Department of Health

Visitor & Migrant NHS Cost Recovery Programme

Implementation Plan 2014–16

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Visitor & Migrant NHS Cost Recovery Programme

Implementation Plan 2014–16

Prepared by Visitor and Migrant NHS Cost Recovery Programme

This implementation plan sets out a structured timeline for how the NHS Visitor and Migrant Cost Recovery Programme will be rolled out over the next two years. It is intended to give the NHS and health partners a clear idea of the timeline and sequencing for building on existing systems and developing the new systems. It does not provide detail of the decisions that have yet to be made.

Alongside this document we are publishing an impact assessment which sets out a cost benefit analysis of the current options.

In developing this plan we have engaged with a wide range of stakeholders from within the NHS and elsewhere. These include:

- NHS hospitals and secondary care providers
- Hospital managers and administrators
- Hospital doctors
- Nurses and midwives
- GPs
- Primary care administrative staff
- Pharmacists
- Dentists
- Opticians
- Patient organisations
- Migrant representative organisations
- Homeless organisations
- Organisations supporting other vulnerable groups
- Professional bodies
- Health regulators
- NHS England
- Public Health England

Contents

Executive summary

1. The Department of Health is working to improve the systems for charging overseas visitors and migrants for their NHS healthcare in England and increase the extent of the services for which they can be charged. The principle that the NHS is free at the point of delivery for residents will not be undermined by this work. We aim to support and reinforce the principle of fairness by ensuring that everyone who can should contribute to the cost of the NHS.

2. The Visitor and Migrant NHS Cost Recovery Programme ("the programme") builds on the Government's consultation response (published in December 2013) and Implementation Outline (published in January 2014) about how the NHS currently manages charging overseas visitors and migrants. The programme's overarching objective is to improve cost recovery and ensure that the NHS receives a fair contribution for the cost of the healthcare it provides to non-UK residents; as is the case in comparable health systems.

3. The work is being led by the Visitor and Migrant Cost Recovery Team in the Department of Health ("the Department") but the programme is being co-produced with delivery partners in the NHS, the Health and Social Care Information Centre (HSCIC), the Home Office and the Department of Work and Pensions. Sir Keith Pearson is the Department's independent adviser to the programme and chairs the NHS Reference Group which provides external strategic leadership to the implementation programme.

4. The primary audience for this plan is the NHS. It explains how the different groups and organisations will be affected by the changes.

5. This implementation plan sets out the envisaged progress of the programme over two financial years. It provides a proposed timeline and information on sequencing, but not on the detail of the delivery of the pieces of work or on the decisions that have yet to be made.

6. The detail of the implementation plan is set out in two chapters based on the years when development and delivery will take place:

   - Year one: financial year 2014/15
   - Year two: financial year 2015/16

7. Over the second year of the programme (2015/16) the expectation is that the delivery of the programme will handover to the NHS and relevant Arm's Length Bodies (ALBs).

8. The cost recovery programme focuses on two principle charging mechanisms. The first is the ability of the NHS to recover the costs of healthcare provided to European Economic Area (EEA) patients (non-resident in the UK) from their home member state.

This is through the European Health Insurance Card (EHIC) system as well as the S1 and S2 agreements. The second is the statutory requirement of NHS provider trusts to charge (as per the Charging Regulations) patients from non-EEA countries directly. The vast majority of these patients will be visitors from non-EEA countries with whom the UK does not hold reciprocal agreements.

9. The programme has split the delivery into four main phases of work and this is reflected in the chapter structures:

- Phase 1: Improving the existing systems

  Addressing the confusion and inconsistency across the current system and helping the NHS get better at collecting the money due to it by:

  – improving existing systems and designing new solutions;

  – developing and delivering financial incentives;

  – encouraging the sharing of best practice from exemplar trusts.

- Phase 2: Aiding better identification of chargeable patients

  Working with delivery partners to make change to our existing identity verification mechanisms and registration processes in primary and secondary care, to allow for better identification of potentially chargeable individuals. This will reduce the burden on staff and improve cost recovery from visitors and migrants

- Phase 3: Implementing the migrant health surcharge

  Delivering legislative change to the National Health Service (Charges to Overseas Visitors) Regulations 2011 to support the introduction of the surcharge (as per the Immigration Act 2014) and possible amendment of existing exemptions and charging provisions; supporting the NHS in the preparations for the rollout of any legislation.

- Phase 4: Extension of the current charging

  Reviewing current charging rules and extending the scope of charging in secondary care and also to non-NHS providers of NHS care; introducing charging for primary medical services (with the exception of GP and nurse consultations) and other primary care services such as pharmacy, optics and dentistry.

10. In each delivery chapter and for each phase this document outlines the key deliverables and the steps taken to achieve these. It also aims to identify where specific areas of work impact on services and staff.

11. This implementation plan is published alongside an impact assessment which sets out a cost benefit analysis of the options for the current work in secondary care in phases 1-3. The programme aims to support this with an additional impact assessment in year two which will cover extensions of charging.

12. During year one the programme focuses on changes and improvements to the processes and the support that is available for cost recovery. This includes development of financial incentives for identification and recovery of cost from visitors

and migrants. The initial development of an NHS IT solution for identifying those who have paid the surcharge will continue throughout this period. Ensuring staff in the NHS are prepared for the changes delivered by the programme will also be a priority.

13. The second year of the programme will focus on consolidating and evaluating the gains of year one as well as shifting towards a clearer delivery programme for extensions to charging.

14. The income from the new health surcharge and increased levels of EEA reporting will be reinvested in NHS frontline services via allocations to commissioners. The income generated by individual providers when recovering costs from non-EEA chargeable patients will be reinvested by the organisations themselves.

15. Where decisions are yet to be made, particularly around any extensions of charging, we will aim to publish further information and guidance in due course as part of the programme's ongoing communication and engagement commitments.

16. As part of policy development, the programme has taken account of the public sector equality duty in the Equality Act 2010 and the Secretary of State's duties under the National Health Service Act 2006, including the duty to have regard to reduce health inequalities as set out in the Health and Social Care Act 2012. We have and will continue to work closely with vulnerable groups' representatives to understand and manage the impact of the programme on equalities, health inequalities and vulnerable groups.

17. Effective communications are essential in ensuring that the objectives of the programme are delivered. The ongoing communications of the programme provide an opportunity to address any misconceptions around the consultation and the response, to reduce concerns and to set out mitigating actions. We will be working with health partners across the system to work with the many different groups affected by, and integral to, these changes.

Key actions in year one

- Develop and launch the EEA financial incentive to encourage and support EHIC information collection and submission;
- Develop and prepare to launch the non-EEA financial incentive and sanction to encourage and support identification and charging of non-EEA patients;
- Raising awareness and understanding of the existing responsibilities of the NHS and the changes over the next two years;
- Launch of the toolbox of standardised documentation and support information;
- Develop and prepare NHS IT systems to support the rollout of the surcharge and better identification processes;
- Pilot recovering costs for treating EEA visitors and migrants in A&E and develop strategy for national rollout through the EHIC mechanism;

- Introduce legislation to support the implementation of the surcharge for non-EEA temporary migrants;
- Launch of the National Intensive Support Team to promote and develop best practice for recovering costs in trusts.

A note on immediately necessary and urgent treatment

NHS providers have a statutory obligation to make and recover charges from patients who are deemed chargeable under legislation. However, providers also have human rights obligations, meaning that treatment which is considered by clinicians to be **immediately necessary (which includes all maternity treatment)** must never be withheld from chargeable patients, even if they have not paid in advance. Failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998.

Treatment which is not immediately necessary, but is nevertheless classed as **urgent** by clinicians, since it cannot wait until the overseas visitor can return home, should also be provided, even if payment or a deposit has not been secured. Providers are nonetheless strongly encouraged to obtain a deposit ahead of treatment deemed urgent if circumstances allow. However, if that proves unsuccessful, the treatment should not be delayed or withheld for the purposes of securing payment.

Non-urgent treatment should not be provided unless the estimated full charge is received in advance of treatment.

Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and should be applied. Providers should take a pragmatic approach as to the most appropriate time to discuss financial arrangements with the patient.

The Department's *Guidance on Implementing the Overseas Visitor Hospital Charging Regulations* includes assistance to providers on what constitutes immediately necessary, urgent and non-urgent treatment and how this must be determined by clinicians only.

Chapter 1: Introduction

18. The Department of Health ("the Department") is working to improve systems for identifying and charging overseas visitors and migrants who use the NHS and increasing the extent of the services for which we can charge those not eligible for free care in England.

19. The proposed changes set out in the Government's consultation response in December 2013 do not seek to undermine the principle that the NHS is, and will remain, free at the point of delivery for our residents. They are being introduced because the Government believes that the NHS can no longer afford to be so open and generous to non-permanent residents and to make a reality of the belief that everyone should make a fair contribution to the cost of their healthcare; as is the case in comparable health systems.

20. The primary audience for this document is the NHS in England. It aims to ensure that each part of the NHS understands the different stages and impacts of the programme. We have also set out the changes for visitors, migrants and where relevant patients. This plan clarifies how the different groups and organisations will be affected, how they will hear about the changes, and what the expectations are of them.

21. This programme of work, though led by the Department of Health, is being co-produced with delivery partners in NHS England and the wider NHS, the Health and Social Care Information Centre (HSCIC), the Home Office and the Department for Work and Pensions (DWP).

22. The NHS Cost Recovery Team is leading this programme within the Department, headed by the Director for Cost Recovery. The team is working with a wide range of stakeholders including frontline NHS staff such as GPs and hospital-based overseas visitor managers (OVMs); migrant representative groups; professional bodies; and the voluntary sector to improve the identification, registration and cost recovery processes in the current and future systems.

23. Senior leadership will be crucial to deliver the changes effectively; Sir Keith Pearson is the independent adviser to the programme and chairs the NHS External Reference Group which provides strategic leadership to the implementation programme.

24. The plans have taken into account concerns regarding public health and vulnerable groups. By retaining free GP and nurse consultations we have recognised the importance of unrestricted access to early and prompt diagnosis and intervention in the health interests of both public and patient health. There is further work underway to consider the impact of the changes on vulnerable groups.

25. To deliver the improvements effectively and with minimal disruption to services, we need a clear understanding of the process required from now until the new system is in place and operational. This implementation plan starts to set this process out and explains how, together with health partners, we will build on existing systems and optimise the rates of NHS cost recovery from chargeable patients.

26. Where decisions are yet to be made, particularly around any extensions of charging, we will aim to publish further information and guidance in due course as part of the programme's ongoing communication and engagement commitments.

27. To set the plan out as simply as possible, this document includes sections covering two years of work: financial years 2014/15 and 2015/16.

28. The programme is subdivided into four main phases of work, these are:

    - Phase 1: Improving the existing systems
    - Phase 2: Aiding better identification of chargeable patients
    - Phase 3: Implementing the migrant health surcharge
    - Phase 4: Extending charging

29. For each phase, we have identified the key stakeholders, what they should expect in terms of changes and what is expected of them to deliver those changes.

30. We recognise this programme is complex and multifaceted, and that it will take time and some initial investment to maximise cost recovery. However, we believe that everyone involved in the NHS has a responsibility towards the management of its resources, financial and other. Article 6 of the NHS Constitution[1] articulates this well, it states that '*the NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources*' and is clear that NHS staff should protect vital services from misuse. The inclusion of the work of this programme in The Mandate to NHS England[2], when it was updated in 2013, was intended by the Secretary of State to send an unambiguous message to the entire NHS that we must all recognise our responsibilities to safeguard the system and its budgets.

31. This implementation plan is published alongside an impact assessment of the options which have been developed so far in secondary care. This document includes a cost benefit analysis of the recommended options outlined in this implementation plan for phases 1, 2 and 3. The programme aims to support this with an additional impact assessment in year two which will cover extensions of charging.

1 www.gov.uk/government/publications/the-nhs-constitution-for-england

2 The Mandate: a mandate from the Government to the NHS Commissioning Board from April 2013 to March 2015 www.gov.uk/government/publications/the-nhs-mandate

Chapter 2: Background

Context

32. The UK is globally connected, with historical ties, economic activities and cultural attractions which bring people here from all over the world. Independent research[3] estimates that on any one day there is the equivalent of 2.5m overseas visitors and migrants present in England (averaged across the whole year). With such a significant transient non-resident population, the Government is concerned that the advantages of benefits and public services should be targeted at UK residents and those with a long-term relationship with the UK.

33. In terms of healthcare, there is concern that the NHS is overly generous to overseas visitors and temporary migrants. The UK currently allows people who are living here temporarily to use the NHS for free and also exempts many visitors from charge. Failures to identify and charge visitors and migrants allow those who are not entitled to receive care without charge. The Government believes that this needs to change and that those visitors and migrants who are here in the short term and use the NHS should make a fair contribution to the costs of the care they receive.

34. It is also clear from the evidence that the NHS struggles to identify and recover the cost from those not entitled to free treatment. This causes NHS resources, both financial and clinical, to be used to treat and care for people who are chargeable but may not be contributing to the UK economy.

35. It is important to note that patients who are chargeable under the Charging Regulations[4] should not be confused with private patients who are in the country specifically for planned elective care (for which they pay at rates determined by the private provider), rather than care that is required unexpectedly whilst in the UK.

36. While the majority of visitors and migrants make only occasional and necessary use of the NHS, the system also attracts a small but still significant number of 'health tourists'; people who have travelled here with an intention of obtaining free healthcare to which they are not entitled. It is this category of direct and deliberate abuse that is, by its nature, hardest to quantify because they are likely to make efforts to conceal their true eligibility status.

37. Underpinning the proposed changes is a commitment to provide immediately necessary and urgent treatment, even if payment is not received in full in advance from chargeable patients. Anyone in genuine need will be able to receive treatment, but we

3 www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

4 www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations

will be working with the NHS to ensure that where people are not entitled to free NHS care, every effort is made to recover the charges.

Evidence

38. To support this development work, the Department commissioned and published two independent studies of how widely migrants use the NHS[5]. These reports provide evidence of the significant financial costs to the NHS and pressures on staff in the current system.

39. In addition to the commissioned research we published an equality analysis with the consultation response. This built on a comprehensive literature review to identify any adverse or unjustifiable impacts on groups with particular protected characteristics[6] in comparison with the rest of the overseas visitor and migrant population.

40. It also considered the impact on vulnerable resident groups and confirmed that the changes could further disenfranchise some groups. We have ensured that the engagement programme works with organisations representing these groups to better understand the impact and identify possible mitigating actions.

Consultation and response

41. Over the summer of 2013, the Department undertook a public consultation on visitor and migrant use of the NHS in England. The consultation looked at how the system might be changed to ensure that it is fairer to the UK taxpayer, by ensuring that those who do not live here permanently contribute towards the cost of the care they receive from the NHS. The Home Office undertook a linked consultation over the same period on UK-wide proposals to regulate migrant access to the NHS including the new mandatory health surcharge for temporary migrants from outside the European Economic Area (non-EEA).

42. The consultation response was published in December 2013[7]. This set out initial decisions and next steps, which are summarised in the table below:

Improving the system	Central Government	Will be getting better at identifying EEA patients' use of the NHS and recovering the money we can legitimately claim back from other EEA member states.
	The Department of Health & the NHS	Will be working on the current system to improve identification, registration and cost recovery from currently chargeable patients. Developing a package of support tools and realigning incentives.

