I would like to work within the communities to explain that this is what they are going to be asked.” (OVO, Proactive)

- Director support for only treating emergency patients for life-threatening condition and not referring them for other conditions; Financial Controller confirms that they are monitoring this so that bad debt comes to reflect treatment that is immediately necessary

“What we are trying to develop is a control whereby the patient gets treated for the illness that they’ve been admitted in via A&E but only that illness and any other things

that are identified while they are in, if it's not life threatening, they don't get referred on to.” (OVO, Proactive)

- If potentially chargeable patients are on a waiting list, the OV team will consult the consultant and find out if the appointment is necessary, and if not, it will be cancelled with the consultant's agreement
- Elective in-patients who are chargeable may be directed to treatment as private patients.

Example 6

- Small team of OVM, OVO and part-time administrative staff who have introduced systems to enable the Trust to identify new chargeable patients before they are treated; this includes charging EEA nationals who cannot prove residency/ do not have an EHIC/ cannot get a PRC

“Certainly the Trust tactic at the moment is that we try to identify everybody who is not entitled to free care before they receive free care, to ensure that they get charged. It's a new procedure to identify those patients at an earlier stage, because previously we were relying on our members of staff being diligent when they are already under pressure. It's early days for the policy, I would be very surprised if we were picking up 100 per cent, but I also think that the way it's being done is quite clever and I'd be surprised if we are not picking up most, but I wouldn't want to put a percentage on it.” (Finance, Proactive)

- Receive a daily report of all referrals coming in the previous day with new registration number; new/no NHS number; no/recent GP registration. Covers In and Outpatients and looking into extending it to X-ray, blood tests. Also follow up if patient has had tests outside the UK. New registrations are also asked to complete a PAF in A&E or staff put notes to one side for the OVO to follow up
- Go through the report every day and check patients on Spine, and possibly with their GP
- Other departments confirm the process e.g. in Renal, patients are asked about residency before seeing a doctor; at Antenatal reception, all those who are new are required to complete a PAF before their notes are passed on. Suspicious behaviour/any indication that the patient has only been in the UK a short time triggers further investigation

“Sometimes they tick yes but we can see by the NHS number, it's maybe 707 and we'll know that that is a spanking brand new or pretty new number. So we won't take that as read. Sometimes we ring the doctor's surgery to see when they registered. In our department, because it is a big problem, we have so many that we are getting a bit you know, 'if you are not entitled to it, you need to pay'.” (Reception/Administration, Proactive)

“We have the booking form come in, in the first instance, if we can see that on the information that we've received, if it says the lady has not been in the UK for the last 12 months, we put an alert on. We put the alert on and if we know that she only arrived in the UK say in April, then we'll type it in, 'she arrived from wherever in April' and then the OV team can see and will look into it and see whether they've got any documentation to say that they are entitled to free treatment or whatever.” (Reception/Administration, Proactive)

- Try to phone all newly registered patients and if get no answer, write/email a series of letters
 - Send explanatory leaflet and a PAF with an SAE, and identify the documentary proof required
 - If the patient does not respond and they have an appointment, the OVO meets them at it and interviews them
 - If the patient is on a waiting list for an appointment, a second letter is sent with an estimate of the cost; most people respond at this point or again, the OVO meets them

when they arrive for the appointment.

“I think it’s because they want the service. You know, it’s prior to the appointment and they are wanting the appointment. It’s so important to do this before the appointment because they are still wanting it. After the event, it’s all too late.” (OVO, Proactive)

- The commissioning team provide worst case scenario costs for the OV team as a basis for collecting payment for Inpatients before going onto the ward, followed by adjusted costs if treatment changes
- The new procedures have led to more ‘did not attends’ (DNAs) and cancellations when patients have decided not to go ahead but the Trust has also recovered far more debt (have approximately doubled over the first five months of this financial year compared to the whole of last year)

“Wrongly or rightly, you do get money out of people who are in front of you and need the service. Once they’ve left the building, you are not going to be getting money out of them. You don’t even know where they are. You’ll get false addresses, addresses that aren’t even houses, all sorts of bits and pieces. You need to get them when they are there or before they access the treatment, or a deposit.” (Nurse, Proactive)

- They log details of visa expiry dates to track patients who re-present and put alerts on the system for reception staff etc. to contact the OVO.

5.6 Summary of Good Practice

Box 7 below summarises the ideas for good practice that can be drawn from across the proactive Trusts and those with a clear sense of direction. They are arranged according to the different steps of the process, from identifying potentially chargeable patients, to recovering charges and tracking patients after they have left the system.

Box 7: Examples of good practice	
Stage of the process	Ideas for good practice
Identifying potentially chargeable patients	<ul style="list-style-type: none"> • Ongoing training of staff, ideally including at induction to stress the importance of asking all patients the residency question • Making patients aware of the possibility of charging with leaflets and posters in waiting rooms; leaflets sent with requests for information • Supplementing/ replacing the 12 month residency question to ascertain pattern of movement, whether a UK national and right to reside in the UK • Using /adapting existing forms used in departments which patients have to complete • Using the forms at all stages of the process to ensure patients are not missed including pre-admission appointments for Inpatients • Proactively asking frontline staff for updates on possible migrants and overseas visitors rather than waiting for them to find time to contact the OVO (especially important for A&E and patients who have been referred onwards and therefore become

	<p>chargeable)</p> <ul style="list-style-type: none"> • Involving back office staff to screen all referrals, check NHS numbers etc • Where reports are provided of potentially chargeable patients, this is done on at least a daily basis to ensure a fast response • Looking for other indicators e.g. recent NHS numbers that can be followed up using Spine • Automatic referral of all new patients from overseas presenting for the first time late in their pregnancy • Copying/ scanning and storing of documents provided as proof of status
Establishing whether the patient is exempt or chargeable	<ul style="list-style-type: none"> • Requesting patients to send in/bring in to their appointment documents that prove their status so as to screen them before treatment • More rigorous questioning of patients and identification of key documents to be provided as proof of OR status • When patients have failed to prove they are exempt, invoicing in advance of treatment to encourage them to provide the documents and if necessary, blocking treatment (with the agreement of the consultant) • Checks performed with Border Force/Immigration Enforcement and DWP (for ex-pats) with patients' consent
Advising and invoicing chargeable patients	<ul style="list-style-type: none"> • Advising patients of the estimated cost/invoicing patients in advance of treatment
Raising and recovering charges	<ul style="list-style-type: none"> • Gaining full or a significant part of the payment in advance • If patients are unwilling to pay, non-urgent appointments may be cancelled • Where patients admitted from A&E are unwilling/unable to pay, their file may contain the statement that they are to be treated until they are stable • Elective in-patients who are chargeable may be directed to treatment as private patients
Ongoing tracking	<ul style="list-style-type: none"> • Logging alerts on the Trust database for chargeable patients in case they return/have not paid their invoice • Also logging of relevant details such as visa expiry dates

6 Impacts and Challenges within Secondary Care

6.1 Introduction

In this section, the impacts of, and challenges associated with treating migrants and overseas visitors in secondary care are reported.

The impacts include:

- financial impacts
- communication issues with their implications for patient care and the additional time needed to provide this
- concerns about the standard of care that can be provided and the risks involved
- different expectations of healthcare and implications for the relationship between providers and patients
- impact on other patients
- impact on staff morale.

The impacts for two frequently used departments (maternity and renal) are described more fully.

It should be noted that these impacts may also relate to the wider population of patients including migrants with ILR, EEA permanent residents, as well as British nationals who have a right of abode and who live in the UK but who have limited use of English.

6.2 Financial impacts

The principal financial impacts involved in treating chargeable patients are the additional costs and the bad debt incurred and this has been described in section 4.6.

Trusts taking part in the research were asked to identify the costs associated with treating chargeable patients in addition to the cost of the care provided. As explained in section 4.5.1, most of the Trusts seemed to be charging patients based on the NHS tariff although some were adding on something to cover administration; some of the following costs may therefore be counted within that additional amount.

A range of types of cost were identified but respondents were unable to easily quantify these as they were unlikely to apply exclusively to chargeable patients. They were:

- **Interpretation** (telephone and face to face) and **translation services**. Many staff across Trusts expressed disquiet about the amount of money spent on interpreters although this cost is not confined to chargeable migrants and overseas visitors and there was some uncertainty about who paid for them
- Costs incurred in **writing to/telephoning** patients to enquire about their status including telephone charges, stationery, postage; telephone costs could also be incurred if liaising with insurance companies (often overseas)
- Costs incurred in **chasing up debts** including legal traces, debt collection agencies
- **Credit card charges** where patients opted to pay in this way.

It was also pointed out that **the time of a wide range of staff** is involved in serving the needs of such patients and this will not be reflected in the NHS tariff; this will include the considerable time spent by the OVO team but also the time of clinicians spent in MDT (multi-disciplinary team) meetings and those delivering diagnostic services such as Imaging/MRI, radiography and haematology. Moreover, it was pointed out that the clinician time reflected in the NHS tariff may not include the additional time required when treating migrants and overseas visitors (especially where there are communication problems). It was also questioned whether all services such as physiotherapy and the cost of drugs were captured.

“I mean obviously they are taking up a bed, obviously they are quite often, we are an overstretched resource, so it might not just be the fact that they are taking up the bed, it might be that a consultant has got to do a special list so there’s additional costs in terms of, he might be coming in on a Saturday or Sunday to treat them. There are plenty of knock-ons, you know outside of direct costs. I’m sure we are not alone, we have got a hospital which is absolutely bursting at the seams, you know you’ve got accident and emergency which is struggling to make things happen. Non-elective payments are obviously set on 2009 volumes and volumes in A&E have gone up 4 or 5 per cent year on year so the pressures are very real.” (Finance, Proactive, T13)

Some hospitals/departments may have small numbers of chargeable patients but the cost of treatment for each can be very high. One specialist Trust in the sample, for

example, over three years, had charged just ten non-EEA patients a total of some £380k (only 12 per cent of which had been paid.) These were very ill patients who had come to the hospital on visitor visas and returned to their countries.

“The number of clinicians in the organisation involved in some of these patients at any one point in time, must be 10/20/25 when you think about theatres, pathology, radiology and the pharmacy department, expensive tests and you know the wider, if they’ve got social problems, social workers, the administration, clinical management. It’s big and it sucks in an awful lot of resource.” (OVO, Proactive, T6)

Respondents based in smaller units without economies of scale or support for migrants in the community, sometimes felt that they were feeling considerable strain on their resources compared with areas that have larger number of overseas visitors where there is an infrastructure to provide support.

“And we are already struggling because of the maternity pathway issues and the fact that we are going to lose income around that, because we are a smaller unit.” (Midwife, Clear direction, T29)

“Because I know that in the [region], they are in a minority compared with other parts of the country, but that doesn’t mean to say it doesn’t have an impact because we are not used to it, as much as others. It has a greater impact because of lack of knowledge of where to direct people.” (Midwife, Clear direction, T18)

However, respondents from larger Trusts with large numbers of migrants sometimes felt that the number and particular needs of migrants in an area is not reflected in NHS contracts; as one respondent pointed out, such Trusts have more users of the service who take up beds but they are not being paid for those users.

“I think the biggest effect that’s having is that it’s a huge migrant area and whilst the NHS contracts are looking at the volume of people within an area, what they don’t count is the migrants in the area, so obviously that is costing us a huge amount of money. So whilst they are saying, say a hospital had for easy purposes, ten beds and they had eight people counted in the volume of location, users of the service, actually it’s probably more like 20 because of the migrants. So you know it takes up our beds, we are not being paid for that volume of people in the area because they are not counted and that is even the non-liaible ones. The liaible ones are extra on top of that. So yeah, for an NHS we are being stretched to the limit.” (OVO, Clear direction, T17)

In several Trusts in the sample, it was noted that while the financial impact of chargeable migrants and overseas visitors may be small compared to the overall activity of the Trust, it was about the lost opportunity cost; the fact that much needed resources were being diverted from priority areas.

“Well the thing is, it is small fry in the grand scheme of things, but when you think that’s over a quarter of a million pounds, we could put that into another scanner, we could improve the service locally for the community. There’s loads of things we could do with that money.” (Administration, Clear direction, T10)

6.3 Impact on Other Patients

This could take several forms.

6.3.1 Bed availability

A number of respondents described the problems faced by their Trust with safely discharging chargeable patients who are either homeless, such as irregular migrants, or who do not have a suitable home environment to go to. This could take an enormous amount of OVO time to sort out while the patient continues to occupy a bed.

“My time is taken up if they are homeless or we’ve got accommodation issues and I’ve got [name of refugee support organisation] saying, ‘are you aware you are breaking Human Rights because of x, y and z’. I’ve got Border Control with the housing, I always keep forgetting the acronym that goes with that, where they are trying to sort out accommodation saying, ‘well actually, they need to have this done first’, trying to get hold of someone. ‘You need to get a social services assessment done’, I ring social services, ‘they are an overseas visitor or an asylum seeker, their asylum has been declined, they’ve had an injury, they are going to be vulnerable if I send them out onto the street’ – ‘no, no they are nothing to do with us’. And it can take hours and hours and hours to get sorted out.” (Nurse, Proactive, T24)

“Again in terms of discharge planning, because sometimes you don’t know where you are actually discharging the patient to and you don’t know what their entitlement to social care or you really don’t know because I mean the whole philosophy of working in a hospital is safe discharge and sometimes you just don’t know what, you know.” (Consultant, Proactive, T20)

Such problems could also arise with EEA nationals who are entitled to access the NHS at no cost if they are OR but who may not be entitled to care accessed through social services.

In the case of specialist Trusts with only limited capacity, patients who urgently require specialist care may be prevented from getting it or may need to access it from another Trust, sometimes at some distance. Other Trusts face similar challenges.

“So, if one of those beds is being occupied by somebody who really shouldn’t be there, for sort of two, three weeks, it may mean, particularly at winter time, that people who are entitled to NHS treatment, can’t access the services here and may need to be put on a [specialist] ambulance to go to [another Trust] or somewhere further afield. So there is a knock-on effect in terms of using up capacity.” (OVO, Proactive, T6)

“For instance, we had a lady that they’d already diagnosed her as terminal before she left the country and then she came here and was in a bed here for three months until she passed away. But then you’ve got patients coming into A&E that we haven’t got beds for, that we then have to obviously find beds at other hospitals for, which is unfair for people in the local community because then it means that they can’t visit their family locally each day.” (OVO, Clear direction, T23)

6.3.2 Increase in waiting lists

The view was expressed by many respondents that the treatment of migrants and overseas visitors is having an impact on the length of waiting lists with one Trust hoping to produce data on the number of NHS patients that could have been treated in their place, in order to try and persuade clinicians not to treat patients who are ineligible for free NHS care and unable to pay, or to limit treatment to what is necessary. They hoped that this would give the clinicians some understanding of how debt could be limited and other patients treated.

“What we want to try and do is say, ‘if you didn’t treat this patient, your area has treated ten patients that cost this much money, but you could have treated this many patients on the NHS’ type thing who are actually entitled to it or, ‘your waiting list has got longer because you wanted to bring that patient in.’” (OVO, Proactive, T24)

“You have to offer slots to these people even though they’re not entitled to them so that means your indigenous population who have been paying their taxes here, you say, ‘actually Mr G, you’ll have to wait, we don’t have any slots.’ It’s not fair. It’s not fair, I don’t think. Whereas we could just stabilise them and send them back to their countries. Because you can stabilise them, you can dialyse them for two to three days, stabilise them and then send them back on the next flight back to their country.” (Matron, Proactive, T20)

“The fact remains that people are utilising the service illegally and that is upping the waiting lists.” (OVO, Clear direction, T17)

In the case of one of the less engaged Trusts that was treating all patients with an NHS number free of charge, they recognised that their policy was having an impact on their waiting lists (presumably because many of those who were liable would decide not to have treatment if they were charged).

“They’re part of our demographic because we don’t capture them, they’re just within our services. I think if we did capture them and we did it correctly, it would have a significant impact. I think if we interviewed and followed the guidance as we should, we wouldn’t have some of the waiting lists that we have.” (OVO, Less engaged, T25)

6.3.3 Giving less time to other patients

On a day to day basis, appointments with patients with language barriers could overrun considerably with the result that the clinician was able to give less time to other patients than they would have liked. Overrunning clinics could have knock-on effects on other services too.

“By definition, I’ve only got a clinic for so many hours of the day and if I am spending much more of my time with one particular patient, it takes me away. You know, I have to be quite precise with spending much time with anyone else to be able to keep the clinic not overrunning by two or three hours, so either the patients stay late or the clinic overruns ... And the stress, I mean for me, if my morning clinic overruns, it then can knock on to starting my elective theatre list and that has huge implications for resources. It’s not just me as the surgeon, it’s the anaesthetist, and theatre you know, incredibly expensive resource.”
(Consultant, Clear direction, T18)

6.4 Concerns about Professional Standards

Staff sometimes expressed concerns about the level of professional care they were able to give migrants and overseas visitors, given communication issues in particular and the fact that patients might present with very complex health issues and without medical records. Moreover, they sometimes commented that they felt that they were at times at risk professionally themselves because of the difficulty of following recommended/mandatory procedures, such as using professional interpreters and gaining informed consent. The problems encountered when needing to make tertiary referrals to specialist Trusts which might not accept a chargeable patient again, were felt to potentially compromise the standard of care that could be given.

6.5 Impact on Staff Morale

Some respondents admitted that while professionally, they had to put aside any resentment they might feel about the fact that certain groups from overseas have free access to NHS services (and benefits) without apparently contributing, or the additional pressure on services, or the way that some migrants and overseas visitor patients may behave, they volunteered that it had an emotional impact.

“There are times where it’s very difficult not to feel resentful, sometimes you feel you are falling over backwards because you know you are feeling cross. So you are trying to compensate because you want to be a good professional. We can’t just keep on the way we are going because you know the workforce can’t do it, if I’m truthful. When you are working your socks off and you’re a taxpayer and your feeling is that people are milking the system for all it’s worth, it’s very difficult for

that not to take a personal toll on you and at the same time, you are pulled because you want to give the best care you can, to everybody.” (Midwife, Proactive, T13)

“There are a lot of people that I think at the moment that are entitled, if you asked the population in the Trust, morally, they probably wouldn’t think that some of these people should be entitled and I have to keep going back to the Regulations and I say, ‘it doesn’t matter what me or yourself feel about it’.” (OVO, Proactive, T27)

6.6 Impacts on Maternity

The use of maternity services by migrants and overseas visitors was identified as one of the greatest challenges for the NHS by many Trusts and Border Force staff interviewed for this research. For all but the specialist Trusts in the sample, Maternity was reported to be one of the departments most frequently accessed by migrants and overseas visitors; for this reason, staff involved in maternity care in five of the case study Trusts were interviewed. These included consultants in obstetrics and gynaecology, staff midwives, lead midwives responsible for the management of community midwife teams, and ante natal reception staff.

The identification of the issue of ‘health tourism’ by what were then UKBA personnel some years ago was prompted by the large numbers of women, notably from West Africa, who were flying in when heavily pregnant and then having their babies in the UK. This same group (notably from Nigeria but also Ghana and Cameroon) was identified by staff in many Trusts in the sample as accessing maternity services along with other groups of migrants and overseas visitors, many of whom are currently eligible for free treatment. Those who are exempt from charging include students/partners of students, partners of EEA workers (most frequently mentioned were those from Poland, Lithuania and Latvia), asylum seekers and the partners of asylum seekers on Family Reunion visas.

Those who may be chargeable for their care include partners of non-EEA nationals, partners of British men who may or may not have the necessary visas, women on visitor visas, ex-pats and undocumented migrants.

“We had a lady recently who’s come over who’s pregnant, has come over to see her husband back in February I think, was due at the end of May and mid-May we get this letter saying, ‘this lady now can’t travel back because she’s too pregnant’. And because she hasn’t got a spousal visa, she came over on a visitor’s visa, she’s got absolutely no entitlement to free NHS care.” (OVO, Proactive, T2)

While staff reported that some women readily admitted that they wished to have their babies in the UK (and accepted, if challenged that they would have to pay), suspicions were also reported that women (both exempt and non-exempt from charging) were seeking to use the UK's maternity services for reasons that they were not keen to share. Examples cited include:

- where the woman was aware of a complication with the pregnancy that required higher levels of care; this was a particular issue for a Trust treating newborns with health problems and the OVO there was resentful that the patient's chargeable status was often not been picked up by the referring Trust or the pregnancy by those issuing the visitor visa
- where non-EEA women may wish to settle in the UK after delivery; using the period following the birth and the fact that their child has been born in the UK to help in their application for leave to remain (having arrived too late to return home)
- where they are simply coming to the UK to have their babies and returning home in between
- women from EEA countries who may not be 'ordinarily resident' but who have some/all their maternity care in the UK and access maternity/child related benefits which they may continue to receive in their home state.

Staff at various Trusts had noted suspicious behaviour on the part of pregnant women and their partners; photographing forms that they were given to complete, arriving two hours before their appointment and asking to be seen for a scan (the receptionist only afterwards finding a phone message to contact the OV team when the patient arrived), or to find patients lying about their history.

“One I had the other day, an older gentleman with a younger wife and they had a son with them and I went through all the details, ‘have you lived in the UK for the last 12 months?’ And he said, ‘oh yes, she has’, and he said to the boy, ‘how long has mum lived in the UK?’ And I said, ‘oh no, there is no need to ask, that’s not fair’. [] So I gave them a form, I said, ‘because I’ve had to make buff notes up for you, we have to ask you to fill a form in’. And he put that they’d been here for 12 months and I went and got the notes. I’d only got the buff notes and the lady was 36 weeks pregnant and on the blue booking form, it said she had only just registered with a GP because she’d had all her care in [non-EEA country]. So I went back out and I said, ‘excuse me I’m sorry, but you did say that you’d

lived in the UK for the last 12 months but I notice that your wife has had all her treatment in [name of country].’ ‘Oh yes, but ...’. So I said, ‘well, you know, when did you come back into the UK?’ and he said, ‘one month ago’. I didn’t say ‘be honest’ but I was thinking that.” (Reception/Administration, Proactive, T13)

As a result of the pressures put upon maternity services by these patients (and by an increasing birth rate more generally) and the cost of the care provided (particularly if there are complications involved), many of the Trusts taking part in the research were making efforts to identify those women who were chargeable. The fact that the package of care took place over an extended period also meant that they had longer to investigate.

The key issues around providing maternity services for women from overseas, particularly those who can speak little or no English, were felt to include:

- communication difficulties
- the cost of interpreter services
- safeguarding
- variation in practices and co-management of care
- risk management
- and recovery of charges.

Each of these issues is outlined in more detail below. It should be noted however, that such difficulties may also apply when treating ‘ordinarily resident’ patients and indeed, UK citizens.

6.6.1 Communication difficulties

The use of a telephone or face to face interpreter was often required for appointments, with one Trust having switched to greater use of telephone for cost reasons. Clinicians were sometimes concerned about the quality of the interpretation by professional interpreters.

“We have the phone; I’m talking. They are saying ‘you want to take this lady to the operating theatre for a caesarean section?’ ‘Right’. I pass it on to her, I don’t know whether she understood what I said to be able then to interpret it with the

same level of urgency, importance, that kind of stuff.” (Midwife, Clear direction, T18)

“Sometimes I wonder if they’re up to medical stuff because what we’re trying to discuss is quite complex... And I sometimes wonder whether they do tell them everything because I just sort of think I have to give them the bottom line, which is ‘if this happens, brain damaged baby’. And you sometimes wonder if they’re saying these things, because I don’t know how much information they actually get sometimes. I like to think they do their job, but sometimes you see their faces sort of ‘oh gosh, do you need to say that?’ And yes I do, because this is medical - I mean legally, I need to say it...”

...Because of informed consent?...

...Yes, so I sometimes, it takes much longer, I’m not always convinced they’re telling them the way I want it told.” (Consultant, Clear direction, T18)

The principal consequence of using an interpreter in appointments or indeed, of communicating with a woman with poor English without an interpreter was the additional time taken. It was reported that rather than booking in appointments lasting an hour, they would typically last twice as long and in one case, lasted over three hours. In general, it was felt that consultations lasted at least twice as long when there were language barriers and while for some clinics, allowance was made by booking double appointments, in others where demand was very high (e.g. gestational diabetes), this was not possible and the clinic simply had to overrun.

The logistics of organising interpreters, particularly for less frequently required languages were also often difficult and telephone interpretation might have to be used when face to face would have been preferred. In some small communities, the interpreter might be known to the woman and was therefore unacceptable and there were reports of interpreters refusing to return because of altercations with the woman and/or her partner; in some cases for political reasons it seemed. Other challenges were when a woman insisted on having a female interpreter (even for the telephone service) although only a male was available or when appointments were arranged and either the woman or the interpreter did not arrive at the appointed time.

Occasionally patients might refuse to have an interpreter because, it was suggested, they did not want to face questioning, and in others, they might insist on an interpreter even though they had reasonable English, perhaps because they were concerned about the medical terminology and not understanding it.

Where available, or in the event of an emergency, staff from the hospital might sometimes be asked to interpret. While family members or friends might also be able to interpret, staff were aware that this was not good practice. Wherever a lay person without medical knowledge was being used, there was a concern that information may not be conveyed accurately either because of a lack of understanding on their part or a desire not to present the full picture, for whatever reason. As a result, there was a concern about whether patients were fully cognisant of what was being said and that staff were gaining truly informed consent necessary for procedures including intimate examinations.

“We had a patient who was expecting twins, and the husband refused an interpreter, very aggressively refused, and we had a doctor at the time, she’s not here any longer, she was Russian, and she went into the room, and obviously it’s a different language, but she could understand enough of what he was telling her to know he wasn’t telling the truth. So that is why then our policy became we can’t have family members interpreting, because we don’t know what they are saying. We don’t know. So that’s why we now have to book interpreters if we possibly can for every patient that needs one.” (Reception/Administration, Clear direction, T18)

6.6.2 Cost of interpreter services

Staff often brought up spontaneously the cost of translation services (although again, this is across all patients needing this support, not just migrants and overseas visitors). They were often aware of the financial cost and how it might be necessary to have an interpreter with the woman for several hours if she has to attend more than one clinic or needs to be accompanied during labour.

“For me, the most significant issue is the cost of translating services, which is phenomenal, and I believe in this directorate, our translation services bills are actually higher than the other directorates. We are very, very heavy users of those services. I couldn’t quote the amount, but significant sums of money are spent on translation services, because so much of our clinical care is based on consent. We can’t touch anybody or do anything to them, or offer screening and investigations and the whole process of labour and birth, without gaining consent every step of the way.” (Matron, Clear direction, T10)

They were very aware also when money was wasted because the patient did not attend her appointment.

“I personally think a lot of people don’t turn up for appointments that have been made and then you’ve got an interpreter there as well so it’s all extra costs that are involved and it’s for no reason, it’s quite frustrating sometimes.” (Reception/Administration, Clear direction, T10)

6.6.3 Safeguarding

A concern mentioned in a couple of Trusts was that of safeguarding pregnant women and the mother and her newborn. One of the consequences of situations where the male partner is interpreting for the woman is that staff cannot talk to the woman by herself or raise issues around her safety. It was noted that there seem to be cultural differences in the acceptability of domestic violence for example, that alcoholism may be present or there may simply be dangers arising from living in shared accommodation. While these could be issues for any woman, the communication barriers exacerbate the difficulties.

“And then it is about making sure that we are aware of any issues, safeguarding issues, domestic violence issues about managing to talk to them on their own you know, and managing to make sure they understand what we are telling them, particularly if they are high risk and they have got medical conditions.” (Midwife, Clear direction, T29)

“I think there’s difficulties with domestic abuse and partners or family members additionally accompanying [the patient], and it’s often difficult to get the women on their own. Although we do have a translation service, we do need to actually separate them from the person who actually uses the service. It’s often difficult to explain why you need to see them on their own...”

...Especially if there is an issue, I guess...

...Exactly. Obviously we are looking at support in a post-natal setting. If they have no family members, or no friends, or they are communal living. Sometimes we find that some groups who actually live in one particular house and they have rooms, so it’s the suitability for a newborn as well with the accommodation, family support, financially if they have got the finances to buy all the equipment they need for a newborn.” (Midwife, Clear direction, T18)

6.6.4 Variation in practices and co-management of care

It was reported in all the Trusts discussing use of maternity services that national differences in the pathway for maternity care can cause women to become anxious and demanding about following a regime that is the norm in their home country.

“For the Polish people, they find that very strange because they are used to being looked after by gynaecologists. Okay, so when they come here, they see our service as a second rate service. So they expect to see doctors and that can be difficult to explain to them culturally how that is different whereas obviously, British women accept that that is the norm. Whereas they don’t and we have to explain that to them and they sometimes have difficulty accepting that. And they get very concerned. And it is extra time that you have to spend with them, extra discussion, extra reassurance, you know, all those sorts of things and of course it is more difficult to do that if there is a language barrier.” (Midwife, Clear direction, T29)

Some staff taking part in the interviews (often the receptionists) were aware that patients were returning to their home country during their pregnancy and receiving further diagnostic tests and advice there. They might then return with the results or requests for particular care or they might be on a specific treatment regime prescribed there. This could result in patients making demands on their UK clinician and clinicians having to negotiate a solution or take time to 'educate' the patient in the different approach taken here.

*"They just say to us 'we're going be going home', back to wherever they're going to go for so long, 'can we have an appointment for when we come back?' So then we make an appointment for when they're due back in the country. I mean, some of them do come back; some of them don't come back."
(Reception/Administration, Clear direction, T29)*

*"You will sometimes have a lady that will come for a booking and she's already had her initial care in her own country and she will come and give you all her blood test results and her scan, but you can't read it because it's not in English."
(Midwife, Proactive, T13)*

It was noted by some respondents that patients sometimes disappeared part way through their care and it was assumed that they had returned home for the birth. To try and mitigate the time wasted in trying to contact these women, one Trust was asking all women at booking whether they intended to deliver in the UK.

*"There are a lot of woman hours wasted trying to find people that have gone. That's much more common. I probably, in terms of my time, I might spent three hours a week on that."
(Midwife, Proactive, T13)*

6.6.5 Risk management

Staff were very aware of the high risk group that some migrants and overseas visitors represented, particularly those from non-EEA countries with poor healthcare systems. Some might present late in their pregnancy and the clinician may have little idea of the woman's history. They sometimes presented with various other co-morbidities affecting both themselves and potentially their baby, that required treatment, and in general, there was awareness of the vulnerability of migrant women and the need to be extra-vigilant.

The shortage of midwives and lack of resourcing were all the more worrying for some Trusts taking part in the research in the context of the large numbers of women from overseas they were seeing. One small Trust, already experiencing a shortfall in midwives based on their last assessment, anticipated that this would increase due to

the higher numbers of women. A large proportion of East European patients had moved practices and registered with a walk-in centre in the middle of town which is open 12 hours per day, every day of the year. Their community midwives originally had no presence there but demand has now increased to such an extent that they are considering instigating a second day of ante-natal appointments. Their concern is that there is now a high risk caseload concentrated in one practice.

In another Trust in the sample, staff reported they are working at capacity and can have 50-60 per cent non-English speakers in a clinic. One of the knock-on effects of being able to see fewer women in a clinic to allow for interpretation, was on the time between a woman first presenting and seeing a midwife in order to organise the first scan.

