January 2017

Overseas Visitor and Migrant

NHS Cost Recovery Programme

Formative Evaluation – Appendices to final report

Prepared for the Department of Health by Ipsos MORI

Contents

List of Tables

A: Programme outcomes

Table A.1: Measurement of Programme Outcomes

Domain	Outcome	Measure
• Financial	• Increased amount recovered from EEA patients (S1, EHIC) • Increased amount recovered from non EEA (individual visitors) • Increased level of invoicing • Increased recovery rates • Minimised cost loss	• Annual data on EEA recovery amount (DWP) • Number of EHIC details logged on the system • Data on non-EEA recovery (DH, Monitor, TDA) • Debt amount written off
• System/Culture	• Commissioners more involved in charging/recovering process • Effective Registration system which enables identification • Increased numbers of chargeable patients being identified • Increased efficiency – less time taken to process chargeable patients	• Qualitative feedback on commissioners' involvement? • Use of pre-registration process • Number of surcharge patients linked with NHS system • Data collected from trusts on number of identified chargeable patients • Feedback from trusts on time taken to process patients • Reporting to HO of high cost debtors (against baseline)
• Unintended outcomes	• Public health deterrence – People being deterred from care which is necessary to prevent the spread of disease • Impact on vulnerable groups (e.g. the homeless) • General deterrence – people being deterred from urgent care. Could lead to worse illness and/or more costly treatment • Initial shifts around health system from one part to another • Improved efficiency	• Percentage of homeless registered with NHS • Monitor outbreaks (outbreaks from abroad) • Patient estimate letters

B: Survey details

Survey methodology

For the baseline survey Ipsos MORI conducted interviews with a total of 2165 respondents between 7th August and 2nd October 2014, using a Computer-Assisted Telephone Interviewing (CATI) methodology. For the interim survey, 2170 respondents were interviewed between 2nd February and 13th March 2015 using the same methodology. For the follow-up survey, 2156 respondents were interviewed between 18th January and 15th April 2016.

Survey question topics

A questionnaire was designed to collect baseline evidence at the early stages of the implementation of the Cost Recovery Programme. In order to do this, questions were designed to cover a range of key themes, as outlined in Table B.1.

The survey was targeted at seven core staff groups, with questions routed depending on the relevance to their role, and prioritisation of what information needed to be collected from each group. Table B.1 below outlines the question topics that were asked of each staff group as part of each survey wave – please note some questions were changed between waves to take account of changes to the Programme or planned future activities.

Table B.1: Question topics by staff group

Staff Group	Questions – Baseline survey	Question topics – Interim survey	Question topics – follow-up survey
OVMs	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence & perceptions of training	Incidence, type and perceptions of training
	Current behaviour around charging	Current behaviour around charging	Current behaviour around charging
	Ease/difficulty of charging processes	Ease/difficulty of charging processes	Ease/difficulty of charging processes
			Support from senior staff and primary care
			Effectiveness of charging processes
	Programme awareness & support	Programme awareness & support	Programme awareness & support
	Culture	Culture	Culture
		Awareness and views on the Cost Recovery Support Team	Awareness and views on the Cost Recovery Support Team
		Incentive schemes	Incentive schemes
Trust Chairs/Board members	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence & perceptions of training	Incidence & perceptions of training
	Inclusion of cost recovery in QIPP programme	Inclusion of cost recovery in QIPP programme	Inclusion of cost recovery in contribution to Efficiency Challenge

	Programme awareness	Programme awareness	Programme awareness
			Confidence in processes; importance of cost recovery
	Culture	Culture	Culture
		Awareness and views on the Cost Recovery Support Team	Awareness and views on the Cost Recovery Support Team
		Incentive schemes	Incentive schemes
CCG Leads/Board members	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence & perceptions of training	
	Inclusion of cost recovery in contracts with Trusts	Inclusion of cost recovery in contracts with Trusts	Steps taken to ensure Trusts' compliance with charging regulations
			Confidence in processes
	Programme awareness & support	Programme awareness & support	Programme awareness & support
	Culture	Culture	Culture
		Awareness and views on the Cost Recovery Support Team	
		Incentive schemes	Incentive schemes
Primary Care staff	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence & perceptions of training	
	Roles and responsibilities	Roles and responsibilities	Roles and responsibilities
	Current behaviour around charging	Current behaviour around charging	Current behaviour around charging
	Programme awareness & support	Programme awareness & support	Programme awareness & support
	Culture	Culture	Culture
		Incentive schemes	
		Cost recovery in Primary care	Cost recovery in Primary care
Hospital Doctors	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence & perceptions of training	Incidence, type and perceptions of training
	Roles and responsibilities	Roles and responsibilities	Roles and responsibilities
	Current behaviour around charging	Current behaviour around charging	Current behaviour around charging
	Programme awareness	Programme awareness	Programme awareness
	Culture	Culture	Culture
		Incentive schemes	Incentive schemes