5 www.gov.uk/government/publications/overseas-visitors-and-migrant-use-of-the-nhs-extent-and-costs

6 As defined in the Equality Act 2010.

7 https://www.gov.uk/government/consultations/migrants-and-overseas-visitors-use-of-the-nhs

Who will be charged?	Non-EEA temporary migrants (including students and workers)	Will be expected to pay a health surcharge as part of the visa process, unless they are exempted. This will mean they are entitled to use the NHS, as an ordinarily resident patient would, whilst they have valid leave to remain (usually between 6 months to 5 years).
	Non-EEA visitors	Those in England for less than 6 months continue to be chargeable (unless covered by a country specific reciprocal agreement or other exemption) but will be more likely to be identified and charged.
	Expatriates	Under current rules, expatriates are normally chargeable for NHS care (or should use EHIC/S2 mechanisms if residing in another EEA country) on the grounds that they are not ordinarily resident in the UK. However, the Government is considering whether to exempt from charges expatriates who have made significant National Insurance contributions in the past. No final decision on this has been taken.
	Vulnerable groups who are not currently exempt	We are considering strengthening exemptions, or other ways of ensuring necessary treatment is provided, for victims of domestic violence, human trafficking and vulnerable children.
	People who are here illegally	Will continue to be chargeable, as they are now.
What services are currently free for everyone but will be chargeable for visitors?	NHS hospitals	Will be considering introducing charges for A&E care, outside EHIC collection (without compromising rapid access to emergency care for those in immediate or urgent need).
	NHS services outside NHS hospitals	Will be considering extending charges to the majority of NHS services including community services, dentistry, optics and pharmacy. Extending current charges to treatment provided by all commissioned providers of NHS services.
Services exempt from charging	GP and nurse consultations in primary care	Will remain free, ensuring everyone will continue to have access to prevent risks to public health such as HIV, tuberculosis (TB) and sexually transmitted infections.

Chapter 3: Programme objective & outcomes

43. The overarching objective of the programme is to improve NHS cost recovery from visitors and temporary migrants in England (who are not entitled to NHS care that is free at the point of delivery) and to ensure that the NHS receives a fair contribution for the cost of the healthcare it provides. To do this the programme will:

    - Aim to maximise recovery from EEA and non-EEA visitors and migrants and from the EEA member states, through short and long term projects;
    - Improve the efficiency of the system overall, delivering additional benefits for staff e.g. reducing the work to establish chargeable status and where individuals are deterred from unnecessary use, reducing pressure on services;
    - Take account of the Secretary of State's statutory duties including the duty to have regard to the need to reduce health inequalities and maintain access to public health services; and
    - Be implemented in phases from now until 2015/16 with ongoing recovery growth towards the middle of the next Parliament.

44. The ambition is to recover £500m annually from improving identification and recovery from chargeable patients and from health surcharge income. This will be invested into the NHS. The ambition is to achieve this by the middle of the next Parliament.

45. The £500m will be made up of £200m a year from health surcharge income, £200m a year from better identification of EEA patients and recharging to their home countries, and £100m from better identification and recovery directly from non-EEA patients. It is a significant improvement on the baseline of £73m recovered in 2012/13.

46. This is a rightly ambitious trajectory progressively increasing the income recovered, and will require combined action from partners across the health and immigration systems. The accompanying impact assessment covers the details of the costs and benefits of the first three phases of the programme.

Financial flows and incentives

47. Key to improving the existing system (phase 1) is the removal of the disincentives (or perverse incentives) that exist in the current system and act as a barrier to the identification and invoicing of chargeable patients. Over the last few months, the Department has been working with its ALBs, the NHS Reference Group and senior finance colleagues working in the NHS to design and test measures to encourage

providers to identify and charge non-EEA visitors and identify and report EEA visitors' usage of their services.

48. The incentives (described in more detail in chapter 4) will, for the first time, compensate NHS providers for the administrative tasks they undertake when reporting EEA activity. They will also partially underwrite the financial risk that providers take on when identifying and invoicing a directly chargeable (typically non-EEA) patient. In parallel, there will also be increased scrutiny of the cost recovery efforts of providers to ensure that their statutory obligation to support NHS sustainability through appropriate identification and charging of visitors and migrants is being met.

49. The income from the new health surcharge and increased levels of EEA reporting will be reinvested in NHS frontline services via allocations to commissioners. The income generated by individual providers when recovering costs from non-EEA chargeable patients will be reinvested by the organisations themselves. Both mechanisms represent key contributions to the sustainability of the NHS in England.

Communications

50. Communications are essential to ensuring that the objectives of the programme are delivered through each of the phases. We have engaged with a wide range of stakeholders from within the NHS and elsewhere. These include:

- NHS hospitals and secondary care providers
- Hospital managers and administrators
- Hospital doctors, nurses and midwives
- GPs
- Primary care administrative staff
- Pharmacists
- Dentists
- Opticians
- Patient organisations
- Migrant representative organisations
- Homeless organisations
- Organisations supporting other vulnerable groups
- Professional bodies
- Health regulators
- NHS England
- Public Health England

51. This is a complex programme of work, and offers a particular opportunity to address the myths around the consultation and the response. Examples are the expectation that NHS clinical staff will act as border guards, or that the new registration system will provide information to the Home Office on the whereabouts or care of illegal migrants. We recognise the vital role effective communication will play in addressing these and other concerns (e.g. around public health), and setting out mitigating actions.

52. In particular we need to ensure that those who are responsible for delivering the changes understand what is expected of them, what will be available to support them, and when they will need to make the changes. We will be working with health partners across the system to engage and communicate with the many different groups affected by, and integral to, these changes.

The geographical reach of the cost recovery programme

53. Within this document, we refer to both England and the UK. Whenever one or other of these terms appears, the choice has been made deliberately, based on the specific context. Health is a devolved matter, and as such, the Secretary of State for Health has jurisdiction over the NHS in England only. Consequently, **this document is primarily intended for frontline staff working in the NHS in *England***, although NHS staff in Wales, Scotland and Northern Ireland may find it useful to be aware of the similarities and differences in charging policies across the administrations. However, **for certain European and international health policies,** it is the **Department that acts on behalf of the whole of the *United Kingdom***.

54. For EEA matters, the Department manages both the 'outward' payments to other EEA member states that have provided healthcare to UK citizens abroad (whether they come from or reside in England, Wales, Scotland or Northern Ireland) and the issuing of invoices to EEA member states for the recovery of costs of healthcare provided by NHS providers in any of the four administrations. As such, we are working with colleagues across the whole of the UK to increase identification and reporting of healthcare provided by the NHS to patients from the EEA under the EHIC, S1 and S2 mechanisms.

55. Reciprocal or waiver agreements that the UK holds with countries outside the EEA are also managed centrally by the Department and negotiated by the UK Government on behalf of all four nations. If and when we seek to renegotiate any of these arrangements, we will inform our colleagues in the devolved administrations.

56. The introduction of the health surcharge is being managed by the Home Office. The Health Surcharge was introduced as part of the Immigration Act (2014). As immigration matters are not devolved, the UK Government will oversee the introduction of the health surcharge on behalf of all four home nations. The NHS in all four nations will benefit from this new revenue stream.

57. The new NHS registration process being developed as part of the cost recovery programme affects the NHS in England only. As such, if an overseas visitor or migrant seeks to access NHS healthcare in one of the devolved administrations, he or she may be subject to different arrangements. The Health and Social Care Information Centre

(HSCIC) only manages the generation and maintenance of NHS records for patients resident in England.

Monitoring and evaluation

58. Currently, the NHS is unable to provide an accurate assessment of its performance in recovering payments from those overseas visitor and migrant patients who are chargeable for their treatment. As such, in partnership with Monitor and the Trust Development Authority, we will be introducing the collection of the following key metrics by NHS providers:

    - Invoiced income
    - Actual cash recovered
    - Bad debt provision
    - Written-off debt

59. This new collection of data will allow the Department and the NHS to monitor in-year quarterly forecasts and hold annual audited accounts of the actual cash recovered by trusts from chargeable overseas visitors and migrants. For the first time, the NHS will be able to measure how well it is recovering the amounts that it is owed.

60. We will undertake a full evaluation of the cost recovery programme whilst it is operating and after its transfer from Department. A formative evaluation will take place during the next two years, while the four phases are being implemented. It will drive programme learning about the success of each aspect to support more effective delivery during the remaining time. A post-implementation evaluation will be undertaken to understand the extent to which the programme's objectives have been achieved and whether the costs and benefits are in line with expectations.

61. We will measure staff and stakeholder attitudes, behaviours and knowledge on the programme and its objectives and how these effect implementation and delivery, providing a baseline and regular updates which will feed into the overall evaluation.

62. The changes outlined in this implementation plan will enable more robust data collection and information about visitors and migrants use and cost of NHS healthcare services in the England. This should provide a better understanding of the geographical distribution of the demands which visitors and migrants make on different parts of the NHS and therefore enabling us to target our actions and efforts accordingly.

Ensuring immediately necessary and urgent treatment is never denied

63. NHS providers have a statutory obligation to make and recover charges from patients who are deemed chargeable under legislation. However, providers also have human rights obligations, meaning that treatment which is considered by clinicians to be **immediately necessary** (including all maternity treatment) must never be withheld from chargeable patients, even if they have not paid in advance. Failure to provide immediately necessary treatment may be unlawful under the Human Rights Act 1998.

64. Treatment which is not immediately necessary, but is nevertheless classed as **urgent** by clinicians, since it cannot wait until the overseas visitor can return home, should also be provided, even if payment or a deposit has not been secured. Providers are however strongly encouraged to obtain a deposit ahead of treatment deemed urgent if circumstances allow.

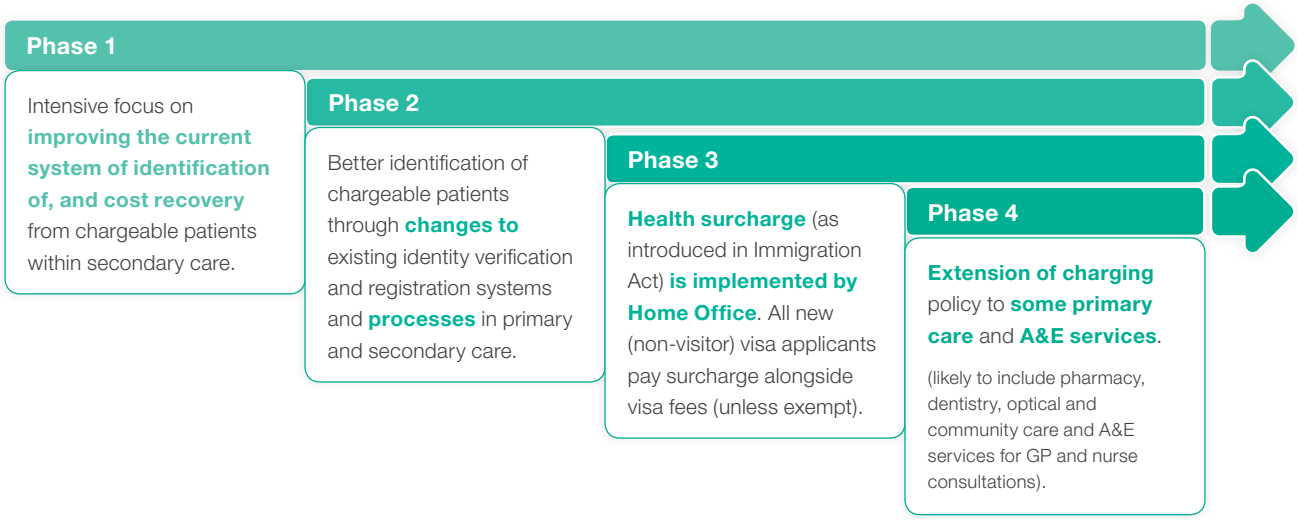
65. **Non-urgent treatment** should not be provided unless the estimated full charge is received in advance of treatment.

66. Treatment is not made free of charge by virtue of being provided on an immediately necessary or urgent basis. Charges found to apply cannot be waived and should be applied. Providers should take a pragmatic approach as to the most appropriate time to discuss financial arrangements with the patient.

67. The Department's *Guidance on Implementing the Overseas Visitor Hospital Charging Regulations* includes assistance to providers on what constitutes immediately necessary, urgent and non-urgent treatment and how this must be determined by clinicians only.

Chapter 4: A phased approach

68. In the implementation outline we set out our intention to divide the work into four phases. These phases and the issues they address are illustrated in the diagram below:



Phase 1: Improving the system

69. The responses to the Department's public consultation and the results of the independent qualitative research showed that there is much confusion and inconsistency across the NHS in terms of who should be charged for healthcare and how this should be done. The qualitative research also highlighted the frustration of clinical staff and others with the existing systems and processes for identification, charging and reporting. NHS hospitals already have a statutory duty to apply the charging regulations, and there are many dedicated individuals and trusts striving to meet this duty. However, the qualitative and quantitative evidence shows that numerous NHS providers are not as successful.

70. Phase 1 of the programme focuses on improving existing cost recovery systems and processes to make it easier for NHS frontline staff to integrate this as part of their "day job". This includes assistance to and facilitation of peer support networks, the provision of a peer-reviewed "toolbox" to share good practice and the deployment of a National Intensive Support Team designed to support both providers and their commissioners to recover money owed to the NHS for healthcare provided to chargeable visitors and migrants.

71. The UK has a number of reciprocal healthcare agreements with a range of countries; the most substantial of these is with the European Economic Area (EEA). The

consultation responses showed widespread support for improving cost recovery from other EEA member states through the European Health Insurance Card (EHIC) scheme and other arrangements including the S1 (for state pensioners) and S2 (for planned treatment) mechanisms.

72. Cost recovery through these mechanisms is poor because the NHS struggles to identify patients holding EHICs and other European forms. Consequently, the UK is unable to invoice the appropriate member state for the costs of treatment. Phase 1 seeks to improve the rates of identification and reporting of EEA patient details (non-clinical) via the existent online portal.

Financial Incentives

73. In phase 1, we have already begun looking at how money currently flows around the NHS and whether that affects the low identification and cost recovery rates for healthcare provided to both EEA and non-EEA patients. Commissioners and providers have told us very clearly that the current money flows and distribution of financial risk does not incentivise providers to recover costs and – in some cases – actively discourages providers to undertake their statutory obligations.

74. The Department therefore intends to introduce measures to rebalance the risks associated with cost recovery by providing financial incentives and support mechanisms to NHS providers. Alongside this, providers should expect to be held to account through increased scrutiny of invoicing, transparency of identification, reporting and recovery rates and the introduction of financial sanctions. This is to ensure that providers support long-term NHS sustainability in abiding by their statutory charging obligations.

75. There are two elements to cost recovery:

    a. State-to-state billing: the UK Government invoices EEA member states for the healthcare the NHS has provided to EEA citizens who are covered by their home country's state health insurance systems under arrangements including EHIC, S1 and S2. This can only be done when NHS providers submit patient demographic and treatment cost information about relevant patients.

    b. Direct charging: an NHS provider invoices the individual, chargeable patient (predominantly non-EEA but also EEA visitors who are uninsured in their home country).