6.6.6 Recovering charges

Maternity presented a particular issue for Trusts with respect to payment because they have to treat all women presenting. While they might present a provisional 'invoice' early on in the care package to those women who are ineligible for free care, some women may be unwilling or unable to pay. In some situations, the woman or she and her partner may feel they have a right to free care and therefore resist payment. One Trust was in the process of taking a woman to court for non-payment; she is claiming that because she is able to access all maternity benefits, ante-natal care and delivery must be free.

"The one we are prosecuting had a Mat B1²⁶, received statutory maternity pay and she had a maternity exemption certificate, but none of that actually says you are entitled to the hospital care, the delivery of your baby. The defence she is taking is 'I've got these so therefore I shouldn't have to pay your bill' and our defence is 'actually, no, that's irrelevant.'" (OVOs, Clear direction, T29)

6.7 Impacts on Renal

Issues around renal care for migrants and overseas visitors were discussed in three case study Trusts although it was perceived to be a national problem by those respondents.

"It's not an uncommon problem up and down the country where patients who are from overseas and are not entitled to NHS treatment, end up needing life saving

²⁶ The Maternity Certificate (MAT B1) allows a pregnant woman to claim Statutory Maternity Pay (SMP) from her employer or Maternity Allowance (MA) from Jobcentre Plus.

treatment for renal failure by dialysis and that is a big issue about if they are denied it then potentially they die, or they go away and then they present as emergencies and then they disappear. They may travel round the country, in the renal world, the nephrology world, this has been an issue that is being discussed and there has been some suggestions made by people, mainly from the London area, where I think it's much more of a problem.” (Consultant, Proactive, T24)

Many of the issues already identified in relation, for example, to patients who do not speak English, will also apply to renal care. The particular issues and concerns that were identified included financial impacts, the demand for what is a limited resource, and staff morale.

6.7.1 Financial impacts

While chargeable patients may be only small in number, it was reported that they could have significant impacts, in part due to the increased pressure on already stretched services and because of the costs involved which are high, for example, £30k pa for dialysis with co-morbidities adding to the cost.

“Our renal directorate would have to be paying for those patients and if you have five of those patients for instance, they cost £30,000 per year, and if they've got HIV and they've got other illnesses like diabetes, you charge for that. So it's £30,000 per dialysis treatment, if you have five patients that's £30,000 times five. It's too much. It's a lot of money, that's per year and we would have to fork out for that so that means I've just lost income.” (Matron, Proactive, T20)

“In our department, I would say the question of whether someone is eligible for treatment probably arises once a month or thereabouts, probably not more than that. But because of the nature of the treatment, i.e. potentially life sustaining treatment and because it's very costly, so you know on average, treating someone for dialysis for a year would be about £35,000. So it is a lot of money, you know it does consume quite a lot of time and effort just trying to sort it out.” (Consultant, Proactive, T24)

The lack of dialysis facilities in many parts of the world and, where they exist, the cost of accessing them, means that many patients from overseas accessing NHS services as an emergency are unable to pay. One Trust currently has two dialysis patients with a debt of £40,000-£50,000. The quote below is from a Trust that has not charged an ex-pat patient.

“We had a gentleman come to us and he was very chatty and I went to meet him on the ward, he'd already had some dialysis, he was not at all holding back with how much money he was owing the previous centre where he'd had his treatment at home. He'd been out of this country for many, many years, he owed an absolute fortune to the authorities there for his health treatment, he'd rocked up here at the airport and he is still having dialysis with us now [for the last 9 months], having lived out of the country for quite a few years. He should be

charged but he isn't, he hasn't got the money, so I don't know if he owes anything." (Nurse, Proactive, T13)

6.7.2 Impact on scarce resources

The dialysis units featuring in this research reported that they were working almost at capacity in terms of their regular patients with a small number of places left for patients who are coming temporarily to the area who organise their treatment in advance. Additional patients who arrive without warning can therefore put a great strain on resources and may displace new local patients.

In one Trust, the demand on renal services is so great that the OVO has the support of the full renal team to check all new patients' eligibility for free treatment; the dialysis matron confirmed the process conducted with new patients and the consultant nephrologist confirmed his prompting of staff to question eligibility.

"I tend to try and think about it and highlight it on the ward rounds, particularly if people don't have NHS numbers, if they have only been in the country a short period of time, I tend to tell the team on the ward round to get [name of OVO] to come and assess them." (Consultant, Proactive, T20)

"The process that we have put in place is they should be asking questions, the same thing as what A&E ask. So if there's any doubt or anything, I'll read the notes as well, you know sometimes the notes can say things, 'the patient has been here on holiday' or 'they're here for a few months', then you know 'the patient is just a student', you know it will say that. So then often we'd say 'actually, we need [OVO] to come in and assess this'. Then [OVO] will come through the process asking more detailed questions about that and asking for proof, 'can you bring this, can your relative bring this, you know this proof of passport, utility bills if you've been living here for years?'" (Matron, Proactive, T20)

Tests, assessments and necessary treatment are continued during the process of screening for eligibility and if a patient is identified as chargeable, the unit will provide emergency dialysis treatment but not offer chronic dialysis; instead, they will try to direct the patient to private providers.

"Well basically, if we find out that the patient is not eligible for treatment, they're given a list of hospitals in London which will offer emergency treatment. Also a list of private hospitals that will do dialysis but they will not be offered a community slot because obviously, as I said, it's long term." (Matron, Proactive, T20)

One of the issues for Trusts and the nephrology community generally seems to be the health economics of treating kidney disease. Those with chronic disease may present as an emergency in A&E without any medical history and a great deal of resources and

expense is spent assessing and stabilising them. If they are chargeable and the Trust redirects them to private dialysis providers (for which they cannot afford to pay), it is likely that they will re-present in A&E at some point in a critical state and have to repeat the same cycle. Some make the argument that it may be better to treat them chronically (or consider a transplant) and absorb the cost as this will be less costly than regular cycles of emergency care which may also result in bed blocking.

“One of my colleagues said to me, this patient that kept on coming back to A&E, kept on enquiring for emergency treatment. They said, ‘well look, it might be cheaper for us to just dialyse them chronically rather than them have to come back for emergency treatment. In another case, a patient, who was on chronic dialysis, they’re not entitled to NHS treatment, who was an asylum seeker²⁷, who kept on going round and round and round with no decision and one colleague said to people, ‘look, the longer she’s on dialysis, the more expensive it is so it would be better for her to be transplanted because it’s cheaper eventually. And then for her to go back to her country of origin with her transplant’. So there are all sorts of issues like that and working out the health economics is very difficult.” (Consultant, Proactive, T20)

An example of treatment for renal disease being accessed by an EEA economically inactive patient was provided by another Trust. The patient’s brother had rung to book him in for dialysis and although he was informed that the Trust had no capacity, they simply turned up and the hospital was forced to treat him as an emergency. Moreover, the dialysis machine could not be used for other patients while he was using it.

“His brother had come and said, ‘my brother is coming, he has booked his flights, he needs dialysis’ and I’m saying, ‘it doesn’t work like that, sorry, we have to have referrals from the unit, we have to have bloods checked. There is a whole load of paperwork you have to go through for people to come to a visiting unit.’ I said ‘we can’t take him, we haven’t got the capacity’. He came anyway. He was carrying a blood borne virus which is infectious, so we had to not only squeeze him in, we had to put him in a side room, which there is a huge shortage of, plus he had to have an isolated machine while he was here because you can’t run the risk of using that same machine for another patient, because there is a huge high risk of blood borne viruses being transmitted between renal patients. So this gentleman, he came in the back door, he had to have his own side room, he had to have his own machine. That has a massive impact on the service really and I couldn’t do that very often to be honest with you, it would make a real problem for us if that happened on a regular basis.” (Nurse, Proactive, T13)

²⁷ This term tended to be used loosely; it is likely that ‘failed asylum seeker’ was intended.

6.7.3 Staff morale

The pressures on staff are such that one renal nurse admitted that she and her colleagues found it difficult not to feel rather cross when patients who were not entitled to free treatment and who were being treated despite not being able to pay, then complained about aspects of the service such as transport (provided by volunteers) being late or needing to wait to get on a dialysis machine.

7 Obstacles to Identifying and Charging within Secondary Care

7.1 Introduction

OVOs and other staff involved in the research identified a variety of obstacles that prevented the identification and charging of patients of chargeable patients. A number of these were internal obstacles within the Trust itself while others were external to the Trust. The representatives from Border Force and Immigration Enforcement identified some additional obstacles.

7.2 Internal Obstacles

7.2.1 Attitudes to the OVO role

It was reported by members of Border Force /Immigration Enforcement and the OVO community that some Trusts have not identified a staff member with responsibility for identifying chargeable patients and it appeared that some OVOs in the sample felt largely unsupported by senior management. When organising the briefing meetings, a very experienced OVO who was retiring made contact and explained that her role was not being filled at the same level of seniority, and another OVO had seen herself downgraded. It was also reported that senior management may see OVOs as creating problems for their Trust because their actions often result in debt and they may come under pressure to limit their activities for this reason.

7.2.2 Resourcing

Resourcing levels for the OV team can mean they find it difficult to operate current systems, and carry out the required level of checks and follow-ups. This means for example, that they sometimes feel unable to check reports or PAFs in a timely manner, follow up requests for documents, and interview patients where required. They may also avoid tackling the more difficult cases.

“When I’m in the middle of accounts there’ll be things that’ll come through which I will just say ‘just put it through contracts’ because we literally haven’t got the time or the resources to follow it through.” (OVO, Clear direction, T5)

“Even though my teams try to follow up as much people as they can, because they get busy during the day, they don’t always get a chance to do all the other follow-ups straightway, so it would be good to have somebody else to do that, the follow-ups. Sometimes you have to get reports from consultants for patient’s

insurance. That holds things up as well so it's like chasing the consultant to do the report." (OVO, Clear direction, T4)

A lack of OV staff on duty in the evenings and at weekends may mean that chargeable patients are more likely to be missed or not followed up sufficiently quickly. Trusts with dispersed sites lacking staff at each site struggle to provide an efficient service and mean that either other staff (including clinicians) need to be involved, or patients are not adequately screened.

7.2.3 Training

While some of the OVOs taking part in the research are highly experienced individuals and have been central to developing systems in their Trust, they and others are very aware of the complexities and sensitivities of the job and the need for themselves and, where relevant, other members of the OV team, to receive proper training. Clearly many are drawing on, and benefitting from, the support of their professional support group and colleagues in some of the larger Trusts, but they also recognised the need for more rigorous training especially for Trusts that seem not to have large numbers of migrants and overseas visitors and therefore find it difficult to learn 'on the job'.

"I think mainly it's because it seems to be almost an add-on, just a small little add-on bit to your job, then that is probably a barrier because you'd like to do something fully and I feel if you need to embrace this then there needs to be the resource there for people to explain what's happening and explain the charging process because they haven't got any idea. Someone who's had training, especially training in dealing with individuals who are in pain or with upset relatives." (OVO, Less engaged, T16)

The lack of training for other staff in the Trust on the issue and the part they need to play was also seen as a barrier. The turnover of staff in certain roles means that there is a constant need for this. Ideally, it would be part of every new staff member's induction, although not all Trusts in the sample were including it; in at least one Trust, it had been dropped from the induction as it was not considered a high enough priority.

Do you think that would've been useful if there had been something [training] or do you feel you know almost what you need to do?...

...No, I think it would've been useful. I've learnt from experience so yes, it would be useful. It's an area that people don't particularly want to acknowledge or do because they're so used to the NHS being someone walks through the door, you treat them. And within the UK no one ever deals with money, that's just not the way it's done." (Consultant, Proactive, T20)

“Yes, I think it’s [training] absolutely essential because I remember one of the key things that features in the case that I described earlier was the son arguing about the legal aspect of things and because he worked in the NHS and he said he’s entitled to this, this and that and I was just sitting in front of him and thinking, ‘do I really know the legality and all the aspects on how to comment on this?’ And you know, luckily I had [name of OVO] with me. If I hadn’t had [OVO] with me, I don’t necessarily think that I’m going to be able to tackle the issue. So I think it’s useful to know what to do when you’re faced with that situation – some training – and I don’t think I have – I think we just sort of wing it really (laugh) with the help of people who know.” (Consultant, Proactive, T20)

7.2.4 Initial screening

Another obstacle reported in some Trusts in the sample was the lack of a defined responsibility to ask screening questions of patients or, if the questions are asked and a potential chargeable patient is identified, to inform the OVO to take it further. This means that the process which currently relies so much on frontline staff playing their role, can be very hit and miss and may come down to individual members of staff who feel strongly about the issue or are aware of the impact it has on their department.

“That’s one thing, whose job is it to identify who’s an overseas patient, who’s chargeable? And as I understand it, there’s no formal checking of that responsibility.” (Consultant, Proactive, T20)

“When they’re filling forms out, our questions are on the forms as well. If they’re admitting a patient, the questions are there. I have come across cases when, after the event, I find out and I go through the notes, they tick the box which is ‘not here all the time’ but nobody’s told us. So it’s like a paper filling exercise but not actually them following through. They’ve just got to tell somebody.” (OVO, Reactive, T8)

OVOs in some of the Trusts were aware that frontline staff, who they rely on to ask the necessary initial screening questions, were often reluctant to do so. They knew some staff found this very difficult, in part because they were worried about a confrontational reaction from the patient and in part, because they had concerns about being perceived as discriminatory. The case studies also revealed something of this reluctance.

“They don’t like it, a lot of them, they think you are victimising them but it’s something we ask everyone so we’re not discriminating. It’s not very nice, it’s not something that I enjoy doing because that’s not my nature but it’s something that has to be done.” (Reception/Administration, Clear direction, T10)

“We’ve got to try and figure out whether they’re chargeable or not, which I really don’t think that’s our responsibility. It’s like we’re on one of the lowest wages and we’re trying to force a patient to tell us all their information, I think it’s not fair.” (Reception/Administration, Reactive, T12)

7.2.5 The attitude of clinicians

The attitude of many clinicians and their frequent desire to treat regardless, without appreciating the implications, was identified as a further obstacle. This outlook means that many in clinical roles are resistant to being involved in any aspect of screening patients for their eligibility and would rather place the onus on collecting the debt that results.

“We are trying to engage with our clinicians massively but they are very anti it. They are shocked that, when you have a meeting with them, they are shocked when you say we’ve got 1.2 million pounds worth of debt, but they don’t see it as an issue for them. They see it as we’ve not done our job properly by collecting that debt in. What I’m saying to him is, ‘well, you can’t come back to me in two months time when there is a debt for £30,000 debited to your department’. And he said, ‘well, that’s for you to collect.’ But it’s impossible, how can you collect something from somebody who is living on the street? Who can I send that invoice to or that letter or the debt collection agency to? I think highlighting the issue within a Trust and the Trust taking it seriously would be the biggest thing I think that I would like.” (OVO, Proactive, T24)

“I think also it’s the consultants as well. To educate them as well because they treat regardless, they just feel that that’s what they should do. And some of the nurses are opposed to us when we go around as well because obviously their job is to treat. I think it’s about educating the consultants as well, them to be more aware of what they can treat and what isn’t deemed to be necessary. They can have the treatment when they go back home.” (OVO, Clear direction, T18)

“I think one of the issues we have is that the NHS is so geared up to treat people who come through the door without thinking about it. So one of the things we have the problem with is doctors and nurses disagreeing with us asking questions, and sometimes they won’t help us ask questions because they don’t want to find out someone needs to be charged.” (OVO, Clear direction, T29)

A number of cases were cited of where a clinician had decided to proceed with treating a patient even though he/she was aware that the patient was chargeable and that their treatment was not immediately necessary. Often, these cases involved major procedures (tumour removal, organ transplant) with a very high associated cost both for the surgery and for the long-term aftercare that would be necessary.

“So in the case of these transplants, I think it was very much a case of, ‘I’m the clinician, I’m here to help people’ and rightly or wrongly, they want to proceed with the operation.” (Finance, Proactive, T20)

Certainly the research suggested that many clinicians felt they should not be involved in any aspect of screening and few seemed to be. In one case, the consultant spontaneously suggested ideas for the pre-screening of patients reported in the press might offer an answer.

“It shouldn’t be in the hands, in my opinion, of the actual care givers, the doctors and nurses. We are supposed to be treating patients without prejudice. If the Government feel that people need to be identified, then it should be done through a separate system and that could be linking it through national insurance numbers, NHS numbers, as I’ve read in the papers and something just comes up saying this patient is not resident and not eligible or they are.” (Consultant, Proactive, T13)

The research also showed how screening patients once they have arrived in the Trust may not be practical for the smooth running of clinics.

“Partly because of the workflow as well, because it may make it very difficult for my workflow if I say to my 3 o’clock appointment, ‘I’m not seeing you till I know you’re NHS eligible’, and then 45 minutes later they email me back and say, ‘yes, they’re NHS eligible’ and then I’ve got my 3.30 and my 4 o’clock appointment there as well. In the meantime I’ve been sat doing nothing.” (Consultant, Reactive, T12)

Even if a patient flags him/herself as someone who is chargeable, staff may not take it further and call upon the OVO, as the following example illustrates.

“I’ve had one gentleman come and said, ‘I’ve asked three people’, asking who do they give their insurance details to. This was the patient asking, ‘who do I give this to?’, and they said, ‘don’t worry about it.’” (Reception/Administration, Clear direction, T29)

It was also on occasion reported that OVOs may come under pressure from other staff to ‘back off’ when trying to do their job responsibly by asking the necessary questions to determine eligibility for free treatment.

7.2.6 Other internal obstacles

Other obstacles that were identified by respondents included:

- The lack of facility in some Trusts to arrive at an estimate of the cost of treatment to enable patients to decide about going ahead or paying in advance plus delays in coding treatments or raising invoices so that patients can be invoiced prior to or at discharge.

“A lot of the issues are that patients who are only in for like a day, don’t understand they can be charged up to £1,000 or over £1,000 or if a patient is in overnight, or two or three days, it can be £3,000. They just don’t understand the charges.” (OVO, Proactive, T24)

- IT systems that do not support the identification of potentially chargeable patients. This can take the form of non-mandatory fields so that essential

information does not have to be entered, or fields which have to be filled, sometimes with misleading information (see the example below), where critical information may be altered very easily, or there is a lack of facility to add in information or alerts about patients.

In one Trust, even though it may be discovered that a patient did not have a GP (a reason to alert the OVO), Patient Services will enter a dummy code so they can process the patient.

“Our Patient Services will keep phoning and pestering the life out of me saying, ‘you haven’t put a GP in’ and I’ll say ‘he hasn’t got one’. Then they just put a dummy code in and that’s where this dummy code is just to get them through the system and I think that’s wrong.” (Reception/Administration, Reactive, T12)

“We don’t have a fantastic system to record overseas visitors because, unfortunately, the patient admin system doesn’t record them in the categories. The number that we charge compared to the number that go through is probably significantly, you know, I think in 11/12 we raised invoices for about £80,000 which is probably just the tip of the iceberg, to be honest.” (OVO, Clear direction, T4)

“Even though the systems aren’t good enough to record it, I mean a lot of the patient tapping in systems aren’t set up to deal with overseas visitors to the NHS. That should be a mandatory field and it isn’t. And, you know, if you’re not recording them and you’re just putting them through the contract then, you know, you just end up making the problem worse for the greater good of the NHS.” (OVO, Clear direction, T5)

7.3 External Obstacles

A range of further obstacles were identified by respondents that were external to the Trust.

7.3.1 Pathways into the Trust

A key challenge for those trying to identify chargeable patients is the numerous entry points into the Trust bringing in patients who have expectations of free treatment. The most critical comments were aimed at primary care.

- **GPs** were principally criticised for making no effort to screen patients and referring patients whom, it was assumed, they should know are not eligible for free treatment but failing to highlight this. It was acknowledged sometimes that GPs did not seem to be aware of the differences in the regulations for charging in primary and secondary care.

“They don’t feel the need to tell us, and sometimes I’ve had complaint letters from GPs where we’ve refused or we’re going to charge them and then we’ll say, ‘that is because they are an overseas visitor’ and they don’t understand the rules themselves. So it’s difficult really.” (OVO, Proactive, T24)

“The GPs don’t seem to realise that, so they’ll write in a referral letter and basically it’ll say ‘oh this patient is exempt from NHS charges’ and then it’s taken as read that’s ok. So there doesn’t seem to be much awareness out there of, it’s an overseas patient so it doesn’t necessarily mean that they are exempt from the charges because they come from a certain country or they’ve got a British passport.” (OVO, Reactive, T14)

“A wipe out, they just don’t seem to bother whatsoever. I’ve had so many, I mean I’ve had somebody on the phone today and I couldn’t get them off because the guy was treated by the GP freely and we charged him and I explained secondary care in hospital is different from GP care. ‘If the GP doesn’t want to charge you, that’s up to them.’ We really don’t connect, I know it sounds silly doesn’t it, GP, hospitals, secondary care is different to primary care.” (OVO, Clear direction, T1)

Moreover, GPs may fail to make the patient aware of the fact that they might be charged or may even reassure patients, when asked, that they will not be charged in secondary care. This then leads to much upset at the hospital when they discover they are ineligible for free care.

“I know they don’t want to be aware, it’s not their problem or it’s not what they want to be dealing with, but they will refer patients and say in a referral, for example, ‘patient has just finished their treatment in, say, Greece and would like to carry on whatever treatment it is at your hospital’, you know. At that point, if that was picked up at the GP surgery and they said, ‘well look, you may not be eligible’ - I’m not suggesting it’s the GP that should be doing it but maybe at the registration process, then you know. The patients, they come, they’re upset because they can’t understand why a GP has referred them and the GP knows that they’re not living here permanently, you know. So that’s really you know, where we get the most frustration outside.” (OVO, Proactive, T21)

There were a couple of examples where OVOs had tried to make local GPs aware of the issues and to involve them in identifying chargeable patients but were disappointed by the lack of interest.

“When I first came into post we targeted all our GPs in both [names of towns] and we sent them a poster and wrote to them saying what we did and some of them have rung back for help for themselves if they have a query. Having said that, less got back to us than I thought they might do. I don’t know why that is but they didn’t so that produced some kind of fruit but not a lot of fruit for the work we put in.” (OVO, Reactive, T3)

- **Community services** (midwives, screening); in one of the briefing sessions, OVOs described how patients registered with a GP might be called in as part of

a national screening programme even though they were ineligible for free treatment. This might then lead to a referral into secondary care.

- Referrals for **X-rays/ blood tests**; it was suggested by some respondents that patients sent by GPs to walk-in sessions at the hospital are less likely to be screened and again, may have an expectation of free treatment following this access.
- **Referrals from secondary care**; large Trusts offering specialisms and specialist Trusts described situations whereby they received patients from other Trusts who had either not been screened for their eligibility by the referring Trust or whose status was withheld from them. Conversely, a small Trust described a situation in which they had found it very difficult to refer a patient to another Trust because they had identified him/her as chargeable.

“We have had other patients referred to us through other Trusts who have come to us, we’ve started treating them on the understanding that they are entitled to care. We too late find out for ourselves that they’re not entitled to free care and that either the referring Trust hasn’t told us or hasn’t done the right checks themselves.” (Finance, Proactive, T20)

“I normally will email the manager, obviously the manager of that hospital and tell them, ‘this patient was referred by this consultant who tells us that the patient has been living here for four months. However, we were not told that the patient is not entitled to NHS care.’ And in most of the cases, consultants themselves from other Trusts say that patient is entitled to NHS care because they have an NHS number. That is a misconception that a lot of hospitals do have.” (OVO, Proactive, T6)

7.3.2 Dishonesty on the part of patients.

It was widely reported across the sample that many patients who are aware that they may be chargeable are very knowledgeable about the answers they should give if screened in the Trust or the behaviour they should display in order to access free treatment. Indeed, it was felt that such knowledge was shared in some communities and it was known that it was publicised in certain countries.

“I feel that people coming into hospital from overseas know the rules better than the staff and I feel that because of that, they can really kind of just say, ‘yeah, I’ve been here 12 months’, basically.” (OVO, Clear direction, T15)

“Well, in effect that they lie, they do, we know they lie, I know you shouldn’t say that, but they lie through their teeth. They know it’s a loaded question, ‘have you

lived in the UK 12 months?’ they know the answer to it and then you need to get the patient in with their documents.” (OVO, Clear direction, T1)

“But it is a well known profile, females will arrive in quite late stages of pregnancy, they will have used forged letters from doctors to get on the aircraft. They’re not abiding by the ‘no travel after 28 weeks pregnancy’ because they are seeking entry to have a safe birth. And I fully understand that but they are on visas that say they’re coming to visit friends, family, go and see Big Ben. It doesn’t mean that they should be going to [name of hospital] and then getting admitted while they’re in labour.” (Border Force/Immigration, airport 1)

Border Force/Immigration Enforcement officers and OVOs involved with the research described various ruses used by patients including false addresses and contact details, false passports with slightly changed details (such as date of birth) to confuse any searches, borrowing relatives’ or friends’ passports etc.

“If the patient doesn’t want to pay and doesn’t want to be found, they won’t be. You know they will give us a bogus address, they will rattle off a phone number but when you try and then phone it, it doesn’t exist. A lady phoned me the other day to say, ‘you’ve just sent us a third reminder to this address, this woman has never lived here, we’ve never heard of her’. Patients like that, if they don’t want to be found, they’re not going to be found, they’ll just disappear somewhere”. (OVO, Proactive, T2)

Patients may be uncooperative, pretending not to be able to communicate or refusing to give details, or they may become very confrontational and insistent that they will not pay.

“She spoke perfect English until we asked her about her GP and then she couldn’t speak English and again, we had to get a translator.” (Reception/Administration, Reactive, T12)

Patients may also claim that they cannot afford to pay for treatment yet it was very difficult to take steps to prove otherwise. Payment plans by which patients committed to pay very small amounts were often felt to be worth very little; the perception was that, in the majority of cases, the debt was never cleared. The question was raised in the discussions with Border Force personnel as to whether and at what point the Agency was informed about defaults on such plans.

“We’ve had several instances of this, where they will offer to pay £5.00 to £10.00 a week or a month, which will then subsequently take our Trust five plus years to recoup all costs, which per our Trust policy, that isn’t acceptable. And it’s per the guidelines as well because I know it has to be acceptable to the Trust too. One of the MP’s colleagues who spoke to me and I quoted from the regulations and it was, ‘well you know it’s a shame, they can’t afford it.’ In the end, because they were always at me, I just had to say ‘well I’m sorry, the Trust is not a charity’.

Then she said, 'well, who makes these regulations?' and I said, 'I think you should know, it's the Home Office'." (OVO, Clear direction, T15)

"But what happens if somebody's got a £3,000 debt, they can't afford to pay it off so they agree to pay £50 per month. What do I do with those? What do I do if they default? When do the hospital tell me?" (Border Force/Immigration, airport 1)

7.3.3 Perceived inadequacy of existing guidelines

There was unanimous and strongly voiced criticism across the research sample of the current guidelines from the Department of Health as being too complex, unclear, inconsistent and contradictory. Moreover, the advice given by the DH 'helpline' was often felt to reflect the guidelines' lack of clarity, with Trusts being left to decide what to do. The lack of clear direction was for many OVOs, a deterrent to following through on equivocal cases and led the more reactive Trusts sometimes to conclude that it was likely that a patient was exempt in some way. OVOs who already lacked confidence in their decision making felt this was further undermined by not being able to develop a good understanding of the regulations.

"I think they sit on the fence because I think probably, the law is not clear in their eyes in certain cases. So we may have a query about a complex case and they'll just, all they will do to you is read back to you the guidance that you've seen yourself rather than provide you with some scenarios or options or further lines of enquiry etc." (OVO, Proactive, T6)

"We do appreciate they are guidelines but they can be quite confusing. You can read it on one page and think you've got the handle and then three pages later you think, 'no, I've just confused myself' so I don't think the guidelines are as clear as they could be." (OVO, Proactive, T28)

It was suggested that some of the documents listed in the guidance as types of proof that can be submitted are insufficiently robust, especially those that can be easily forged.

"I think it's this slight ambiguity of, you know, the suggestion that you can have certain documents but actually, they're not worth the paper they're written on. I think the directions and regulations should be very much more, you know, 'these are the Border Agency papers or whatever they're called that you must see to entitle somebody to NHS care.' Be that prescriptive and then it makes it easier for teams like mine to ask those questions without being accused of racism." (OVO, Proactive, T2)

7.3.4 Difficulties sharing information

Rules governing the exchange of information that prevent the sharing of information such as an NHS number outside of the Trust for business reasons (which include

eligibility/chargeable status enquiries) means that it is necessary to obtain the patient's authority for their NHS number to be communicated; some patients will wish to withhold this. Border Force representatives also identified this as an issue for themselves.

“Will you sign this piece of paper to allow me to use your NHS number to check out whether you are entitled to treatment or not?” So you know what the answer to that is going to be.” (OVO, Proactive, T6)

The sometimes lack of timely response from UKBA, especially the centralised offices, was a further obstacle. Some OVOs reported that they were liaising with their local Immigration Enforcement offices to good effect but others had stopped doing this since they were directed to use a central resource. Some respondents reported similar problems with DWP.

“Our problem is, you have to check all these things out and you have to phone different numbers to get the different answers and you know it is really difficult that you have to go pretty much everywhere before you get an answer on someone's legal status or whether they are liable or not. That is one of the big problems because it took me hours yesterday to get through to DWP, to get that answer.” (OVO, Proactive, T6)

Immigration officers were keen to have the contacts in Trusts and sometimes differentiated between those Trusts where they had good working relationships and those where there was no identified person and/or interest.

“I have actually made enquiries myself and I've contacted site managers at hospitals and I've been told various different things. One hospital manager was happy to go into PAS and tell me whether someone has an outstanding bill to pay. Whereas other site managers have said to me 'we're here to take care of patients, who do you think you are?'” (Border Force/Immigration, airport 1)

7.3.5 Other external obstacles

Other external obstacles identified during the research included:

- **Local support organisations helping patients** to access treatment and contest decisions; patients may take letters and invoices along to such organisations that may give them conflicting information and may also approach the Trust on the patient's behalf. This, it was reported, can be done in a rather aggressive way as they assert the patient's case. One OVO was exasperated with the local Citizens Advice Bureau handing out, what they considered to be misinformation to potential patients.

“The Citizens Advice Bureau, they cause an awful lot of trouble for me, because the patients trundle off there and they say, ‘oh no, no if you are on holiday and you are ill and it’s an emergency, you get it free.’ That is a big bugbear.” (OVO, Clear direction, T1)

- The **difficulty of identifying individuals** perhaps because of the similarity of the names of people of certain ethnic groups.
- Concern about **Human Rights legislation** being used as a basis for having entitlement to free treatment and the legal wrangling/expenses that this can involve; it was sometimes felt that this can make it very difficult when dealing with irregular migrants.