Hospital Nurses	Knowledge and awareness	Knowledge and awareness	Knowledge and awareness
	Incidence & perceptions of training	Incidence, type and perceptions of training	Incidence & perceptions of training
	Roles and responsibilities	Roles and responsibilities	Roles and responsibilities
	Current behaviour around charging	Current behaviour around charging	Current behaviour around charging
	Programme awareness & support	Programme awareness & support	Programme awareness & support
	Culture	Culture	Culture
		Incentive schemes	Incentive schemes
Administrative Staff	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules	Knowledge and awareness of charging rules
	Incidence & perceptions of training	Incidence, type and perceptions of training	Incidence & perceptions of training
	Roles and responsibilities	Roles and responsibilities	Roles and responsibilities
	Current behaviour around charging	Current behaviour around charging	Current behaviour around charging
	Programme awareness & support	Programme awareness & support	Programme awareness & support
	Culture	Culture	Culture
		Incentive schemes	Incentive schemes

Achieved sample profile

During fieldwork, quotas were set for each of the seven staff groups to ensure that the requisite number of interviews was achieved. In addition, minimum quotas were set within the staff groups by a number of other variables, for example region[1] and role/seniority to reflect the known population profile of NHS staff in England. Furthermore, 'soft quotas' were set by organisation; interviewers were instructed to limit the number of interviews completed with staff in individual Trusts or CCGs (aiming for no more than 2-3 per staff group in any organisation), to ensure that the final sample included representatives from a good spread of Trusts, primary care practices and CCGs across England.

Table B.2 shows the final number of interviews achieved within each staff group for the baseline, interim and follow-up surveys.

---

[1] Based on Health Education Areas.

Table B.2: Achieved sample profile and quota details

Staff group	Achieved interviews: Baseline survey	Achieved interviews: Interim survey	Achieved interviews: Follow-up survey	Quotas set
OVMs	50	50	50	Region (based on HEE areas)
Trust Chairs & Board Managers	200	203	203	Region (based on HEE areas)
CCG Leads/Boards	202	200	200	Region (based on HEE areas)
Primary care: clinicians (GPs and practice nurses)	202	200	200	Region (based on HEE areas); Role (min. 100 GPs & 100 Practice Nurses)
Primary care: practice managers	100	100	100	Region (based on HEE areas)
Hospital Doctors	401	402	400	Region (based on HEE areas); seniority (Consultant or equivalent; Registrar or equivalent; Junior doctor – prior to-full registration)
Hospital Nurses	400	414	401	Region (based on HEE areas); seniority (Senior – band 6 or above; Staff nurse/Band 5 or equivalent)
Admin Staff	610	601	602	Region (based on HEE areas); Role (200 Senior Accountants; 200 Consultant Secretaries; 200 Reception staff)
Total	2165	2170	2156	2150

Source: Ipsos MORI.

Awareness of charging

Much of the analysis presented in this report is based only on those participants who reported being aware that some patients are chargeable for NHS healthcare.[2] This is highlighted throughout the report, either in the main body of the text or in footnotes where appropriate. The survey questions this applies to are as follows;

KR5, KR5a, KR6, KR7, KR8, RR1A, RR2, RR3, RR7A, RR8, RR9, RR10, RR11, RR12, RR13, RR14A, OVM1, OVM2, OVM4A, OVM4B, OVM5, OVM6, OVM7, CCG1, CCG2, CC2, CC3, PA6, PA7, IA1, IA3, IA4, IA5, IA6, PC1, PC2, PC2a, PC3, PC3a, PC4, PC4a, PC5.

Table B.3 provides a breakdown of the base sizes for each staff group, after filtering by awareness of chargeability.