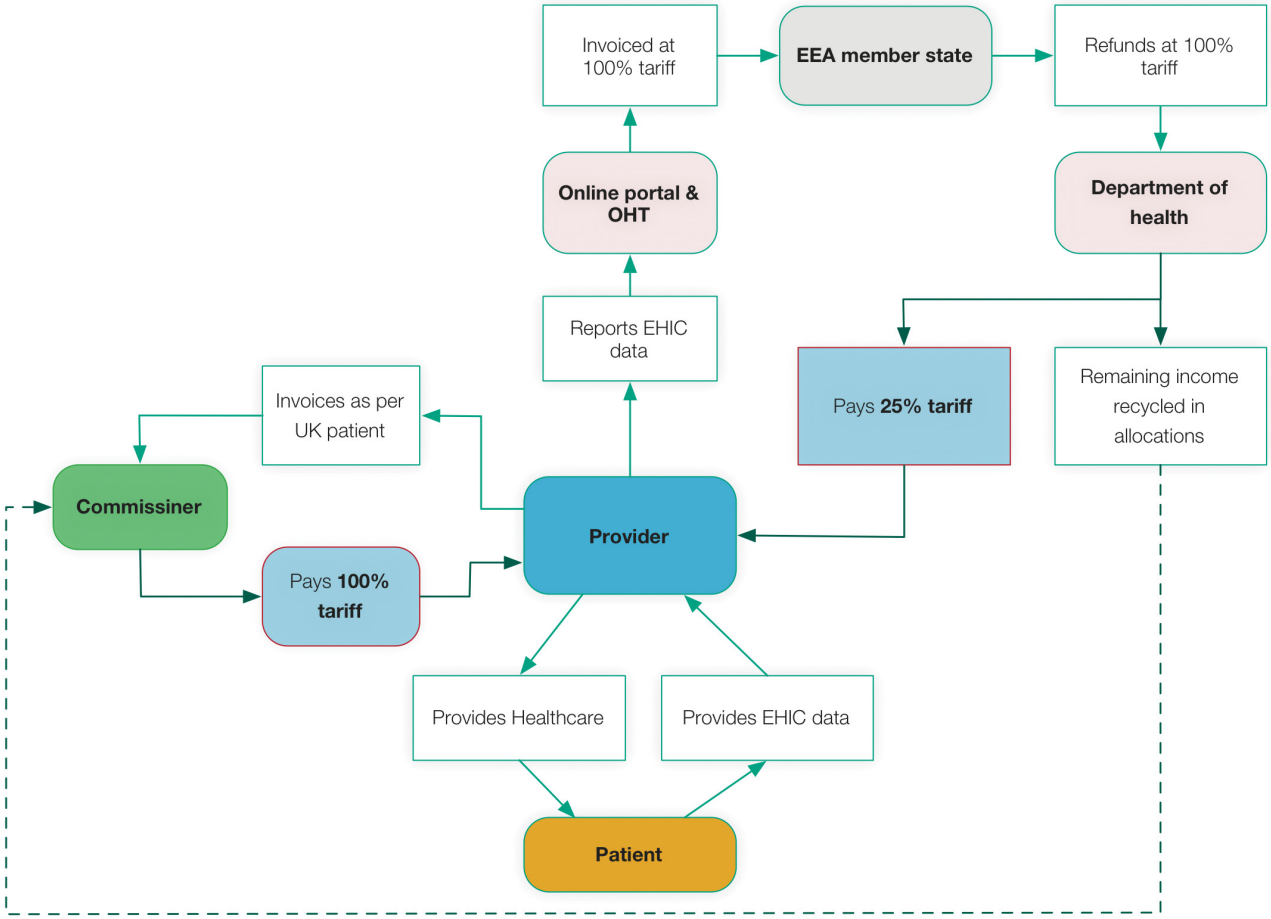
EEA incentive

76. Under the current system, although providers are expected to collect the necessary demographic and administrative information for EEA patients, we recognise that they are not currently compensated for this additional clerical function. Furthermore, although the benefits of reporting EEA activity are significant to the NHS, individual providers do see direct benefit to invest in administrative resources for reporting.

77. The Department is committed to changing this behaviour and we will be introducing from autumn 2014 a substantial financial incentive designed to increase the new behaviours which this programme depends upon. The incentive will focus on reporting

of European Health Insurance Card (EHIC) information. S1 and S2 reporting will not initially be linked to financial incentives although we will keep this under review.

78. From the autumn 2014, for every valid entry an NHS provider makes on the Overseas Healthcare Team (OHT) online portal concerning care provided to an EEA patient who is non-resident in the UK, the provider will receive a payment worth 25% of the current tariff rates for the cost of care provided. This is in addition to the payment they receive from their commissioner for the cost of the treatment (i.e. 100% of tariff). The mechanism will work as follows:



79. The financial incentive will be delivered to support and encourage trusts to identify and record the patient's details through the EHIC portal. Its overall objective will be to enable the UK to recover a higher percentage of the costs of the healthcare provided to non-resident EEA patients. We expect that the additional revenue raised from EEA states through the increase in identification rates will more than offset the cost of the incentive. Our analysis, as published in the Impact Assessment, estimates that the EEA financial incentive could enable an additional recovery of £12m by the end of 2015/16. However, this may not be realised in cash terms until a year later due to the time lag in receiving payments from EEA member states.

80. The incentive will be valid for treatment provided by an NHS secondary care trust to EHIC holders after the launch date of the scheme. It will not be paid on retrospective reporting for healthcare provided to patients prior to this date. The scheme will be

reviewed again after 12 months to ensure it is having the expected results. We will look to reduce the percentage of the incentive in future years – once reporting has become the norm rather than the exception – to a level that covers the actual administrative costs.

EHIC pilot in Accident and Emergency (A&E) settings

81. The rules of the European Health Insurance scheme allows the UK to recover the costs of healthcare provided to EHIC holders in A&E, urgent care centres and minor injury units. Until now, reporting rates in these settings has been very low due to practical constraints. Therefore, alongside the introduction of the EEA incentive scheme in secondary care, we will be conducting a trial in a number of A&E settings around the country to assess the feasibility of collecting EHIC information as part of the registration process when patients arrive.

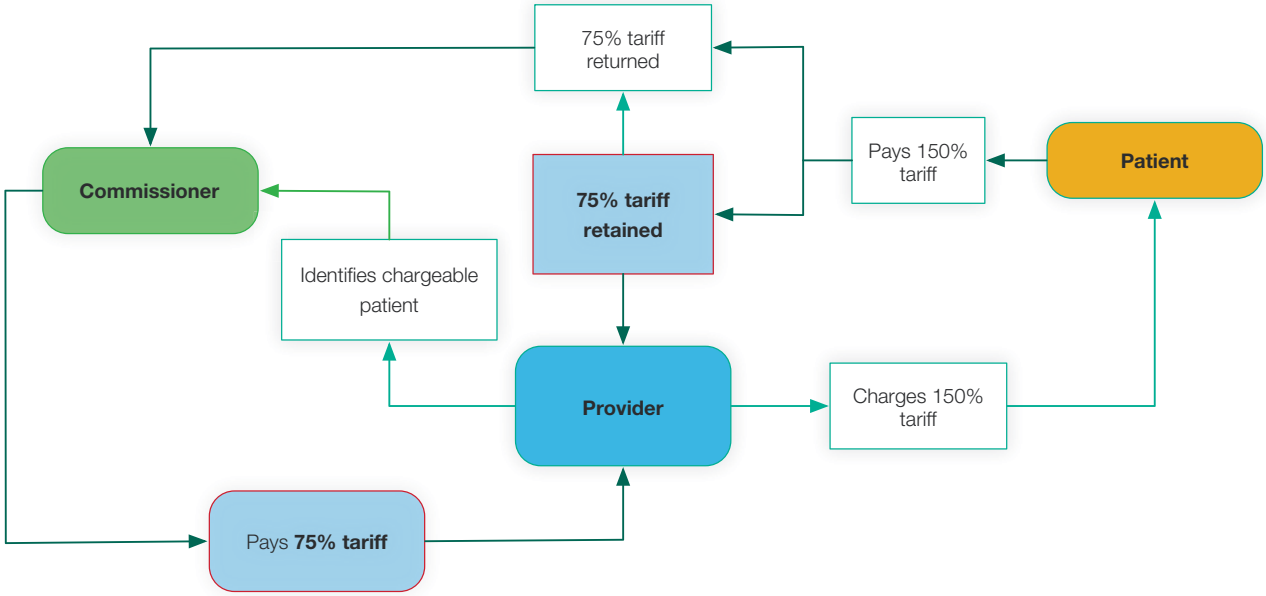
82. This pilot will allow us to work closely with providers to determine how we can support this function to improve overall cost recovery whilst minimising any additional administrative burden. This pilot does *not* represent an extension of charging to the patient for emergency care in A&E as this is not subject to charging regulations.

Non-EEA incentive

83. We recognise the current NHS payment flows present an active disincentive for providers to identify and seek to recover costs from chargeable, non-EEA patients. When providers identify an individual as chargeable, the full financial risk burden for recovering the debt sits with the trust. If providers – intentionally or otherwise – avoid identifying patients as chargeable, the costs of healthcare continue to be borne in full by the commissioner.

84. To support the recovery of costs from chargeable non-EEA visitors and migrants (i.e. patients who are charged directly) we will be introducing a new mechanism. It will share the risk of unpaid debt to provide a direct financial incentive to encourage trusts to invest in identification and cost recovery processes. This will deliver a major step change in behaviour and process.

85. Under the new mechanism, when a provider identifies a chargeable patient, their commissioner will pay the provider 75% of the standard NHS tariff for the cost of the patients care. This means that for any such patient, the provider is guaranteed a minimum level of income. The patient will then be billed by the provider at a rate of 150% of tariff. On payment by the patient, the 150% tariff fee received will be split equally between the provider and the commissioner. This means the commissioner is reimbursed and the provider balance would be worth 150% of tariff. The flows will be as follows:



86. Under section 175(4) of the National Health Service Act 2006, the Secretary of State for Health has the power to set the level of charges for healthcare provided to chargeable patients on any basis he considers to be the most appropriate commercial basis. The charges must be set in secondary legislation. As such, the Department will lay regulations before Parliament in the autumn setting out how NHS providers must calculate their charging. This affects only patients seeking NHS healthcare rather than private healthcare provided by NHS hospitals.

87. The increase of charging to 150% of the NHS standard tariff for non-EEA patients recognises that there is a significant additional workload for providers when identifying chargeable patients and seeking to recover costs. The programme has reviewed comparable direct charges for healthcare under other care provisions and found that 150% of tariff still represents very good value for the extent and quality of NHS healthcare provided.

88. The non-EEA incentive mechanism will also be reviewed after 12 months to ensure its success. The Department will continue to work with NHS England, Monitor, the NHS Trust Development Authority, NHS providers and CCGs to ensure that the changes to financial flows are not detrimental to patient care and hospital budgets.

Sanctions

89. Phase 1 also intends to implement a process of sanctions whereby a sanction is levied against a provider if they are found to be failing to identify chargeable patients despite the support that is being made available. This will act in unison with the positive incentives to drive behavioural change from both sides. Work will continue throughout year one to design and implement an effective structure for this function.

90. The programme will review the use of sanctions after a year of operation to check their effectiveness and determine whether their use should be adjusted.

Extent of incentives and sanctions

91. The rollout of incentives and sanctions will not apply to local authorities (LAs) at this point. As the programme continues we will carry out an assessment of the LA charging mechanisms as part of phase 4. The current proposals will not change the charging regimes for LAs. The programme will publish additional guidance on this as part of the ongoing communications strategy in due course.

Reciprocal agreements

92. Reciprocal agreements with non-EEA countries will be reviewed as part of phase 1. As was signalled in the consultation response, there is considerable variation in the cover different agreements provide and their interpretation. We are therefore undertaking a full review to confirm whether they may trigger an exemption from the surcharge, and where appropriate discuss and agree any conclusions with representatives of their governments.

Phase 2: Aiding better identification of chargeable patients

93. The commissioned qualitative research found that NHS staff faced a particular challenge in determining whether individuals presenting to them for care are chargeable. Phase 2 of the programme is responsible for making changes to existing systems and processes to assist staff in doing so.

94. The changes will mean patients will not have to produce official identification at every appointment. A unified process will offer an opportunity to manage free access to the NHS through better use of information. The changes will allow for the identification of an individual's status throughout the NHS, without the need for patients to provide documentation at every visit. They aim to facilitate greater consistency and should reduce the burden on NHS staff.

95. The changes will build on existing NHS information systems. A new process will provide identification for those who have paid the surcharge, and are therefore entitled to use the NHS as a person ordinarily resident in the UK would, whilst they have valid leave to remain.

96. The same process will also form the foundation for improving cost recovery from visitors and others, who are already chargeable. It will ensure that individuals themselves are aware that they would be expected to cover the costs of their hospital care before having treatment, and are equipped to make a decision about their best option. The new process will, over time, capture the chargeable or non-chargeable status of increasing proportions of the population, facilitating easier identification of chargeable patients across all NHS settings.

97. Changes will vary in secondary and primary care, because of the different NHS information systems used. We have split this phase into two separate work streams, to allow for this.

Phase 2a: Secondary care

98. In secondary care, a new process will enable Overseas Visitors' Managers (OVMs) to identify those who have paid the surcharge, more effectively. An NHS record will be created for the individual at the time of their entry to the UK. The OVM will then be able to look the individual up on the NHS Spine using this record. We aim also to be able to give OVMs the opportunity to record information about visitors and others, who are already chargeable. This information will then be able to be used to facilitate easier identification of chargeable patients across all NHS settings which in turn will improve cost recovery.

Phase 2b: Primary care

99. In primary care, the aim will be to update processes already used to register new patients, so that the status of these patients can be recorded. This information will then be able to be used throughout the NHS to determine whether individuals presenting for care are chargeable.

Phase 3: Implementing the surcharge

100. The Immigration Act 2014 changes the meaning of 'ordinarily resident' for the purposes of the NHS Act so that in the future non-EEA nationals will not be deemed ordinarily resident unless they have been granted Indefinite Leave to Remain (ILR) in the UK. Building on this, the Act also allows legislation to be introduced that will require those non-EEA nationals subject to immigration control who are coming to the UK for more than six months to pay an 'immigration health surcharge' (surcharge) with their visa application fee. This is expected to be £150 per year for students and £200 per year for others, and will be paid upfront for the duration of the visa. There will be limited exemptions e.g. for those seeking asylum, refugees and victims of human trafficking.

101. Many of those who can currently access NHS care for free upon moving to the UK will instead be contributing towards the cost of any NHS care they need during their stay. Those who pay the surcharge (or are exempt from paying it) will then be able to access the NHS on the same basis as a resident for as long as their leave to remain is valid.

102. The Department has been and continues to work closely with the Home Office on relevant aspects of the legislation. A key action for the Department and the NHS to support implementation of the Act is to support the NHS in responding to the surcharge. This will need to ensure that the NHS is ready for the impact of the surcharge as well as supporting a wider communications package to payees of the surcharge to promote effective information on their care entitlements. This will include the Department making the necessary changes to the NHS Charging Regulations so that those who have paid the surcharge will be able to access NHS care in the same way as a person who is ordinarily resident.

103. The UK has reciprocal agreements with several non-EEA countries. As was signalled in the consultation response, they are typically in relation to short term visitors in need of treatment for unexpected accidents and illnesses, rather than comprehensive health needs that the surcharge will provide access to, so we anticipate that the surcharge will still be applicable to temporary migrants from those countries. However, since there

is variation in the cover different agreements provide and how they are interpreted we are reviewing them to confirm whether they may trigger an exemption from the surcharge, and will discuss and agree this process and any conclusions with representatives of their governments.

Reviewing exemptions and vulnerable groups

104. In its consultation response the Government committed to ensuring that any new system takes into account international law and our humanitarian obligations. As a consequence vulnerable groups such as asylum seekers, refugees, humanitarian protection cases, victims of human trafficking and children in Local Authority care will continue to have free access to the NHS and will not be subject to the surcharge.

105. The response also committed the Department to give further thought to strengthening exemptions, and other ways of ensuring that necessary treatment is provided for vulnerable groups and to consider the position of entitlement to free NHS care for ex-pats no longer living in the UK. This work will be undertaken throughout the first year of the programme, feeding into the work on revising the NHS Charging Regulations

Phase 4: Extending charging outside NHS hospitals

106. Phase 4 examines amending and extending current charging regulations and practices. This includes considering extending charging in secondary care into A&E services and also to non-NHS providers of NHS care; introducing charging for primary medical services (with the exception of GP and nurse consultations but including community services) and other primary care services such as pharmacy, optics and dentistry. The majority of people who would be affected by this extension are tourists and short term migrants – people here for less than six months.

107. This phase will require considerable discussion and development over the coming year. Some exemptions for charging in primary care are contained in both primary and secondary legislation and it would require careful management to introduce successful change. Working with the NHS and other health partners over the coming months we need to make decisions about the practicalities of the roll out of charging and to better understand the potential consequences in public health and other areas. Any decisions regarding the services and the sequence of roll-out will be made with advice from professional bodies, relevant stakeholders and frontline staff to ensure it is workable.

108. We will also begin to consider issues around tariff and/or recovery of full costs (including administration) for services. In working this through, we recognise the need to mitigate for any adverse impacts proposals might have on particular groups and the implications for public health and inequalities. This includes consideration of the needs of vulnerable resident populations (e.g. the homeless or the traveller community), who could also struggle to provide evidence of eligibility for free care, and might therefore be assumed to be chargeable or might fail to seek necessary care.