“We had somebody who has caused several hospitals, gone to one hospital, the other and we’ve all said no, we’ve all charged them and they’ve applied to appeal, been turned down and then they got through under Human Rights. And really, if you look at their status they are not really entitled but because of the Human Rights Act.” (OVO, Clear direction, T4)

- The tension between the timescale for identification of chargeable patients and the **deadline to put an eligible patient through on the CCG contract**. The three month window was felt to put pressure on OVOs to opt for one route or the other when they needed more time to unravel a patient’s eligibility.
- The **inadequacies of the visa application system** that mean that the visas are processed on-line and there is no opportunity to see the individual and ascertain their state of health. For visas longer than six months, a medical certificate is required but this could become out of date very quickly (and according to some respondents, may have been obtained through bribery). Both Border Force staff and some OVOs commented on the need for procedures that prevent women who are heavily pregnant being able to travel to the UK for the purposes of having their baby in the UK.

“If you were 28 weeks pregnant and say you are coming to do an MBA, on paper it doesn’t say and I still believe that’s the case – it doesn’t say ‘Are you pregnant?’ Because if you are, that would obviously change the issuing officer’s decision. And then they arrive at the port, and they are pregnant, ‘I’m coming to start a course next week’. ‘When are you having the baby?’ ‘Oh, I didn’t realise’. Because a lot of the applications aren’t issued in person, they are issued on line; a lot of people get through. It doesn’t ask you if you have any medical conditions.” (Border Force/Immigration, airport 3)

- **The need to wait three months before reporting a debt to a Trust of over £1,000** rather than much earlier.

*“They need to pay that charge when they’ve left the hospital. Within seven days we should be able to chase it up with the UKBA. Then when they fly out they’ve got it on record, so when they want a visa to come back in, it’s questioned.”
(OVO, Clear direction, T1)*

- The **lack of awareness/promotion of EHICs** in some EEA countries and the time taken to obtain a PRC (it can be 28 days) or an S1.
- The **poor quality of documentation for asylum seekers** and the fact that even though an asylum seeker’s appeal has failed, he/she is able to retain the ARC card (which has no expiry date on it) and use it as evidence of exemption.
- The **lack of support in the community** and differences in obligations to provide social care may lead to bed blocking in particular, by homeless irregular migrants.

7.4 Additional Obstacles identified by Border Force/Immigration Enforcement

A number of additional obstacles were identified during the interviews with representatives from the Border Force and Immigration Enforcement and these have been summarised below.

- **Resourcing issues** that mean that however much they are aware of the need to tackle ‘health tourism’, this takes a lower priority than other duties.
- Border Force **does not have a remit to tackle ‘health tourism’** so that even if a passenger admits to coming to the UK to access the NHS, they cannot refuse entry; they can only do this if the passenger is trying to access services without paying when they are chargeable or if they have been identified as having an NHS debt of £1,000 or more. Moreover, it is **difficult to prove deception** unless the documents that are provided to prove OR status are retained in some way.

“So our main challenge there is where people turn up knowing that but we can’t prove that they’ve come here for health tourism because there’s no remit in the rules to prevent it. It can be as blatant as someone arrives in the United Kingdom 8 ½ months pregnant with two suitcases full of children’s clothes but as far as the law is concerned that’s not grounds to say, ‘you’ve come here to have a child on the NHS so therefore we’re refusing you entry’. They have to be allowed entry and then they go to the local hospital who can’t turn them away. At that

point it becomes an NHS issue and whether they're actually going to recoup the costs so a lot of what we find is that we're informing the NHS that these people are coming and then that's our bit done. Once we hand over, there's nothing we can do about it." (Border Force/Immigration, airport 4)

- **Lack of a Memorandum of Understanding** between Border Force and DH to enable them to share information. This means that it is not possible to alert Trusts in general about someone coming into the UK who may try to access care even though they may be chargeable. Instead, they have to alert individual Trusts on the basis of intelligence which is both hit and miss and time-consuming.
- **Lack of feedback from Trusts/DH** to know how useful information provided by Border Force is; positive feedback will motivate staff to continue to communicate information

"I know I ask for feedback from a lot of the OVOs and I don't know whether it's because of data protection, but I don't get a lot of feedback, therefore I can't put accurate figures as backup to my analyst. We never ask for medical details at all, we just ask for status details, but [] unless we can see exactly what's happening, we won't know what the true figures are." (Border Force/Immigration, airport 5)

- **The lack of a clear responsibility to tell patients that they may not be eligible for free health care;** if patients are not told, it is not only unfair when they are presented with an invoice but they can also plead ignorance. Moreover, in order to prove a patient has intent to deceive, it is necessary to keep a record of answers given to questions and the documents that have been shown and this is not being done as routine.

"But if no one asks them, or no one tells them, we don't do it when they're issued the visa, we don't do it on arrival, can't guarantee that a GP surgery will tell them. They get to the hospital, it must come, sometimes as quite a nasty surprise. And it's not fair if someone has had treatment, then it's a lot of burden on the overseas department, 'oh by the way you owe us £12,000'. No one's told them." (Border Force/Immigration, airport 1)

- The fact that not all Trusts are recording details of outstanding debts as well as the fact that a patient may have **debts with several hospitals** (each of less than £1,000) means that UKBA will not be notified even though the total may exceed £1,000.

"But debt that is accrued at one hospital could be £600, they then go to the next hospital and have another £600 worth of treatment and because it's not linked

up, we don't get that total, so we don't get that magic number. And hospitals vary, I think it's a quarter of them are actually using the service where they can put their debt information onto our systems. It's three months after the debt has occurred so the passengers, patients are long gone. And so, if they don't put that information on, then we don't know." (Border Force/Immigration, airport 1)

The fact that some hospitals refuse to raise invoices retrospectively also means the patient's debt does not appear on the Border Force database.

8 Systems and Procedures within Primary Care

8.1 Introduction

The discussions among staff working in primary care explored:

- their awareness and understanding of who can register with their Practice, as well as whether and under what circumstances patients might be charged for NHS services
- the systems and procedures the Practice has in place for registering new patients
- estimates of the numbers of migrants and overseas visitors that are registering with their Practice
- when referring a patient to a Trust, whether the Practice would notify the Trust if they considered the patient to be potentially chargeable.

8.2 Who they Can/Cannot Register and Charge

When it comes to migrants and overseas visitors accessing primary care, the main requirements relate to registering them either on a temporary or permanent basis. The NHS guidelines to visitors to the UK state:

“If you need to see a doctor during your stay in the UK then you can register with a GP (general practitioner) practice as an NHS patient. You can register as a temporary patient with a GP practice when you are in the area for more than 24 hours and less than three months. It is up to the GP practice to decide whether to accept new patients or not. Treatment will be free of charge.” (NHS Choices)²⁸

However, there was some confusion and disagreement across Practices taking part in the research both in terms of who they can and cannot register and whether or not overseas visitors can be charged for non-emergency treatment. This confusion is not limited to the healthcare professionals; for example, the Citizens' Advice Bureau offers the following guidance:

²⁸ Source: <http://www.nhs.uk/NHSEngland/AboutNHSservices/uk-visitors/Pages/accessing-nhs-services.aspx>

“There is no charge for basic GP treatment for NHS patients who live in the UK. There are charges for visitors from overseas, except in the case of an emergency. There may also be charges for certain services, for example, check-ups for employees and vaccinations for travelling abroad.” (CAB website)²⁹

while the UK Border Agency states that visitors to the UK can only use the NHS for emergency care:

“If you are in the UK as a visitor, you cannot use the National Health Service except in an emergency.” (UK Border Agency)³⁰

Many of the Practices taking part in the research believed that they had no choice other than to register and/or treat anyone who asks provided they are based within the practice catchment area for a minimum of 24 hours (and the practice list has not been closed). However, one Practice was applying ‘the six month rule’ whereby they would only register someone if they had been in the country for at least six months and would only offer emergency treatment to everyone else. The period of six months reflects the length of a standard visitor visa. As a consequence, this Practice saw very few migrants and overseas visitors. Another Practice also worked to this ‘rule’ but interpreted it as meaning anyone who intends staying for six months and will register them immediately.

“You know, there was a sort of six months marker, if they haven’t got any proper documentation, they can’t access a GP surgery for six months, on the NHS. But how do you police that, how do you turn them away for six months when all their family are here, or they are pregnant or whatever and that was the discretion of the Practice.” (Practice partner, practice manager, nurse & receptionist, PC24b)

Yet others were applying ‘the 3 month rule’ whereby they will register patients who either have stayed or intend staying in the UK for three months. In another variation, a practice receptionist in a walk-in centre said that they would only register someone as a temporary patient if they are living in the UK (have a UK address) and are registered with a GP surgery elsewhere in the UK; otherwise they would be treated privately.

Like their colleagues in secondary care, there was some confusion about the meaning of the passport stamp ‘no recourse to public funds’ and whether this applies to healthcare. There was also some confusion over the meaning of different types of visa

²⁹ Source:

http://www.adviceguide.org.uk/england/healthcare_e/healthcare_nhs_healthcare_e/nhs_patients_rights.htm#GPcharges

³⁰ Source: <http://www.ukba.homeoffice.gov.uk/visas-immigration/general-info/visa-holders/>

in relation to healthcare. For example, one respondent thought that someone on a spousal visa was not entitled to NHS treatment.

Not only were there differences in opinion about who they could/must register, it was evident that there was some confusion and disagreement across the sample as to whether GPs can charge overseas visitors/temporary patients for non-emergency treatment. Some felt that they were unable to do so while others were charging.

“It would be private treatment. If it is something like a rash then we would give them the choice of seeing a pharmacist first because obviously, pharmacists don’t charge. So we do give them that option to say, ‘look at an alternative clinician in terms of a pharmacist’, and then, if they still insist on seeing a GP, it would be privately.” (Practice manager, PC10b)

“The guidelines, as we understand them, are, for emergency treatment, we have to provide emergency treatment on the NHS free of charge, and if the presenting individual perceives that their problem is an emergency, we would register them and treat them. If it is somebody who says ‘I’m visiting from the States, and I have a bit of a sore throat for the last couple of weeks, I would like to be seen’, we would say, ‘we are happy to see you’, but we would then make a charge for the consultation, and issue a private prescription. The grey area is how does the individual perceive an emergency or not, because what may be an emergency for the patient may not be an emergency for the doctor. That is a grey area.” (CCG representative, 18)

“I came from a Practice that was strict on registering. If they’re outside the EU, they have to pay a £30 consultation, £10 after that, so coming to this Practice where there aren’t any strict guidelines, that’s what we’re working on at the moment, to try and get a system together for how we approach it. So I think more clear guidance would definitely be [helpful].” (Practice partner, practice manager, nurse & receptionists, PC12b)

The walk-in centre referred to above was charging all overseas visitors a flat fee of £40 before they were seen by a doctor/nurse and the patient was informed that they may incur additional charges if further treatment was needed. This is flagged on the system so the clinician knows when they see the patient that they are chargeable. If they live within the EEA and if the treatment is deemed immediate and necessary, the fee is refunded.

Where Practices were limiting treatment to emergency care only, they reported that what the patient considers an emergency often does not meet the clinician’s definition which can result in arguments. Also, as reception staff should not be making this decision, it takes up GP time even when the decision is not to treat.

There was also some confusion among respondents as to whether they can limit overseas visitors to emergency treatment only.

“Versus a tourist who would be here on a tourist visa with a definite end point, where they would not have access to NHS care except in emergency services, as far as I’m aware, although as we’ve said, as far as we get from the people from the health authority, there is no such thing as an emergency, you have to see everybody if they want to come in and see you.” (Practice partner, practice managers, nurse & receptionist, PC20b)

There were also what could be considered inconsistencies within a Practice. For example, one Practice reported that they had charged an overseas visitor who needed a prescription for Warfarin but declined to test someone seeking a smear test (she had had an abnormal one during her travels and was after a second opinion). Another Practice that limited temporary patients to emergency treatment commented that while they do this, there is nothing to back them up from a legal perspective.

“A lot of British [patients] would have their families abroad and they visit them so obviously we end up looking after them, although we make sure that we tell them that it’s only for emergencies. ‘We cannot have you for routine treatment’, if they have pre-existing conditions. But we can only do so much because we don’t have any laws to back us up and we don’t want to be in trouble, so wherever possible, we tell them and half of them understand but the other half don’t.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

It could also be problematic differentiating between people from EEA countries in terms of whether they are an overseas visitor or someone who is ‘ordinarily resident’.

“I think it’s very important that we are aware of it but we don’t have guidelines from the NHS or the Department of Health as to whom to treat, who not to treat. But with emergencies, we have been told that we have to treat whoever it is but other routine care says we don’t have to treat. But it’s difficult sometimes to find out whether they live here, whether especially the people from the European Union, they come here and the moment they come, they ask for treatment. Not only treatment, investigations as well. We refuse that scenario, we tend to discourage that sort of patient, unless they are registered with us.” (Practice partner, PC10b)

“In a busy surgery, it’s very frustrating and difficult for the staff, to get to the bottom of what somebody is entitled to, especially if someone turns up as an emergency. You have to figure out what their rights are, what we can give them and what we can’t give them. Do we have to charge, do we not, how far can we go, how far can they stay with us, how long? It is difficult to work these things out as a surgery.” (Practice partner, practice manager, nurse & receptionist, PC24b)

Indeed, a consistent message from respondents working in primary care, echoing their colleagues in secondary care, was the perception that there is a notable absence of

clear guidance not just about charging such patients but also as to their entitlement to care.

“But we shouldn’t really be having to have these conversations, the guidance is so woolly. There isn’t a person that you can ring up and say, ‘right it’s this, this and this’, and nobody enforces it.” (Practice manager & receptionist, PC18a)

“I think, as a clinician, I do not want to be having to get involved. I think there need to be clear rules, so we know where we stand. So that we know what we are allowed to do for people and we know what we are not allowed to do for people, according to rules that somebody else says. And then I want to treat the patient, because we don’t have time to be getting involved in the ins and outs of people’s rights and not rights.” (Practice partner, PC13a)

8.3 Registering New Patients

All of the participating Practices were following a broadly similar set of procedures when registering a new patient although some of the specifics in terms of what information was recorded varied.

Practices need to establish proof of identity, proof of address (to establish the patient is based within the practice area and in order to communicate with the patient) and whether the patient has previously registered with a GP (to establish if a health record already exists).

“It’s not compulsory to ask for ID but we ask because we are aware that they were registering, I don’t know that it’s happened to us particularly but we’re very cautious that forms were being filled in for children who weren’t in the country.” (Practice manager & receptionist, PC29a)

“As a general rule, we register everybody as long as they’ve got proof of identity and proof of address and they can fill in all the forms, we tend to register everybody.” (Practice partner, practice manager, nurse & receptionist, PC24a)

While all of the Practices consulted were asking for this information, they did so with varying degrees of strictness depending, for example, on their policy regarding those of NFA. Thus, in the case of a migrant or overseas visitor, they may or may not ask to see a passport or proof of address. One walk-in centre that was set up to cater for the needs of ‘hard to reach’ patients will allow those of NFA to use the health centre address. While some Practices were copying/scanning documents and attaching them to the patient record, others merely asked to see them.

“They don’t really have to, if they haven’t got photographic ID, then we would say, ‘we need something to prove your address’, so we’d need a utility bill or

something like that with their name and address on. But if they give us photographic ID, we don't do that." (Practice manager & receptionist, PC29a)

"We ask for a copy of their passport as well which we do photocopy and hold on record and within that we do try to check their best status to be in the country. It can be very difficult. There are often quite hard language barriers to get over and things like that, but we do try where possible but we always get a copy of their passport and things like that." (Practice manager, PC13a)

"We can't possibly do that, the cost to the Practice would be immense, if we are photocopying all that and putting it onto the system. So I think the law says that we don't have to do that, so all we ask for is that they've got a UK address." (Practice partner, PC13b)

Practices may also collect other details such as ethnicity, nationality, date of entry into UK, language requirements, cigarette/alcohol consumption, dietary requirements, religion, whether disabled but there was no sense this was being done in a systematic manner across all participating Practices. As well as getting patients to complete new patient record forms (typically the GMS1), they were also going through new patient procedures which might involve an initial appointment with a healthcare assistant or practice nurse for a basic health check and/or asking the patient to complete a medical questionnaire.

In some cases, access to clinicians may be limited, for example, for seven days while their records are being processed or until they have had the initial appointment with the healthcare assistant or nurse.

Details would be entered onto the electronic patient database, possibly with checks on Spine where appropriate. Estimates of how long this takes for a patient with a good grasp of English varied between five and 45 minutes. This would depend on whether, for example, the patient had downloaded a patient registration form and completed it before presenting at reception, whether the process involved an appointment for an initial health check, and whether various checks were needed on Spine to confirm/clarify certain details.

8.4 Registering Migrants and Overseas Visitors

Although Practices were collecting certain information as part of the registration process, this varied from Practice to Practice (see above). However, they were not systematically categorising patients according to the different types of migrants and overseas visitors so they were unable to provide data on the numbers of such patients on their list. In most cases, they were able to provide an estimate of the number of new patients they were registering every week or month. They were also able to provide

some estimates of the overall numbers of migrants and overseas patients they were registering based on proxy measures, such as the proportion of patients who did not have an NHS number or the proportion that had English as a second language (this was recorded to facilitate the provision of interpreters). These estimates reveal wide variations in the number of patients being registered as well as the proportion likely to be migrants and/or overseas visitors. This is illustrated below where Practices have been ranked in order of the estimated number of monthly registrations together with an indication of how many of these may be migrants and/or overseas visitors (see Table 17).

On the face of it, it is difficult to assess how significant these numbers are, and they probably reflect the high rate of worker migration to the UK over the last few years. Nevertheless, it was very clear from the discussions around the impacts of migrants and overseas visitors within primary care that the majority of Practices taking part in the research were experiencing significant challenges and difficulties on a daily basis. This ranged from the time it takes to register a new patient, especially when they have little if any English, to impacts on the delivery of healthcare to all the patients on the Practice's list. These challenges and impacts are considered in greater detail in section 9.

The point was made by respondents in a number of Practices that in their experience, people arriving in the UK are often well informed about how the system works and one of the first things they do is register with a GP.

"It could almost be their first port of call, seriously because of the forms - if they haven't had a doctor before, they have to put the date they came into the UK. They can literally come in on the Friday, the Monday they're into us. They're here, straightaway they're in to get the paperwork and we are almost their first port of call." (Receptionist, PC10a)

"Even before they come, they hit UK, land, they know where to go, what to claim. They come and register with the GP straightaway, they get an NHS number. They get an NHS number, they get an NI number, they get an NI number, they get their benefits, everybody is well equipped with this knowledge." (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

Staff may suspect that things are not as they should be, for example, having multiple patients registered at the same address, but feel powerless to do anything about it. They cannot refuse to register or treat them and they also do not feel they can or should report them to other authorities.

“I’ve heard of cases where it will be a three bedroom terraced house with about eight different names all in there.” (Practice partner, practice manager, nurse & receptionists, PC12b)

Table 17: Estimates of the number of new patients being registered and indication of what proportion of new patients/patients on their list are migrants/from overseas		NB very low base
New patient registrations (monthly estimates)	Indication of how many may be migrants/overseas visitors (Practice best estimate)	
300	50% of new patients do not have an NHS No; ‘high proportion’ of non-English speakers on their list of 10k+ patients	
200	two-thirds of new patients do not have an NHS No; approximately 18% of non-English speakers on their list of 10k+ patients including a ‘substantial’ Gypsy population from Czech Republic and Romania	
200	receptionist estimates that 50% of patients being seen on any one day are migrants/OV especially Poles, Russians and Indians	
150	estimate that one-third of new registrations are migrants	
150	only a ‘small proportion’ are from overseas/visiting on a temporary basis	
80-100	‘several a week’ do not have an NHS No.	
50-70	‘majority’ of new patients do not have an NHS No.; 20% do not have English as a first language	
30-50	less than 10% of new patients from overseas	
40	20% of new patients do not have an NHS No; ‘A large number’ are from overseas	
20	‘a few’ do not have an NHS No; have a large number of patients who are Chinese, Indian, Polish and Lithuanian	
10	at least 90% have an NHS No.; their registration policy means they have relatively few migrants and OVs on their list (patients are required to demonstrate they have been resident in the UK for at least 6 months)	
<4	majority of new patients have an NHS No.	
n.a.	majority of new patients have an NHS No.; the practice holds a daily walk-in children’s surgery and they estimate that 50% of patients accessing it are Polish or Chinese	
n.a.	list includes a large proportion of Asian patients (although many are likely to be UK citizens) as well as Somalis and Poles.	

There was a perception that some people are abusing the system not just in terms of healthcare but, for example, by using GP registration and NHS numbers to access other services and benefits.

“Once they get the National Insurance number and everything, they get onto the social services, they don’t really want the treatment but they want to get all the benefits, whatever. Some of them are not allowed to work but some of them, they work but they won’t get paid but they know that if they elaborate this condition more, they can get onto all the benefits. That puts a lot of pressure on us, filling in the social services forms again and again and again.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

“It’s interesting to note the number of patients who actually say to us ‘when will I get the card?’ and it’s like it can take 2-3 months sometimes, it all depends how quick. And they’re, ‘oh, I have to wait so long?’ because once they’ve got that card, it’s proof of who they are as well. It’s kind of like an ID thing as well...

... You can use your NHS card for...

... To open a bank account, can’t you?...

... It’s nonsense, isn’t it? Absolute nonsense. And you can turn up to our reception desks, say you’re Uncle Tom or you know, an Uncle Sam, or I’m Joe Blogs, ‘oh yes, register on this line, thank you very much’. Passport, you can have the most fake passport in the world or any proof or identity, that’s fine. ‘NHS number, not a problem, we’ll send you a card’.” (Practice partner, practice managers & reception manager, PC20a)

One Practice spoke about how patients may bring pressure to bear on the Practice to provide them with written confirmation of their registration while they wait for their NHS number to arrive.

“They always want the letter, ‘I need the letter confirming that I’m registered, when will I get that?’ Everything is, ‘when will I get that? I need it now, I need to be able to get xyz’. There is always a lot of forward thinking.” (Practice manager, PC10a)

This same Practice was investigated in relation to Child Benefit payments due to the large number of children who were registered at the same address.

“The reason we had to set the policy that we have, where we actually have to see all children, is that we got hit about four years ago with so many letters from the Child Benefit Office because they had families of 20 children living in one house. So they then were writing to us to say, ‘is this person actually registered with you?’ and the answer is, ‘yes, they are but I’ve never seen that patient because they’ve never seen a doctor since the day they registered.” (Practice manager, PC10a)

8.5 Referrals to Secondary Care

While a GP may advise a patient from overseas that they may be charged for secondary care, including the cost of tests, respondents reported that they were less likely to raise this in referral letters to Trusts.

“If we know people have come from abroad and they’re not entitled to NHS treatment we do highlight that should they need secondary care, they will be charged. So it’s something that if we know, we will inform the patient or people, whoever it may be, even people who are UK residents who live in, say Spain, that have come back and think they can get NHS treatment just because they’re a UK citizen, so we do say that’s not really the case.” (Practice partner, practice manager & receptionist, PC10b)

“As far as we’ve been told, as long as they’re eligible for NHS care, they have everything free from us and if they’re not eligible for NHS care, it is not our responsibility to look into that, we are supposed to treat them clinically and refer them appropriately and then the fall-out for that will be dealt with by the hospital and people who will claim the cost of that.” (Practice partner, practice managers, nurse & receptionist, PC20b)

One Practice described a case that had just happened where they had referred a patient who had been living in Australia to the local Trust only to receive a phone call from the Trust stating that if the patient turned out to be chargeable, the Trust would charge the cost of the treatment to the Practice. The Practice was understandably confused and concerned.

“I don’t really understand the rules, to be honest. In fact only this week I had a phone call from a secretary about a referral I’d done on a child whose parents were Australian and they had been in the country for 18 months and the secretary was ringing me to check that I understood that if they saw the patient and discovered they weren’t entitled to NHS services, then the Practice would be charged, the Practice would be invoiced, which seemed a bit bizarre.” (Practice partner, PC13a)

Some respondents spoke about occasionally getting calls from Trusts looking for information about potentially chargeable patients but said they are usually unable to help other than confirm whether a patient is registered with them.

9 Impacts and Challenges in Primary Care

9.1 Introduction

Although the scale of the challenge varied from one Practice to the next, many of the same issues were identified:

- Language difficulties
- Patient expectations
- De-registration
- Cultural issues
- Nature of health issues
- Use of A&E

These issues were perceived to be having a significant impact on many of the Practices. The main impacts were said to be in relation to Practice finances, the quality of care they were able to offer to both the migrants and overseas visitors but also all other patients, and on staff morale.

The discussions were often animated and emotionally charged; many GPs and Practice staff felt that they were facing huge issues which they are struggling to get to grips with and that the current arrangements fail to take any of this into account.

The views of the three CCG representatives taking part in the research are also summarised.

It should be noted that these impacts and challenges may also relate to the wider population of patients including migrants with ILR, EEA permanent residents as well as British nationals who have a right of abode and who live in the UK but who have limited use of English.

9.2 Main Challenges within Primary Care

9.2.1 Language difficulties

This was a very significant problem for nearly all the Practices. While it is not limited to migrants and overseas visitors, for example, some first generation migrants who are permanently settled within the UK may have limited or no English, it was described in all Practices taking part in the research as the main issue they face when trying to treat

migrants and overseas visitors because it affects so many aspects of the service they are providing. One Practice reported that it was the highest user of Language Line³¹ in the area, and more generally, Practices need to provide interpretation across a huge variety of languages. For example, another Practice listed the main languages being accessed via Language Line as, Polish, Farsi, Mandarin, Czech, Cantonese, Urdu, Kurdish, Arabic, Tigrinya, Portuguese, Romanian, Russian, Somali, French, Bengali, Lithuanian, and Turkish.

“What are some of the other issues or difficulties that you experience?...”

...The language barrier is the biggest...

...And some of them, they can't fill in the forms because they don't know English or anything. They will come to the desk, ask the staff to fill in the forms for them.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

Dealing with patients with little or no English was said by all respondents to be extremely time consuming; registration may take three times as long, patients need double or triple appointments, and, as a result, Practices have often had to extend surgery times. The impact of this can again be huge; for example, one Practice estimated that one in three appointments were with patients who do not have English as their first language.

“Same thing for reception, it depends who comes in on the morning. You could spend 20 minutes, we have spent 20 minutes with one patient maybe just trying to book an appointment because they just don't understand, we don't understand, they don't understand.” (Receptionist, PC10a)

“They have to have double appointments, all of our patients are offered a 10 minute appointment but if they're of a different nationality, you have to double it. So they have to have a minimum of 20 minutes, even if they've got a friend or relation translating because the clinician's still got to talk to them, to tell them, so you still have a minimum of a 20 minute appointment.” (Practice manager & receptionist, PC29a)

“It could take a lot longer, a family for instance could come in and they've got six kids, it's gathering all that information and that can take a lot of time, it could take about an hour, especially if English is not necessarily their first language...”

...So maybe three times the amount of time?...

³¹ Language Line is an interpretation service; other similar services, such as The Big Word, were also being used by some Practices/Trusts.

...Absolutely, yes....

...We've gone from 20 minutes of receptionist time to one hour of receptionist time, plus 20 minutes of [Assistant Practice Manager's] time, plus 10 minutes of my time [Practice Manager], suddenly a lot more people...

...So why have you two guys suddenly got involved?...

...Because they've come asking for advice, 'could you speak to the patient? The patient's not very happy', and all of these staff members, obviously there's a cost attached...

...So we're coming away from our jobs and reception." (Practice partner, practice managers, nurse & receptionist, PC20b)

It can also result in forms being filled out incorrectly, issues over spelling, for some ethnic groups different patients have the same or very similar names, the date of birth might be recorded incorrectly (and, in some cases, not known), all of which means that staff need to spend time trying to arrive at the correct details. This, in turn, can create further difficulties, for example, when using Spine to track down a patient's history or being challenged by the CCG when the details of the patient do not match their records.

"And sometimes when they're spelling things I quite often give them a bit of paper to write their name on because you can't understand it where that would be difficult to access on the phone. And quite often, a few of them have got a similar date of birth..."

...Yes that's the problem we get. And you do sometimes wonder whether that's the date of birth or whether they just don't know and someone told them that's what they have to do and that's what they've done." (Practice manager & receptionist, PC18a)

Practices need to arrange for interpreters to be available for these patients and, based on comments from respondents, these were variable in quality. Language Line was described as 'clunky' in part, because it may require the telephone handset to be passed backwards and forwards between the member of staff and the patient. Of particular concern to clinicians in the sample was the feeling that they could never be sure they had a full understanding of patient needs and that the patient fully appreciated what they were being told.

"I don't know exactly how he's interpreting what I've said, I would never know and I have actually had some people saying to me, who speak English but they want an interpreter in their own language, 'that's not what I've just told him' and it's been followed up but I don't know how they interpret it to the patient." (Practice partner, practice manager, nurse & receptionists, PC12b)

"I had a new diabetic, poorly, with very poor English and I couldn't find anything, any literature to give him so my difficulty helping him was severely compromised and in fact he spent 2½ hours in this building, inclusive of me seeing him, arranging his urgent hospital appointment and communicating with him and making sure he was safe in between other patients because obviously I had to continue my surgery as well. But there was no information I could give him in the written sense to back up what I was trying to communicate to him and he hadn't brought anybody with him, even though he could not speak English." (Practice nurse, PC13a)

Concerns were also expressed by some respondents in relation to patient confidentiality as well as around compliance. For example, pharmacists normally do not have access to interpreters, and so may not be able to confirm with the patient the instructions on how to use the medication and patients will not understand any written details that come with their medication.

"Because that's a worry in case they don't understand properly, it's like when they've been in to see the doctor and they get medication, I always think when they go to the chemist, do they understand?" (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

"So they have no way of having that conversation of, 'this is the drug that your doctor's prescribed, but you need to do this and you need to do that and do you understand it?' So half of what they are obliged to do when they hand over medication, they can't do." (Practice partner, PC18a)

Some patients may bring another member of their family to act as the interpreter and, while this was recognised as far from ideal, Practices often felt they had little choice. Examples were given of the problems this can create such as an eight year old child translating for grandparents, or a young teenage son translating for his mother in relation to a smear test.

"When it's a family member, that's completely different, you don't know what's going on and sometimes they will listen to you and then move on as if you're having a conversation with them and you say, 'look, could you tell the patient what I've just said' and then they'll, in a very brief thing, somehow say what you said in five minutes and so you wonder whether not all of what you've conveyed to the interpreter has been sent over to the patient as well." (Practice partner, practice managers, nurse & receptionist, PC20b)

"They'll bring inappropriate members of their family, say young children, to translate for sexual problems or those sorts of things." (Practice manager, nurse & receptionist, PC10a)

9.2.2 Patient expectations

Migrants and overseas visitors were often perceived by Practice staff to have very high and inappropriate and/or unrealistic expectations which gave rise to the frequently reported view that they can be ‘very demanding’.