Table B.3: Sample sizes when filtered by awareness of chargeability

	Aware that some patients are chargeable for NHS healthcare: Baseline survey	Aware that some patients are chargeable for NHS healthcare: Interim survey	Aware that some patients are chargeable for NHS healthcare: Follow-up survey
OVMs	47	48	47
Trust Chairs & Board Managers	163	158	159
CCG Leads/Boards	126	130	122
Primary care: clinicians (GPs and practice nurses)	113	109	105
Primary care: practice managers	48	52	36
Hospital Doctors	208	210	226
Hospital Nurses	166	174	198
Admin Staff	310	268	372
Total	1181	1149	1265

Source: Ipsos MORI.

Technical information

As part of the data preparation, weighting was applied to the data within all staff groups apart from OVMs. Due to a small base size and the fact that no weighting was applied please treat results for OVMs as indicative only.

The following questions included an 'Other (specify)' response option: KR2, KR3, KR4, KR5a, KR8, RR1A, RR2, RR12, RR13, CCG1, PA3, PA4A, PA4B, PA4C, ST3, ST4, IA1, IA3, IA5, PC1, PC2a, PC3a, PC4a.

---

[2] Answering 'yes' to the question; *Thinking about services other than dental, optical and prescriptions, as far as you are aware, is there anyone who is chargeable for the NHS healthcare they receive, or not?*

Our specialist coding team assimilated all responses which fell into the 'Other (specify)' category to create several new response codes for each question. Thus any large differences between waves in the proportions giving particular responses to these questions should be interpreted with caution.

'*%' represents a value of less than one half of one percent, but greater than zero.

The weighting schemes were derived based on available HSCIC data for region and/or grade. Table B.4 details the criteria by which the data for each staff group was weighted.

Table B.4: Weighting criteria

	Weighting criteria
OVMs	No weighting applied due to small base size
Trust Chairs & Board Managers	Region (based on HEE areas)
CCG Leads/Boards	Region (based on HEE areas)
Primary care: clinicians (GPs and practice nurses)	Region (based on HEE areas); Role (GP/Practice Nurse)
Primary care: practice managers	Region (based on HEE areas)
Hospital Doctors	Region (based on HEE areas); seniority (Consultant or equivalent; Registrar or equivalent; Junior doctor – prior to full registration)
Hospital Nurses	Region (based on HEE areas); seniority (Senior – band 6 or above; Staff nurse/Band 5 or equivalent)
Admin Staff	Region (based on HEE areas)

Source: Ipsos MORI.

All data presented is based on all respondents within a staff group, unless otherwise stated.

For some of the survey results, sample sizes are very small. Where results are based on fewer than 30 respondents, figures are shown as raw numbers rather than percentages. These findings should be interpreted with caution and considered indicative only.

Because a sample, rather than the entire population, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50% of the people in a (weighted) sample of 200 respond with a particular answer, the chances are 95 in 100 that this result would not vary more than ten percentage points, plus or minus, from the result that would have been obtained from a census of the entire population (using the same procedures). An indication of approximate sampling tolerances is given in table B.5.

Table B.5: Confidence intervals

	Differences required for significance at the 95% confidence level at or near these percentages					
	Baseline	Interim	Follow-up	10% or 90%	30% or 70%	50%
OVMs	50	50	50	12	18	20
Trust Chairs & Board Managers	200	203	203	6	9	10
CCG Leads/Boards	202	200	200	6	9	10
Primary care: clinicians (GPs and practice nurses	202	200	200	6	9	10
Primary care: practice managers	100	100	100	8	13	14
Hospital Doctors	401	402	400	4	6	7
Hospital Nurses	400	414	401	4	6	7
Admin Staff	610	601	602	3	5	6

Source: Ipsos MORI.

Note on Hospital Doctors

For the follow-up survey, 2156 respondents were interviewed between 18th January and 15th April 2016. Please note that three junior doctors' strikes took place during this fieldwork period; this had a significant impact on response rates among the hospital doctors sample group, and registrar-level doctors proved particularly difficult to schedule interviews with. The fieldwork period was extended for this reason. Furthermore, there were fewer completed interviews among registrar-level doctors vs. the quota targets set, and compared with previous waves.

Although the results for the hospital doctors group were weighted so that the profile of respondents matches the known population of hospital doctors as closely as possible, we would advise that the results for this group are interpreted with particular caution.