Equalities and Health Inequalities

109. As part of policy development, the programme has taken account of the public sector equality duty as set out in the Equality Act 2010 and the Secretary of State's duties under the NHS Act 2006, including the duty to have regard to the need to reduce health inequalities.

110. To consider the impact of the programme on equalities and health inequalities and vulnerable groups we have undertaken a number of actions, including:

- The Equality Analysis was published in December 2013;
- Continued to work with frontline NHS staff such as GPs, overseas visitor managers and secondary care representatives; and
- Engagement meetings with charitable groups, representatives of vulnerable groups and other stakeholders.

111. The programme has actively engaged with stakeholders in testing the policy and programme proposals. The NHS reference group, which includes members of vulnerable group representatives and key NHS and Public Health professionals, performs a key function in holding the work of the programme to account.

112. We have listened to key stakeholders, vulnerable group representatives and interested parties and committed to the following mitigating actions:

- To maintain free GP and nurse consultations to take account of concerns regarding public health and vulnerable groups and the importance of unrestricted access to early diagnosis and intervention;
- Continue to exempt, some specific groups such as refugees, victims or suspected victims of human trafficking, asylum seekers and Home Office supported failed asylum seekers as before on humanitarian grounds;
- Immediately necessary and urgent treatment will not be delayed or denied, but may be limited to what is clinically necessary and payment sought after treatment; and
- No charge will be made for those detained for treatment under the Mental Health Act 1983, or treatment imposed by a Court Order

113. As the work progresses through year one and two the programme will:

- Engage with vulnerable group representatives and stakeholders, working together to identify impact of proposed policy and consider mitigating action;
- Hold a workshop with vulnerable group representatives to listen and consider their concerns on health inequalities and work together to find a way forward;
- Undertake additional analysis as the policy proposals develop to ensure continued compliance with all relevant statutory duties, including the public sector equality duty and Secretary of State's duties under the NHS Act; and

- Ensure that documentation and guidance has due regard to issues of equality, health inequality and impact on vulnerable groups.

114. The programme will also aim to publish additional guidance and information on the impact of the programme on equality, health inequality and vulnerable groups as the scope of the work develops into year two.

Chapter structure

115. Clearly there is considerable overlap between the different phases and the work contained within them. To ensure this implementation plan is as clear and straightforward as possible for those people actually delivering the changes, we have divided the detailed programme discussion into two chapters covering the main financial years of development and delivery.

116. Within each chapter we look at the deliverables for each phase to help identify specific areas of work, on which services and on whom they will impact with outputs and outcomes. The delivery chapters are broken down by the two main periods of the programme:

- Year one, financial year 2014/15
- Year two, financial year 2015/16

Key decisions

117. There are a number of key decisions that will need to be made as the programme progresses, some of which have yet to be identified. Further guidance outlining the decisions made and the impact and practicalities of implementation will be published in due course. However the priority decisions which will need to be taken include:

- Whether or not to exempt expatriates who have made a substantial contribution to the UK in the past;
- Any change to the vulnerable group exemptions;
- Moving from the initial data sharing solution for registering NHS patients, where staff have to look up the immigration status to one where the information is flagged up for attention;
- The extent to which charging will be extended to the majority of services and the sequencing of that process;
- Which reciprocal agreements and European formula payments can and should be renegotiated; and
- Whether the EHIC collection and recording can be rolled out to GPs.

Chapter 5: By the end of year one

Summary of outputs and outcomes over the financial year 2014/15

Phases	Outputs & outcomes
1: Improving the system	• Toolbox published including examples of patient letters, EEA healthcare mechanisms guide & updated contact lists. [Annex C] • Increased public and NHS staff awareness and compliance. • NHS staff training commenced and feedback from participants. • New data collection from providers agreed and in place. • Central support team in place and deployed to trusts as needed. • EEA incentive scheme fully implemented and delivering increased recovery rates. • Non-EEA incentive scheme secondary legislation complete. • Non-EEA incentive and sanction developed and ready for roll out. • Regional cost recovery networks functioning well. • Professionalised OVM cadre. • Increased reporting to EEA portal from trusts. • Increased reporting of persistent, high-cost NHS debtors to the Home Office. • Updated and revised guidance to support changes in legislation. • A&E EHIC trial and evaluation completed and full roll out of charging EEA member states for A&E services for EEA visitors via EHIC underway.

Phases	Outputs & outcomes
2: Aiding better identification of chargeable patients	• Final preparations for the implementation of the pre-registration process will be underway in parallel with the Home Office rollout of the surcharge. • Initial data sharing solution will be available to trusts via the Spine • Scoping of solution for the storage of information in relation to EEA and non-EEA visitors in trusts will be continuing • Work to consider, scope and develop GP processes and systems to support identification of chargeable patients in the primary care setting will be continuing. • Privacy Impact Assessment on the new registration process will be completed ahead of the rollout.
3: Implementing the surcharge	• Delivery of legislation change to NHS (Charges to Overseas Visitor) Regulations 2011 to support commencement and implementation of the surcharge in partnership with the Home Office on time to ensure temporary migrants contribute to the NHS. • Prepare, redraft and implement NHS (Charges to Overseas Visitors) Regulations to make compatible with the new surcharge arrangements. • Staff awareness training and processes in place in secondary care prior to introduction of the surcharge. • Updated guidance (including summary and patient information).
4: Extending charging to A&E, primary medical services and other services	• Scope and consider extensions of charging. • Scope and consider changes to the exemptions from charging regime. • Scope and consider changes to cost recovery in local authorities and other providers.

Phases	Outputs & outcomes
Communications	• Distribution of relevant actions and context for different NHS and stakeholder audiences. • Continued engagement with key organisations, professional bodies and NHS staff. • Raising awareness in staff across the NHS; initial focus on: • Clinical staff for referring on identification • Managerial staff for support on cost recovery • Support Home Office communications to non-EEA citizens paying the surcharge about what their NHS entitlement is and to inform them that they will be pre-registered. • Continued engagement and communications with key organisations, professional bodies and NHS staff. • Develop branded standard information for overseas visitors and temporary migrant patients. • Promoting awareness for EEA citizens, focusing on their need to carry an EHIC card.

118. The key activities in each of the phases during this period are set out in the text below in a milestone chart in Annex A. What the changes will mean to individual staff members and their organisations is summarised in the tables on page 34-46.

Year one: what have we achieved so far?

119. In the year to date the programme has undertaken significant amounts of preparatory work across all phases. This has enabled the programme to have a much clearer and accurate view of the future of the work and be well on the way to delivering key aspects. In particular we have:

- Supported the Home Office during the Immigration Bill's passage through Parliament. The Bill received Royal Assent on 14 May 2014, becoming the Immigration Act 2014;
- Developed and announced the structure of the EEA financial incentive;
- Significant preparatory work to support the development of the process for aiding better identification within the NHS IT systems;
- Development of toolbox documentation based on best practice and behavioural insights;
- Established the regional OVM networks in London and the North East;
- Established the finance directors' network in London;

- Conducted engagement visits with key stakeholders including NHS providers and organisations providing services to vulnerable groups; and
- Developing relationships with ALBs.

Phase 1: Improving existing systems

120. Phase 1 includes a wide range of projects for development, all of which focus on developing and supporting the current charging system to maximise cost recovery. We have prioritised specific improvement work to be undertaken during year one following extensive dialogue with the NHS reference group, overseas visitor managers and other senior NHS staff.

Toolbox and Process Improvement

121. The main objective of phase 1 is improving the processes and materials involved in cost recovery to help improve its success rate. The toolbox is a collection of standardised documents, tools and guidance which will help trusts achieve best practice in the management of overseas visitors and migrant charging. These have been developed with and tested by overseas visitor managers. The resulting toolbox includes examples of pre-attendance forms, detailed information leaflet on EEA healthcare mechanisms and portal user guide and template patient communication letters.

122. The first version of the toolbox is published alongside this implementation plan.

123. The toolbox will continue to grow and adapt to provider and patient needs over year one to take account of wider user feedback and any new policy developments. Fully revised guidance on overseas visitor charging regulations will be added to the toolbox in line with any new legislation that is made during year one. We also expect that the documentation and guidance will be kept current beyond the life of the cost recovery unit, providing a long-term resource.

124. We shall also be working with our partners to increase awareness across the system of the EEA patient cost recovery mechanisms. This will focus on how to recognise, collect and report EHIC, S1 and S2 forms using the existing mechanisms (online or paper-based).

125. As part of phase 1 we are considering the cost effectiveness of undertaking an audit of past S1 forms that have been provided to GP practices by state pensioners from other EEA countries retiring in the UK. There is evidence that a significant number of forms have not been registered with the DWP, and an audit would allow us to retrospectively reclaim the costs of care for those pensioners from the country responsible for their pension. If cost effective, we would look to undertake this during the second half of year one.

126. We will also be working with trusts during year one to ensure S2 forms are identified and managed efficiently. We expect the success of this work to be measurable with an increase in invoicing to other EEA member states.

Financial Incentives and Sanctions

127. Incentives form a key part of phase 1 in the first year. They aim to support and encourage providers to fulfil the statutory duty to identify and seek cost recovery from visitors and migrants. This document explores the structures of these at para 73ff.

128. Work to deliver the EEA financial incentive will be an early priority for the phase. We anticipate that this will be rolled out in the autumn of 2014. The details of the payment mechanisms for providers will be published closer to the rollout time.

129. During this period of phase 1, we will also be finalising details of the non-EEA incentive and sanctions. In the winter 2014, the programme expects to lay the regulations before Parliament to set the amount NHS secondary care providers must charge. This will be equivalent to 150% of the standard NHS tariff.

130. The programme will be working with NHS colleagues (providers, commissioners and regulators) to design the structure and mandate of the non-EEA sanction. The sanction will act as a fair, yet effective deterrent to providers deliberately choose not to identify chargeable patients and bill their commissioners in full. The timing of its development will allow the incentive and sanction to align with the implementation surcharge and IT registration solution. These measures will act as a coherent package to significantly increase the level of support and oversight involved in identifying and charging non-EEA patients.

131. Further detail on the final structure, rollout schedule and impact of the non-EEA incentive and sanction will be published closer to April 2015.

132. As the work moves beyond year one the programme will be monitoring the effects and impact of the incentives and sanction and will be preparing for a full review of its effectiveness and rates of incentive.

Data Sharing

133. Since 2011, providers are able to share non-clinical information on individuals subject to immigration controls who hold £1,000 or more of debt to the NHS with the Home Office[8]. The people who owe a substantial debt to the NHS could be refused permission to re-enter or remain in the UK until they clear that debt, subject to human rights obligations. We will be working with providers to increase their reporting of the most serious debtors so as to maximise the deterrent effect associated with this rule.

Intensive support team and other support structures

134. During phase 1, we will be developing and deploying a cost recovery national intensive support team (IST) during year one. This will be based on the successful intensive support team model, run by NHS Interim Management and Support (IMAS), and will be deployed to assist providers and commissioners with cost recovery on request. The type of support offered will evolve as the cost recovery programme itself evolves. We expect the IST to be available for deployment by autumn 2014 and will likely operate for the length of the programme.

8 www.gov.uk/government/uploads/system/uploads/attachment_data/file/254537/ovs_visitors_append_7_oct13_acc.pdf

135. In terms of wider peer support, phase 1 will continue to build on and expand the networks of overseas visitor and finance colleagues. London networks have already been established and are meeting regularly. In April 2014 the programme held the first North East network meeting. We expect that this will be further rolled out across the country during the first half of year one.

A&E EHIC pilot

136. As part of phase 1, we will be conducting a pilot in a number of Emergency Departments around the country to assess the feasibility of collecting EHIC information as part of the registration process here. We are clear that this is not an extension of charging but will support increased recovery of the cost of NHS care in respect of EEA nationals from their responsible member states. However we have found that currently EHIC data is generally not collected from patients due to practical considerations. It is our intention to work closely with providers to determine how we can support this function to improve overall cost recovery. We anticipate that the trial will begin in August 2014 and will be completed before the winter peak period of 2014 commences. Evaluation of this trial will be undertaken during the second half of the year one and will inform the process for a national rollout.

137. Phase 1 also aims to prepare for a nationwide rollout of A&E EHIC collection process and support early in year two, based on the outcome of the trials. This will involve working closely with trusts and stakeholders in year one to ensure this function can maximise cost recovery. This is subject to the results of the trials although the programme is clear that this is an important area of cost recovery and should be prioritised.

Support functions tested but rejected

138. In the first part of year one, we have explored some possible support functions that have ultimately been found to be unsuitable for further development as part of the programme. This includes a centralised debt collection and recovery process and a centralised pooling of debt.

Phase 2: NHS Registration

2a: In secondary care

139. Developing the process to aid better identification of chargeable patients in secondary care will initially focus on the HSCIC enhancement of the NHS National Spine. This will enable information to be supplied by the Home Office about non-EEA migrants who have paid the surcharge, to be made visible to OVMs. We also hope to be able to use it to enable storage of status-related demographics information (such as country of origin, or EHIC number for EEA individuals) and subsequent creation of NHS records for EEA and non-EEA visitors and EEA migrants at the point of access to the NHS.

140. The process will work by allowing overseas visitors managers and other trust staff to ‘look up’ a patient on the Spine via the Summary Care Record (SCRa) portal. We hope also to develop the SCRa for use as a ‘way in’ to the Spine to store information collected from EEA and non-EEA visitors, and EEA migrants, at the point of access to

the NHS. This would be a with a view to creating NHS records for these individuals, where their status can be displayed to facilitate easier identification of chargeable patients across all NHS settings.

141. The part of the process dealing with non-EEA migrants who have paid the surcharge is reliant on data being transferred to HSCIC from the Home Office. We will build and test this data transfer system during year one and begin to test it towards the end of year one.

142. The surcharge payees' part of the process also requires pre-registration arrangements for migrants who have paid the surcharge. We aim to align these arrangements with those the Home Office are putting in place for the issue of entry documents and distribution of Biometric Residence Permits (BRPs) to individuals at the Post Office local to where they will be living during their stay in the UK. Pre-registration will supply individuals with an NHS record, which will be flagged with their immigration status. This status will then be able to be displayed via the SCRa portal.

143. Once the Spine has been enhanced HSCIC will run user acceptance testing to familiarise OVMs and other staff with the new process. We will also use relevant communications channels to publicise the new process and how it aims to assist staff in secondary care settings to identify chargeable patients.

144. In accordance with the need to consider the implications of the improvements a Privacy Impact Assessment will be carried out on the new identification process in secondary care.

145. Our aim is for the better identification process to be ready for roll-out by the beginning of year two, to coincide with likely dates for Home Office to commence the charging of the surcharge.

2b: In primary care

146. In year one we will work with HSCIC and other relevant stakeholders to scope the possibility of altering existing GP systems and registration processes and procedures so that the status of EEA migrants, and EEA and non-EEA visitors can be captured in primary care. The onus will be on making changes which allow these details to be captured without creating extra work for practice staff.

147. We will also use communications channels to alert practice staff to the fact that non-EEA migrants who are pre-registered with the NHS and have who paid the surcharge may wish to register with their practice and make use of their services.

148. Depending on the outcome of the initial scoping work, we may also scope changes in other primary care settings, charging systems and processes by the end of year one.

Phase 3: Implementing the surcharge

149. During the first quarter of year one this phase has focused on supporting the Home Office with the passage of the Immigration Bill through Parliament. On 14 May, Royal Assent was granted to the Bill, which then became the Immigration Act 2014. This phase will continue by supporting the Home Office as they introduce the secondary

legislation during year one which will set out the detail of the surcharge, including who is exempt from having to pay it.

150. The Overseas Visitor Charging Regulations, which currently make provision about the services and overseas visitors that are chargeable, will require amendment. The date for laying the regulations is linked to the Home Office timetable for the regulations setting out the detail of the surcharge. However, this phase expects to deliver the secondary legislation to align with a spring rollout of the surcharge.