“I have to say the Eastern Europeans, some of them, particularly the Baltic State people, they are terribly demanding and critical of the NHS compared to what they say they can get at home, which again creates tensions when you feel you are a little bit on the defensive – well this is what we do here, you know we’re doing the best for you and this is what everybody is entitled to.” (Practice partner, PC13a)

“They’ll be backwards and forwards and they’ll be on the phone again, ‘has it been done yet, has it been done yet?’ So it’s time wasted really and we do try and tell patients, ‘it’s going to be at least five working days before you get a letter sorted out, or you’ve got a referral. That maybe you will be contacted from the hospital and not from us’. But that still doesn’t stop them phoning back to make sure it’s been done and has it gone and how long will it be? I think it is the expectation.” (Receptionist, PC13b)

One of the main reasons for this appeared to be a lack of understanding of the difference between primary and secondary care. This may reflect differences in how healthcare is arranged in the home country. It can result in such patients expecting and demanding GPs to provide immediate access to the full range of services; for example, pregnant women expecting to be seen by a gynaecologist or parents requesting vaccinations for their children that are provided as the norm in the home country but which are not routinely offered in the UK. It can also result in patients demanding specific investigations, tests and treatments without having had a consultation or diagnosis.

“In Poland they have a different programme than what we have here so we’re asked quite frequently, ‘can they have BCG and Hepatitis B?’” (Practice partner & nurse, PC29b)

“That is a problem, from the European Union, a lot of patients come here for treatment. Rather than telling their problems, they say, ‘can I have a scan, can I have this, that sort of investigation?’ So we flatly refuse and say, ‘you better tell me about the problem you have, then I will decide what investigation to do’. That is the problem I’m encountering with those patients, but those are the people who are increasing in number now over the last few years”. (Practice partner, PC10b)

Migrants and overseas visitors were described by some respondents as presenting more frequently but also failing to attend an appointment more often.

“Because their demand on health is, certainly Eastern Europeans, expectations and demand, the feeling is that they’re much keener to access services than the indigenous population and they’re used to same day services or they really like the same day services they get and use them and use them and use them.” (CCG representative, 29)

“Today’s Wednesday, so they might make an appointment for Friday or next Tuesday or something like that and then they DNA. So we’ve turned an awful lot of patients away between now and then because they come in with their son – which also needs a 20 minute appointment – so that’s 40 minutes, two people and then they don’t turn up.” (Practice manager & receptionist, PC29a)

“I know just from the handful of patients we’ve got that fit into these categories, we’ve had situations where lots of appointments have been wasted, interpreters have been booked and the patients have missed these double appointments that have been booked for them.” (Practice partner, practice manager, nurse & receptionists, PC12b)

Some respondents commented that some patients also expect to be able to access other benefits, such as free nappies or baby milk. Where a patient’s expectations are not fulfilled, this can result in complaints being raised which was seen by Practice staff as simply adding to their heavy workload.

“We waste a lot of our time having to argue with patients that we’re terribly sorry, we can’t do it...”

...It gets them very cross as well.” (Practice partner, practice managers & reception manager, PC20a)

9.2.3 Cultural differences

Some of the above perceptions might stem from cultural differences; for example, one respondent observed that some nationalities tended to have what might seem to someone from this country as a more abrupt manner. This, coupled with language constraints and experiences of healthcare working in a different way, may contribute to the impression that they are ‘very demanding’ and time consuming.

“So in those instances yes, they can be quite long consultations and quite awkward consultations if they’re also dealing with a sort of cultural appreciation of what’s wrong with them which is different to ours. So it’s hard to deal with the cultural anomalies along with the language difficulties and, and that, that is really quite time consuming.” (Practice partner & nurse, PC29b)

High levels of DNAs were sometimes attributed to differing cultural norms regarding time keeping but where this also involves appointments being missed where an interpreter has been booked, it is both frustrating and costly for the Practice.

For some patient groups there may also be issues whereby female patients need to be seen by female clinicians and/or female interpreters. There can also be cultural differences with regards to young children and elderly patients where the expectation might be that they should be seen immediately without the need to 'wait their turn'.

Some respondents also commented on difficulties promoting preventative care to some patient groups where this does not happen in the home country. This, in turn, can impact on QOF targets³².

"My perception is that they see healthcare as something they go and get when they want it. They don't get proactive healthcare, they don't get preventative healthcare, that's something they get less of but when they want it, they want it. But it's usually reactive more than anything else." (Practice manager & receptionist, PC18a)

9.2.4 Nature of health issues

It was reported that some migrants and overseas visitors, especially refugees and asylum seekers, present with complex health issues including mental health, such as post-traumatic stress disorder (PTSD), as well as infectious diseases, such as tuberculosis, HIV, and hepatitis.

Such patients may often present with incomplete or missing health records and, combined with language issues, these individuals are likely to be resource intensive to treat and manage.

"It's because the overseas patients have a need, they don't have minor issues. If they're here for a reason and often it's because they have a complicated medical problem, so they demand time and resources which could be used for other people who need those resources. It's the resources we've got here plus the costs. Very expensive medication, even when there's the secondary care implications as well..."

...[] The other thing is because they're from overseas and they're often from high risk areas of the world, they have very complicated problems, there's a lot of psychological problems because a lot of them are going to come from places in the world where they've had a lot of psychological trauma." (Practice partner, practice managers & reception manager, PC20a)

³² The Quality and Outcomes Framework is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. Source: <http://www.nice.org.uk/aboutnice/qof/qof.jsp>

“Because a lot of them have come with chronic conditions and some of them aren’t necessarily the standard hypertension or diabetes and things like that, some of them sadly are the TB’s and the HIV and hepatitis and those kind of things. Hell of a lot of kind of post-traumatic stress disorder type things, a lot of them under the Mental Health Asylum Team who we work quite closely with. But equally, some of them do have the hypertension and the cardio-vascular disease and stuff like that, probably untreated for a long time.” (Practice partner, PC18a)

9.2.5 De-registration

While all Practices experience difficulties knowing when a patient has moved away, the research suggests there are particular problems for those in areas with highly transient populations. This includes those in locations that provide seasonal work as well as areas of high deprivation. Patients often move on very quickly and do not inform the Practice. The Practice may only discover this if it has cause to write to the patient and gets a response to the effect the patient has moved away, or when the patient re-registers somewhere else, or if they have made multiple unsuccessful attempts to contact the patient at the address provided on the patient’s records. Not only is this both time consuming and expensive to do, it has a significant impact on a Practice’s ability to hit QOF targets, such as for childhood immunisations and smear tests.

“Only the day before yesterday, I rang somebody for a smear appointment and she said, ‘but my mum doesn’t live here’, and I said, ‘all right, so where is she now?’ ‘She’s back home’. I said, ‘I need to take her off the list’. She said, ‘no, she’s coming this autumn’. I said, ‘you can register her when she comes back, temporary this time’.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

9.2.6 Use of A&E

Either because of the language difficulties or the perceived limitations of primary care, respondents commented that migrants and overseas patients may present at A&E for health issues that should be addressed within primary care.

One Practice said this was monitored and if a patient was deemed to have used A&E for something they could have got from their GP, the Practice is quizzed as to why this has happened and told to take steps to prevent a recurrence, thereby creating additional work as they have to contact the patient and try to explain why they need to attend the Practice.

“I monitor that A&E attendance and we hardly get any English names in A&E...”

...[] And that might be what puts people off phoning for an appointment, they can't speak English, they don't phone for an appointment and they just go straight into A&E." (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

In contrast, confusion over whether Practices can only treat overseas visitors for urgent and necessary care may result in them referring such patients to A&E. An example was given by one Practice of a woman who was in the UK visiting her daughter, who needed treatment for diabetes. The Practice had registered her as a temporary patient but felt they could not treat the diabetes as it was a pre-existing condition so she was referred to A&E. In contrast, the second Practice from the same case study area used the example of an overseas visitor needing treatment for diabetes as a case in point where they would offer treatment.

9.3 Impacts of Migrants and Overseas Visitors on Primary Care

9.3.1 Demand for the service

Many of the Practices reported that the volume of migrants and overseas visitors using their services has grown significantly in recent years (see section 8.4 for details of numbers of new patients being registered).

"I've worked here for 17 years at this Practice and I have noticed over the last, perhaps five years, the influx and our whole population and demand has changed dramatically because of the changing nature of our patients. We haven't got enough appointment times to meet their need or the demand is much, much greater and not necessarily needed." (Practice manager, PC10a)

"I've been here for 20 years and when I started here, I would say it was mainly all right. It's within the last five or six years the whole population has kind of really changed with the influx of foreign workers, and also the asylum seekers." (Practice partner, GP, practice manager, nurse & receptionist, PC18b)

This is on top of an increasing requirement to adopt a more preventative approach to healthcare.

"We have increasing requirements and demands upon our resources. We're having to see more and more patients. Not in terms of just numbers of patients who are attending because they're not well but because of all the preventative medicine and all the chronic disease prevention we do as well. And that's increasing because the DH wants us to do more chronic disease prevention. So we're increasing our workload because we're inviting patients in. Then we have more and more patients coming into the country, using the NHS, so we've got a double whammy. And we've only got finite resources." (Practice partner, practice managers & reception manager, PC20a)

9.3.2 Financial impacts

The financial impacts of trying to meet the challenges presented by migrants and overseas visitors were the result of the combination of increased costs and lost income.

Many of the Practices taking part in the study reported that they had had to take on additional staff at all levels, and extend surgery hours, in order to cope with the added demand. Although the cost of interpreters is met by the CCG, nevertheless, this impacts indirectly on their funding and there were additional costs associated with the need to write to and/or telephone these patients as well as offer information/consent forms etc. in multiple languages. For example, one Practice reported that its annual stationery bill had doubled from £5,000 to £10,000.

Cultural differences in attitudes towards preventative healthcare, as well as patients moving away without informing the Practice, meant that many of the Practices in the sample struggled to meet their QOF targets, resulting in the loss of an important source of income. One Practice spoke about where a patient has given false details, or where these have been mis-recorded due to language difficulties, the CCG may withhold payment if it is unable to trace/identify the patient.

“Because the patient’s still registered, we miss all the targets because they’re not at that address or they’ve moved on because they’re transient patients. So we probably lose thousands of pounds a year because we’re not able to keep track of those patients...”

...[] We’re target driven these days, we’ve got the DH which wants us to reach targets, and well, you can’t reach targets on patients who are not there really and are just invisible patients and mess the system up.” (Practice partner, practice managers & reception manager, PC20a)

“And we could end up getting not paid from the PCT, we’ve coded it properly but the patient can’t be found. So there’s that impact that the Practice has.” (Practice partner, practice managers & reception manager, PC20a)

Some respondents questioned the basis on which GP practices were funded whereby the cost is met out of their ‘global sum’. This is largely based on the number of patients on the practice list and the perception was that this does not adequately reflect the huge extra demands certain patients place on a practice.

“I think the guideline on it is poor, I think we only now know that guideline because we had to go into it with them and they said it was all paid for in our global sum, which doesn’t really pay for this. Especially if you’re a surgery close to where people are coming in from abroad, versus surgeries who will get the

same amount in their global sum as those where they don't have a large transient tourist population, that's my bug bear." (Practice partner, practice managers, nurse & receptionist, PC20b)

"A lot of the QOF requirements are ten times harder for us because actually we have a huge language difficulty or a cultural difficulty in trying to provide that care [] and we don't get paid any more funding for it but it can take us three times as long." (Practice manager & receptionist, PC18a)

"I think generally speaking we don't mind seeing foreign patients, people have different stories, can be very interesting, they have different illnesses. However, they take an extraordinary amount of time, and using Language Line is great but it's at least double the consultation time, and we're not actually being reimbursed for the extra time." (Practice partner, GP, practice manager, nurse & receptionist, PC18b)

One Partner commented that their Practice had come close to going under at one point.

"We've employed more doctors. We've opened our times during lunch now so we have telephone consultations, start at 8 am instead of 9, that first hour was spent on paperwork, now it's not..."

...So you've got to find other time to do that ...

...Where are you going to find the time? There is no time. So we've got more doctors, more nurses, we've employed a healthcare assistant now because it was just too much work...

...We've had to increase the reception because of the demand...

...More admin hours...

... So of course we've spent more, obviously more money on telephones, our bill for paperwork went from five grand to £10,000...

...[] So in terms of just the sort of finances of the Practice, it sounds as though it's sort of ...

...It went quite tight at one point, yes...

...It does have a big impact, absolutely." (Practice partner, practice managers, nurse & receptionist, PC20b)

9.3.3 Quality of care

Concerns were expressed by a number of respondents that it could be difficult to offer migrants and overseas visitors the quality of care the Practice would expect to provide. This can be because of the lack of a full medical history as well as problems with communication. Where a patient regularly travels between the UK and the home country (for example, EEA temporary residents), respondents reported difficulties in

trying to co-manage the patient's care. For example, patients may return to the UK with test results or expecting to have exactly the same medicines prescribed.

“The ones who go home, they come back and they've had sometimes amazing investigations, they come in with their MRI scan and throw them all down on the table. I had one on Monday who came in with an amazing number of investigations when they've gone home.” (CCG representative, 29)

“I would say there is a challenge in treating patients who are not always resident in this country. The Polish population have a habit of going back to Poland, getting a second opinion, getting a scan, getting treatment and then coming back here and expecting us to either agree with the treatment, interpret the scan or continue the therapy that we, nine times out of ten, disagree with.” (Practice partner, practice manager, nurse & receptionist, PC24a)

Practices were also concerned about the impact on other patients. Even after allowing for increased staffing levels and surgery hours, respondents reported that other patients may still find it very difficult to book an appointment or end up experiencing long delays. This results in increased levels of complaints and higher levels of dissatisfaction.

9.3.4 Impact on staff

The extra workloads, plus the perception that migrants and overseas visitors can be very demanding, were said to create stress for all staff, whether this is GPs running late on a daily basis or reception staff having to deal with complaints.

“There's stress of staff, be it the doctor who's run late for his whole clinic, who's then got to come to this consultation or sign prescriptions or have his afternoon clinic, there's stress for reception staff, potential complaints from patients, complaints from other patients who are then waiting for their appointment because that appointment was half an hour late. So the knock-on effect arguably, never stops.” (Practice partner, practice managers, nurse & receptionist, PC20b)

“That in fact, is massively disproportionate and then it engenders the bad feeling because you think you know sometimes it's hard enough to work in the NHS today, it can be incredibly rewarding, but sometimes it's hard enough.” (Practice partner, practice manager, nurse & receptionist, PC24b)

9.4 The CCG View

Given that only three out of the seven CCGs approached decided to put forward a representative to discuss the issue of migrant and overseas visitors accessing NHS services, and that two of the three were based in the same region (but were from different CCGs), the response is not necessarily going to be representative.

Nevertheless, for the sake of completeness, the views expressed are summarised here,

in part because they are somewhat different to those expressed by colleagues in primary care.

The three CCG representatives taking part indicated that, as far as they were aware, their CCG does not collect data on the overall numbers of migrants and overseas visitors accessing healthcare in their regions, let alone having a breakdown by different categories.

Moreover, and in marked contrast to colleagues working in primary care, the use of healthcare services by migrants and overseas visitors was not considered to be a significant issue. The perception was that the numbers of such patients and the associated cost of treating them, was small.

“For example, the urgent care board met this morning to discuss urgent care plans. The use of urgent care services such as A&E by migrants or overseas visitors has not been highlighted as a significant problem.” (CCG representative, 18)

“I don't think there's much awareness within the CCG, I don't think there's necessarily a need to have much awareness because I don't think the scale of the problem's big enough. Now if we were close to Heathrow and had very significant problems, then the Trust wouldn't be able to deliver cost improvement programmes if they're giving away free healthcare to those they can't afford to and also it is an opportunity for them to earn money, to help deliver their cost improvement programmes. So we would have a very significant interest if we believed it had an economic effect on the Trust, of significant proportion. So if they could save £3m a year, we might be nagging them to do it, if it's small beer, then that's their business, really.” (CCG representative, 29)

Indeed, one respondent felt that migrants and overseas visitors should actively be encouraged to use primary care services in preference to presenting at A&E which is more expensive.

“I think they actually want to encourage them to use primary because what we find is that a lot of people, because of the health systems in their countries they may come from, will tend not to have access to sort of a well developed primary care system, and so do not necessarily register, and therefore they miss out on all the screening or preventative work. But equally, when they become unwell, they are then chucked in A&E or somewhere like that, which is not necessarily the most appropriate place for them to be going and to be seen. So, to some extent, I think there is an argument to say we should be encouraging these people to register and potentially to keep the primary care aspect of their care free, because it will be cheaper for the health system. Unless we know we can always get the money back from treating these patents, it will be cheaper to treat them in primary care for free than to allow them to impact on secondary care and not recover the costs.” (CCG representative, 10)

When the issue of chargeable patients with an NHS number not being picked up in secondary care was raised, at least one respondent had not appreciated this could be happening and, moreover, that the CCG would not be able to identify such cases.

“From a CCG finance perspective, we would absolutely want our budget to be protected for people who were eligible. It probably isn’t a major issue in our neck of the woods, but even a relatively small amount would be worth ensuring that the money is going through to the right places...”

...Is it something you are able to do currently – to scrutinise what comes through from the Trust to see whether you should be picking up the tab?...

...Certainly the business intelligence team can break down information to NHS number but without an NHS number, I’m pretty sure the business intelligence guys would be checking up on that. So I guess there may be ones where there is no NHS number, that would be quite an easy thing to identify. The number of individuals coming through the system without an NHS number...

...The problem is lots of these people would have NHS numbers because they have registered with a GP...

...It’s the registering with the GP that has caused the system to...

...That’s the difficulty. If they have got a GP and an NHS number it’s very easy for the Trust to put them through...

...I see. In that case the answer is ‘No, we wouldn’t be able to identify them’.” (CCG representative, 18)

Another respondent acknowledged that the CCG might be carrying the cost of treating chargeable patients who have not been identified; however, the numbers and amounts could not be quantified and overall, it was felt that the issue was not significant in terms of the financial burden the NHS already faces.

“I think it probably does happen to some extent [CCG carrying the cost of chargeable patients] and I have no idea of what the scale is. In terms of the figures that have been bandied around in the press overall compared to NHS budgets and that, is this a big financial area? I don’t think it is. I think it is an area that could be clarified and could be done better and if we can do lots of little areas better, then that gives us a better result overall. But the resource and the practicality in the real world of a solution working, it has to be balanced against the return on the investment. The last thing we want to do is to have a system whereby we are actually spending more money trying to sort of identify this group of patients and collect fees from them, than we’re getting in and, you know, behaving in a way that is actually sort of potentially depriving human beings of good healthcare.” (CCG representative, 10)

The third respondent commented that under the terms of the recent Health and Social Care Act it would be illegal for the CCG to attempt to identify such patients.

“Put them through and we’ll pay for them, yes. That is a risk but actually, now the new Health and Social Care Act has been enacted, we’re in an absolutely ridiculous position because we can’t validate any of the returns because we can’t look at patient identifiable data. That’s a concern that comes up in all sorts of areas, so we cannot do any checking down to patient level of Trust returns because of the stupidity in the Act and it is a stupidity.” (CCG representative, 29)

10 Response to the Proposals

10.1 Introduction

Towards the end of the case study interviews, respondents' views on the Department of Health's proposals for change, which had been published for public consultation³³, were briefly explored. Very few respondents had read the consultation documents and, in most instances, the only things they were aware of were those they had come across in the media. There clearly was not time for respondents to study the full range of proposals and the discussions focused on some of the key points. It should also be kept in mind that these were introduced and discussed one at a time so that the inter-relationship between different proposals was not always clear to respondents.

10.2 Overall

In both primary and secondary care, respondents felt passionately about the NHS and had real concerns about the impacts migrants and overseas visitors, both those who are chargeable and those who are entitled to free healthcare, were perceived to be having on the service. Indeed, some of the discussions were animated and emotional particularly where respondents perceived the current state of affairs to be unfair or putting the service under strain.

In one Primary Care Practice, it was suggested that the proposal to extend charging could represent the first step in a move towards universal charging. A similar opinion was expressed by one of the CCG representatives.

"It's lovely to think, yes we could charge, but you're going to get to a point where we live in the EU so who else is going to get charged? We are because we live in the EU!" (Practice partner, practice manager & receptionist, PC10b)

"This is going to sound paranoid now but I think if you are pushing to set that system up in primary care, which I think you would need to do to underpin charging for this group of patients, some people will see that as a step towards privatising the NHS. Because once you've got that infrastructure in primary care, in general practice, it's very easy then to say, patients should get this bit of care from the NHS, but maybe pay a top-up fee for that bit of care, for convenience or something else. So I think that there's a sort of, some people may see that as a direction of travel with more sinister motives behind it than perhaps are intended." (CCG representative, 10)

³³ http://consultations.dh.gov.uk/overseas-healthcare/migrant_access/consult_view

However, the majority of respondents were broadly supportive of what they had heard/read although the specific proposals often gave rise to questions about how and whether things would work in practice. There were also questions as to whether, and to what extent, the proposals would address the issue of large numbers of EEA nationals accessing healthcare (issues around volume of use as well as, in some cases, perceptions of misuse) as well as addressing the issue of irregular migrants (issues around inability to pay).

10.3 Contributory Principle

The principle that everyone obtaining healthcare from the NHS should make a contribution to the cost of the service appealed to many respondents on the grounds of fairness. At the same time, a number of them expressed concerns that the cost of setting up a complex infrastructure to enable more ineligible patients to be charged might outweigh any increased income. While only a few respondents expressed the view that the costs of treating migrants and overseas visitors are insignificant compared to the total cost of the NHS, others questioned whether this might be the case.

“It makes me wonder though, the cost of that administration, setting up that whole process compared to the number of immigrants and overseas visitors that are legally eligible, I’m not so sure that the maths would stack up.” (Finance, Reactive, T12)

“If the idea is to charge for more things I think that is going to create a huge, I think there would have to be a significant administrative support behind that and I suppose it slightly worries me. I mean someone would have to work out if it was worthwhile in terms of the cost of running the system.” (Consultant, Proactive, T24)

“At the end of the day, you have to look at how many people are actually coming through the system. I’ve read all sorts of numbers. The lowest number I read was 100 million pounds a year to the cost of the NHS and if it’s as low as that, I know that in absolute numbers that is a huge sum of money, but given that the NHS budget is £100 billion, £100 million, there is no point in chasing that. You could say there is a principle and I agree with that, I think there is a principle here, but from a practical point of view setting up a system, multiple systems to close a loophole for £100 million is pointless.” (Consultant, Proactive, T13)

Concerns were also raised by some respondents in relation to:

- those already in the system registered with GPs, with NHS numbers and hospital numbers who would not be identified as chargeable
- irregular migrants who will not be in a position to contribute

- the numbers of non-working EEA patients; the perception was that many of these people do not make a sufficient contribution in their home state which means they do not qualify for healthcare (this is one reason that they do not have EHICs) and they were perceived by some respondents to come to the UK to access healthcare here. Concerns were also expressed that, by registering with a GP and being issued with an NHS number, such individuals are also able to obtain other benefits, which they may or may not be entitled to, a number of which are exportable; this means they can continue receiving them if they return to their home state

“If that is not looked after, then we are doomed I feel, because that’s certainly our biggest problem. The Europeans are just, without doubt, absolutely massive and they are getting bigger and bigger.” (OVO, Proactive, T13)

10.4 Health Levy

The idea of a health levy had been reported in the media and this tended to be the most widely known aspect of the proposed changes³⁴.

“Personally I agree with it. We all pay towards our healthcare, if we go abroad we might have an E111 but we still have to pay for any healthcare anywhere else in the world that we go. It’s not free and there is lots of money coming out of the pocket, there is not as much money going in. So I think we need to recoup some of that so it’s fair and equitable across the board really.” (Nurse, Reactive, T12)

In a few cases, there was confusion between the proposed health levy and the recent Home Office announcement of a visa levy.

A few respondents recognised that many visitors do not place huge demands on the NHS and, in the case of migrants, they may be contributing to the cost; in this context, the proposed levy was sometimes perceived to be appropriate.

“It’s not a large amount of money but when you say if everybody does pay it and then there is a percentage that you need, then probably it would cover...”

...I think it’s good...

...It’s an amount that is reasonable, affordable...

³⁴ It should be noted that the levy would not be applicable to short term visitors, who would continue to be charged directly unless covered by a reciprocal agreement. This may not have been apparent to all respondents.

...They're all students, most of them...

...And then bear in mind those working people are contributing to the economy as well, if they are working, the worry is the non-working people." (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

In most cases however, respondents were not familiar with the rationale behind the proposed size of the levy, and the two levels mentioned in the consultation, £200 and £500 a year, were invariably perceived to be inadequate on the grounds that these sums could be consumed by a single consultation or minor treatment.

"If you go to America, that will just probably cover your blood test. Or if you want a prescription or something, it will probably just cover your prescription." (Matron, Proactive, T20)

"So I'm not particularly happy on someone paying just £200 upfront when they know they can get something which may end up being £10,000 worth of surgery." Reception/Administration, Reactive, T12)

There was also a concern that it could have unforeseen consequences in that people who otherwise would not access healthcare might have a greater sense of entitlement which they might exercise.

"My fear on that one would be if you are taking a small amount, you are actually encouraging them to come here because they'll think actually, '£200, brilliant, I'll go and have £5,000 worth of treatment, thanks very much, because I'm going to be covered'." (OVOs, Clear direction, T29)

"But there are always going to be people who abuse this, 70 year olds who come in and say, 'I'll pay my £200, I want ten grand's worth of treatment, I want an echo for my heart checks'. It's going to happen because we've got an NHS and it's open and free for all." (Practice partner, practice managers, nurse & receptionist, PC20b)

A couple of finance managers assumed it would offer no direct benefit as far as individual Trusts were concerned, as they assumed the funds would not be passed on to Trusts to recompense them for the treatment they provided.

"Maybe I'm a cynic but when the Department of Health give you some money in one hand, they take it off you so it will go into a black hole somewhere, we'll never really see it. If we do, it will be given to you there and taken away there, so to be honest, I can't see that anything they're suggesting at the moment will benefit the NHS." (Finance, Reactive, T12)

"I don't think a levy, a small levy on migrants or people visiting, would necessarily benefit us to any great degree because the levels that were being suggested, I don't know how they relate to real costs of delivery. I don't think we would see the benefit of that quickly enough, I don't think it would filter through to us." (Finance, Clear direction, T10)

10.5 Compulsory Insurance

This was sometimes seen as a preferable alternative to a levy, at least in part because there was a perception that this is what most British people take out when they travel abroad.

“It should be in a way a bit like when you have a car, you have to have it insured. So when you come to get a visa, when you apply for a visa in whatever country you are, if you’re not eligible for NHS treatment, you must have compulsory medical insurance, just as you have car insurance. And there’s a database in the UK so that if you’ve got an MOT or whatever, the police can look up. The Border Agency can look up as you come in, ‘has this person got insurance with a proper insurance company overseas?’ And therefore you come in and then they’re billed.” (Practice partner, practice managers & reception manager, PC20a)

At the same time, it was recognised that there could be problems with an insurance based approach. For example:

- it was assumed that in some countries there might a lack of reputable insurers; one suggestion was for the DH to provide an approved list of insurance companies as happens in some other countries
- that disputes could easily arise over pre-existing conditions – if the insurer refuses to meet a claim on these grounds and the patient cannot afford to pay the bill, the NHS would be left picking up the costs
- individuals might take out cover in order to obtain a visa only to cancel it once they arrived in the UK.

Trusts involved in the research had had mixed experiences of dealing with insurance companies and many would prefer to invoice the patient and leave them to deal with the insurer (see section 4.5.1 for more details).

10.6 Pre-registration

The consultation document sets out a possible system whereby new migrants and overseas visitors register with the NHS before they can access any form of primary or secondary care. The body charged with pre-registration would conduct a full eligibility check and issue a new care record/NHS Number that would differentiate between individuals who are:

- exempt from charging/entitled to free healthcare

- temporary residents who have paid the healthcare levy
- EEA nationals
- directly chargeable.

This would mean that whenever and wherever the patient presents within the NHS, their status would be immediately flagged up.

Many respondents supported the idea in principle. The idea of a card or number that has to be produced takes responsibility away from the providers and had appeal. Primary Care Practices often described feeling overwhelmed already with the numbers of new patients they were registering, and would not want to take on the role of establishing whether or not new patients were chargeable.

“We can’t be the gatekeepers because (a) we don’t have the time; (b) we don’t have the expertise.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

Within secondary care, the main difficulty was in identifying potentially chargeable patients. Because of the volumes of patients concerned, it was almost impossible to adequately screen everyone and chargeable patients were either not being identified or only picked up during or after treatment. Such a system should mean that chargeable patients are immediately identified.

“I think if they were registered at the beginning, that would work because everybody would know and then we wouldn’t be having to ring up another Trust to find out what they’d done, because it is annoying that we get people transferred into the Trust, and we have, from other hospitals, and they have no idea whether they are liable.” (OVO, Proactive, T24)

It was thought that it might also discourage those patients who know they should pay for their healthcare and who currently ‘try their luck’ and, if challenged, move to another Trust in the hope they will not be identified a second time.

“Yes I think that’s fantastic because also, as well, if you’re on holiday from somewhere and you realise you are going to have to start paying charges and you realise that at the GP, that would put a lot of people off pursuing it any further and trying their luck once they know that there’s proper screening in place.” (OVO, Reactive, T12)

The clinicians in the sample also often welcomed this idea as it meant there was a clear separation between the administrative and financial side of the relationship with the patient, and the clinical side.

“I agree with them because I think the issue is that you don’t want conflict with the medical providers because we have to be impartial to people’s situations. And what you don’t want is to then engender conflict between nurses, doctors, and the patient.” (Consultant, Proactive, T20)

“It shouldn’t happen at the GPs either, he is the same as me! He wants to treat everybody who comes to him!” (Consultant, Clear direction, T10)

Despite welcoming the idea in principle, a number of respondents felt that implementation could be problematic. It was often assumed that many patients would present as ‘emergencies’ before they had an opportunity (or felt inclined) to pre-register so some screening would still be needed in surgeries and A&E.

“If they haven’t done so before they arrive but they’re still entitled to free care but they don’t have this number, what happens then? I think that it could potentially cause a lot of problems for people that might be entitled to care but haven’t registered via this mechanism.” (Finance, Proactive, T20)

Questions were raised about how the system would keep up to date with changes in an individual’s status.

On the assumption that the process would involve face to face contact, some respondents suggested that the body responsible for pre-registration would need to be easily accessible across the country with outlets in each town. Suggestions were put forward in terms of existing offices/outlets where such a service might be made available including Job Centres, council offices, as well as separate centres within hospitals.

“I think there should be a central place where people can register for the NHS because I do think it’s becoming too big for GP surgeries.” (Practice manager, nurse & receptionist, PC10a)

The ideal for some would be if it could be done at the border.

“I think if the Border Force had people who gave these patients a card saying ‘I am entitled to this level of medical service’ then they turn up at the desk and give this card, one would hope that something could be done. As long as people are quite clear as to what the rules are. And I think that’s the problem that we have, even as a doctor I don’t understand what the rules are. That’s why I tend to ignore them! I think it would be nice if the patient actually had a card that they could show you. [] If they knew they had to produce the card to register with the

GP to remain in this country, the patient would automatically produce that card. And if they couldn't produce that card then presumably we wouldn't treat them." (Practice partner & nurse, PC29b)

The question was raised as to what would happen with irregular migrants who would not present for screening.

10.7 Extension of Charging

Many respondents offering a view supported the idea of extending charging to include A&E and primary care.

"Yes, I do think they should pay. If you're over here visiting for whatever reason from whatever country, there should be some charge that's made." (Practice manager, nurse & receptionist, PC10a)

Comparisons were drawn with what happens to UK citizens when they are abroad.

"Even if it's an emergency, we have to pay, or if you're in Europe, you show your EHIC but if we don't have one you have to pay and claim it back when you come back. The whole focus is the other way round. When they come here, we give treatment and then we try and work out whether they're entitled to it or not." (OVO, Clear direction, T29)

"I think the NHS has carried the burden of foreigners' illnesses and ops and things for far too long and it is going to crumble under the weight. It's got to. I would expect to have to pay for my emergency treatment [overseas], I wouldn't expect it to be free." (Reception/Administration, Proactive, T13)

One or two would go further and charge all patients a nominal amount.

"For any service, even for accessing the GP, A&E, you get advisory health, you get charged a little bit of money, and what that does, it adds to the little bit of the pot and then it spreads the costs out. [] And this little payment will just be a nominal fee which just allows them to have a degree of responsibility for the use of the service." (Consultant, Clear direction, T10)

However, other respondents were wary of the idea. Some commented that it would need a major cultural shift within the NHS while others were worried about the potential impact on patient relationships.

"I think it's a really difficult topic and I'm not convinced on the basis of a best guess that the amount of effort and systems and administration that is required weighed up against the changes to people's practice and the kind of negative feeling that I think you would have, thinking, 'I can't treat this person because they can't afford to pay' or 'because it will ruin them for the next 40 years'. It's not something that is in our training or our psyche as doctors and I think you may struggle to persuade people that that is the right thing to do." (Consultant, Proactive, T24)

“I think that it goes against the whole ethos of the NHS, full stop. I think if you have an emergency you need to be able to access emergency care and regardless of how much money you’ve got, regardless of whether you are a migrant or whether you are an asylum seeker, or whatever.” (Consultant, Proactive, T13)

Some perceived A&E to be a necessary way of carrying out an initial assessment (which they felt should be free) to decide if any treatment was required (which they agreed should be charged).

“They have to be assessed, that is the purpose of A&E, it’s kind of the gateway to decide what further treatment, if any, is needed. So I don’t agree with charging for A&E. But I think the identifying of people that are OV still needs to be their responsibility.” (OVO, Clear direction, T10)

“If it’s true emergency treatment in A&E, then they shouldn’t get charged because they will get their charge if they end up getting admitted.” (Nurse, Clear direction, T10)

There were also some qualms about charging for genuine emergency care, such as injuries caused by a road traffic accident where the patient is not at fault, as opposed to pre-existing conditions.

“I feel that emergencies should be treated, say somebody came to the country and fractured something, that should be treated. But if somebody comes with nephrology conditions or somebody needs chemotherapy, they come for that specially, I don’t think we should have the burden of treating those people if they don’t have the right to live in this country.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

Some respondents were concerned that it could encourage what they perceive to be already demanding patients to become even more demanding, for example, expecting to be seen immediately rather than waiting their turn.

“And are you going to get these people who are paying, demanding that they are seen immediately? That’s what will happen. If they’re paying for a service, they’re going to expect, when they phone up along with the other 300 to 400 per day we get on the phone, to then say ‘I’m paying for this, I want an appointment’.” (Practice manager & receptionist, PC29b)

It was also suggested that charging in both primary care and A&E could result in the need to raise a large number of invoices for small sums for those individuals who are only seen for 15 minutes.

Some raised questions about the nature of charging; for example, would there be a flat fee or would charges be based on treatment? Some argued that a common tariff will be

required across all services (GPs, out of hours, A&E, etc) because otherwise, differential pricing could push patients in a particular direction.

“If you are going to charge for GPs, you’ve got to make emergency services chargeable also, otherwise your A&E departments are going to be full to the brim with overseas visitors. Once they establish that A&E is free and primary care isn’t, that is where they’re going to head and our A&E services are pushed to capacity now.” (OVO, Proactive, T13)

“I think you’ve got to be very careful though about charging them for the whole of primary care which will then put them off the preventative sort of work that we do. It will make them more inclined to use secondary care and unless we know that we’ve got an absolutely robust system for charging them for that care and being able to actually get the money back, we could equally be costing ourselves more money.” (Practice partner, practice manager & receptionist, PC10b)

Some respondents felt they would need to collect payment up-front, for example, a consultation fee for a GP appointment paid on arrival or a chargeable triage point in A&E.

“Billing patients is fraught and unless you’re used to doing it, it’s actually quite difficult. Even in the private sector, I have had problems chasing patients for their money. You have to get patients to pay up instantly so you’re going to have to have credit card machines or a cash register at reception.” (Practice partner, practice managers & reception manager, PC20a)

Some staff in Primary Care Practices were uncomfortable with the idea of asking patients for payment. Others were willing to take it on provided there was very clear guidance about who should be charged, for what, and the amounts involved.

“Very reluctant to ask for money, we’ve been brought up that the NHS is free at the point of care and so it’s very uncomfortable to ask...”

... Very uncomfortable...

...And I would worry about the admin side of it.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

“I’m sure there’ll be new and different challenges but like J said, I think what we’re missing is clear guidance. [] Who takes the money? Where do you put the money? How do you charge?” (Practice partner, practice manager, nurse & receptionists, PC12b)

In the case of money being collected at A&E, it was suggested that a greater security presence might be needed and there were also concerns it could impact on patient flow. A matron commented that payment for prescriptions is already a difficult territory within A&E which suggested that widening charging could also present difficulties. A similar opinion was expressed by a receptionist.

“I think it would be a challenge for our admin staff; they would need some training because asking for payment at point of care is quite hard and we’re open to quite a bit of challenge as it is and abuse in the ED department.” (Matron, Clear direction, T29)

“But how would money exchange because we wouldn’t take money in A&E, that isn’t what A&E’s do, they treat people, that isn’t what we do. We don’t handle money, we don’t have anything to do with it. It’s too high risk. So I would want to know (a) how that information gets fed into the Trust and (b) how does that information feed back? It would be like saying to people ‘you need an x-ray, that’s going to be £20. Oh you need a splint, that’s going to be...’ That wouldn’t be something that we would do in an A&E, it’s not the environment to do it. It’s not appropriate, I personally wouldn’t think that’s appropriate.” (Reception/Administration, Clear direction, T29)

There were also questions about:

- what happens if someone decides they can’t/don’t want to pay, leaves without receiving treatment only for something to happen to them

“Because what you’ll end up with having, you’ll have 99 cases out of the 100 that are absolutely fine to be sent away but you’ll have one horrendous story which would risk your reputation.” (Matron, Clear direction, T29)

- what happens to those who simply can’t afford to pay? Is there a danger patients may compromise their healthcare in order to keep costs down, such as a pregnant woman opting to see the midwife less often

“It’s a really difficult question because you know there are people that can afford to pay and should be paying, but there are people that come from desperate circumstances and they need help...”

...And you wouldn’t want to get in the way of that.” (Practice partner, GP, practice manager, nurse & receptionist, PC18b)

- whether the health of the wider population may be compromised if people with communicable diseases are not seeking treatment because they cannot afford to pay for it.

“How are we going to be sure we don’t miss HIV and TB and the things that we are supposed to be treating?” (Practice partner, PC18a)

10.8 Centralised Invoicing and Recovery

Some respondents could see the benefits of scale this could give rise to as well as the possibility of greater expertise being brought to bear.

“I suppose the advantage there would be the economies of scale, in that this organisation, whoever they would be, would have dedicated knowledge around credit control functions, and all that kind of thing, so that would be an advantage.” (Finance, Clear direction, T29)

“I can see how that could work, it could be beneficial, focusing knowledge and expertise, shared knowledge rather than having it disparate all over the country. I can see how that would work, it would remove some of the admin from us.” (Finance, Reactive, T12)

However, some Trusts in the sample were outsourcing this side of their work already and, where this was with Shared Business Services (SBS), not all of them had been impressed with the service they received. For example, some Trusts found themselves chasing debts once the efforts of SBS had been exhausted.

It was pointed out that a centralised resource should mean it was possible to identify accumulated small debts across a number of Trusts to cross the UKBA threshold of £1,000.

“If one place was doing the debts, you would then actually know and hopefully you’d also spot a patient coming backwards and forwards, which, at the moment, if somebody comes here and then flies back and then comes and goes to [town] and then flies back and then goes to London and then flies back and then comes over and goes to [town] and then flies back, you know, there’s no way for us to pick that up really. And in terms of, at the moment, with the Border Agency and their limits, I think it’s a £1,000 limit if they’ve got a bad debt, I don’t think any of ours actually hit that level, frustratingly, £890 or something! But actually, if you were then coordinating all of that person’s debts, if you like, and if you could then say, ‘actually, overall, you owe –’, you know. Individually, you would never have informed the Border Agency, because their debt might be 200 quid, but if it was 200 quid here, 200 quid there and 200 quid, then actually that might add up and then you would spot them as the health tourists.” (OVO, Clear direction, T29)

A key factor would be the speed with which an invoice was raised; the view was that the sooner this is done, the more likely it is to be settled.

“The massive thing with invoicing for overseas visitors, is that you need to invoice as soon as possible because once they’ve gone, if you do it four weeks later then, you know.” (OVO, Proactive, T24)

The sharing of information implies the need for a secure, legal gateway but given that patient data is shared already with CCGs, this was not seen as a significant barrier (see 10.10).

“How do we make sure that the information that we have being collected, confidential and data secured patient data, is passed across to that new agency or new organisation in an appropriate fashion and are there the right [safeguards in place] - that we’d be breaching security issues by doing so. I suspect that the

same way we do with CCGs for patient data to enable us to pass across the relevant information.” (Finance, Proactive, T20)

They would not want to see payment to the Trust delayed by an extra layer of administration and there was a degree of scepticism that a Trust may have a bad debt return to its balance sheet if the new body failed to recover it or the Trust may have to pay a percentage for recovery (cf. factoring).

“It depends upon the timing. If there is a cash lag or delay in the settlement through the central recovery unit, we may well end up just adding another layer of delay in the process.” (Finance, Clear direction, T10)

“They might come back and say, ‘oh, these are still bad debts, so you can have the bad debts!’” (OVO, Clear direction, T29)

One or two respondents wondered whether it would give Trusts a disincentive to code and invoice promptly or be as diligent in questioning the patient or the urgency of treatment given that payment would be guaranteed.

“I think there would be an incentive to do that because the clinicians wouldn’t have to worry about the financial risk in theory so they wouldn’t have to be concerned with, if I refer, you know, about wanting to treat patients. So they can refer without fear of us saying, ‘no, we’re not going to treat.’” (Finance, Proactive, T20)

“If we were responsible just for getting to the stage where we request an invoice to be raised by the central agency or bureau and then we get that income as soon as we raise that request, then it’s not in our interest to do any more work than the bare minimum. So as soon as we send that over to them, that’s our income, we may get slack in getting the right level of information from the patients. It’s just moving the problem to them rather than us being responsible for everything surrounding that debt. I think the responsibility for recovering the debt needs to be as close to the service as possible, the service who is receiving the income.” (Finance, Proactive, T24)

The question was also raised whether a centralised service would apply to primary care. Some Practices had no desire to be responsible for invoicing, feeling this could damage the doctor-patient relationship as well as adding to the demands on staff.

“Well again, we can barely cope with what we’ve got. I think I could do without having to be a tax collector. That sounds like another item on a job description and with the workload we’ve got, I’m not happy to do that.” (Practice partner & nurse, PC29b)

10.9 Ex-pats

While it was felt that the proposed changes will help address the challenge of identifying ex-pats and the negative response that this can lead to, there were mixed views about

this change. Some felt it was fair, given the individuals had previously made a contribution to the cost of healthcare, however, others were unsure that they should be exempt if they have chosen to live elsewhere and are no longer contributing.

“I think that could be potentially quite good because that’s one of my bones of contention. The ex-pats hate the fact that I’m talking to them, they think it’s totally outrageous. They have contributed to the UK their entire lives, how dare I be telling them that they have to pay because they’ve chosen to live overseas? I just say, ‘well, sorry them’s the rules’. But obviously I think the issue is, it’s always been emergency care is free to anyone who can prove they’re a former resident. It’s the planned care that often isn’t free because if, for example they are living in Spain, the UK are paying for them to be in Spain. So how can they then come back and fund them in the UK? Once I explain that to them they go, ‘oh right, yeah, that makes sense. I didn’t realise that’.” (OVO, Clear direction, T10)

“You pay in and expect to be able to use it when you like, so I have got a lot of sympathy for ex-pats who’ve paid in and worked all their lives and made a big contribution, maybe not used the service and then as you get into older life, in the last few years of your life, you need some care, I think it’s pretty harsh that we just say, ‘you’re no longer a resident’.” (Finance, Reactive, T12)

If the exemption was to work, and if unpleasant confrontations were to be avoided, it was felt there would need to be a quick and easy way of demonstrating the patient had the required history of contributions.

10.10 Legal Gateway

There was more or less unanimous support among respondents for this proposal which was perceived to be a sensible development given the need to consult other agencies, such as the Border Force, and given that some OVOs had experienced difficulty in negotiating the various protocols. It was assumed that establishing a legal gateway should overcome any delays in getting responses to requests for information (see section 4.4 for further details). A similar view was expressed by representatives of the Border Force who were keen to remove the frustrations of not being able to share information fully.

“So there are systems for us to transfer but I don’t know whether the systems on the reciprocal end are as robust, so it would have to have a wholesale review of everything there. But yes, I could see how that would be of benefit. As you say, it’s being able to talk to each other on an immediate basis rather than having to wait for days for people to get back or the offices are now shut, so it’s like the digital revolution, the public services are still waiting to catch up with that.” (Finance, Reactive, T12)

“Anything that sort of opens up an avenue of communication that is simpler and doesn’t require constant letters of authority and this, that and the next thing. So

long as it's established who's who and who's entitled, I think that would be a huge benefit." (Border Force/Immigration, airport 2)

"All of us – the Police, Border Force, Customs, DWP, HMRC, NHS – we've got so much information that is of use to other people, colleagues, that if it were all legally allowed to be shareable, we could certainly have some fantastic results, I think." (Border Force/Immigration, airport 5)

It was considered a logical development and was seen as following in the steps of other areas of multi-agency working where clear protocols have been developed. It was acknowledged that there would need to be clear guidance on what can and cannot be shared but this was not felt to be a major issue. Suggestions for how such a gateway could be used included:

- allow checking and reporting of immigration status (and sometimes other issues, such as a history of violence)

"They are the ones that are actually illegally here, they've got no right to be here. They know they are unlawfully here, but they know the UKBA can't find them so they are just laughing and I can't tell anyone, even though I've just spoken to you in our department so I know you are here, I know you're unlawfully here because you haven't lied to me, I can't tell anyone about it." (OVO, Clear direction, T10)

- the identification of patients with a record of debt/treatment with other Trusts

"I think there is all this information that is out there in the cloud so to speak. There is all this information out there and we, as NHS hospitals, have no access to it. We are not even linked together so a person can go from X Hospital to us, like I've just had one then and X Hospital haven't seen him. I've seen him so I now know he's a visitor that we can claim from Spain for him, but does my colleague at [neighbouring Trust] know that – probably not. There is no centralised system whereby we can all be linked together." (OVO, Clear direction, T10)

- links to DWP and benefit entitlements.

A group of Border Force and Immigration Enforcement officers suggested that having such a facility might preclude the need to invest very large sums in a system for pre-registration because it could enable all parties concerned to make the necessary checks and determine a patient's chargeable status.

"I know that confidentiality and privacy is a big issue at the moment but we're not looking to see people's medical records or anything like that. I mean, you could have a gateway that had elements of the Home Office, the DWP, the NHS or whatever, so that a perfectly, well you can't say perfectly but as best as possible objective decision can be made as to whether somebody should be charged for something. Hopefully you've covered all the bases before you get to the stage

when legal challenge came in, you know because that's what happens, people play us off against each other. If we'd all agreed at the early stage that this person didn't qualify or this person did qualify, that's the end of it as far as we're concerned." (Border Force/Immigration, airport 4)

10.11 Other Ideas Generated by Respondents

During the interviews, various ideas were invited and suggested that might improve identification, charging and recovering payment from chargeable patients in advance of and/or in addition to the changes implied by the proposals being consulted on. The main ones are summarised below.

10.11.1 Culture change within the NHS

A need was identified for a change in the culture of the NHS whereby it is accepted that people have to pay for certain treatments, in certain circumstances. The view of a number of OVOs was that clinicians need to be introduced to this as part of their training including understanding about not treating if not immediate and necessary until any charging and/or payment question is settled, as well as stabilising and discharging if necessary.

"The attitude of some clinicians may need to change in relation to the provision of care, I think that's a cultural issue." (Finance, Clear direction, T10)

Reflecting the fact that some OVOs did not feel they had the support of their Trust in carrying out their duties, another suggestion was that OVOs should work directly for the DH rather than for individual Trusts to ensure consistency of approach; that they should be given greater support and resources, possibly working in clusters with neighbouring Trusts.

OVOs were aware that some of their colleagues in other Trusts had developed better ways of identifying, charging and recovering monies from chargeable patients and there was a call for examples of good practice to be actively shared between Trusts. In this context, there was widespread support for a single model to be developed and for this to be applied across all Trusts, as opposed to the current situation where each Trust is left to develop its own way of working.

Some Trusts reported that they already have good working relationships with local Immigration offices and it was proposed that there could be more active working between officers from different departments at a local level.

“What we need is someone, not necessarily senior but someone who knows about the operation at a junior managerial operational level, meeting with the equivalent of themselves in, say DWP and NHS, or someone who either represents the local NHS Trust or a representative from each of the hospitals within that catchment area, so that you can all sit together, discuss the issues on a monthly basis, discuss lists of people who may crop up of interest to the other parties and that’s the only way we’re going to be able to do it. By having much more local input and then those officers internally being able to go to their national equivalent at the ports and liaise.” (Border Force/Immigration, airport 4)

There was broad support for proper training for OVOs, adequate resourcing and for recognition of their role including the fact that they are called upon to make difficult decisions while often being relatively junior staff members. Several participants suggested that there should also be compulsory training for all staff, possibly delivered online.

10.11.2 Active programme of communication about the possibility of charging

It was felt that there was a need for publicity before and when people come to the UK about eligibility, costs and how the healthcare system in this country works. This could be linked to various elements of the process including visa applications, information available via travel companies, information displayed on landing cards as well as posters at airports warning passengers and stressing the importance of health insurance.

“When they are sending out the tickets, if there is something in with the ticket that says, ‘healthcare will be charged’, you know, even if you’ve got the A&E price list, you know, this is the sort of thing you’re looking at, because then you do away with the ‘I didn’t know’ defence. There almost needs to be a box that when you are signing, ‘I undertake, I accept responsibility for paying for healthcare’, that they sign, because actually then you say if Border Force keep that, there’s evidence.” (OVO, Clear direction, T29)

There was also a call for clear, consistent instructions for staff that can be shared with patients on the must-have documents to demonstrate eligibility as well as the tariff of charges.

“It kind of needs to be blanket, so that everybody does the same thing and it is made really, really clear when you are coming into the country that this is now how it works...”

...And charges on A&E’s board, overseas patients, these are the charges.” (OVOs, Clear direction, T29)

10.11.3 Regulatory framework and clarity

There was a perceived need for:

- a clear legal framework setting out eligibility for free treatment. One suggestion was to reclassify NHS services as a 'public fund' and link it to the visa stamp in passports
- consistency/co-ordination between NHS/social care/immigration rules for clarity and better working, for example, so that homeless people who are ready to be discharged do not end up occupying a hospital bed for days, weeks or, in some cases, months
- mandatory eligibility checks by referring Trusts in advance of tertiary referrals; this was felt to be one way in which the referring Trust could 'pass the buck'
- a generic procedure/system that is used by all Trusts to screen patients for their eligibility for free treatment including the documentary evidence that is required and the storing of this electronically

"There has to be a generic way of doing this, there must be a generic way and what's done in one Trust should be done in other Trusts as well." (Matron, Proactive, T20)

- compulsory reporting to DH of migrant and overseas visitor activity using consistent performance indicators to ensure that all Trusts are screening patients, identifying those who are chargeable and invoicing them, and that they are doing this in the same way
- improved support from DH and the provision of clear guidance
- a nationally agreed strategy for dealing with chronic conditions, such as kidney failure, to tackle the problem of patients serially re-presenting as an emergency at greater cost to the NHS
- families/'sponsors' for visitors should be responsible for paying any healthcare bills that an overseas visitor incurs in the event that patient is unable or unwilling to do so.

10.11.4 Systems

Suggestions in relation to systems included:

- Clarify/facilitate/accelerate the sharing of information between Border Force/ Immigration Enforcement and Trusts; allow Trusts to notify Border Force of debt within seven days rather than three months
- Improve the tariff that can be charged so that costs are fully recovered (including allowance for bad debts, administration etc)

“So what I’m thinking is, if we failed to recover two-thirds of the cost, then the tariff should be two-thirds higher to absorb the non-payers.” (OVO, Clear direction, T29)

A CCG representative suggested that chargeable patients should be charged at the NHS tariff plus five per cent to reflect additional costs, such as interpreters. He felt this would then incentivise Trusts to identify chargeable patients given that they would benefit from the slightly higher tariff.

“It would incentivise the Trust to want to identify that group of patients because they know they are going to get five per cent additional income compared to, if they just bill it back to the CCG or to, you know, NHS England if it’s a specialist service.” (Practice partner, practice manager & receptionist, PC10b)

- Enhancements to PAS/other patient information systems and Spine to provide immigration and charging status. The Exeter Registration System was suggested by one OVO as a possible candidate for an improved Spine.
- NHS cards that expire every five years for everyone and which have to be renewed (possibly along with one’s passport) to ensure all chargeable patients are identified including those whose status has changed.

“I think there should be expiry dates on NHS cards, same as I think NI cards. To avoid those that have been lawfully resident giving their documents to someone else to use and also to say ‘hang on, your circumstances might have changed since this NHS card was given, is it still valid?’” (Border Force/Immigration, airport 1)

10.11.5 Border Force/Immigration

There were a number of suggestions put forward by representatives of Border Force (and others) including:

- Having a clear remit and greater priority (and resourcing) given to Border Force to tackle ‘health tourism’
- Improvements to the visa application process to include questions about existing health conditions (including pregnancy) as well as being able to seek evidence of the applicant having sufficient funds to support their healthcare needs

“If you have to go to Australia or America, you have to be screened for it. We’ve got patients here who, some of them are really unwell. They’ve got heart conditions, they’ve got severe diabetes, they’ve got COPD and then they’ve got stress issues and anxiety, we end up with all that.” (Practice partner, practice manager, nurse, receptionists & other admin staff, PC12a)

“Something as simple as a box on an application form for a visa ‘Have you sought medical treatment previously?’; ‘are you pregnant?’ Something like that. And obviously if they don’t disclose it and we find out that they have, then we can refuse them because they haven’t been truthful. But if they tick ‘Yes’ the checks can be done prior to them being issued. It doesn’t say ‘have you previously accessed or intending to access? If you say ‘Are you registered with an NHS GP?’ and obviously if they are, then you know.” (Border Force/Immigration, airport 3)

“I think there should be a statement to say, I don’t know how they would put it diplomatically, but certainly ‘do you have any existing medical conditions’ or something like that.” (Border Force/Immigration, airport 5)

- The collection of a signature (e.g. at the border) whereby the individual agrees to pay/have means in place if healthcare is needed during their stay and they are found to be chargeable
- Trusts to keep a record of enquiries about treatment from people prior to travelling to the UK and for this information to be shared with the Border Force to help demonstrate intention to access healthcare
- Reintroduction of embarkation checks to pick up patients leaving with a debt to the NHS.

“What we’re saying is, if they raise that invoice and they put it on our system we would know about it and we’d identify that at embarkation and we’d say, ‘I’m sorry, you can get on the flight but you still owe us £25,000, how much have you got on you? Bring out your credit card and stick it in this machine’.” (Border Force/Immigration, airport 4)

11 Appendices

11.1 Sample Details

11.1.1 Structuring the Sample of Trusts for the Scoping Study

The 161 acute Trusts were mapped onto the following variables:

- Trust expenditure
- Asylum dispersal areas*
- Specialisms (specifically, cancer, renal, maternity)
- Presence of A&E
- Proximity to international airport*
- Urban/rural locations*
- English regions

Some of the data (marked above with *) are based on Local Authority areas. In order to map the Trusts onto this, the postcode of the Trust 'head office' was used to allocate it to a Local Authority area. It should be noted that this is only an approximation as a Trust may include a number of hospitals that cover an area that overlaps with several local authorities (for example, Pennine Acute Hospitals NHS Trust includes hospitals in Manchester, Oldham and Rochdale).

Trust Expenditure³⁵

Expenditure data for 2011/12 was provided by DH. There was no data for three Trusts which meant they were not available for sample selection. For the remaining Trusts, expenditure ranged from £20m to £1.1b per annum. The 158 Trusts were grouped into three equal size bands:

- High (>£337m pa)
- Medium (£216-337m pa)
- Low (<£216m pa)

The aim was to sample equally from each of these bands.

³⁵ Source: Trust expenditure data: Foundation Trusts: Monitor; the data was for 2011/12. Acute Trusts: DH; the data was for 2011/12.

Asylum Dispersal Areas³⁶

The majority of Local Authorities have either no or very few dispersed asylum seekers. The top 10 per cent of Local Authorities (33 out of 326) were identified based on the numbers of dispersed asylum seekers (these range from 167 to just over 1000). On this basis, just over a quarter of Trusts (27%) are based in a Local Authority that is in one of the top 10 per cent.

The aim was to ensure 25-30 per cent of Trusts fell into a top 10 per cent area.

Specialisms

- Cancer: using a combination of information provided by each Trust on NHS Choices, and a list of Trusts that were included in a survey about cancer treatment³⁷, Trusts that provide oncology services were identified. This revealed that 69 per cent of Trusts provide oncology services, including three specialist Trusts.
- Maternity: based on information provided by each Trust on NHS Choices, 86 per cent of Trusts offer maternity services
- Renal: based on information provided by each Trust on NHS Choices, 60 per cent offer renal services.

The aim was to include the three specialist cancer Trusts in the sample but not to control for any other specialisms; these should fall out broadly in line with the national profile.

A&E

- Based on information provided by each Trust on NHS Choices, 90 per cent have an A&E dept in one or more of their hospitals.

There was no need to control for this.

³⁶ Source: <https://www.gov.uk/government/publications/tables-for-immigration-statistics-january-to-march-2013>; Asylum data tables Immigration Statistics January to March 2013 volume 2; sheet as_16_q

³⁷ Source: <http://www.quality-health.co.uk/surveys/2011-2012-cancer-survey-trust-level-reports>

Proximity to International Airport

The websites of each of the 20 airports in England were explored to see what destinations they cover. On this basis, four were identified as offering scheduled long haul flights (Heathrow, Gatwick, Manchester and Leeds/Bradford). Five other airports cover mainly European destinations but within this, they fly to one or more East European destinations (Birmingham, Liverpool John Lennon, Luton, Stansted, and Newcastle). European flights may also link up with long haul flights at European hubs. The remaining airports are mainly providing charter flights or fly exclusively to 'mainstream' European destinations (Bournemouth, Bristol, Robin Hood/Doncaster and Sheffield, Durham Tees Valley, East Midlands, Exeter International, Leeds Bradford, Liverpool John Lennon, London City, Newquay Cornwall, Norwich International, Southampton, and Southend).

Each Trust was categorised according to whether it is within 25 miles of either a 'long haul' or an 'European' airport which covers Eastern European destinations:

- 29 per cent of Trusts are in the catchment area of a long haul airport
- 22 per cent are in the catchment area of an 'European' airport

NB These will overlap in some instances.

The aim was to ensure 25-33 per cent of the sample was in the long haul catchment and 20-25 per cent were in the 'European destination' catchment areas.

Location

Defra's classification of local authority areas was used³⁸. Each Trust was put into one of four categories:

- Metropolitan (39%)
- Urban (29%)
- Rural (24%)
- Mixed (8%)

The aim was to achieve a split that was close to 40:30:25:5

³⁸ <http://www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/rural-urban-definition-and-la/rural-urban-local-authority--la--classification--england-/index.html>

Region

The split of Trusts across the nine English regions is as follows:

- London: 17%
- South East: 13%
- South West: 11%
- East of England: 11%
- East Midlands: 5%
- West Midlands: 12%
- North West: 17%
- North East: 5%
- York & Humber: 9%

The aim was to broadly mirror this.

This meant that the sample was structure on the basis of five key variables. When interlocked, this gave rise to a matrix of 648 cells.

The 158 Trusts for which there was a complete set of data were mapped onto these variables as shown in Table 18. The cell values were multiplied by a factor of 30/158 to show how many Trusts from each cell would be required in order to draw a sample of 30 Trusts that were representative of the total population. The result is shown in Table 19. Starting with the row and column totals, the values were rounded to the nearest whole number to yield the matrix shown in Table 20.

The individual Trusts were also mapped onto the matrix and where there were more Trusts than were needed, a random selection was made. For example, there were two Trusts that were classified as high expenditure, in a top 10 per cent asylum seeker dispersal area, outside the catchment area of an airport, located in London (see first cell in the matrix in Table 18. Of these, only 1 was to be included (see corresponding cell in the matrix in Table 20) and this was drawn at random.

NB The region variable has been excluded from Tables 20 to 22 in order to protect the identity of the Trusts selected to take part in the research.