151. Phase 3 will also focus on preparing the NHS for the changes that will come in as a consequence of the Immigration Act. This will include updating the charging guidelines and providing a summary plain English version for NHS staff to use on a day to day basis. A short summary of the key points for overseas visitors and temporary residents will also be developed, which will form part of the toolbox and will be translated into a range of languages for local use. Phase 3 will deliver this to support the rollout of the surcharge in year one.

Phase 4: Extending charging

152. In anticipation that, with the exception of those services to protect public health and GP and nurse consultations, we may be extending charging to almost all NHS services, the focus of phase 4 during year one will be the initial of scoping the boundaries of chargeable services considering possible areas for extension. There will also be a strong focus on assessing the potential impact of any changes on vulnerable groups. The phase will be considering local authority charging mechanisms.

153. Given the complexity and extent of the potential changes it is very likely that announcements on the proposed scope of changes and preparation for any legislative changes based on this scoping will fall into year two of the programme.

FY 2014/15 – What it means for you if you work in:

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An NHS trust or Foundation trust	More attention at senior level (including Board) given to overseas cost recovery processes and debt management within trust Clarity on the current charging rules and best practice to utilise in your trust including training for administrative and clinical staff Face-to-face advice and expertise available through the national intensive support team Clarity on requirements regarding information gathering and reporting from EEA patients via the portal Clarity around charging for non-EEA visitors and the mechanisms to recover funds Clarity around how financial incentives and sanctions will work for your trust Clarity on requirements regarding sharing data on high-cost NHS debtors with DH/Home Office Trust data collection required and performance data now available Aware of likelihood of increase overseas patients identified and potential for increase in debts	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients in your trust. These will support eligibility checks for EEA and non-EEA patients. These will also enable your OVMs to recognise who has paid the surcharge. Aware that the programme is making related changes to existing registration processes in order to aid better identification of potentially chargeable patients in primary care. Towards the end of the year: aware of how the improved mechanisms will work for OVMs/other relevant staff in your trust. Aware that the new mechanisms will roll out in early 2015/16	Aware that the new process is being set up and that in future, those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services in the same way as an ordinarily resident patient for as long as their leave to remain is valid.Aware that the improved identity verification mechanisms are being developed to help your OVMs and others identify who has paid the surcharge.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
	Expect to work with DH, NHS England and the regulators to ensure balance of risk between commissioner and provider is not destabilising the system Process the information from ambulance forms which have identified: • EEA patients who will be charged via their EHIC and entering the information on the portal and • Patients with travel insurance. In pilot trusts: Identify EEA patients in A&E In all trusts: entering their EHIC/S2 information on the portal		

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An NHS trust finance team	Clarity around EEA money flows and roll out of EEA incentives Expect to support staff recovering more funds centrally by entering EEA patient details Clarity around non-EEA money flows and change in risk sharing arrangements between commissioner and provider for non-EEA chargeable patients Trust data collection required and performance data now available Aware of likelihood of increased overseas patients identified and potential for increase in debts Work with DH to scope the potential for a better debt management system Expect to work with DH, NHS England and the regulators to ensure balance of risk between commissioner and provider is not destabilising the system	Aware that your OVMs' (or other staff) use of the improved identity verification mechanisms will be likely to uncover more potential debt.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services in the same way as an ordinary resident for as long as their leave to remain is valid.Aware that the improved identity verification mechanisms being developed will help relevant trust staff identify who has paid the surcharge.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An NHS walk-in centre	Pilot sites: working with the Department to scope and test EHIC reporting processes All sites: Clarity on requirements regarding entering data on EEA patients All sites: Clarity about the overall charging rules system and support package available	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients. These will support eligibility checks for EEA and non-EEA visitors. These will also enable relevant staff to recognise who has paid the surcharge. Aware that the programme is making related changes to existing registration processes in order to aid better identification of potentially chargeable patients in primary care.	Aware that the new process is being set up, and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services in the same way as an ordinary resident for as long as their leave to remain is valid.Aware that the improved identity verification mechanisms being developed will help staff identify who has paid the surcharge.
An urgent care centre/minor injuries unit	Pilot sites: working with the Department to scope and test EHIC reporting processes All sites: Clarity on requirements regarding entering data on EEA patients All sites: Clarity about the overall charging rules system and support package available	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients. These will support eligibility checks for EEA and non-EEA visitors. These will also enable relevant staff to recognise who has paid the surcharge. Aware that the programme is making related changes to existing registration processes in order to aid better identification of potentially chargeable patients in primary care.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services in the same way as an ordinary resident for as long as their leave to remain is valid.Aware that the improved identity verification mechanisms being developed will help staff identify who has paid the surcharge.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A GP practice	Expect to work with DH to develop a workable solution to recovering costs from EEA member states for EHIC holders using NHS primary care services. Expect to recognise and transmit S1 forms from newly-registered EEA pensioners settling in the UK. Expect to receive more letters from secondary care providers to indicate patients' chargeable status. Responsibility to inform non-resident/ visiting patients of potential costs and flag their potential chargeability status when referring them to secondary care.	Aware that the programme is scoping and testing changes to the registration process which will aid better identification of patients who are chargeable further down the care pathway. Aware that these changes will support eligibility checks for EEA and non-EEA patients in primary care. Aware that the programme is scoping and testing a new process to aid better identification of chargeable patients in secondary care.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid. Aware that from early 2015/16, individuals who have paid the surcharge may wish to register with your practice and that they are entitled to do so. Able to recognise BRPs when presented

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A clinical commissioning group or a specialised commissioner	Expect to establish more robust systems to manage contracts with providers around recovering costs from chargeable patients (as per the standard contract) and ensure providers are reporting EEA patient's details Clarity around non-EEA money flows and change in risk-sharing and incentives arrangements between commissioner and provider for non-EEA chargeable patients Greater understanding of potential opportunity cost of paying for ineligible and chargeable patients More intelligent customer with better means for scrutinising invoices Performance data to support contract management Work with providers to ensure better identification system is set up If feasible, collaboration on an audit of past S1 and S2 forms Consider using cost recovery rates as opportunity to demonstrate QIPP savings. Expect to work with DH, NHS England and the regulators to ensure balance of risk between commissioner and provider is not destabilising the system.	Aware that improvements are being made to existing identity verification mechanisms and that in future, improved information will be provided on those receiving commissioned care. Currently these patients are treated free but are not identified.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, including those primary care services that will become chargeable to visitors, in the same way as an ordinary resident for as long as their leave to remain is valid.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A commissioning support unit	Expect to establish more robust systems to manage contracts with providers around recovering costs from chargeable patients (as per the standard contract) and ensure providers are reporting EEA patient's details Clarity about change in risk sharing arrangements between commissioner and provider for non-EEA chargeable patients. More intelligent customer with better means for scrutinising invoices. Work with providers to ensure better identification system is set up. If feasible, collaboration on an audit of past S1 and S2 forms. Expect to work with DH, NHS England and the regulators to ensure balance of risk between commissioner and provider is not destabilising the system.	Aware that improvements are being made to existing identity verification mechanisms and that in future, improved information will be provided on those receiving commissioned care. Currently these patients are treated free but are not identified.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, including those primary care services that will become chargeable to visitors, in the same way as an ordinary resident for as long as their leave to remain is valid.
An NHS ambulance trust	A new tick box on the existing information transfer forms to identify if the patient is from the EEA and has an EHIC. In line with current practice, this will be handed over to the receiving clinician at A&E.	N/A	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A regulator (Monitor/ the TDA)	Greater understanding of the rationale behind the programme and information to act as a conduit to the system for dissemination of changes and best practice. Assistance to providers in regard to data collection/returns. More systematic scrutiny of providers reporting low numbers of chargeable (EEA/non-EEA) patients in areas of high visitor and migrant mobility. Involvement in the design and roll out of the new incentives mechanisms (EEA/ non-EEA) and sanctions (non-EEA). Expect to work with DH, NHS England and the other ALBs to ensure balance of risk between commissioner and provider is not destabilising the system.	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients. These will support eligibility checks for EEA and non-EEA visitors. These will also enable relevant staff to recognise who has paid the surcharge. Aware that the programme is scoping and testing changes to the registration process which will aid better identification of patients who are chargeable further down the care pathway. Aware that these changes will support eligibility checks for EEA and non-EEA patients in primary care.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid.

FY 2014/15 – What it means for you if you are:

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An overseas visitors manager	More attention at senior level (including the Board) to cost recovery and debt Increasingly professionalised OVM cadre with strong regional networks with senior support Clarity on the current charging regulations with examples of best practice and tools to utilise in your trust including in disseminating information to administrative and clinical staff Clarity on requirements regarding entering data on EEA patients Clarity around charging for non-EEA visitors and the mechanisms to recover funds Clarity around national support team "offer" to your trust Expect more systematic identification of visitors to increase debts EEA patients with EHICs should be flagged up in A&E either via the ambulance transfer form or directly by admin staff in A&E or elsewhere in the hospital and their information entered on the portal Identify EEA patients for planned treatment and enter their S2 information on the portal	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients in your trust. Aware that these changes mean that from early 2015/16 you will be able both to look patients up, and that depending on progress with the work you should be able to patient information directly on to the Spine 'Summary care record portal'. The information you capture will support eligibility checks for EEA and non-EEA patients. You will also be able to 'view' who has paid the surcharge as they will be issued with an NHS record along with their visa. Aware that these changes will start to roll out from early 2015/16 and that you will be able to take part in testing the new system.	Understand how the new identification process system will work and that those who have paid the surcharge, or are exempt from paying it, are not chargeable and are entitled to the full range of NHS services in the same way as ordinary resident for as long as their leave to remain is valid.Become more familiar with BRPs in recognition that they will be the main document a temporary migrant carries.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A secondary care clinician	Clarity on existing charging rules for both EEA and non-EEA visitors and migrants and how they can assist their trust without compromising their clinical responsibility towards their patients Clarity around national support team "offer" to your trust Understand that quicker identification of a patient's chargeability will help provide costs and decisions on treatment to patient Those receiving patients from an ambulance will need to flag up the fact that a patient is chargeable through their EHIC or travel insurance if the transfer form flags up that they have either.	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients in your trust. Aware that these changes mean that from early 2015/16 OVMs and other relevant staff will be able both to look patients up, and that depending on progress with the work they should be able to record patient information directly on to the Spine 'Summary care record portal'. Aware that the information captured will support eligibility checks for EEA and non-EEA patients.	Aware that the new system is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services in the same way as an ordinary resident for as long as their leave to remain is valid. Aware of changes to the system and recognise BRPs when presented.
An NHS trust manager or ward clerk	Aware of the tools to assist identification and management of chargeable patients Understand role in identifying chargeable patients and EHIC/S2 patients and alerting trust's overseas visitor department and/or finance team. Those receiving patients from an ambulance will need to identify chargeable patients through their EHIC or travel insurance if the transfer form flags up that they have either.	Aware that the programme is scoping and testing changes to existing identity verification mechanisms to aid better identification and recording of potentially chargeable patients in your trust. Aware that these changes mean that from early 2015/16 OVMs and other relevant staff will be able both to look patients up, and that depending on progress with the work they should be able to record patient information directly on to the Spine 'Summary care record portal'. Aware that the information captured will support eligibility checks for EEA and non-EEA patients.	Aware that the new system is being set up and that in future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services in the same way as an ordinary resident for as long as their leave to remain is valid. Aware of changes to the system and recognise BRPs when presented.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A primary care clinician	Clarity on existing charging rules for both EEA and non-EEA visitors and migrants Responsibility to inform potentially chargeable patients that secondary care could be charged to them directly. Responsibility to flag up known chargeable patients when referring them to secondary care.	Aware that the programme is scoping and testing changes to the registration process which will aid better identification of patients who are chargeable further down the care pathway. Aware that these changes will support eligibility checks for EEA and non-EEA patients in primary care. Aware that the programme is scoping and testing a new process to aid better identification of chargeable patients in secondary care.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid. Aware that from early 2015/16, individuals who have paid the surcharge may wish to register with your practice and that they are entitled to do so. Able to recognise BRPs when presented.
GP practice manager or receptionist	Clarity on existing charging rules for both EEA and non-EEA visitors and migrants Responsibility to inform potentially chargeable patients that secondary care could be charged to them directly. Responsibility to flag up known chargeable patients when referring them to secondary care. Expected to work with DH on improving S1 data collections, possibly extending to EHIC data collection if system development permits. Responsibility to pass on S1 forms received from any EEA retirees registered at their practice.	Aware that the programme is scoping and testing changes to the registration process which will aid better identification of patients who are chargeable further down the care pathway. Aware that these changes will support eligibility checks for EEA and non-EEA patients in primary care. Aware that the programme is scoping and testing a new process to aid better identification of chargeable patients in secondary care.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid. Aware that from early 2015/16, individuals who have paid the surcharge may wish to register with your practice and that they are entitled to do so. Able to recognise BRPs when presented.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A commissioner	Expect to verify invoices more effectively and work with providers around recovering non-EEA costs and EEA reporting Prepare for introduction of new non-EEA incentive and sanctions mechanisms Clarity around national support team "offer" to your trust More information to hold providers to account Consider using cost recovery rates as opportunity to demonstrate QIPP savings	Aware that improvements are being made to existing identity verification mechanisms and that in future, improved information will be provided on those receiving commissioned care. Currently these patients are treated free but are not identified.	Aware that the new process is being set up and that in the future those who have paid the surcharge, or are exempt from paying it, are not chargeable and entitled to the full range of NHS services, in the same way as an ordinary resident for as long as their leave to remain is valid.
An insured visitor or resident pensioner from the EEA	Expect to be asked more systematically to provide EHIC or S1 forms to verify status (or an S2 form if here for elective treatment)	Understand that from early 2015/16 you will be expected to present EHIC, S1 or S2 when seeking NHS healthcare.	Understand that from early 2015/16 you will expect to be asked more systematically to provide EHIC or S1 forms to verify status.
A visitor from a non-EEA country **(here for less than 6 months)**	Anticipate your visit by arranging travel insurance before arriving in the UK Expect to be asked to provide evidence of home address and other identification when receiving hospital care from the NHS. Expect to pay for hospital care you receive when in the UK. If you have insurance, you will be asked to pay up front and claim back your costs from your insurance company yourself.	Understand that from early 2015/16 there will be a mechanism to register with the NHS but expect to be asked to provide evidence of home address and other identification when receiving hospital care from the NHS. Expect to receive an invoice for care services provided From early 2015/16 anticipate your visit by arranging travel insurance before arriving in the UK.	Understand that from early 2015/16 you will not be eligible to pay the surcharge BUT will be liable for the full cost of treatment if you access the NHS, unless an exemption applies From early 2015/16 anticipate your visit by arranging travel insurance before arriving in the UK.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A temporary migrant from a non-EEA country/subject to immigration control	Aware that in the future as part of the surcharge process you will need to pre-register for an NHS record and demonstrate/confirm non-chargeable status You will be pre-registered for an NHS record which will demonstrate/confirm your non-chargeable status Expect to present your BRP when using NHS services and be aware that you are entitled to the full range of NHS services in the same way as a person who is ordinarily resident so you will only pay for services for which UK ordinary residents pay (e.g. prescription charges, NHS dentistry etc.). You will be subject to the same clinical priorities/waiting lists as ordinary residents and will access services in the same way and under the same rules.	Aware that from early 2015/16 as part of the surcharge process you will be pre-registered for an NHS record on entry to the UK and your data will be shared with HSCIC from the HO.	Aware that from early 2015/16 you will be liable to pay the surcharge but this will give you access to the NHS in a similar manner as a permanent resident in the same way as someonw who is ordinarily resident in the UK for as long as their leave to remain is valid.
A UK ordinarily resident patient	May be asked to provide certain details before attending outpatients or pre-attendance clinics for elective care Will be expected to provide details to confirm residency when moving GP practices Will be asked to provide details to confirm residency if you do not have a pre-existing NHS record before attending outpatient clinics and accessing increasing numbers of NHS services	Aware that from early 2015/16 you will be asked for your details to confirm residency if you do not have a pre-existing NHS record.	N/A

Chapter 6: By the end of year two

Summary of outputs and outcomes over the financial year 2015/16

Phases	Outputs & outcomes
1: Improving the system	• EEA incentive implemented and rates under evaluation. • Non-EEA incentive and sanction fully implemented. • Increased reporting to EEA portal from NHS trusts and primary care leading to increased claims to EEA member states. • Improved metrics to support better commissioning decisions. • Better data sharing with the Home Office to report high-value NHS overseas debtors leading to fewer health tourists as a result of the deterrent effect.
2: Aiding better identification of chargeable patients	• Work to consider, scope and develop GP processes and systems to support identification of chargeable patients in the primary care setting will be continuing. • The surcharge from the Immigration Act will be in place and the programme will have completed the rollout of the new process to support this. Solution for the storage of information in relation to EEA and non-EEA visitors in trusts should be in place • Scoping in relation to potential improvements to the new processes, and future expenditure around this, will be continuing
3: Implementing the surcharge	• Surcharge and associated supporting legislation in place and all visa applicants and those exempt from paying the surcharge are pre-registered with the NHS and have BRPs issued.
4: Extending charging to A&E, primary medical services and other services	• To be determined by decisions in the first year of the programme.
Communications	• Increasing awareness amongst NHS staff regarding the technical updates to the Spine.