Table 18: Trusts mapped onto the five key variables

Table 19: Proportion in each cell based on a representative sample of 30 Trusts

Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure		Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure
High	Y	None	Metro	3	11	24	53		High	Y	None	Metro	0.57	2.09	4.56	10.06
			Urban	7								Urban	1.33			
			Rural	0								Rural	0			
			Mix	1								Mix	0.19			
		LH	Metro	6	6					Metro	1.14					
			Urban	0						Urban	0					
			Rural	0						Rural	0					
			Mix	0						Mix	0					
		Euro	Metro	4	7					Metro	0.76					
			Urban	3						Urban	0.57					
			Rural	0						Rural	0					
			Mix	0						Mix	0					
	N	None	Metro	1	18	29	29		High	N	None	Metro	0.19	3.42	5.51	
			Urban	11								Urban	2.09			
			Rural	2								Rural	0.38			
			Mix	4								Mix	0.76			
		LH	Metro	8	9					Metro	1.52					
			Urban	0						Urban	0					
			Rural	1						Rural	0.19					
			Mix	0						Mix	0.00					
Euro	Metro	1	2	Metro	0.19											
	Urban	0		Urban	0											
	Rural	0		Rural	0											
	Mix	1		Mix	0.19											
Med	Y	None	Metro	1	2	7	53	Med	Y	None	Metro	0.19	0.38	1.33	10.06	
			Urban	1							Urban	0.19				
			Rural	0							Rural	0				
			Mix	0							Mix	0				
		LH	Metro	3	3					Metro	0.57					
			Urban	0						Urban	0					
			Rural	0						Rural	0					
			Mix	0						Mix	0					
		Euro	Metro	2	2					Metro	0.38					
			Urban	0						Urban	0					
			Rural	0						Rural	0					
			Mix	0						Mix	0					

Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure		Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure
N	N	None	Metro	0	27	46	46		N	N	None	Metro	0	5.13	8.73	
			Urban	15								Urban	2.85			
			Rural	10								Rural	1.90			
			Mix	2								Mix	0.38			
		LH	Metro	11	14						Metro	2.09	2.66			
			Urban	1							Urban	0.19				
			Rural	1							Rural	0.19				
			Mix	1							Mix	0.19				
		Euro	Metro	3	5						Metro	0.57	0.95			
			Urban	2							Urban	0.38				
			Rural	0							Rural	0				
			Mix	0							Mix	0				
		Y	Y	None	Metro						0	2	13	13		
Urban	2				Urban	0.38										
Rural	0				Rural											
Mix	0				Mix											
LH	Metro			3	4	Metro	0.57	0.76								
	Urban			0		Urban										
	Rural			0		Rural										
	Mix			1		Mix	0.19									
Euro	Metro			7	7	Metro	1.33	1.33								
	Urban			0		Urban										
	Rural			0		Rural										
	Mix			0		Mix										
N	N			None	Metro	1	21	39	39	Low	N	N			None	Metro
		Urban	1		Urban	0.19										
		Rural	18		Rural	3.42										
		Mix	1		Mix	0.19										
		LH	Metro	4	9	Metro	0.76						1.71			
			Urban	1		Urban	0.19									
			Rural	3		Rural	0.57									
			Mix	1		Mix	0.19									
		Euro	Metro	2	9	Metro	0.38						1.71			
			Urban	3		Urban	0.57									
			Rural	2		Rural	0.38									
			Mix	2		Mix	0.38									
						158	158						158	158		

Table 20: Sample structure for 30 Trusts

Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure
High	Y	None	Metro	1.00	2.00	4.00	10.00
			Urban	1.00			
			Rural	0.00			
			Mix	0.00			
		LH	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
		Euro	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
	N	None	Metro	0.00	3.00	6.00	
			Urban	2.00			
			Rural	0.00			
			Mix	1.00			
LH		Metro	1.00	2.00			
		Urban	0.00				
		Rural	1.00				
		Mix	0.00				
Euro		Metro	1.00	1.00			
		Urban	0.00				
		Rural	0.00				
		Mix	0.00				
Med	Y	None	Metro	0.00	0.00	1.00	
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
		LH	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
		Euro	Metro	0.00	0.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			

Expenditure	A seeker dispersal	Airport catchment	Location	Location	Airport catchment	A seeker dispersal	Expenditure
	N	None	Metro	0.00	5.00	9.00	
			Urban	3.00			
			Rural	2.00			
			Mix	0.00			
		LH	Metro	2.00	3.00		
			Urban	0.00			
			Rural	1.00			
			Mix	0.00			
		Euro	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
Low	Y	None	Metro	0.00	0.00	2.00	10.00
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
		LH	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
		Euro	Metro	1.00	1.00		
			Urban	0.00			
			Rural	0.00			
			Mix	0.00			
N	None	Metro	0.00	4.00	8.00		
		Urban	0.00				
		Rural	4.00				
		Mix	0.00				
	LH	Metro	1.00	2.00			
		Urban	0.00				
		Rural	1.00				
		Mix	0.00				
	Euro	Metro	1.00	2.00			
		Urban	1.00				
		Rural	0.00				
		Mix	0.00				
				30.00	30.00	30.00	30.00

11.1.2 Primary Care Practice profiles

Fourteen Primary Care Practices took part in the research, two from each case study area. A summary of each Practice, in terms of patient numbers and profiles, is provided below. The Practice identifier corresponds to the Trust taking part in the case study exercise. Thus, Practice 20a is one of the two Primary Care Practices visited in the locality of Trust 20.

Table 21: Primary Care Practice profiles		
Case Study Area 1: A metropolitan location within the catchment area of an airport serving long haul destinations. It is a 'high' migration cluster area but not a 'high' asylum seeker dispersal area.		
	Practice 20a	Practice 20b
Numbers:	10k+	10k+
Profile:	The Practice has a high proportion of non-English speakers including refugees, unemployed, people with mental health and social problems. There are a large number of hostels and temporary accommodation in the area and the patient base is very transient with a turnover of approximately 25% pa.	The profile is mixed but is relatively wealthy/professional and young. The Practice has developed relationships with a number of hotels and has a large number of tourists using their services; they offer their own patients an emergency walk-in service but have been told by the PCT/CCG that they must offer this to anyone who presents at the surgery.
Case Study Area 2: A metropolitan location within the catchment area of an airport serving European destinations. It is a 'high' migration cluster area as well as a 'high' asylum seeker dispersal area.		
	Practice 12a	Practice 12b
Numbers:	<3k	<3k
Profile:	The Practice has a high proportion of working class patients including members of the local BME community as well as migrants. They have experienced an influx of Eastern Europeans in the last few years and also see a small number of asylum seekers. The Practice has a high turnover of around 20% of patients pa.	This Practice is small, diverse and stable but is seeking to grow in size. It is situated close to an asylum seeker complex although, to date, only a small number have registered with the Practice.
Case Study Area 3: An urban location that falls outside the catchment area of an airport. It is a 'moderate' migration cluster area outside a top 10% asylum seeker dispersal area.		
	Practice 10a	Practice 10b
Numbers:	10k+	7-10k
Profile:	The Practice serves a very mixed population and about a fifth of the list have English as a second language; this	The Practice serves a very mixed population including a large number from very deprived areas. They have a

	includes a substantial Gypsy population from the Czech Republic and Romania.	registration policy which means they do not register anyone who cannot prove they have been residing in the UK for the last 6 months; as a consequence, they have relatively small numbers of migrants and overseas visitors on their list.
Case Study Area 4: A rural location that falls outside the catchment area of an airport. It is a 'low' migration cluster area outside a top 10% asylum seeker dispersal area.		
	Practice 29a	Practice 29b
Numbers:	3-6k	10k+
Profile:	The Practice is a walk-in centre. Although their list is relatively small, the Centre is open 12 hours a day, 365 days of the year and they treat anyone who comes in, including those registered elsewhere and those who are unregistered. It is located in an area of deprivation and treats a significant number of patients with substance abuse and mental health issues. It also attracts a large number of migrants (in part because of its extended opening hours) who now make up about a third of the list. They have a very inclusive registration policy and will accept patients of NFA, allowing them to use the Centre as their address.	Based near the centre of town, the majority of patients are of working age. They estimate that 750-800 of their patients (~7%) are migrants with Poles, Indians, Chinese and other Asians as the main groups.
Case Study Area 5: An urban location that falls outside the catchment area of an airport. It is a 'high' migration cluster area outside a top 10% asylum seeker dispersal area.		
	Practice 18a	Practice 18b
Numbers:	7-10k	<3k
Profile:	Their catchment area includes one of the most deprived wards in England and a high proportion of properties are 'bed sits'; this results in a highly transient patient profile. Patients are predominantly young people and families, including single parents and the unemployed and those with substance abuse issues. They have on their list a significant proportion of non-English families including illegal immigrants, asylum seekers, and migrant workers. They take referrals from other practices and organisations such as those supporting asylum seekers and people with mental health issues.	This is a small Practice located in an area of deprivation with a large number of 'bed sits'. They hold a daily walk-in children's surgery and they estimate that 50% of the patients accessing it are Polish or Chinese. They have a large number of non-British patients although many move to the area from elsewhere in the UK.

Case Study Area 6: An urban location that falls outside the catchment area of an airport. It is a 'high' migration cluster area and in a top 10% asylum seeker dispersal area.

	Practice 24a	Practice 24b
Numbers:	7-10k	7-10k
Profile:	The Practice is located in a very mixed, multicultural area with large Asian and Somali populations, and an increasing Polish population. There is considerable deprivation within the area.	This is a suburban Practice, serving two key population groups – white, elderly patients and young, middle aged, reasonably affluent Asian patients, predominantly from an Indian background.

Case Study Area 7: A 'mixed' location that falls outside the catchment area of an airport. It is a 'high' migration cluster area however it is not located in a top 10% asylum seeker dispersal area.

	Practice 13a	Practice 13b
Numbers:	3-6k	7-10k
Profile:	Their list is very diverse in terms of ethnicity, mainly people of working age, plus a growing younger population/ babies and children. In particular, they have a large Chinese patient group, Indian patients, and growing numbers of Polish and Lithuanian patients. They also have students living in the area. It is located in one of the more deprived areas of the town which means they see 'lots of complex cultural and social issues'.	They are open 7 days a week; the Practice is open 8 am until 8 pm, the walk-in centre 7 am until 9 pm every day. They have a lot of patients who access the walk-in centre because they work in the city centre and can't access their own GP during the day. It is a varied patient population, ethnically diverse, young (75% under 45). It includes many East European patients, especially Polish, as well as Indian patients on short term contracts with a local employer. They also see deprivation, mental health problems, dependency issues, etc.

11.2 Data

A summary of the data provided by each Trust on identifying chargeable patients and recovering money is provided in Table 22. A breakdown of the data according to the key variables used to structure the sample is provided in Tables 24 to 32.

Greater care is needed when interpreting these tables (see section 2.4 for guidance).

Table 22: Trust Data

base: Trusts taking part in scoping study; n=30. Trusts marked with * were case studies

NB low bases

Trust	How many people are asked about their OR status	How many are determined to be OR	For how many people are you looking into their exemption status?	How many are determined to be exempt	How many are charged?	How much is the total amount charged?	How many do not pay?	What is the income generated?	Proportion of charges recovered	What is the current level of bad debt?	Level of debt has been written off
1	396	180	36		216	756000		5500	0.7		
2			9	4	351	327000	115	217000	66.4	700000	172900
3			247	204	39	101613	30	24178	23.8	113290	11191
4			1300		720	180000					
5	6000	4000	1200	720		80000		60000	75.0	20000	11000
6			144	141	3	127382	3	15977	12.5	334211	52709
7			118	74	12	3794		1581	41.7		
8			60		12	27943	3	21186	75.8		
9			1820	1560	25	59000	17	20000	33.9	39000	8000
10*	520	442	740	626	75	230383	19	71345	31.0	147608	385000
11	2600	2080	40	0	35	15000	23	8750	58.3	21000	0
12*			18	14	2	9316	0	9316	100.0	0	5986
13*	901	195	706	549	157	171156	114	73475	43.0	186559	83015
14			125	63	9	30404		3532	11.6	27000	5700
15			500	338	144	136530	53	86530	63.4	50000	0
16			24		43	22404	9	10184	45.5	5000	0
17					180	180000	144	36000	20.0	144000	60000
18*			270	216	22	24280	2			706	
19	0		1	1	0					0	0
20*	300000	1100	1100	600	500	912718	335	261495	28.7	651224	427045
21	13620	13412	260	234	26	92746					
22	416				210		116				
23	149743	142255	624	562	70	38347	40	16468	42.9	21878	15804
24*	500000				470	835215	271	128528	15.4	706687	1020009
25	0		12	6	6						
26			12		6						
27			313	244		115038		101062	87.9	0	3482
28	258	132	132	66	6	5204	1	4898	94.1	4606	0
29*	365	182	200	100	17	24977	2	22723	91.0	2254	
30	238	32	230	40	54	55500	11	16500	29.7	800	2317
base	15	11	27	22	29	26	21	23	23	22	20
min	0	32	1	0	0	3794	0	1581	0.7275	0	0
max	500000	142255	1820	1560	720	912718	335	261495	100	706687	1020009
sum	975057	164010	10241	6362	3387	4561950	1308	1216228	1092.15	3175823	2264158

Table 23: Number of patients being asked about their exemption status per Trust pa by key variables

base: no. of Trusts providing an estimate

NB Very low bases

Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	27	7	8	8	3
range	1 to 1,820	9 to 1,100	36 to 1,300	12 to 1,820	1 to 24
total	10,241	2,664	4,870	2,440	37
Expenditure	total	High	Med	Low	
n	27	7	9	11	
range	1 to 1,820	24 to 1100	9 to 1300	1 to 1820	
total	10,241	2,308	3,311	4,622	
Asylum dispersal	total	top 10%	other		
n	27	4	23		
range	1 to 1,820	18 to 624	1 to 1820		
total	10,241	925	9,316		
Airport catchment	total	None	Long Haul	Euro	
n	27	13	10	5	
range	1 to 1,820	1 to 1820	9 to 1300	12 to 1200	
total	10,241	5,191	3,796	1,266	
Location	total	Metro	Urban	Rural	mixed
n	27	11	5	10	1
range	1 to 1,820	12 to 1300	12 to 740	1 to 1820	706 to 706
total	10,241	4,965	1,654	2,916	706
Migration Cluster	total	High	Mod	Low	
n	27	15	8	4	
range	1 to 1,820	12 to 1820	1 to 740	24 to 500	
total	10,241	8,007	1,197	1,037	

Table 24: Number of patients being determined to be exempt per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	22	7	6	6	2
range	0 to 1,560	4 to 600	100 to 720	0 to 1,560	1 to 6
total	6,362	1,838	2,562	1,915	7
Expenditure	total	High	Med	Low	
n	22	5	8	9	
range	0 to 1,560	0 to 600	4 to 626	1 to 1,560	
total	6,362	1,431	1,549	3,382	
Asylum dispersal	total	top 10%	other		
n	22	3	19		
range	0 to 1,560	14 to 562	0 to 1,560		
total	6,362	780	5,582		
Airport catchment	total	None	Long Haul	Euro	
n	22	12	7	3	
range	0 to 1,560	1 to 1,560	0 to 600	6 to 720	
total	6,362	3,877	1,745	740	
Location	total	Metro	Urban	Rural	mixed
n	22	8	4	9	1
range	0 to 1,560	6 to 720	66 to 626	0 to 1560	549 to 549
total	6,362	2,481	1,246	2,086	549
Migration Cluster	total	High	Mod	Low	
n	22	13	6	3	
range	0 to 1,560	0 to 1,560	1 to 626	100 to 338	
total	6,362	4,846	834	682	

Table 25: Number of patients being determined to be chargeable per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	29	8	8	9	3
range	0 to 720	3 to 500	19 to 720	2 to 210	0 to 43
total	3,387	1,488	1,466	350	49
Expenditure	total	High	Med	Low	
n	29	9	10	10	
range	0 to 720	6 to 500	6 to 720	0 to 70	
total	3,387	1,565	1,562	260	
Asylum dispersal	total	top 10%	other		
n	29	6	23		
range	0 to 720	2 to 376	0 to 720		
total	3,387	913	2,474		
Airport catchment	total	None	Long Haul	Euro	
n	29	15	10	5	
range	0 to 720	0 to 376	3 to 720	2 to 210	
total	3,387	1,364	1,762	267	
Location	total	Metro	Urban	Rural	mixed
n	29	11	7	10	1
range	0 to 720	2 to 720	6 to 376	0 to 351	157 to 157
total	3,387	1,835	809	586	157
Migration Cluster	total	High	Mod	Low	
n	29	17	8	4	
range	0 to 720	2 to 720	0 to 351	19 to 144	
total	3,387	2,641	471	275	

Table 26: Amount charged per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	26	8	9	7	1
range	£3,794 to £912,718	£5,204 to £912,718	£24,280 to £756,000	£3,794 to £101,613	£22,404 to £22,404
total	£4,561,950	£2,586,459	£1,650,517	£247,070	£22,404
Expenditure	total	High	Med	Low	
n	26	8	9	9	
range	£3,794 to £912,718	£5,240 to £912,718	£3,794 to £327,000	£9,316 to £127,382	
total	£4,561,950	£2,741,977	£1,282,470	£537,503	
Asylum dispersal	total	top 10%	other		
n	26	5	21		
range	£3,794 to £912,718	£9,316 to £835,215	£3,794 to £912,718		
total	£4,561,950	£1,740,491	£2,821,459		
Airport catchment	total	None	Long Haul	Euro	
n	26	14	9	3	
range	£3,794 to £912,718	£3,794 to £835,215	£15,000 to £912,718	£9,316 to £80,000	
total	£4,561,950	£2,627,481	£1,822,749	£111,720	
Location	total	Metro	Urban	Rural	mixed
n	26	10	6	9	1
range	£3,794 to £912,718	£9,316 to £612,718	£5,204 to £835,000	£3,794 to £327,000	£171,156 to £171,156
total	£4,561,950	£2,320,526	£1,411,612	£658,656	£171,156
Migration Cluster	total	High	Mod	Low	
n	26	16	6	4	
range	£3,794 to £912,718	£9,316 to £912,718	£3,794 to £327,000	£22,404 to £136,530	
total	£4,561,950	£3,638,273	£624,728	£298,949	

Table 27: Number of patients that are charged but do not pay per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	21	6	6	6	2
range	0 to 335	1 to 335	2 to 144	0 to 116	0 to 9
total	1,308	839	260	189	9
Expenditure	total	High	Med	Low	
n	21	8	5	8	
range	0 to 335	1 to 335	19 to 144	0 to 40	
total	1,308	871	361	76	
Asylum dispersal	total	top 10%	other		
n	21	5	16		
range	0 to 335	0 to 271	0 to 335		
total	1,308	457	851		
Airport catchment	total	None	Long Haul	Euro	
n	21	11	7	3	
range	0 to 335	0 to 271	3 to 335	0 to 116	
total	1,308	634	549	125	
Location	total	Metro	Urban	Rural	mixed
n	21	7	6	7	1
range	0 to 335	0 to 335	1 to 271	0 to 115	114 to 114
total	1,308	533	490	171	114
Migration Cluster	total	High	Mod	Low	
n	21	13	5	3	
range	0 to 335	0 to 335	0 to 115	2 to 53	
total	1,308	1,106	138	64	

Table 28: Sums recovered per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	23	7	7	7	1
range	£1,581 to £261,495	£4,898 to £261,495	£5,500 to £86,530	£1,581 to £24,178	£10,184 to £10,184
total	£1,216,228	£892,435	£298,566	£88,543	£10,184
Expenditure	total	High	Med	Low	
n	23	7	7	9	
range	£1,581 to £261,495	£4,898 to £261,495	£1,581 to £217,000	£9,316 to £101,062	
total	£1,216,228	£492,830	440,166	£283,232	
Asylum dispersal	total	top 10%	other		
n	23	5	18		
range	£1,581 to £261,495	£5,500 to £128,528	£1,581 to £261,495		
total	£1,216,228	£183,990	£1,032,238		
Airport catchment	total	None	Long Haul	Euro	
n	23	13	7	3	
range	£1,581 to £261,495	£1,581 to £128,528	£8,750 to £261,495	£9,316 to £60,000	
total	£1,216,228	£571,674	£565,054	£79,500	
Location	total	Metro	Urban	Rural	mixed
n	23	8	5	9	1
range	£1,581 to £261,495	£5,500 to £261,495	£4,898 to £128,528	£1,581 to £217,000	£73,475 to £73,475
total	£1,216,228	£403,118	£327,301	£412,334	£73,475
Migration Cluster	total	High	Mod	Low	
n	23	13	6	4	
range	£1,581 to £261,495	£5,500 to £261,495	£1,581 to £217,000	£10,184 to £101,062	
total	£1,216,228	£676,187	£319,542	£220,499	

Table 29: Proportion of charges recovered per Trust pa by key variables					NB Very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	23	7	7	7	1
range	1% to 100%	13% to 94%	1% to 91%	12% to 100%	45% to 45%
Expenditure	total	High	Med	Low	
n	23	7	7	9	
range	1% to 100%	1% to 94%	12% to 66%	13% to 100%	
Asylum dispersal	total	top 10%	other		
n	23	5	18		
range	1% to 100%	1% to 100%	12% to 94%		
Airport catchment	total	None	Long Haul	Euro	
n	23	13	7	3	
range	1% to 100%	1% to 94%	13% to 76%	45% to 100%	
Location	total	Metro	Urban	Rural	mixed
n	23	8	5	9	1
range	1% to 100%	1% to 100%	15% to 94%	12% to 91%	43% to 43%
Migration Cluster	total	High	Mod	Low	
n	23	13	6	4	
range	1% to 100%	1% to 100%	12% to 94%	45% to 91%	

Table 30: Current level of bad debt per Trust pa by key variables					NB very low bases
base: no. of Trusts providing an estimate					
Segment	total	Proactive	Clear direction	Reactive	Less engaged
n	22	7	7	5	2
range	£0 to £706,687	£0 to £706,687	£706 to £147,608	£0 to £113,290	£0 to £5,000
total	£3,175,823	£2,583,287	£386,446	£200,290	£5,000
Expenditure	total	High	Med	Low	
n	22	7	6	9	
range	£0 to £706,687	£706 to £706,687	£27,000 to £700,000	£0 to £334,211	
total	£3,175,823	£1,575,782	£1,181,898	£418,143	
Asylum dispersal	total	top 10%	other		
n	22	4	18		
range	£0 to £706,687	£0 to £706,687	£0 to £700,000		
total	£3,175,823	£841,855	£2,333,968		
Airport catchment	total	None	Long Haul	Euro	
n	22	13	6	3	
range	£0 to £706,687	£0 to £706,687	£21,000 to £700,000	£0 to £20,000	
total	£3,175,823	£1,309,220	£1,841,603	£25,000	
Location	total	Metro	Urban	Rural	mixed
n	22	7	6	8	1
range	£0 to £706,687	£0 to £651,224	£706 to £706,687	£0 to £700,000	£186,559 to £186,559
total	£3,175,823	£1,145,603	£1,053,607	£790,054	£186,559
Migration Cluster	total	High	Mod	Low	
n	22	13	5	4	
range	£0 to £706,687	£0 to £706,687	£0 to £700,000	£0 to £50,000	
total	£3,175,823	£2,239,355	£879,214	£57,254	

11.3 Research Materials

NB Some of the research materials used different terms from those used in the body of the report:

- EEA and non-EEA temporary residents were described as ‘non-permanent residents’
- Irregular migrants were described as ‘undocumented migrants’

11.3.1 Letters of Authority

Expert Briefings

Dear Overseas Visitor Manager and Head of Finance

As you will be aware, the Department for Health is undertaking a review of policy relating to charging migrants and overseas visitors for the use of NHS services. Preliminary ideas for changes will go out to Public and NHS Consultation at the end of June. The Department is working in partnership with NHS England on this engagement.

To further help with our Impact Assessment on these proposals, the Secretary of State has commissioned independent research to help us understand the nature and scale of the problem across England. This will be conducted by the research consultancy, Creative Research Ltd, and will take the form of an initial scoping exercise among a sample of Overseas Visitor Managers (OVMs) followed by a number of more in-depth studies in specific areas involving clinicians, managers and admin staff in primary and secondary care.

As a first step in the research, we would like to invite OVMs with greater experience of migrants and overseas visitors in their Trusts to participate in a briefing meeting to help the research team increase their understanding of the complexities of the issue and inform the research generally. It is to this end that I am now writing to you.

Two such meetings, each lasting two hours, will be organised for Tuesday 4 June, one in London and the other in Leeds. Creative Research will organise and run the discussions. The number in each meeting will be limited because we anticipate that everyone will have a great deal to say and therefore, attendance will be confirmed on a ‘first come’ basis. There may also be opportunities for some of those attending and those unable to attend to take part in other parts of the research.

I can reassure you that, all the research is being conducted according to the Code of Conduct of the Market Research Society which means that no comments will be attributed to either the participants or their Trusts. Moreover, the identities of the participants will not be known to the Department.

Please respond to Ros by email if you would like to take part. Should you wish to talk to someone in the Department in advance of the meeting, please call Craig Keenan on 0113 254 6438.

Many thanks for your continuing interest and input on this.

Letter sent by Creative Research on behalf of:

Nick Tomlinson

Deputy Director, EU & Global Affairs, Department of Health

cc Trust Chief Executive

Scoping Interviews (OVOs and head of finance)

Dear Overseas Visitor Manager and Head of Finance

As you will be aware, the Department for Health is undertaking a review of policy relating to charging migrants and overseas visitors for the use of NHS services. Preliminary ideas for changes will go out to Public and NHS Consultation at the end of June. The Department is working in partnership with NHS England on this engagement.

To further help with our Impact Assessment on these proposals, the Secretary of State has commissioned independent research to help us understand the nature and scale of the problem across England. This will be conducted by the research consultancy, Creative Research Ltd, and will take the form of an initial scoping exercise among a sample of Overseas Visitor Managers (OVMs) followed by a number of more in-depth studies in specific areas involving clinicians, managers and admin staff in primary and secondary care.

The initial scoping exercise is being carried out amongst OVMs in 30 Trusts who have been selected by Creative Research using a random stratified sampling method. You and your Trust have been selected and it is to this end that I am now writing to you. You may feel that your Trust is used by only very few overseas visitors who do not present an issue for you; it is however very important that we talk to Trusts with a range of levels and types of experience in order that we can gain an idea of the scale and nature of the challenge nationally.

This stage of the research is being carried out by means of individual interviews, mainly by telephone, which Creative Research will organise, conduct, analyse and report on. I can reassure you that all the research is being conducted according to the Code of Conduct of the Market Research Society which means that **no comments will be attributed either to the participants or their Trusts. Moreover, the Department will neither be informed which Trusts have been selected nor who has taken part.**

One of the Creative Research team will be in touch in the next few days to see if it is possible to arrange an interview or, in the meantime, you can respond to Ros. Should you wish to talk to someone in the Department about the research, please call Craig Keenan on 0113 254 6438.

I do hope you will feel able to take part in this very important research and in particular, take this opportunity to comment on the changes that are being proposed. Thank you for your input.



Nick Tomlinson

Head of EU and Global Affairs, Department of Health

cc Trust Chief Executive

Scoping Interviews (Border Force and Immigration Enforcement)

Dear UKBA colleague

The Department of Health is undertaking a review of policy relating to charging migrants and overseas visitors for the use of NHS services. Preliminary ideas for changes will go out to Public and NHS Consultation at the end of June.

To further help with our Impact Assessment on these proposals, the Secretary of State for Health has commissioned independent research to help us understand the nature and scale of the problem across England. This will be conducted by the research consultancy, Creative Research Ltd, and will principally take the form of research among Overseas Visitor Managers (OVMs) and clinicians, managers and admin staff in primary and secondary care. However, we would also like to understand the issue from the point of view of UKBA staff at the main points of entry to England and especially the major airports.

This stage of the research is being carried out by means of individual interviews which Creative Research will organise, conduct, analyse and report on. I can reassure you that all the research is being conducted according to the Code of Conduct of the Market Research Society which means that **no comments will be attributed to individual participants.**

Should you wish to talk to someone in the Department of Health about the research, please call Craig Keenan on 0113 254 6438.

I do hope you or your colleagues will feel able to take part in this very important research. Thank you for your input.



Nick Tomlinson
Head of EU and Global Affairs, Department of Health

Case study Interviews (Trust CE)

Dear

I am writing in relation to the review that the Department for Health is undertaking relating to charging migrants and overseas visitors for the use of NHS services. Preliminary ideas for changes are going out to Public and NHS Consultation this week. The Department is working in partnership with NHS England on this engagement.

To further help with our Impact Assessment on these proposals, the Secretary of State has commissioned independent research to help us understand the nature and scale of the problem across England. This will be conducted by the research consultancy, Creative Research Ltd, and to date has taken the form of an initial scoping exercise among a sample of 30 Overseas Visitor Managers (OVMs). As you may be aware, your Trust was selected as part of the sample for those interviews. Creative Research is now going to be following this up by carrying out a number of more in-depth studies in specific Trust areas involving clinicians, managers and admin staff, both in primary and secondary care. The purpose of these 'case studies' is to be able to develop a better understanding of the scale and nature of the challenges that Trusts face with overseas visitors and migrants and how they are dealing with them.

Your Trust has been selected by Creative Research as one that they would like to involve as a case study and it is to this end that I am now writing to you. They would like to visit your Trust and talk individually to a mix of consultants, nurses and reception staff/ward clerks, as well as a senior manager in your Finance department and your overseas visitor manager/team. The interviews could be anything from 30 minutes to an hour each but the research team will of course work around your staff member's availability. I can reassure you that all the research is being conducted according to the Code of Conduct of the Market Research Society which means that **no comments will be attributed either to the participants or their Trusts. Moreover, as with all this research, the Department will neither be informed which Trusts have been selected nor who has taken part.**

One of the Creative Research team will be in touch in the next few days to see if it is possible to arrange an interview or, in the meantime, you can respond to Ros. Should you wish to talk to someone in the Department about the research, please call Craig Keenan on 0113 254 6438.

I do hope you will feel able to take part in this very important research and in particular, take this opportunity to comment on the changes that are being proposed. Thank you for your input.



Nick Tomlinson
Head of EU and Global Affairs, Department of Health

cc Trust Chief Executive

You may feel that your Trust is used by only very few overseas visitors who do not present an issue for you; it is however very important that we talk to Trusts with a range of levels and types of experience in order that we can gain an idea of the scale and nature of the challenge nationally.

11.3.2 Expert briefing

Topic Guide

Introductions to ...

The moderator and OVMs

The objectives of the research programme and an outline of the programme

- the extent and nature of use by migrants
- how clinicians, managers and administrators deal with issues around migrant access to NHS services
- how they react to proposed ways of changing the system

What we hope to accomplish in this session; we want to focus on the first two objectives and then spend a little time discussing what they see as the priorities for changing the system (although these will probably start to emerge as we discuss the issues). We want to:

- look at issues 'in the round' – learning from their experience without looking at individual cases in depth
- understand what information is available and what isn't
- explore any suggestions they have to help us in conducting the research

The recording of the discussion and how it will be used, i.e. reiterate reassurances about anonymity.

Nature and scale of migrant use of NHS services

Each participant will be asked to sum up succinctly, how significant an issue they think overseas visitors are for their Trust in the context of all its activities and the impact they have

We will firstly set out the categories of overseas visitor identified to date, both those who are exempt from charging and those who are liable to be charged.

Asylum seekers

Undocumented migrants

illegal immigrants

failed asylum seekers (some of whom will be exempt)

illegal overstayers

those applying for leave to remain

Economically active and inactive **EEA** non-permanent residents and their families (legally in the UK for under 5 yrs and with no permanent right to reside)

students

workers

self-employed

Jobseekers

Economically inactive migrants who have a right of residence as a family member (e.g. spouse of someone working here)

Economically inactive migrants who do not have a right of residence as a family member

Economically inactive migrants who are state pensioners in another state who register with an S1 form

Economically active and inactive non-EEA non-permanent residents and their families (legally in the UK for under 5 yrs and with no permanent leave to remain)

students

workers

self-employed

taking up residency on some other basis e.g. joining a family member already settled in the UK

Visitors who 'fly in' and 'fly out' ('health tourists')

Visitors who fall ill unexpectedly while temporarily in UK

British ex-patriates

visiting

returning

Do they think there are any other categories that are missing? Would they classify overseas visitors in this or some other way – what would it be?

Which of these categories does each OVM see in their Trust? Which are the main categories for their Trust? Are they seeing any trends/ patterns in the types of overseas visitor and any thoughts on why this might be happening?

Do they collect statistics according to these categories? If not, what do they record? (e.g. do they have different processes in place to identify and record EEA and non-EEA visitors/ migrants?)

If they do not collect statistics on these categories, do they have any idea (however anecdotal) of the number of such patients presenting/ being treated in each (e.g. is it one a week)? If an estimate is provided: what is the estimate based on? Or do they think about their frequency/ the scale in some other way?

What proportion do they think they identify/ charge/ recover the costs from?

Would they be able to share the data they hold with us subsequent to this meeting?

Understanding Types of Overseas Visitor

How do the different categories of overseas visitor present?

- Pathway into the Trust (A&E, referral etc)
- Use of which NHS services/ types of treatment
- Any patterns of use e.g. seasonality

At which point might they be identified as meriting investigation into their eligibility for free treatment? How are they identified (not just questions around residency but other signals that prompt further investigation)?

Would they associate any particular characteristics with overseas visitors in these categories? We will explore (as relevant) characteristics such as gender, nationality, age etc.

Systems and their effectiveness

What systems do they have in place for dealing with overseas visitors – identifying, checking out eligibility, advising them of costs of treatment, charging, recovering costs? How, if at all, does it differ across the categories of visitor?

Overall, how well do the current systems work?

Examples of good practice / useful learnings

What obstacles do they face in carrying out their role? We will explore

- Internal barriers; in terms of the source (senior managers, finance, legal, admin, clinicians, patients) and nature of the barrier (e.g. fear of loss of income, fear of litigation by patients, refusal to question patients on eligibility, definition of 'urgent', lack of support for their role etc.)
- External barriers; in terms of the source (GPs, DH, Home Office) and nature of the barrier (e.g. GP reluctance to advise patients/Trust of the possibility of charging, lack of clear direction as to appropriate course of action etc.)

What are the costs currently involved in identifying, charging and recovering costs from overseas visitors (number of staff, grade, salary) in their Trust? If the eligibility criteria were to change from ordinary residents to permanent residents, what would be the impact on these costs?

Priorities for change

We will explain that because specific changes have not yet been announced, we will not discuss these at this stage. We are also aware that some of the groups at least, will have discussed some options at last year's workshops run by the Department of Health. So at this stage it would be useful to explore what are changes that, in their view, would

- make eligibility fairer
- make it easier to recover the costs from those ineligible for free treatment (in the broadest sense, including making identification easier)?

Further stages

Do they have any thoughts/ suggestions for the research programme in terms of advice for carrying it out/ overcoming obstacles we might encounter? E.g.

Scoping exercise

- any 'burning' issues that they think should be explored

Case studies

- recommendations for the most effective way of getting other Trust staff on board to participate
- any 'burning' issues that they think should be explored

Diaries

- exploration of the key measures that it might be feasible to ask OVMs / other staff members to collect and how this is best done (time period, online data entry etc)

NB. These are the possible changes mentioned by the Secretary of State in the House of Commons in March.

- plans to extend charging to some visitors and temporary residents who were previously exempt so that the default qualification for free NHS care would be permanent, not temporary, residence
- ending free access to primary care for all visitors and tourists
- introducing a prepayment or insurance requirement for temporary visitors to pay for NHS health care
- improving how the NHS can identify, charge and recover charges where they should apply. We will retain exemptions for emergency treatment and public health issues.

11.3.3 Scoping study materials

Topic Guide (OVOs)

NB. Note to moderator: wherever respondent provides figures, ask whether based on data collected or estimates. Also confirm what period they relate to. If estimates, ask how arrived at. If respondents have data but they are not to hand, ask them to send the form back later. Moderators should use a copy of the form during the interview to record data – be sure to write in the name of the Trust it relates to.

The interviewer introduces

Him/herself and Creative Research

The recording of the discussion and how it will be used; again, giving reassurances about anonymity

The objectives of the research programme

- the extent and nature of use by migrants and overseas visitors
- how clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- how they react to proposed ways of changing the system

How this interview fits into the bigger research picture

The OVM is asked to introduce their Trust

Number of sites, specialisms, the area it serves

How big is their department – how many staff across the Trust are involved in identifying and charging overseas patients? What are their roles/ grades/ levels of training?

Which staff elsewhere in the Trust are involved in identifying overseas patients?

How significant an issue are overseas visitors and migrants for their Trust in the context of all its activities; both those who are exempt from charging and those who are not? “On a scale from 0-10 where 0 is ‘they are not an issue at all’ and 10 is ‘they are a major issue’, where would you place your Trust?” Why do you say that?

Bearing in mind the difficulties Trusts face in identifying and charging non-exempt patients, to what extent do they think their Trust is on top of the issue? “On a scale from 0-10 where 0 is ‘we are not on top of the issue at all’ and 10 is ‘we are fully on top of the issue’, where would you place your Trust?” Why do you say that?

Categories of Migrants and Overseas Visitors

Referring to the categories of overseas visitors and migrants they have been sent (page 1), do these include the types of patients they see in their Trust? Are there other categories that are not included in the list (what are they)?

Are they seeing any trends/patterns in the types of overseas visitor/migrant presenting and any thoughts on why this might be happening? Are numbers going up, down or stabilising? Are they aware of any seasonal variations?

Processes for identifying chargeable patients

*We will ask the respondent to look at Page 2. Moderator explains we are going to focus on the three categories outlined, one at a time, starting with those who are **Ordinarily Resident***

What processes do you have in place for identifying if a patient is **ordinarily resident**?

- who is asked: all patients/certain patients

- if certain patients, which ones e.g. all new patients in A&E, all new referrals (including those from other Trusts), new in-patients, those without a GP, those with a new NHS number (070s and 080s)
- are there particular pathways into the Trust? (e.g. GP referrals, A&E, etc)
- where/when is the process of identifying patients carried out?
- by whom?
- what questions are asked and what proof is sought?
- if not mentioned, prompt about use of pre-attendance form (for which types of patients/where/when)

Note to moderator: please come away with a clear picture (not necessarily at this point) of whether all hospital admissions are being screened eg whether there is 24/7 coverage, in all or some specialities, of emergency/ elective in-patients and outpatients.

What difficulties do you face when trying to establish OR? What loopholes are you aware of/ ways in which patients may present themselves as OR when they are not? How often do you think this happens?

How many people are you asking about their OR status in a week/month/year etc? What proportion/how many are determined to be OR?

Looking now at page one: when it comes to determining OR status which, if any, of the categories represent

- the largest numbers presenting?
- any particular characteristics (gender, age, nationality etc)?
- particular problems in determining OR status – why is that?

What data, if any, is collected in relation to the different categories (if not at category level, do they collect data on EEA and non-EEA patients?)

Regarding EU residence/treaty rights, is there an issue with people who claim to be ordinarily resident in their own right (i.e. not a family member of an EEA national who is employed or permanently resident here) and who are economically inactive – strictly speaking, such individuals are supposed to be ‘self sufficient’ and to have CSI (Comprehensive Sickness Insurance)?

- what difficulties do you face with this group?
- how many do you see in a week/month/year?

Have you noticed any pattern with EEA nationals who are economically inactive and resident (rather than EHIC visitors) who are accessing hospital treatment within a short period of arriving in the UK eg for cancer treatment or other chronic conditions?

Is there an issue with people who are state pensioners from another EEA country who move here without registering an S1 form?

- what difficulties do you face with this group?
- how many do you see in a week/month/year?

Moderator refers respondent to page 3; NB this is not an exhaustive list and respondents are free to suggest other clinical areas as appropriate

Which if any of these clinical areas are accessed in particular by migrants with OR status?

Are there any other clinical areas not included on page 3 that are accessed in particular by migrants with OR status?

Moderator explains we are moving on to consider the next category, namely **Overseas Visitors that are exempt from charging**

If they find someone is not OR but may still be exempt from charging, how do they decide whether one or more of the exemptions applies to them?

- what questions are asked and what proof is sought?
- where/when is this done – are there particular pathways into the Trust ?
- by whom?

For how many people are you looking into their exemption status in a week/month/year etc?
What proportion/how many are found to be exempt?

What difficulties do you face with trying to establish exemptions? What loopholes are you aware of/ ways in which patients may present themselves as qualifying for these exemptions when they are not entitled? How often do you think this happens?

Looking now at page one: in terms of overseas visitors who are exempt from charging, which of the categories represent

- the largest numbers presenting?
- any particular characteristics (gender, age, nationality etc)?
- particular problems in determining exemption status – why is that?
- the greatest impact on the Trust in terms of resources and cost? We will explore the types of impact they have (clinical, administrative etc.)
- what data, if any, is collected about these different categories?

Moderator refers respondent to page 3

Which if any of these clinical areas are accessed in particular by overseas visitors who are exempt from charging?

Are there any other clinical areas not included on page 3 that are accessed in particular by overseas visitors exempt from charging?

*Moderator explains we are now going to focus on the third category, **chargeable overseas visitors***

Now that you have arrived at the patients who are chargeable, how do you decide whether you will charge them or not (clinical need, whether they are likely to be able to pay, potential legal repercussions)?

- what questions are asked/what information is sought?
- where/when is this done – are there particular pathways into the Trust ?
- by whom? Prompt for who else is involved beyond the OVM team

What is the process for charging a patient? What difficulties do you face in presenting the charges?

How many do you charge in a week/month/year? How much is the total amount charged per week/month/year?

What is the income generated from those who are charged? (try to obtain latest figures with time period)

What proportion of those charged do not pay? What is the current level of bad debt? What level of debt has been written off

How many each week/month/year should be charged but are not (for whatever reason)?

- can you estimate how much they should be charged (if not possible get some examples of low charges and high charges)
- what are the main reasons why those that should be charged are not?

Looking now at page one: when it comes to chargeable patients, which if any of the categories present

- the largest numbers presenting?
- any particular characteristics (gender, age, nationality etc)?

- the greatest difficulty in identifying them as chargeable?
- particular problems when it comes to recovering charges; why is this?
- the greatest impact on the Trust in terms of resources and cost? We will explore the types of impact they have (clinical, administrative etc.)
- what data, if any, is collected about these different categories?

Moderator refers respondent to page 3

Which if any of these clinical areas are accessed in particular by chargeable overseas visitors?

Are there any other clinical areas not included on page 3 that are accessed in particular by chargeable overseas visitors?

Impacts and costs

What, in your view, are the main impacts on the Trust of overseas visitors and migrants?

What are the costs to the Trust (within their own department/within other departments) of overseas visitors and migrants in terms of

- staff time (dealing with patients, training)
- administrative costs (postage, stationery, phone calls)
- other costs – explore what these are

Are they able to quantify these at all?

Systems and their effectiveness

We have been discussing the systems you have in place to deal with overseas visitors - overall, how well do you think your current systems work? Are there any things you do that you feel are examples of good practice that other Trusts could learn from?

Do you have any ideas for how your systems could be improved?

What obstacles do you face in carrying out your role? We will explore

- Internal barriers; in terms of the source (senior managers, finance, legal, admin, clinicians, patients) and nature of the barrier (e.g. fear of loss of income, fear of litigation by patients, refusal to question patients on eligibility, definition of 'urgent', lack of support for their role etc.)
- External barriers; in terms of the source (GPs, DH, Home Office) and nature of the barrier (e.g. GP reluctance to advise patients/Trust of the possibility of charging, 'Choose and book', lack of clear direction as to appropriate course of action, Data Protection and difficulties of exchanging information with other agencies etc.)

If not mentioned earlier, check whether they liaise with the local UKBA/Home Office about specific cases and explore how they help (each other), the types of information exchanged. If relevant identify which office this is.

Response to proposals for change

Moderator explains that the specific changes that will go out to consultation have not yet been finalised so on page 4 are those that are currently under consideration.

The moderator will take them through **each** and ask

In your opinion, would this be a helpful step? In what way? Might there be any unforeseen consequences?

1. Plans to change the core eligibility trigger for free NHS access from 'ordinary residence' to permanent residence (for non-EEA nationals).
2. Plans to extend charges to other settings, such as Primary care (GP) services, other primary medical services, emergency treatment. This is not about limiting access but extending charges.

3. Plans to introduce prepayment or insurance requirement for temporary residents to pay for NHS health care.
4. We would continue to charge short-term visitors directly at the point of use for hospital treatment. There are proposals for mandatory requirement for hospital/travel insurance for tourists and other short term visitors.
5. Proposals to address the whole process from referral to admission, treatment, charging and recovery. NHS England is currently considering the potential of a managed pilot in the London region.

(In relation to 1.) If the eligibility criteria were to change from ordinary residents to permanent residents, what would be the impact on your department of dealing with overseas visitors?

- staff numbers/ grades
- training of own staff/ staff elsewhere in Trust

(In relation to 2.) If charging was introduced in primary care and emergency care, what would be the impact on your department? (primary care might be helpful to them because patients should be assessed for eligibility at this stage/ emergency care could mean more work?)

What are your own views on the priorities for changes? Are there any examples of access to NHS services which you feel we have not covered but which you feel are unfair?

Further stages

Moderator explains that the next stage is for us to select a number of Trusts and talk to clinicians, managers and administrators in those Trusts as well as similar staff in primary care in the area. These interviews will be face to face.

- Do you think your Trust would be a good one to include? We will explore reasons why and why not.

We will explain which staff we are looking to interview in their Trust: themselves again, FD, 2 doctors or consultants, 2 nurses and 2 reception staff.

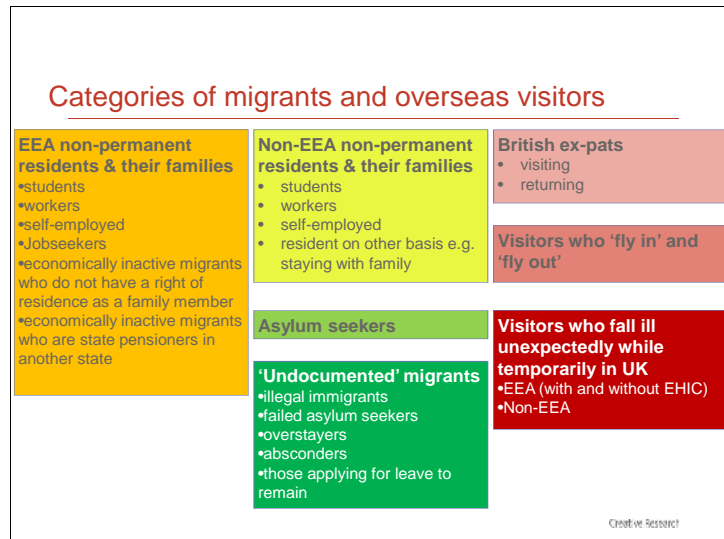
- Can you think of such staff who would be best placed to comment on their experience of overseas visitors? In which departments?
- Do you think that such staff would be interested and happy to help with the research, again, on a completely anonymous basis? If we wanted to follow this up, can we come back to you to see if you can help with setting up such interviews?
- Would you be able to suggest primary care settings (GP practices/ walk-in centres) from which you receive referrals for migrants and overseas visitors?

We will emphasise that we will only know which Trusts we wish to talk to again once we have spoken to all 30 Trusts so that we can arrive at a good mix.

We will also explain that we want, at some point, to ask all Trusts involved in all parts of the research to collect data about overseas visitors and migrants over a certain period of time.

- Would you be willing to do this?
- How is this best done? (time period, online data entry vs hard copy spreadsheet etc)

Stimulus (OVOs)



Some possible NHS services accessed by overseas visitors and migrants

A&E	Oral surgery/Maxillo-facial
Cardiology	Orthopaedics
CASH	Paediatrics
Dermatology	Renal
Fertility treatment	Stroke
GUM	Termination
Maternity	Transplant
Neurology	Urgent care centres
Oncology	Other
Ophthalmology	

Creative Research

Possible changes under consideration

1. Plans to change the core eligibility trigger for free NHS access from 'ordinary residence' to permanent residence.
2. Plans to extend charges to other settings, such as Primary care (GP) services, other primary medical services, emergency treatment. This is not about limiting access but extending charges.
3. Plans to introduce prepayment or insurance requirement for temporary residents to pay for NHS health care.
4. We would continue to charge short-term visitors directly at the point of use for hospital treatment. There are proposals for mandatory requirement for hospital/travel insurance for tourists and other short term visitors.
5. Proposals to address the whole process from referral to admission, treatment, charging and recovery. NHS England is currently considering the potential of a managed pilot in the London region.

Creative Research 4

Questionnaire (OVOs)

During the course of the interview, we would like to find out what data your Trust has on certain issues. We have set out the questions below. It would be helpful if you had this information to hand during the interview. Don't worry if this is not possible, there will be the chance to send the information to us afterwards. We are also aware that your Trust may not collect all of the data. If you are able to provide an estimate, please do so but indicate it is an estimate.

Ordinarily Resident status

How many people are asked about their OR status? Please indicate which time period this covers e.g. per day/week/month/year	
How many/what proportion of these are determined to be OR?	

Overseas Visitors Exempt from Charging

For how many people are you looking into their exemption status? Please indicate which time period this covers e.g. per day/week/month/year	
How many/what proportion of these are determined to be exempt?	

Chargeable Overseas Visitors

How many people do you charge i.e. raise an invoice? Please indicate which time period this covers e.g. per day/week/month/year	
How much is the total amount charged? Please indicate which time period this covers.	
What is the income generated from those that are charged? Please indicate which time period this covers.	
How many/what proportion of those charged do not pay? Please indicate which time period this covers.	
What is the current level of bad debt?	
What level of debt has been written off? What period does this relate to?	

Topic Guide (Border Force and Immigration Enforcement)

Introductions

The interviewer

The objectives of the research programme and an outline of how it is being conducted

Why we would like to talk to Border Force staff at the major airports – to understand their perspective, in particular with respect to what has been called ‘health tourism’ – people coming into the UK with the purpose of accessing NHS services

The recording of the discussion and how it will be used, i.e reiterate reassurances about anonymity. If at any points they would prefer the recorder to be switched off (if discussing issues relating to security), willingness to do this

Their role and experience (how long, where gained), in particular with respect to identifying and following up people who they suspect may be entering the UK to access NHS services.

Nature and scale of the problem

Is ‘health tourism’ recognised as an issue at their airport? Is it something that Border Force staff are instructed to look out for? We will explore the different roles involved and how they work together e.g. Intelligence and front desk staff

Who are ‘health tourists’ – what are the different categories that they might identify as entering the UK in order to access NHS services?

- Fly in/ fly out, economically inactive staying with relatives, ex-pats, students etc.
- Characteristics of different categories – nationalities/ age
- Types of treatment sought (if known)

Do they see their airport as having any distinctive characteristics with regard to ‘health tourists’ e.g. the types of people using it as a gateway to the UK? We will explore any reasons for this.

Are they seeing/have they seen any patterns in the numbers or type of ‘health tourist’ – any increases/ decreases in certain types - and why this might be?

Is data formally captured – of what type? Any idea of numbers per week/ month/ year? If estimates, what are these based on? If the respondent is on the front desk and is seeing x passengers of a particular type coming through in a week, how should we factor that up to give an estimate? E.g.

The number of staff typically on the passport control desks?

What is the picture across terminals (relevance of the starting point of flights?)

Are there any patterns with respect to times of the day/ seasonal variations when ‘health tourists’ might arrive? We will explore any reasons for this.

Processes and systems

How might ‘health tourists’ be identified at the airport? What are the sorts of questions asked/ answers looked for? What might give cause for staff to investigate further?

What form does this further investigation take? Where does it take place, who might be involved, what documentation is sought etc?

- Do they gather information around whether visitors have sufficient resources (incl. insurance) to finance their stay (including any health needs)?
- How seriously do they think this requirement is taken in their checks?

Do visitors try to disguise the fact they are in the UK for hospital treatment? We will explore ways in which visitors present in order to do this.

If someone is identified as a ‘health tourist’, what can be done about it?

Do Border Force advise potential 'health tourists' about possible charging by the NHS? How do they tend to react?

Are they able to communicate with NHS Trusts any concerns they may have about specific people? We will explore the nature, limitations and perceived effectiveness of such communications.

Perceived issues with the current regulations/systems and response to proposals that have gone out to consultation

Perceived loopholes in the system/ difficulties for staff in identifying or dealing with 'health tourists'

What do they see as the priorities for change?

We will then go through the proposals that have gone out for consultation, focusing on those which are most relevant to entry requirements (e.g. around mandatory insurance cover) and explore their responses to these. What impact do they think they will have on

- Numbers of 'health tourists'
- The role of Border Force staff at the airports
- Anything else?

11.3.4 Case study materials (Secondary Care)

Topic Guide (OVOs)

The content of this interview will depend on a number of factors:

Whether we are just seeing the same person or someone new in their team too

Whether the OVM has been instrumental in providing the new data or worked on it with the Finance department. If they have been responsible in large part for the figures, there is likely to be overlap with the FD topic guide, we will ask the OVM to talk us through the figures, where there are gaps, encouraging them to provide estimates, etc.

The interview will also give them the opportunity to comment on the proposed changes.

The interviewer reminds the OVM of

Him/herself and Creative Research

The recording of the discussion and how it will be used; again, giving reassurances about anonymity

The objectives of the research programme

- the extent and nature of use by migrants and overseas visitors
- how clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- their response to some of the ideas for changing the system that have gone out to consultation

Moderator explains we are focusing on what happens in their Trust currently, not what might happen after any changes are introduced (altho' we will cover that at the end).

Moderator finds out who is best placed to discuss the data we have requested.

Revisiting the scoping interview/familiarisation with the Trust

If the discussion with the OVM is at the beginning of the visit, we will quickly revisit with them the main points around the impact of overseas visitors and migrants on the Trust – if there is a

new member of the team present, we will invite them to contribute any new thoughts/ insights e.g.

- The scale of the issue for the Trust – both according to data that is captured and perceptions, and the impact on various departments
- The systems in place and any departments which are particularly effective at identifying potentially chargeable patients
- Problems faced in identifying, charging and recovering payment
- Attitudes within the Trust to the issue and whether there has been any discussion about the proposals that have gone out to consultation

We will try and identify with the OVM any issues/ questions that would be relevant for particular staff members that we will be interviewing.

Data on Chargeable Visitors

This is a duplication of the part of the FD topic guide discussing the data that is available. We will not cover all of this in both interviews but tailor it as appropriate. Where we have some data already, we will also compare that with what is now provided.

Regardless of what else is covered, we will be sure to ask about patients who are chargeable but not charged (highlighted).

EHICs and Reciprocal Arrangements

In terms of recording these patients, what records do they keep

How many patients were identified as holding an EHIC in the last financial year?

- how about in previous years?
- do they record country of origin?
- which countries of origin tend to occur most frequently?

How many patients were identified as being covered by a reciprocal arrangement in the last financial year?

- how about in previous years?
- do they record country of origin?
- which countries of origin tend to occur most frequently?

Identifying and charging chargeable patients – moderator, make it clear that we are now talking about patients who are personally chargeable (as opposed to their state being charged)

In terms of recording those patients who have been identified as chargeable, what records do they keep for the various categories (if at all)?

How many patients were identified as chargeable and charged in the last financial year?

- How about previous years?
- Do they hold data on the different categories of chargeable patient
- If they do not record data according to these categories, do they have any feel for how last year's total might divide? Do they think this has changed over the years?

Moderator – explain that we are aware from talking to a range of Trusts that sometimes they put through patients as ordinarily resident or exempt when they should probably be charged. This means that the CCG pays for such patients.

What are their views on this? What is their Trust's policy on this?

Do they have any idea whether and how often it happens in their Trust (even if the policy is to charge them – some may be slipping through)?

which groups of migrants/OVs are most likely to be included? Why might they not be charged?

If it was possible to screen all patients to identify all who are chargeable, how many more patients do they estimate they might end up charging?

Which groups of migrants/OVs are currently least likely to be identified?

How much was invoiced last year to chargeable patients in total?

- How about previous years ?
- Are they able to break this down by the different categories of chargeable patient?
- If they do not record data according to these categories, do they have any feel for how last year's total might divide? Do they think this has changed over the years?
- Are they able to break this down according to the services used?
- If they do not record data according to services used, do they have any feel for how last year's total amount invoiced might divide? What are the main services used by chargeable patients? Do they think this has changed over the years?

Recovering payment/ debt

Of the patients who were charged last year, how many have so far paid in full?

Are there any that have paid in part/ have arranged a payment plan?

What proportion would they expect to pay in full eventually?

(Moderator to double check that they can arrive at a figure for the number who have not paid anything and who are not expected to do so based on above responses)

How does this compare with previous years? Is the proportion paying improving/ declining/ pretty stable?

What is the total amount of money so far recovered from patients charged in the last financial year, including any sums that were invoiced in previous years

Is the proportion of the total amount invoiced that is recovered typical of previous years? Is it improving/ declining/ pretty stable?

What is the total amount of money that was outstanding at the end of the last financial year including any sums carried over from previous years but excluding any sums written off?

What level of debt has been written off (what period does this cover)?

Are they able to break down the sums recovered according to

- the Trust's services used i.e. are patients using certain services more likely to pay than others?
- advance payments for elective care (are these more likely to be recovered than post-treatment costs?)
- post-treatment costs for admissions via the emergency department
- other post-treatment costs invoiced retrospectively
- costs for in-patient vs out-patient treatment (is it easier to recover the smaller sums incurred for out-patient?)

Costs

To be asked only where we do not have a complete picture from the scoping study. Note to moderator – you may wish to double check the information you recorded previously with the respondent.

Can they identify the total time spent by each staff member in OV on identifying, charging and recovering costs from migrants and overseas patients? We will explain that we are interested in the staff cost to the Trust incurred on these duties and will ask for the bands of those involved in this work.

Moderator to probe for each member of staff involved, their pay band and the proportion of their time spent on this.

Other costs may be covered in responses to the questionnaire – in which case they will only be touched on here.

What other costs are incurred in identifying, charging and recovering charges? When /how are these services used e.g. does the use of debt recovery agents depend on the size of the debt?

Can they provide costs for each type of costs specifically for these tasks?

- interpreters/ translation
- debt recovery agents
- stationery, phone calls etc.

Response to proposed changes

Are they aware of any of the changes currently being considered by the Department of Health in relation to charging migrants and overseas visitors

- what have they heard
- what are their feelings about any of the things they have heard about?

What would be the impact if, rather than having to recover costs from individual chargeable patients, they were paid for the costs incurred (and another body took on the recovery of those charges)? How might this affect, for example, the proportion of chargeable patients who were identified?

- might it, for example, make it worthwhile increasing the size of the OV team to ensure as many chargeable patients as possible are identified?

If time and not already raised by respondent ask the following questions from the consultation document (NB respondents may not feel equipped to answer all of them depending on how familiar they are with what is being considered)

What services should we charge for?

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E?

Question 19: What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?

Making the system work in the NHS

Question 22: How could current hospital processes be improved in advance of more significant rules changes and structural redesign (i.e. before any of the proposals are introduced)?

Question 24: Where should initial NHS registration be located and how should it operate?

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

Topic Guide (Finance)

The level of detail covered in this interview will depend on who we speak to (Director or senior manager), whether they are familiar with the data in question (e.g. FD may not be), whether data has been gathered and whether it has been sent to us in advance. This will need to be discussed at the beginning of the interview.

The interviewer introduces

Him/herself and Creative Research

The recording of the discussion and how it will be used; again, giving reassurances about anonymity

The objectives of the research programme

- the extent and nature of use by migrants and overseas visitors
- how clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- their response to some of the ideas for changing the system that have gone out to consultation

We are focusing on what happens in their Trust currently, not what might happen after any changes are introduced (altho' we will cover that briefly at the end).

1. Finance and OV

What is the involvement of Finance with OV - do staff with OV responsibilities come under Finance? Where do the responsibilities of OVMs (or their equivalent) end and those of Finance begin (we may simply be checking out what we have been told by the OVM here) e.g. coding of treatments, raising and presenting invoices, following up patients for payment, recovering debt etc.

Apart from the parts of the process carried out by the OVM team (which we will cover with that team), who else is involved in Finance (or elsewhere) in coding, raising invoices, chasing payment, recovering debt etc. with respect to OVs (i.e. not private patients)

2. Perceptions of significance of the issue and its impact

In their opinion, how significant an issue are overseas visitors and migrants for their Trust from a financial perspective? We will invite them to differentiate between

- Overseas visitors who are currently chargeable and migrants who may currently not be chargeable
- Different categories of overseas visitors and migrants
- Migrants from other EEA countries who are referred to the Trust (via S2 claims)
- Illegal immigrants

What are the challenges presented by each in terms of

- Identifying those who are exempt and those who are chargeable (N.B. may not be part of Finance's role)
- Charging those who are chargeable
- Recovering the cost from those who are chargeable?

How effective do they think their Trust is in identifying patients who should be charged and then charging them?

What is the Trust's policy/ practice in invoicing chargeable patients e.g. in advance of treatment wherever possible, after completion once the full cost is known? Any reasons for this? What do they regard as the ideal?

Do they see DH guidance on charging as optional or mandatory (statutory)?

3. Data relating to Chargeable Patients

If respondent is not familiar with the level of detail asked for in the questionnaire, moderator to ask the question relating to patients who are chargeable being treated as OR or exempt – underlined below - and then skip to section 4 'response to proposed changes'

If respondent is familiar with the level of detail but the questionnaire has not been completed, moderator will talk respondent through the questionnaire to clarify what is being requested, to note any comments. We will ask for the questionnaire to be completed and sent to us.

If respondents is familiar with the level of details and the questionnaire has been completed, moderator will talk respondent through it to clarify any issues. Where there are gaps, moderator will encourage respondent to provide estimates

EHICs and Reciprocal Arrangements

In terms of recording these patients, what records do they keep

How many patients were identified as holding an EHIC in the last financial year?

- how about in previous years?
- do they record country of origin?
- which countries of origin tend to occur most frequently?

How many patients were identified as being covered by a reciprocal arrangement in the last financial year?

- how about in previous years?
- do they record country of origin?
- which countries of origin tend to occur most frequently?

Identifying and charging chargeable patients – moderator, make it clear that we are now talking about patients who are personally chargeable (as opposed to their state being charged)

In terms of recording those patients who have been identified as chargeable, what records do they keep for the various categories (if at all)?

How many patients were identified as chargeable and charged in the last financial year?

- How about previous years?
- Do they hold data on the different categories of chargeable patient
- If they do not record data according to these categories, do they have any feel for how last year's total might divide? Do they think this has changed over the years?

Moderator – explain that we are aware from talking to a range of Trusts that sometimes they put through patients as ordinarily resident or exempt when they should probably be charged. This means that the CCG pays for such patients.

What are their views on this? What is their Trust's policy on this?

Do they have any idea whether and how often it happens in their Trust (even if the policy is to charge them – some may be slipping through)?

- which groups of migrants/OVs are most likely to be included? Why might they not be charged?

If it was possible to screen all patients to identify all who are chargeable, how many more patients do they estimate they might end up charging?

- Which groups of migrants/OVs are currently least likely to be identified?

How much was invoiced last year to chargeable patients in total?

- How about previous years?
- Are they able to break this down by the different categories of chargeable patient?
- If they do not record data according to these categories, do they have any feel for how last year's total might divide? Do they think this has changed over the years?
- Are they able to break this down according to the services used?
- If they do not record data according to services used, do they have any feel for how last year's total amount invoiced might divide? What are the main services used by chargeable patients? Do they think this has changed over the years?

Recovering payment/ debt

Of the patients who were charged last year, **how many have** so far **paid in full**?