154. The key activities in each of the phases during this period are set out in the text below and in a milestone chart in Annex A. What the changes will mean to individual staff members and their organisations is summarised in the table on page 50-56.

Phase 1: Improving existing systems

155. By the end of year one the majority of improvements to the existing system will be at least partially implemented. Year two will see work continuing to embed and refine the changes made by the programme based on continuous re-evaluation by and consultation with NHS frontline staff.

156. The toolbox will have been already subject to review and qualitative evaluation by NHS staff (and patients where appropriate). Further tools and information to accompany the introduction of the non-EEA incentive and sanction, the new process to aid better identification of chargeable patients and any changes to legislation will also be added. By the end of the financial year, the toolbox will have proven its utility and be a solid resource for NHS staff.

157. At the end of year two the EEA incentive will have been operating for over a year. The programme will undertake a full evaluation of the incentives success and will review the level of financial incentive provided before the end of year two. The non-EEA incentive and sanction will have been fully implemented and will be coming to the first year of operation milestone. The programme will be preparing to carry out a full evaluation of its success.

158. The National Intensive Support Team will have been deployed to providers and commissioners, with the support “offer” adapted to suit the changing needs of the NHS as the programme develops and embeds.

159. The A&E pilot for EHIC reporting will have been completed and the results analysed. We hope that a standard, easy-to-implement process will have been designed and will be rolled out to all emergency care settings in England who are not currently reporting EHIC data.

160. Data sharing mechanisms between providers and the Home Office will have been simplified, with providers systematically reporting large-value NHS debtors to the Home Office, who are in turn able to take action against debtors when they seek to renew or apply for a visa.

161. In primary care the S1 reporting will be developed and used systematically to identify EEA patients and recover costs from their member states. In secondary care, S2 forms will be systematically requested and sent to the overseas healthcare team for processing.

Phase 2: NHS Registration

2a: In secondary care

162. It is our aim for the better identification process in secondary care to be ready for roll-out by the beginning of year two, to support and interface with the surcharge.

163. In addition to developing the initial solution, further consideration will be given to decisions about longer term expenditure. The analysis of the programme will continue, in order to understand possible future development options and related costs.

164. Future development options would be likely to take the form of a process to provide push alerts. We could work with HSCIC to develop these. The aim of these alerts would be to prompt staff about the chargeable status of the patient when they enter the details of the patient on to the system. This would reduce the need to look up the patients charging status on the Spine. There might also a possibility to link the Spine to the DWP EHIC portal, to allow it to speak to the portal and populate it directly with information about individual EHIC status and that of chargeable member states.

2b: In primary care

165. It is likely that the work on this part of the phase will continue during year two, within both GP practice and other primary care settings. Depending on the outcome of the scoping in year one, it is likely that in year two we would be undertaking some form of implementation work.

166. Implementation work would be likely to take the form of changes to GP and other primary care information systems, along with changes to existing registration processes for overseas visitors and migrants. We would be working with HSCIC and other stakeholders on this.

167. The focus of any work we undertake would be to change systems and processes without adding extra burden to staff.

168. Depending on the outcome of the work on this part of the phase during year one, we may also be considering and scoping processes to implement and support an appeals process for those who believe that they are not chargeable.

169. We would also be likely to be considering running a pilot for this work in primary care settings.

Phase 3: Implementing the surcharge

170. The second year of this phase will focus on meeting the education and training needs of the NHS, to ensure that the new system is familiar to all and that the guidance available meets the service's needs. Once this is established, the work will involve getting the required secondary regulations laid, and any appropriate primary legislation ready for when a suitable legislative vehicle becomes available.

Phase 4: Extending charging

171. As set out earlier in this document, many of the decisions which will need to be made with regard to phase 4 will be taken during the year one of this implementation timetable. The programme will aim to publish additional guidance on the decisions taken around this phase in due course.

FY 2015/16: What it means for you if you work in:

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An NHS or foundation trust	Senior support for overseas cost recovery and debt reduction Clarity about the system and comprehensive support package, including face-to-face advice and expertise, available Routine reporting of EHIC and S2 forms via the online portal Routine reporting of high-value overseas debts Routine data returns as part of standard financial reporting responsibilities Reinvestment of income from EEA and non-EEA incentives in better cost-recovery systems	An improved mechanism will be in place to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification will be underway.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in hospital
An NHS trust finance team	Established financial incentives and debt management systems working effectively Reinvestment of income from EEA and non-EEA incentives in better cost-recovery systems	An improved mechanism will be in place to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification will be underway.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in hospital.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An NHS walk-in centre	Systematic collection of EHIC and other status information relevant to EEA and non-EEA patients and status recording and notification should be underway. Requirement to identify and collect EHIC details of patients accessing care in the centre who are not eligible for free care	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in the centre
An urgent care centre/minor injuries unit	Systematic collection of EHIC and other status information relevant to EEA and non-EEA patients and status recording and notification should be underway. Requirement to identify and collect EHIC details of patients accessing care in the centre who are not eligible for free care	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in the centre

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A GP practice	Routine identification of EEA patients either through EHIC/S1 Routine identification of temporary visitors from outside the EEA Identification of chargeable patients as part of referral process to secondary care Expect to receive more letters from secondary care providers to indicate patients' chargeable status. Responsibility to inform non-resident/ visiting patients of potential costs and flag their potential chargeability status when referring them to secondary care	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. Individuals who have pre-registered with the NHS may wish to register with the practice. They are entitled to do so. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification should be underway.The work to amend the GP IT systems to enable recording of charging status will be underway	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it.
A clinical commissioning group	Intelligent customer with better data for scrutinising invoices Work with providers to ensure better identification system is embedded Consider using cost recovery rates as opportunity to demonstrate QIPP savings Established financial incentives and debt management systems working effectively	Be aware of the new process to aid better identification of chargeable patients.	Aware of the established mechanism.
A commissioning support unit	Intelligent customer with better data for scrutinising invoices Work with providers to ensure better identification system is embedded	Be aware of the new process to aid better identification of chargeable patients.	Aware of the established mechanism
An NHS ambulance trust	N/A	Be aware of the new process to aid better identification of chargeable patients.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A regulator (Monitor/ the TDA)	Robust data collection in place to facilitate clinical commissioning decision making Ensure providers in secondary and primary care are adhering to competition regulations in managing NHS chargeable patients Established financial incentives and debt management systems working effectively	Be aware of the new process to aid better identification of chargeable patients.	Aware of the established mechanism

FY 2015/16: What it means for you if you are:

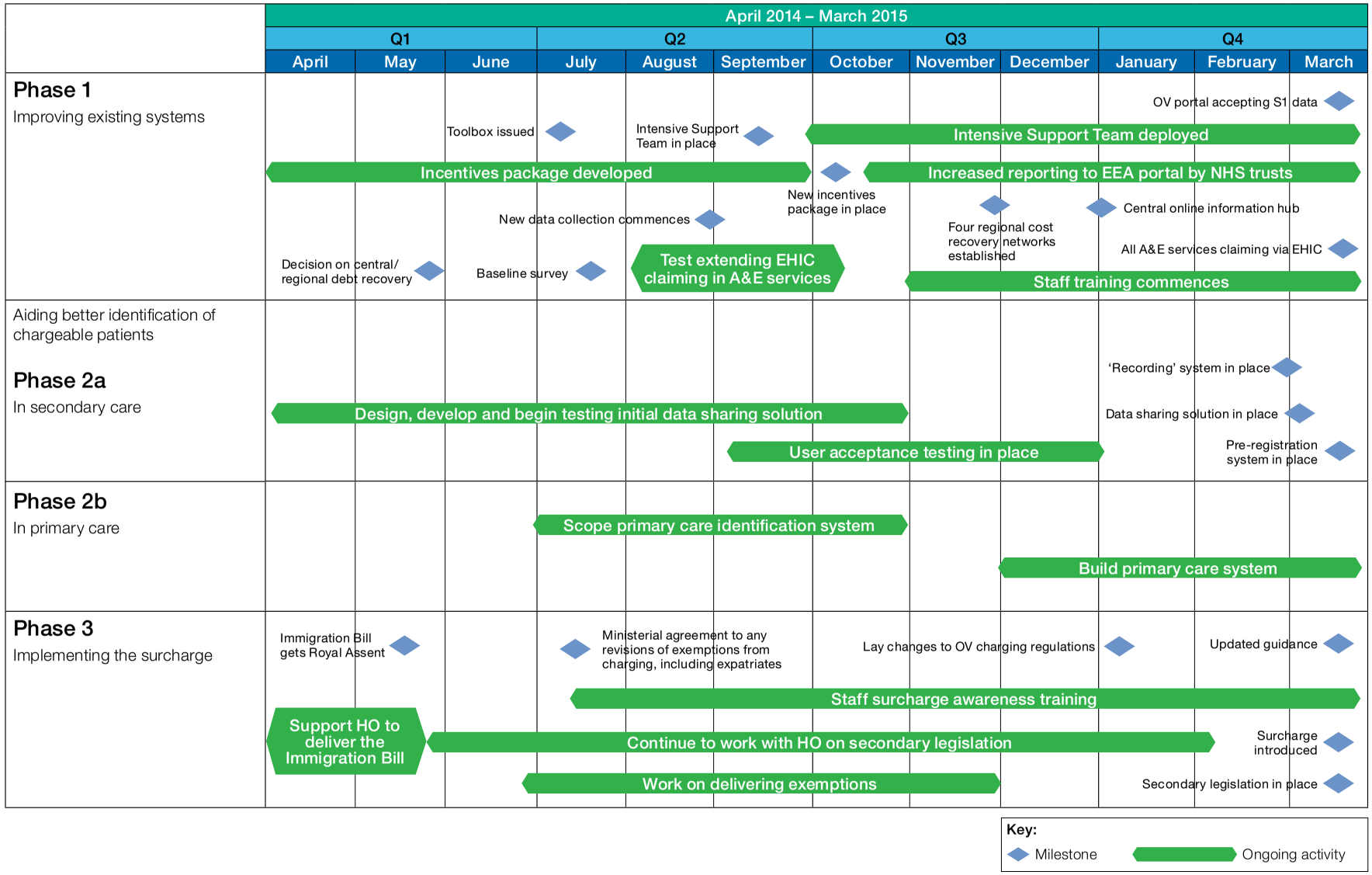
	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An overseas visitors manager	Senior support for overseas cost recovery and debt reduction Clarity about the system and comprehensive support package, including face to face advice and expertise, available Systematic reporting of EHIC/S1/S2 via the portal and high-value overseas debt Effective regional network of support	An improved mechanism will be in place to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification should be underway.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in hospital.
A primary care clinician	Clarity about the system and comprehensive support package, including face-to-face advice and expertise, available	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification should be underway.	Understand the rules for those paying the surcharge, or exempt from paying it, presenting in GP practice.

	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
A secondary care clinician	Clear about the information to give to OVMs and the finance team Routine identification helping to provide costs and decisions on treatment promptly to patients	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification should be underway.	Understand the rules for those paying the surcharge, or exempt from paying it, in the hospital
An NHS trust manager or ward clerk	Clarity about the system with more straightforward identification of chargeable patients to flag up to OVMs and/or finance teams	There will be a mechanism to confirm those who have paid the health surcharge. Temporary residents from outside the EEA will start to have BRPs to present once the system is rolled out by the Home Office. An NHS record will be created for someone who has paid the surcharge. It will need to be checked and they will then be treated without further charge. Systematic collection of EHIC and other status information relevant to EEA and non EEA patients and status recording and notification should be underway.	Established mechanism to identify those who have paid the surcharge, or who are exempt from paying it, in hospital.
A commissioner	More and increasingly familiar data to hold providers to account	Providers will be able to identify those patients who are chargeable and from whom costs of care should be recovered.	Aware of the established mechanism.

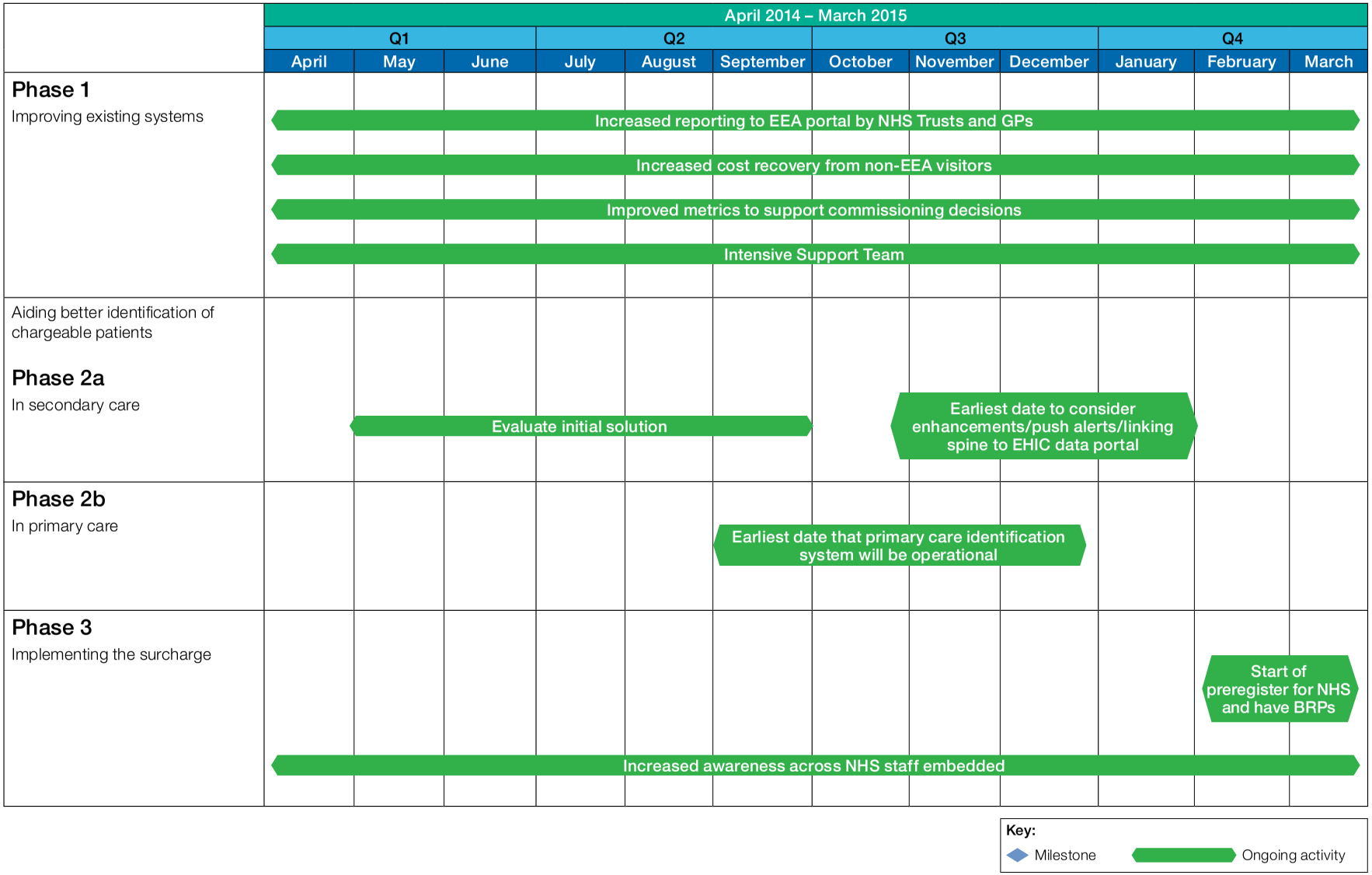
	Phases		
	1: Improving the system	2: Aiding better identification of chargeable patients	3: Implementing the surcharge
An insured visitor or resident pensioner from the EEA	Expect to be asked to provide EHIC or S1 forms to verify status in all NHS settings (or S2 forms if you are here seeking elective care)		

A non-EEA visitor (here for less than 6 months)	If visiting the UK and no exemption from charge category applies to you expect to pay in advance or to receive an invoice for care services provided on an immediately necessary basis. Be aware that failure to pay a debt of £1000 or more will usually mean refusal of a future visa or further leave to remain in the UK.
A Temporary migrant from a non-EEA country/subject to immigration control	Identified through the pre-registration system as having paid the health surcharge, or exempt from paying it, and free to access the NHS in the same way as an ordinarily resident patient. Able to present your BRP when requested by NHS staff.
An ordinarily resident patient	Will be expected to be asked to provide details to confirm residency when moving GP practices. Will be asked to provide details to confirm residency if you do not have a pre-existing NHS record before attending outpatient clinics and accessing increasing numbers of NHS services.