- Are there any that have paid in part/ have arranged a payment plan?
- What proportion would they expect to pay in full eventually?
- (Moderator to double check that they can arrive at a figure for the number who have not paid anything and who are not expected to do so based on above responses)
- How does this compare with previous years? Is the proportion paying improving/ declining/ pretty stable?

What is the total amount of money so far recovered from patients charged in the last financial year, including any sums that were invoiced in previous years

- Is the proportion of the total amount invoiced that is recovered typical of previous years? Is it improving/ declining/ pretty stable?

What is the total amount of money that was outstanding at the end of the last financial year including any sums carried over from previous years but excluding any sums written off?

What level of debt has been written off (what period does this cover)?

Are they able to break down the sums recovered according to

- the Trust's services used i.e. are patients using certain services more likely to pay than others?
- advance payments for elective care (are these more likely to be recovered than post-treatment costs?)
- post-treatment costs for admissions via the emergency department
- other post-treatment costs invoiced retrospectively
- costs for in-patient vs out-patient treatment (is it easier to recover the smaller sums incurred for out-patient?)

Other Costs

Can they identify the total time spent by each staff member in Finance on identifying, charging and recovering costs from migrants and overseas patients? If possible, can they say how much time is given over to debt recovery? How much priority is it given?

We will explain that we are interested in the staff cost to the Trust incurred on these duties and will ask for the bands of those involved in this work.

Moderator to probe for each member of staff involved, their pay band and the proportion of their time spent on this.

What other costs are incurred in identifying, charging and recovering charges? When /how are these services used e.g. does the use of debt recovery agents depend on the size of the debt?

Can they provide costs for each type of costs specifically for these tasks?

- interpreters/ translation
- debt recovery agents

- stationery, phone calls etc.

4. Response to proposed changes

Are they aware of any of the changes currently being considered by the Department of Health in relation to charging migrants and overseas visitors

- what have they heard
- what are their feelings about any of the things they have heard about

Moderator to ask everyone

What would be the impact if, rather than having to recover costs from individual chargeable patients, they were paid for the costs incurred (and another body took on the recovery of those charges)? How might this affect, for example, the proportion of chargeable patients who were identified?

- might it, for example, make it worthwhile increasing the size of the OV team to ensure as many chargeable patients as possible are identified?

If time and not already raised by respondent ask the following questions from the consultation document (NB respondents may not feel equipped to answer all of them depending on how familiar they are with what is being considered)

What services should we charge for?

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E?

Question 19: What systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?

Making the system work in the NHS

Question 22: How could current hospital processes be improved in advance of more significant rules changes and structural redesign (i.e. before any of the proposals are introduced)?

Question 24: Where should initial NHS registration be located and how should it operate?

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

Topic Guide (Other Trust staff)

NB This is the topic guide for clinicians, nursing staff and reception staff. Separate topic guides will be developed for the interviews with finance and OVMs.

Questions will be tailored as appropriate to the role of the respondent.

Interviewer Introduction

Introduction of interviewer/Creative Research

Thanks and emphasise the value of their Trust's participation in the research

Recording, use of the information, reassurances regarding anonymity and confidentiality

The objectives of the research programme

- the extent and nature of use by migrants and overseas visitors
- how clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- their feedback on proposed ways of changing the system

Respondent Introduction

Role/job title, department/clinical area worked in, any particular specialisms they have in that area/in the Trust

Any particular working patterns (e.g. do they work particular days/shifts that might impact on the OV numbers/profile seen)

Awareness of the issue

Understanding of terms

- do they feel that they have a clear understanding of the terms, 'migrant' and 'overseas visitor' – how might they define them?
- do they feel that they have a clear understanding of which patients are chargeable – does it matter?
- moderator to clarify: in the context of the interview, we are using the term migrant to refer to those people who have moved to the UK but who have not got indefinite leave to remain or taken out British citizenship; depending on their circumstances, they may or may not be chargeable
- if necessary, clarify that we are not talking about private patients from overseas in the UK on medical visas for treatment but those from overseas who are charged according to the NHS tariff

Based on their experience, how significant an issue are overseas visitors, migrants and 'chargeable patients' for their Trust in the context of all its activities

- why do they say this, what is this view based upon, what comparisons/context is the issue being placed in
- do they think their department/clinical area sees more/less/the average number of overseas visitors and migrants compared to other parts of the Trust – why is this
- has the significance of overseas visitors and migrants as an issue for the Trust changed in recent months/years? In what way, what do they think might be driving this change?

Perceived role and systems

What is their role with respect to, for example:

- Screening patients to see if they are overseas visitors
- Identifying potentially chargeable patients
- Completing databases
- Informing OVM or equivalent person/ dept

- Deciding what treatment is urgent and necessary

Approximately how much of their time is taken up on this

- moderator will ask for an estimate of the proportion/percentage of their time spent on these types of activities
- moderator to record respondents grade/pay band (explaining this is so we can get an estimate of the impact on staff costs)
- note to moderator: do not ask about grade/pay band when interviewing doctors/consultants

Have they had any training/information/advice in relation to this role e.g. how to screen OV or identify potentially chargeable patients

- if so, what form did it take?
- who provided it?
- how helpful has it been?

What are the systems and procedures that they follow when dealing with overseas visitors and migrants – ask to take through the processes they follow step by step

- what would signal to them that a patient may fall into one of the categories discussed?
- what steps, if any, do they take to identify whether a patient does belong to one of the categories of overseas visitor discussed, if they suspect a patient is not resident in the UK?
- what questions do they ask, of whom?
- what processes do they follow?
- how is the information recorded e.g. PAF, electronically?
- if electronically, are the fields obligatory (i.e. can't move on until they have been answered) or optional?

What triggers them to contact the OVM?

- how often do they contact the OVM?
- are there patients where they make a judgement not to contact the OVM – what patient types/occasions are these, how many patients is this/how often does this happen?

Nature and scale of the challenge

[Respondent shown the various categories of migrants and OV] Looking at the main categories of overseas visitors and migrants – does this reflect the categories that they encounter – which are seen, not seen, which are the main groups seen, which are increasing – why do they think this is?

[NB our expectation is that respondents will not be able to quantify how many they see but where it is possible to do so, we will encourage them to provide estimates or to indicate which groups they see most often, etc] Overall, can they quantify the number of migrants and overseas visitors they see

- is any data held/recorded in their area/department about overseas visitor numbers/profiles; if data is held, how far back is data available for, what information could be accessed
- even if no data is held, what is their own estimate of the overall patient volumes that they see – what is the timeframe and context for any estimates/data given (e.g. per day/week, if per clinic, how many clinics are held per week etc)
- can they quantify the number of patients seen in each category/any of these categories – if there is no data, can they provide any estimates of the numbers involved

What patterns are they seeing/have they noticed in the numbers of migrants/ overseas visitors presenting

- any particular specialities, any patterns in emergency/elective presentations, any particular conditions

Impact of Overseas Visitors and Migrants

What, in their view, is the impact upon the Trust of overseas visitors and migrants?

What is the impact upon their own department, upon their own role?

What, if any, are the difficulties and challenges they face in dealing with the overseas visitors and migrants that present; ask unprompted then as appropriate prompt

- in terms of the pathways/points of referrals into the Trust
- in terms of particular types of patient/patient population group
- desire to treat regardless
- difficulties of defining what is urgent or immediate and necessary treatment
- needs/attitude of the patient especially where they may have difficulty paying

Overall, how well does the system work in their Trust as far as their department is concerned, as far as their role is concerned?

What would make it easier to identify chargeable patients from their perspective

- why would these specific changes make it easier
- what current barriers to identifying chargeable patients would be overcome
- how might things be improved

What would make dealing with overseas visitors work better from the perspective of their role, what changes if any would they like to see

Response to proposed changes

Are they aware of any of the changes currently being considered by the Department of Health in relation to charging migrants and overseas visitors

- what have they heard
- what are their feelings about any of the things they have heard about

We will then probe on the following points:

- how they feel about charging non-EEA visitors and other chargeable migrants for access to emergency treatment (whether in A&E or in emergency GP settings)? – (Moderator – make it clear that treatment will never be delayed or withheld)
- what systems and processes would be needed to enable charging in A&E without adversely impacting on patient flow and staff?
- do they agree that we should extend charging to include care outside hospitals and hospital care provided by non-NHS providers?
- how could current hospital processes be improved in advance of more significant changes in the rules and redesign of the structure for identifying, charging and recovering payment from chargeable patients?

Questionnaire

As part of this stage of our research, we are looking to collect data from each case study Trust. We have set out the key questions below. Wherever possible, please base your answers on Trust records.

If data is not available but you feel able to provide an estimate, please indicate this with an “*” next to the entry e.g. if you estimate that 20% of the individuals identified as chargeable are undocumented migrants, write in as ‘20%*’. If you do not feel able to provide an estimate, please leave it blank.

If any of your answers relate to a different period to that shown in the table, please indicate what period it refers to e.g. if you came across 5 chargeable ex-pats over the last 3 months, write in as ‘5 between Feb/June 2013’

We appreciate that you may not have access to data on every question, please complete what you can.

If possible, please complete and send the information to us in advance of our visit. We recommend you password protect the document using the password we have provided. If you do not have time to send it in advance, please have as much of the information available at the time of our visit.

EHICs and Reciprocal Arrangements

Please provide information about the number of patients who have been treated who either held an EHIC or were covered by a reciprocal agreement. Please also provide information about the amount of money that was charged.

Year	Total no. of individuals who have been treated and who held an EHIC	Total amount of money charged in relation to EHICs	Total no. of individuals who have been treated and who were covered by a reciprocal agreement	Total amount of money charged in relation to reciprocal agreements
2012/13		£		£
2011/12		£		£
2010/11		£		£
2009/10		£		£
2008/9		£		£

Chargeable Patients

Please provide information about the number of individuals who have been identified as chargeable and charged for their treatment. **If possible**, break this down by visitor type and by financial year.

Year	Total No. of individuals who are charged for treatment	Visitors from EEA (e.g. those without an EHIC)	Visitors from non-EEA	British ex-pats	Undocumented migrants (e.g. illegal immigrants, failed asylum seekers, etc)	Visitors who 'fly in' and 'fly out' (sometimes referred to as 'health tourists')	Others (please briefly specify what this covers)
2012/13							
2011/12							
2010/11							
2009/10							
2008/9							

Please provide information about the total amount of money that has been charged. **If possible**, break this down by visitor type and by financial year.

Year	Total amount of money charged to individuals for treatment	Visitors from EEA (e.g. those without an EHIC)	Visitors from non-EEA	British ex-pats	Undocumented migrants (e.g. illegal immigrants, failed asylum seekers, etc)	Visitors who 'fly in' and 'fly out' (sometimes referred to as 'health tourists')	Others (please briefly specify what this covers)
2012/13	£	£	£	£	£	£	£
2011/12	£	£	£	£	£	£	£
2010/11	£	£	£	£	£	£	£
2009/10	£	£	£	£	£	£	£
2008/9	£	£	£	£	£	£	£

If it is possible to do so, please break down the total amount charged according to the main services used. We have included maternity as an example heading, please write in up to five further services, choosing those where the Trust is treating the largest number of chargeable individuals. For example, if your Trust treats a large number of chargeable patients for dialysis, write in 'dialysis' as one of the column headings.

Year	Total amount of money charged to individuals for treatment	Amount charged for maternity services					
2012/13	£	£	£	£	£	£	£
2011/12	£	£	£	£	£	£	£
2010/11	£	£	£	£	£	£	£
2009/10	£	£	£	£	£	£	£
2008/9	£	£	£	£	£	£	£

Recovery of Charges

Please provide information on the number of individuals who have been charged and who have paid in full, the number of individuals who have not paid in full (they may have part paid or have set up a payment plan), the total amount of money that has been charged and recovered and the total amount that remains outstanding.

Year	Total no. of individuals who have been charged and have paid in full	Total no. of individuals who have been charged but who have not paid in full	Total amount of money that has been recovered including any sums that were invoiced in previous years	Total amount of money that has not been recovered at year end including any sums carried over from previous years but excluding any sums written off
2012/13			£	£
2011/12			£	£
2010/11			£	£
2009/10			£	£
2008/9			£	£

If it is possible to do so, please break down the total amount of money recovered according to the services used. We have included maternity as an example heading, please write in up to five further services, choosing those where the Trust is treating the largest number of chargeable individuals. For example, if your Trust treats a large number of chargeable patients for dialysis, write in 'dialysis' as one of the column headings.

Year	Total amount of money recovered for treatment	Amount recovered for maternity services					
2012/13	£	£	£	£	£	£	£
2011/12	£	£	£	£	£	£	£
2010/11	£	£	£	£	£	£	£
2009/10	£	£	£	£	£	£	£
2008/9	£	£	£	£	£	£	£

Other costs

If it is possible to do so, please provide an indication of other costs to the Trust of dealing with chargeable individuals **excluding staff costs**. This might include the use of debt recovery agents, interpreters etc. Please write in the appropriate headings below.

Year							
2012/13	£	£	£	£	£	£	£
2011/12	£	£	£	£	£	£	£
2010/11	£	£	£	£	£	£	£
2009/10	£	£	£	£	£	£	£
2008/9	£	£	£	£	£	£	£

11.3.5 Case study materials (Primary Care/CCG)

Topic Guide (Primary Care)

NB This is the topic guide for practice partners, practice managers, nurses and reception staff. Questions will be tailored as appropriate to the role of the respondent.

Interviewer Introduction

Introduction of interviewer/Creative Research

Thanks and emphasise the value of their Practice's participation in the research

Recording, use of the information, reassurances regarding anonymity and confidentiality

The objectives of the research programme

- The extent and nature of use of NHS Services by migrants and overseas visitors
- How clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- Their feedback on proposed ways of changing the system

How this interview fits into the bigger research picture

Outline the agenda for the discussion

Respondent Introduction

Role/job title, size of Practice – number of patients on their list, number of partners, profile of the patient population served

We will start out by saying that we are aware that primary care practitioners are currently under no obligation to check the residency status of people who seek to register with their practice but it would be helpful to understand what form their registration process takes.

What is the process for new patients registering with the practice? Do prospective patients fill in a form in the practice/online? What information is asked for? Do they need to produce any documents?

Do they attempt to identify, at registration, in any way, patients who might be chargeable in secondary care (e.g. temporary patients)? Do they ask any particular questions, record any particular information – of/about whom, in what circumstances?

Awareness of the issue

In discussing their thoughts on the scale and nature of the challenge presented to the NHS by overseas visitors, the terms 'migrant' and 'overseas visitor' are often used ...

Do they feel that they have a clear understanding of the terms, 'migrant' and 'overseas visitor' – how might they define them?

- moderator to clarify as needed: in the context of the interview, we are using the term migrant to refer to those people who have moved to the UK but who have not got permanent leave to remain or taken out British citizenship; depending on their circumstances, they may or may not be chargeable

Do they feel that they have a clear understanding of which patients are chargeable in secondary care for certain services? Do they think it matters if they are aware of who is chargeable in secondary care?

Would they, for example, indicate in any way, when referring a patient to secondary care whether they are potentially chargeable?

To start by getting an overview, how significant are overseas visitors and migrants for their Practice

- why do they say this, what is this view based upon, what comparisons/context is the issue being placed in?
- do they think their Practice sees more/less/the average number of overseas visitors and migrants compared to other practices – why is this?

Has the significance of overseas visitors and migrants as an issue for the Practice changed, in what way, what is driving this change?

Nature and scale of the challenge

Overall, can they quantify the number of overseas visitors and migrants that they see?

(NB throughout, explore what exists/what can be shared in terms of access to any data/summary data held - with patient details removed - as available/ appropriate/possible)

- do they have any data on the number/proportion of overseas visitors/migrants on their list – if so, how are they defining a patient as an overseas visitor/migrant ?
- even if no data is held, what is their own estimate of the OV patient volumes that they see – what is the timeframe and context for any estimates/data given (e.g. per day/week, if per surgery, how many surgeries are held per week etc), what is the basis upon which a patient is being considered OV?
- is this different from any OV patients recorded formally – in what way, why is this, can they provide estimates of the scale/numbers involved?

How many new patients register at the practice per week

- of those, how many don't have an NHS number?
- do they have any data/ do they have any impression of the proportion of those without an NHS number that are overseas visitors/migrants?
- can they make any comparisons between the numbers of new and existing presentations by overseas visitors?

Do they have any data about the categories/profiles of those overseas visitors, do they keep a record of where patients come from – what data is held, on what groups of patients?

Looking at the main categories of overseas visitors and migrants, does this reflect the categories of overseas visitors that they encounter – which are seen, not seen, which are the main groups seen, which are increasing – why do they think this is?

- can they quantify the number of patients seen in each category/any of these categories –if there is no data, can they provide any estimates of the numbers involved?
- what patterns are they seeing/have they noticed in the overseas visitors presenting –any patterns in emergency/routine presentations, any particular conditions, reasons to present, particular surgeries that overseas visitors present at?
- do they have any data/impression regarding the proportion of their emergency cases that are overseas visitors?
- do they have any impression of the number of their out of hours patients that are overseas visitors?
- do they have any data/impression of the numbers of patients they refer to secondary care who will be chargeable there?

Impact of Overseas Visitors and Migrants

What, in their view, is the impact upon NHS services of overseas visitors and migrants?

What is the impact upon their own Practice, upon their own role?

- can they quantify the amount of time spent treating overseas visitors – by whom, are there particular people in the practice who would spend time dealing with overseas visitors and migrants?

What, if any, are the difficulties and challenges they face in dealing with the overseas visitors and migrants that present in primary care?

Do they encounter particular areas of difficulty/problems

- in registering overseas visitors and migrants
- in referring patients to secondary care
- in dealing with patients they know will be chargeable in secondary care
- with particular types of patient/patient population group?

What would make dealing with overseas visitors work better from the perspective of their role? What changes, if any, would they like to see?

Response to proposed changes

Are they aware of any of the changes currently being considered by the Department of Health in relation to charging migrants and overseas visitors

- what have they heard
- what are their feelings about any of the things they have heard about?

If necessary, we will describe the main proposed changes that are likely to impact on primary care

- registering with a GP practice, and creating a healthcare record (NHS Number), must allow those who will be chargeable for NHS services to be identifiable and must facilitate the sharing of this information to subsequent healthcare providers that they may be referred to
- any chargeable migrant or visitor should, in future, be charged for GP and other primary medical services, but not for registering with a GP practice
- the practicalities of charging for primary dental services, ophthalmic services and prescription charges in community pharmacy are being considered further
- emergency treatment (via A&E or GP) - will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment.

We will then probe on the following points:

What services should we charge for?

Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?

Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?

Question 21: How can charging be applied for treatment provided by all other

healthcare providers without expensive administration burden?

Making the system work in the NHS

Question 24: Where should initial NHS registration be located and how should it operate?

Question 25: How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

Topic Guide (CCG)

Interviewer Introduction

Introduction of interviewer/Creative Research

Thanks and emphasise the value of their participation in the research

Recording, use of the information, reassurances regarding anonymity and confidentiality

The objectives of the research programme

- The extent and nature of use of NHS Services by migrants and overseas visitors
- How clinicians, managers and administrators deal with issues around migrant and overseas visitors access to NHS services
- Their feedback on proposed ways of changing the system

How this interview fits into the bigger research picture

Outline the agenda for the discussion

Respondent Introduction

Title/ role on CCG and other main position ('the day job')

Characteristics of the CCG and the area it covers; size and profile of the patient population, structure of the CCG, number of Acute/ Foundation Trust hospitals, number of GP practices/ walk-in centres

Awareness of the issue

In discussing their thoughts on the scale and nature of the challenge presented to the NHS by overseas visitors, the terms 'migrant' and 'overseas visitor' are often used ...

Do they feel that they have a clear understanding of the terms, 'migrant' and 'overseas visitor' – how might they define them?

- moderator to clarify as needed: in the context of the interview, we are using the term migrant to refer to those people who have moved to the UK but who have not got indefinite leave to remain or taken out British citizenship; depending on their circumstances, they may or may not be chargeable

Do they feel that they have a clear understanding of which patients are chargeable in secondary care for certain services? Do they think it matters if they are aware of who is chargeable in secondary care?

To start by getting an overview, how significant an issue are overseas visitors and migrants for their CCG?

- why do they say this, what is this view based upon, what comparisons/context is the issue being placed in?
- do they think their CCG sees more/less/the average number of overseas visitors and migrants compared to other CCGs – why is this?

Has the significance of overseas visitors and migrants as an issue for the CCG changed, in what way, what is driving this change?

Nature and scale of the challenge

Does the CCG capture data on the use of NHS services by any of the main groups of overseas visitors and migrants?

- what data, where from, purpose

We will start out by saying that we are aware that primary care practitioners are currently under no obligation to check the residency status of people so they may not know whether their patients are overseas visitors or migrants.

As far as they are aware, are overseas visitors and migrants an issue within **primary care** in their area? On what basis do they say that? Any particular locations where overseas visitors or migrants may present in larger numbers? Why might this be?

Are they aware of any particular needs of these groups with respect to primary care services? Which services/ any particular groups e.g emergency services, out of hours services, ante-natal, dentistry, ophthalmology, community pharmacies etc?

How about in **secondary care** – are there any Trusts/ locations where overseas visitors or migrants may present in larger numbers? Why might this be? Do these Trusts tend to have an Overseas Visitor team/manager in place?

Are they aware of any particular needs of these groups with respect to secondary care services? Which services/ any particular groups e.g emergency services, maternity, renal, orthopaedics etc?

Impact of Overseas Visitors and Migrants

What, in their view, is the impact upon NHS services of overseas visitors and migrants?

What is the impact upon the CCG?

Is the use of NHS services by overseas visitors and migrants the subject of discussions within the CCG or between it and the services it contracts to?

- What aspects have been discussed, with which type of service and have any changes been made as a result eg. with respect to data capture, systems etc.

Are they aware of any difficulties and challenges faced in dealing with overseas visitors and migrants who present in primary care? E.g. with respect to

- registering overseas visitors and migrants
- referring patients to secondary care
- dealing with patients they know will be chargeable in secondary care
- with particular types of patient/patient population group?

What would make dealing with overseas visitors work better from the perspective of primary care? What changes, if any, would they like to see?

Are they aware of any difficulties and challenges faced in dealing with overseas visitors and migrants who present in secondary care? E.g. with respect to

- identifying chargeable patients
- charging such patients
- recovering payment

Do they think that any of these difficulties impacts upon the CCG? Prompt if not mentioned, are they at all concerned about the CCG carrying the cost of treating chargeable patients who have not been identified?

- do they think it happens – if so, on what scale?
- are they concerned about this?
- what are they doing/ might they do about it?

Response to proposed changes

Are they aware of any of the changes currently being considered by the Department of Health in relation to charging migrants and overseas visitors

- what have they heard
- what are their feelings about any of the things they have heard about?

If necessary, we will describe the main proposed changes that are likely to impact on primary care

registering with a GP practice, and creating a healthcare record (NHS Number), must allow those who will be chargeable for NHS services to be identifiable and must facilitate the sharing of this information to subsequent healthcare providers that they may be referred to any chargeable migrant or visitor should, in future, be charged for GP and other primary medical services, but not for registering with a GP practice

the practicalities of charging for primary dental services, ophthalmic services and prescription charges in community pharmacy are being considered further

emergency treatment (via A&E or GP) - will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment

processes for identifying, charging and recovering debt from referral to admission will be improved. Where appropriate, treatment will be provided only after payment has been received. Measures will be adopted to improve the collection of these payments.

We will then probe on the following points:

What services should we charge for?

Question 15: Do you agree with the continued right of any person to register for GP services, as long as their registration records their chargeable status?

Question 16: Do you agree with the principle that chargeable temporary migrants should pay for healthcare in all settings, including primary medical care provided by GPs?

Question 17: Do you have any comments or ideas on whether, and if so how, the principle of fair contribution can best be extended to the provision of prescribing, ophthalmic or dental services to visitors and other migrants?

Question 18: Should non-EEA visitors and other chargeable migrants be charged for access to emergency treatment in A&E or emergency GP settings?

Question 21: How can charging be applied for treatment provided by all other healthcare providers without expensive administration burden?

Making the system work in the NHS

Question 24: Where should initial NHS registration be located and how should it operate?

Question 25: How can charges for primary care services best be applied to those who need to pay in the future? What are the challenges for implementing a system of charging in primary care and how can these be overcome?

Question 26: Do you agree with the proposal to establish a legal gateway for information sharing to administer the charging regime? What safeguards would be needed in such a gateway?

What are your views on an arrangement whereby, rather than having to recover costs from individual chargeable patients, Trusts were paid for the costs incurred (and another body took on the recovery of those charges)?

11.3.6 Diary

Q1	Name of your Trust				
Q2	Patient ID: this is so you can identify each patient record you complete in case you need to add more details later - <u>you should delete this before sending the form back to us</u>				
Q3	Gender	<input type="checkbox"/>		female	<input type="checkbox"/>
	male				
Q4	Age	0-4 <input type="checkbox"/>	15-44 <input type="checkbox"/>	65-74 <input type="checkbox"/>	Not known <input type="checkbox"/>
		5-14 <input type="checkbox"/>	45-64 <input type="checkbox"/>	75+ <input type="checkbox"/>	
Q5	Nationality (write in: if not known write in DK)				
Q6	Date patient entered UK (write in: if not known write in DK)				
Q7	Category of migrant/overseas visitor				
	Unable to determine at this point (for example, if you are waiting for the patient to provide evidence; if this becomes available during the diary period, please up-date as appropriate)				<input type="checkbox"/>
	UK citizen/resident with indefinite leave to remain	<input type="checkbox"/>	Asylum seeker		<input type="checkbox"/>
	visiting UK	<input type="checkbox"/>	illegal immigrant		<input type="checkbox"/>
	British ex-pat: returning to reside in UK	<input type="checkbox"/>	failed asylum seeker		<input type="checkbox"/>
	student	<input type="checkbox"/>	Undocumented migrant: overstayer (visa expired)		<input type="checkbox"/>
	worker	<input type="checkbox"/>	absconder		<input type="checkbox"/>
	self-employed	<input type="checkbox"/>	applying for leave to remain		<input type="checkbox"/>
	EEA non-permanent resident/family member: job seeker	<input type="checkbox"/>	visitors from EEA (with EHIC)		<input type="checkbox"/>
	economically inactive	<input type="checkbox"/>	Visitors who fall ill unexpectedly while temporarily in UK: visitors from EEA (without EHIC)		<input type="checkbox"/>
	state pensioner in another state	<input type="checkbox"/>	visitors from other countries (with reciprocal agreement)		<input type="checkbox"/>
	Non-EEA non-permanent residents/family member: student	<input type="checkbox"/>	visitors from other countries (no reciprocal agreement)		<input type="checkbox"/>
	worker	<input type="checkbox"/>	Visitors who 'fly in' and 'fly out' (i.e. as far as you can tell, they have come to the UK with an existing condition with the intention of accessing NHS services)		<input type="checkbox"/>
	self-employed	<input type="checkbox"/>			
	resident on another basis	<input type="checkbox"/>			
	Something else (tick here and write in brief description below)				<input type="checkbox"/>

Q8 As far as you are able to tell, would you classify the patient as

Ordinarily resident in the UK

Exempt from charging

Chargeable

Unable to determine at this point (for example, if you are waiting for the patient to provide evidence; if this becomes available during the diary period, please up-date as appropriate)

Q9 Pathway into the trust

A&E (discharged from A&E) In-patient (via A&E) Outpatient (via A&E)

Other (tick here and write in below) In-patient (elective) Outpatient (elective)

Q10 Which services does the patient require? Please choose from the following list; if the service is not included, please tick 'other' and write in a brief description in the box below

A&E <input type="checkbox"/>	Geriatric medicine <input type="checkbox"/>	Pain management <input type="checkbox"/>
Cardiology <input type="checkbox"/>	Gynaecology <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>
Cardiothoracic surgery <input type="checkbox"/>	Haematology <input type="checkbox"/>	Plastic surgery <input type="checkbox"/>
Children's & Adolescent <input type="checkbox"/>	Hepatology <input type="checkbox"/>	Respiratory medicine <input type="checkbox"/>
Dentistry & Orthodontics <input type="checkbox"/>	HIV <input type="checkbox"/>	Rheumatology <input type="checkbox"/>
Dermatology <input type="checkbox"/>	Infectious disease <input type="checkbox"/>	Sexual health <input type="checkbox"/>
Diabetic Medicine <input type="checkbox"/>	Maternity <input type="checkbox"/>	Sleep medicine <input type="checkbox"/>
Diagnostic Endoscopy <input type="checkbox"/>	Minor injuries <input type="checkbox"/>	Stroke services <input type="checkbox"/>
Diagnostic Imaging <input type="checkbox"/>	Nephrology/dialysis <input type="checkbox"/>	Surgery (breast) <input type="checkbox"/>
Diagnostic Physiological Measurement <input type="checkbox"/>	Neurology <input type="checkbox"/>	Surgery (vascular) <input type="checkbox"/>
Ear, Nose and Throat <input type="checkbox"/>	Neurosurgery <input type="checkbox"/>	Trauma services <input type="checkbox"/>
Endocrinology & Metabolic Medicine <input type="checkbox"/>	Obstetrics <input type="checkbox"/>	Urology <input type="checkbox"/>
Family Planning services <input type="checkbox"/>	Oncology <input type="checkbox"/>	Vascular services <input type="checkbox"/>
Gastrointestinal & Liver services <input type="checkbox"/>	Ophthalmology <input type="checkbox"/>	Wound care <input type="checkbox"/>
General Medicine <input type="checkbox"/>	Oral and Maxillofacial surgery <input type="checkbox"/>	Other (tick here and write in brief description below) <input type="checkbox"/>
General surgery <input type="checkbox"/>	Orthopaedics <input type="checkbox"/>	
Genito-urinary medicine <input type="checkbox"/>	Paediatrics <input type="checkbox"/>	

11.4 Approach to Analysis

All the interviews and discussions were recorded (subject to respondents' consent), and the recordings were transcribed. Working directly from the transcripts (and referring back to the recordings if necessary), each researcher wrote up a set of detailed notes based on the sessions he/she had conducted to identify the key themes and issues emerging. There was also a constant interchange between the four members of the

research team which ensured any new and emerging themes were shared. Separate sets of notes were prepared for each scoping study interview. For the case studies, a single set of notes was prepared for each Trust, with contributions from different respondents colour coded to ensure each respondent's contribution was clear. In the case of the Primary Care Practices, a single set of notes was prepared for each pair of practices; these were also colour coded to ensure the contribution from different sessions and each Practice was identified. The production of the notes was an iterative process, so that themes that emerged from later sessions were built into the notes and, where appropriate, early sessions were re-visited to establish whether the same issues were apparent. The researchers incorporated a large number of verbatim quotes in order that key issues were illustrated wherever possible in respondents' own words.

The research team then exchanged their individual analyses and considered where they had identified the same or similar themes, together with points of difference. The team then came together to discuss and explore their collective findings and interpretation of these. The aim here was to make sure all the themes, and the extent to which these were held across different parts of the sample, were identified. These internal debriefing sessions took place after both the scoping and the case study strands of work.

The two lead researchers then prepared a presentation of the key findings which was shared with DH. Following feedback on this, the report was written.