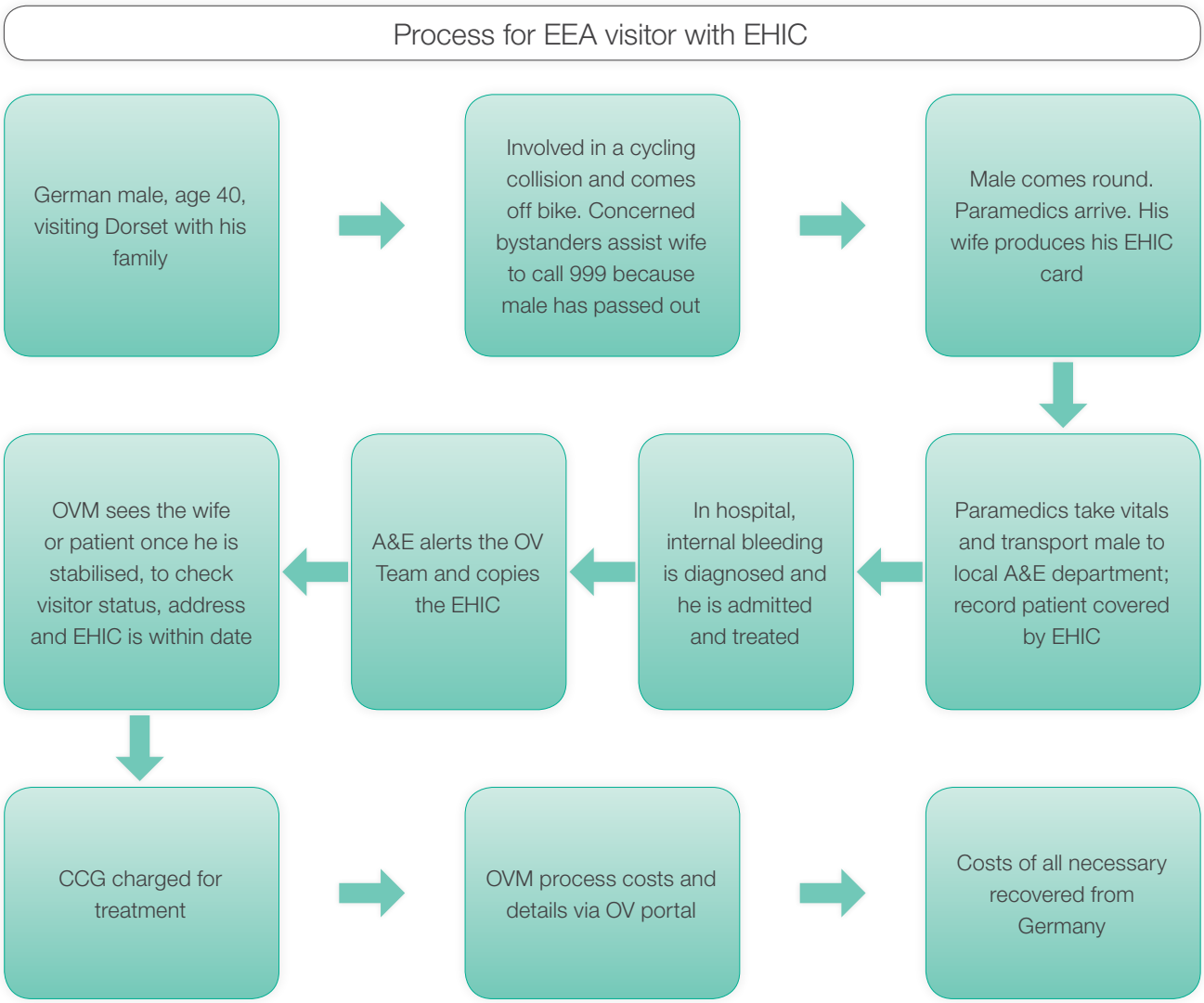
Annex A: Project plan timeline: April 2014– March 2015

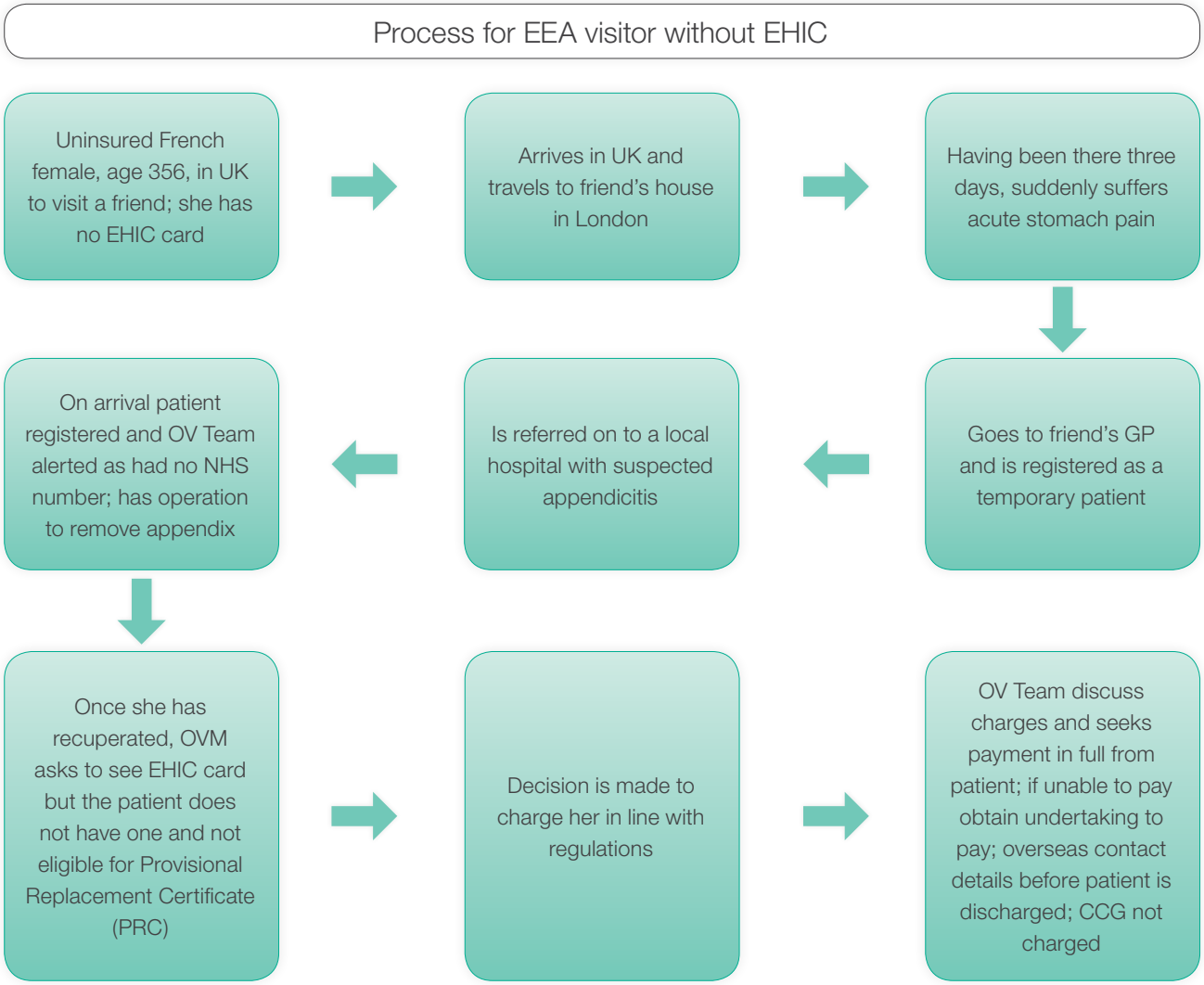


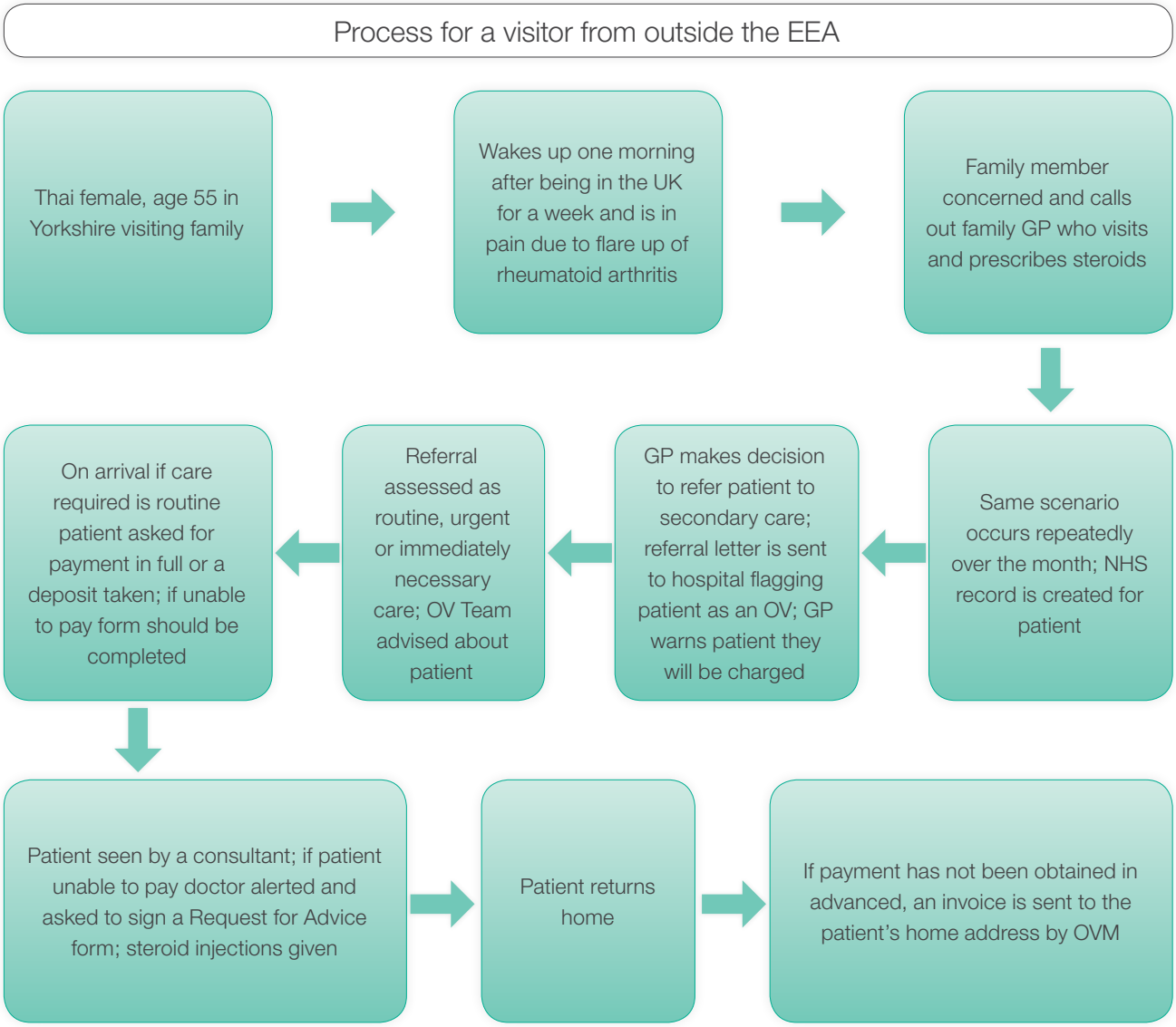
April 2015 – March 2016

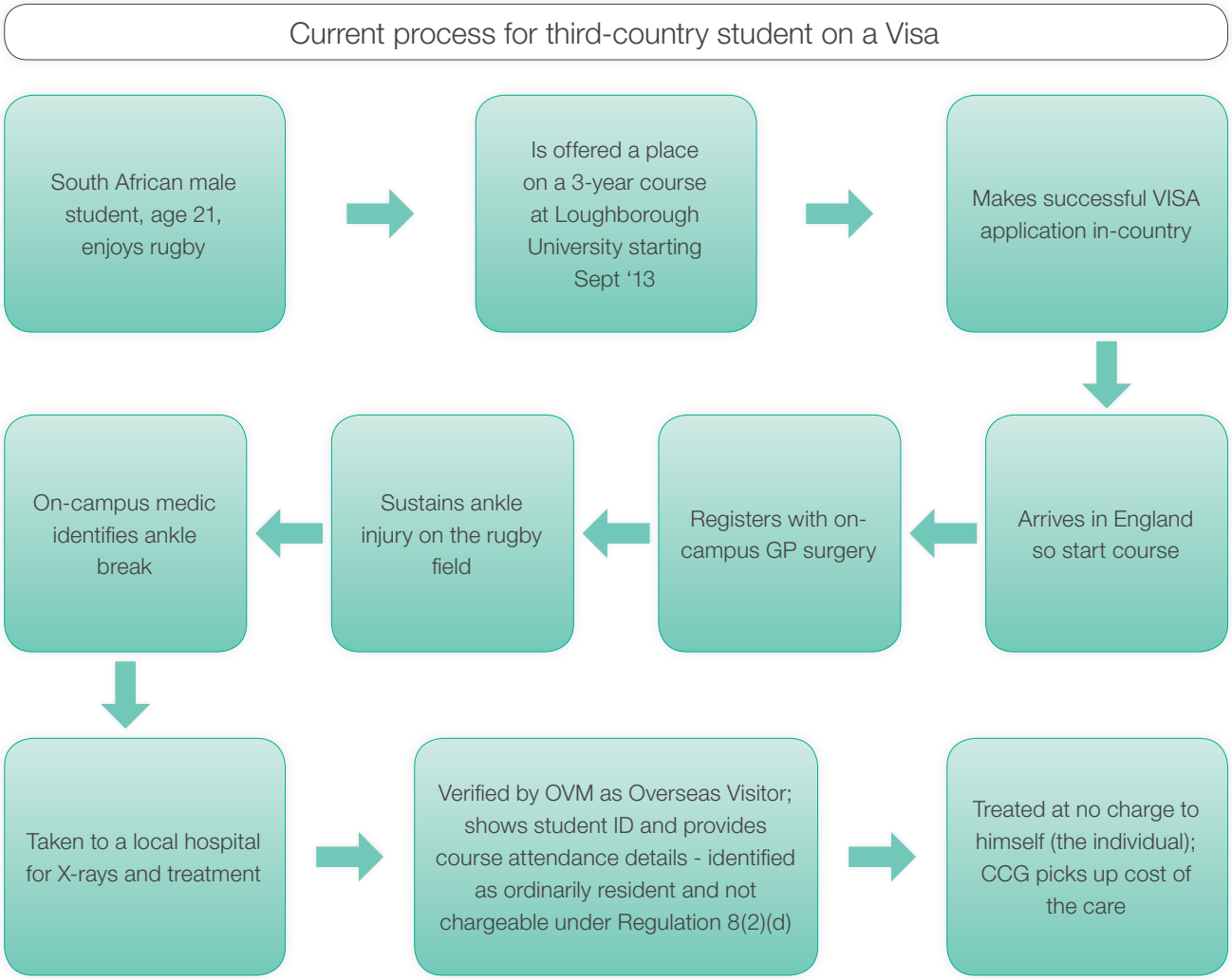


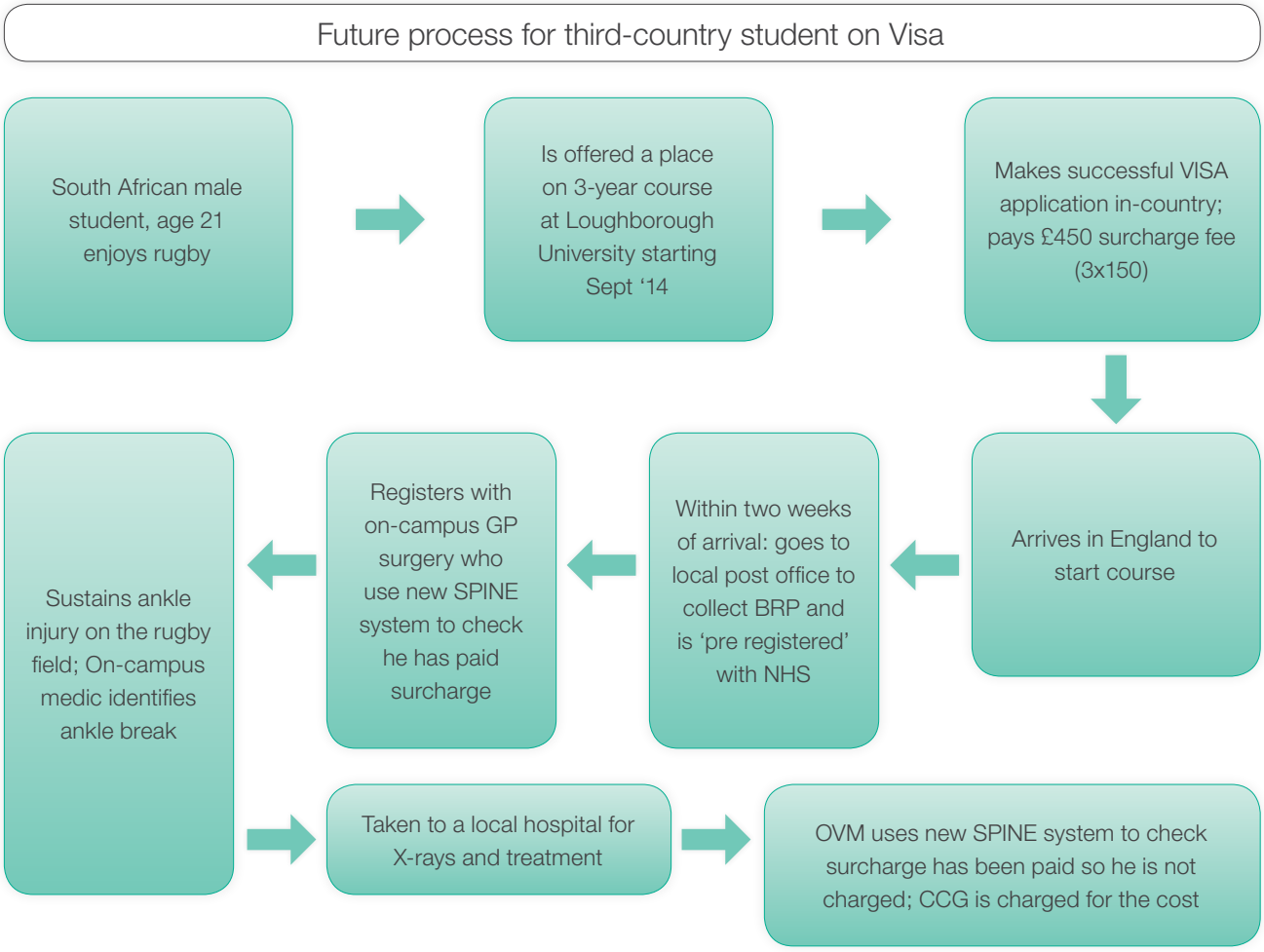
Annex B: How the system should work




Process for EEA visitor without EHIC
Uninsured French female, age 356, in UK to visit a friend; she has no EHIC card
Arrives in UK and travels to friend's house in London
Having been there three days, suddenly suffers acute stomach pain
Goes to friend's GP and is registered as a temporary patient
Is referred on to a local hospital with suspected appendicitis
On arrival patient registered and OV Team alerted as had no NHS number; has operation to remove appendix
Once she has recuperated, OVM asks to see EHIC card but the patient does not have one and not eligible for Provisional Replacement Certificate (PRC)
Decision is made to charge her in line with regulations
OV Team discuss charges and seeks payment in full from patient; if unable to pay obtain undertaking to pay; overseas contact details before patient is discharged; CCG not charged


Process for a visitor from outside the EEA
Thai female, age 55 in Yorkshire visiting family
Wakes up one morning after being in the UK for a week and is in pain due to flare up of rheumatoid arthritis
Family member concerned and calls out family GP who visits and prescribes steroids
Same scenario occurs repeatedly over the month; NHS record is created for patient
GP makes decision to refer patient to secondary care; referral letter is sent to hospital flagging patient as an OV; GP warns patient they will be charged
Referral assessed as routine, urgent or immediately necessary care; OV Team advised about patient
On arrival if care required is routine patient asked for payment in full or a deposit taken; if unable to pay form should be completed
Patient seen by a consultant; if patient unable to pay doctor alerted and asked to sign a Request for Advice form; steroid injections given
Patient returns home
If payment has not been obtained in advanced, an invoice is sent to the patient's home address by OVM


Current process for third-country student on a Visa
South African male student, age 21, enjoys rugby
Is offered a place on a 3-year course at Loughborough University starting Sept '13
Makes successful VISA application in-country
Arrives in England so start course
Registers with on-campus GP surgery
Sustains ankle injury on the rugby field
On-campus medic identifies ankle break
Taken to a local hospital for X-rays and treatment
Verified by OVM as Overseas Visitor; shows student ID and provides course attendance details - identified as ordinarily resident and not chargeable under Regulation 8(2)(d)
Treated at no charge to himself (the individual); CCG picks up cost of the care


Future process for third-country student on Visa
South African male student, age 21 enjoys rugby
Is offered a place on 3-year course at Loughborough University starting Sept '14
Makes successful VISA application in-country; pays £450 surcharge fee (3x150)
Arrives in England to start course
Within two weeks of arrival: goes to local post office to collect BRP and is 'pre registered' with NHS
Registers with on-campus GP surgery who use new SPINE system to check he has paid surcharge
Sustains ankle injury on the rugby field; On-campus medic identifies ankle break
Taken to a local hospital for X-rays and treatment
OVM uses new SPINE system to check surcharge has been paid so he is not charged; CCG is charged for the cost

Annex C: Tool Box

Refreshed documents

The following documents have been previously made available to the NHS and now form the basis of the 'toolbox' for use by overseas visitor managers (OVMs) and other NHS staff. They include:

- Pre-attendance form;
- UK permanent residence entitlement; and
- Useful contacts.

In addition, **certain flowcharts** that are included in the full version of *Guidance on implementing the overseas visitors' hospital charging regulations* will be made available in more accessible, poster-sized formats for use by OVMs.

Additional documents

The following documents will be made available for the first time as part of the toolbox:

- An '**aide memoire**' document showing all types of visa in circulation and how this relates to a person's immigration status;
- An awareness-raising guide for secondary care providers on **EEA mechanisms**;
- A quick guide to using the **EEA web portal** for EHIC and S2 form declarations;
- A printable quick guide to **EEA countries and contact points**; and
- A printable map of countries with which the UK has **bilateral healthcare arrangements**.

Template letters

In addition to the above tools, we have worked with OVMs, behavioural insights experts and the Depatment of Health's legal service to develop a package of template letters for use by NHS provider trusts. They are based on best practice principles of simplicity, brevity and clear English and are therefore strongly recommended for use by overseas visitor managers in their communication with possible or confirmed chargeable patients:

- First and final requests to patient to supply evidence of non-chargeable status;
- Letter to patient acknowledging receipt of documents and confirming chargeable status for procedure;

- Letter to patient acknowledging receipt of documents and confirming free access to procedure;
- Letter to patient acknowledging non-receipt of documents and confirming chargeable status by default;
- Undertaking to Pay NHS hospital costs form for patient's completion;
- Letter to patient with estimated maternity costs;
- Letter to GP informing him/her of patient's chargeability status; and
- Declaration form for clinicians to confirm urgent, immediately necessary or non-urgent status of treatment.

Annex D: Glossary

Accident and Emergency (A&E) services	These are services that are needed immediately in an emergency situation and under current regulations are free of charge to all overseas visitors, whether provided at a hospital accident and emergency (or casualty) department, an urgent care centre, a minor injuries unit, walk-in centre, or elsewhere, up until the point that the overseas visitor is accepted as an inpatient or given an outpatient appointment. Emergency treatment that is given after admission to the hospital (e.g. intensive care or coronary care) is chargeable to a non-exempt overseas visitor.
All medically necessary treatment	Treatment of all emergency, urgent and chronic conditions including the routine monitoring of them. It only applies to those visitors from the European Economic Area (EEA) and Switzerland who have valid European Health Insurance Cards (EHIC) or have Provisional Replacement Certificates (PRC) for them.
Application Registration Card (ARC)	An ARC is a credit card sized plastic document issued to all asylum seekers and dependents aged over five years. It indicates that they are going through the asylum process (including any appeal) and are eligible for free NHS care.
Asylum seekers	An asylum applicant is a person who either: (a) makes a request to be recognised as a refugee under the Geneva Convention on the basis that it would be contrary to the UK's obligations under the Geneva Convention for him to be removed from or required to leave the UK, or (b) otherwise makes a request for international protection.
Biometric Residence Permit (BRP)	A BRP is a card which holds biographic details (name, date and place of birth) together with 'biometric data' (fingerprints and facial image) which shows the immigration status and any entitlements a migrant may have while in the UK. People who pay the surcharge will be issued with a BRP in the future.
Community services	Services delivered in the community rather than at a hospital including things like rehabilitation, minor surgery in primary care.

European Economic Area (EEA)	Countries of the European Union (EU), plus Iceland, Liechtenstein and Norway, those states having signed an agreement to participate in the EU internal market. Whilst not a member of the EEA, Switzerland also signed up to EU legislation on the internal market and free movement of people. In this consultation, where EEA is referred to, for simplicity, this will include a reference to Switzerland.
European Health Insurance Card (EHIC)	A valid EHIC demonstrates that a visitor (including a student) is entitled to the provision of services under the EU Regulations and therefore entitled to free NHS treatment that is medically necessary during their visit. If they cannot show their EHIC, they may instead produce a Provisional Replacement Certificate (PRC) to prove entitlement under the EU Regulations. EHICs are individual documents to each family member, including children, have their own. For the UK to reclaim costs, the EHIC data must be sent to the Department of Work and Pensions' Overseas Healthcare Team.
European Union (EU)	An economic and political union established in 1993 after the ratification of the Maastricht Treaty by members of the European Commission.
Expatriate (Expat)	A British national who is no longer resident in the UK. Non-UK nationals may also be former residents of the UK and former contributors of UK National Insurance Contributions.
Immediately necessary treatment	Treatment which a patient needs: to save their life; to prevent a condition from becoming immediately life-threatening; or promptly to prevent permanent serious damage from occurring.
Indefinite leave to remain (ILR)	Indefinite leave to remain (often known as 'ILR' and 'settlement') is permission to remain in the UK without any time restrictions on the length of stay.
Non-European Economic Area (non-EEA)	Any country other than EU Member States, Norway, Iceland, Liechtenstein and Switzerland.
Non-urgent treatment	Routine elective treatment that could wait until the patient can return home.

Ordinary residence (OR)	OR is not defined in legislation but the concept has been developed by case law. A person will be OR in the UK when their residence is lawful, adopted voluntarily and for settled purposes as part of the regular order of his or her life for the time being, whether of short or long duration. The concept of "settled purpose" has also been developed by the courts. There may be one purpose or several, it may be specific or general, and it may be for a limited period. All that is necessary is that the purpose for living in the UK has a sufficient degree of continuity to properly be described as settled. Determination of OR is ultimately a question of fact and will depend on the individual circumstances of each case. The Immigration Act 2014 changes the meaning of OR in respect of non-EEA nationals subject to immigration control will not be able to be classed as ordinarily resident unless they have indefinite leave to remain in the UK, i.e. they are also a permanent resident of the UK. The new definition is expected to commence in early 2015/16.
NHS Overseas Visitors Managers (OVMs)	Not a specific title but the term often used to describe a designated person in an NHS hospital whose role is to see that the Charging Regulations are applied in practice.
Primary Care	Care provided by GP practices and other providers who act as the main first point of consultation for patients. This includes dental and ophthalmic services.
S1 form	The S1 is a European healthcare entitlement form for state pensioners living in a different European country to where their pension is paid. The S1 certificate of entitlement allows state pensioners access to the healthcare system in the European country where they have chosen to retire, and for that country to reclaim costs. For the UK to reclaim costs, the S1 must be sent to the Department of Work and Pensions' Overseas Healthcare Team.
S2 form	The S2 form is a mechanism that entitles patients to state-funded pre-authorised treatment in another EEA country or Switzerland, with the treatment being provided under the same conditions of care and payment as for residents of that country. For the UK to be reimbursed for the treatment the NHS has provided, the S2 details must be recorded and reported to the Department of Work and Pensions' Overseas Healthcare Team.
Secondary Care	Secondary care is defined as a service provided by medical or dental specialists who generally do not have first contact with patients.

The Spine	The Spine is part of the national NHS IT infrastructure that supports the delivery of health care in the UK. Amongst other things the Spine holds a record for every NHS patient, including their NHS number, and demographic details, which can be accessed via various methods, including a web-based portal (the Summary Care Record application) and local trust and GP systems where these are integrated with the Spine. These records are held in a database known as the Personal Demographics Service, facilitating the safe, efficient and accurate sharing of patient information across organisational and system boundaries within the NHS and providing non-clinical reference information for more than 70 million patients.
The Surcharge	The immigration health surcharge (the 'surcharge') is a payment, made on visa application, which will give those who pay it access to NHS services in the same way as a person ordinarily resident of the UK. It will be paid by most non-EEA temporary migrants when they apply for leave to enter or remain in the UK. It will not apply to non-EEA visitors (here for less than 6 months), who will continue to be charged for any treatment as now, unless exempt.
Temporary migrant	A non-EEA national who is in the UK for a time-limited period (usually between 6 months and 5 years).
Urgent treatment	Treatment which clinicians do not consider immediately necessary, but which nevertheless cannot wait until the person can be reasonably expected to return home.
Visitor	A non-EEA national in the UK for a short period (maximum of six months), such as tourists and those visiting friends and relatives, during which their main centre of interest remains in their own country.

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