C: Management information analysis

This note provides an overview of the sources of Management Information (MI) analysed in the compiling of this report, any additional sources of data drawn upon, such as the International Passenger Survey data, as well as an overview of the results of the initial analysis. At this stage in the implementation of the programme the analysis focussed on an early assessment of the evidence on how the Programme is performing with regards to delivering an increase in the level of costs recovered from overseas visitors and migrants receiving treatment through the NHS.

Sources of Management Information

EEA Data

In helping develop a better understanding of the performance of the Programme during the first two years of implementation, an analysis of the data made available by the Overseas Visitor Team at the Department for Work and Pensions, for EEA patients. This data included:

- Costs identified and logged for treatments delivered to patients who were residents of EEA countries in the period April 2009 to March 2016 (inclusive).

- The data from the web portal included:

- All treatments delivered via EHIC or S2 arrangements.[3]

- Each entry includes details of: Trust at which treatment was received; country of residency; Date of treatment (start and end); Date entry created; Date entry last updated; Date processes; Whether incentive has been paid; and total cost of treatment.

- Data was edited to remove treatments delivered by Trusts or primary care practices in Wales, Scotland and Northern Ireland for the purposes of this analysis.

At the time of producing this report, there was no data available for the use of S1 forms.

Data relating to non-EEA residents

Further to the above data relating to costs recovered from EEA residents through EHIC agreements, data was also made pertaining to the recovery of costs from non-EEA residents. This data is based on the data provided to NHS Improvement by each individual NHS Trust and NHS Foundation Trust. Data was available for the financial year immediately prior to the launch of the Programme (2013/14), and the first two years of the Programme's implementation (2014/15 and 2015/16). Data was available at an individual Trust level for each year across each of the following variables:

- **Income recognised in year:** The total value of treatments provided to non-EEA (and directly chargeable EEA) residents, and for which invoices have been received, during the financial year in question.

---

[3] For the purposes of this analysis only treatments covered by EHIC agreement were included.

▪ **Cash payments received in-year:** The actual cash income received by a Trust in the financial year in question. This payment may relate to invoices raised in the current financial year, or in previous financial years.

▪ **Amounts added to provision for impairment of receivables:** The total value of treatments for which payment is yet to be received, but where a Trust still maintains a hope of recovering the value of the treatment. This figure may relate to invoices raised in the current financial year, or in previous financial year. This debt may, for example, have been passed to a debt recovery agency.

▪ **Amounts written off in-year:** The total value of treatments for which the payment is partially or fully outstanding, and Trusts have deemed this to be unrecoverable, and is therefore counted as a loss. This figure may relate to invoices raised in the current financial year, or in a previous financial year.

Additional information

In addition to the sources of MI outlined in the table above, the further key supplementary sources of information which fed into this analysis were:

▪ Data on the volume of overseas visitors to the United Kingdom, from EU countries, compiled by the Office for National Statistics based on the International Passenger Survey[4], with data available up until March 2016 (inclusive).

---

[4] http://www.ons.gov.uk/ons/about-ons/get-involved/taking-part-in-a-survey/information-for-households/a-to-z-of-household-and-individual-surveys/international-passenger-survey/index.html

D: Case study methodology

A series of case studies and interviews conducted across thirteen NHS Trusts in England during the course of the evaluation. Separate sets of case studies were conducted as part of each of Years One and Two of the evaluation.

Year One case studies

A total of seven NHS Trusts in England were involved in case studies between September 2014 and May 2015. These case studies had originally been designed to encompass baseline and follow-up visits to Trusts to speak to OVMs, and other staff members across a range of areas within the Trusts. These case studies were designed to provide more detailed feedback on the Programme and its implementation, to complement the Staff Survey, as well as to provide feedback on a key set of processes involved with the Emergency Care pilot (in which three case study Trusts were participating). However, due to the difficulties experienced in setting-up case study visits, a number of compromises were made to fit in with the Trusts involved. Three Trusts participated in baseline and follow-up visits, while the remaining Trusts participated in fewer visits, as outlined below:

- One Trust in a baseline visit only;

- One Trust in a one-off visit at the time of the other follow-up visits;

- One Trust in a baseline visit and a follow-up OVM consultation; and

- One Trust in two OVM consultations.

As part of the case study work, a wide range of staff were interviewed across the Trusts involved. Staff groups consulted included: OVMs (or their equivalent if no distinct role); Senior Trust staff (e.g. Finance Directors/Governance Directors/Operational Performance Directors/Deputy Director of Nursing); Administrative staff (receptionists, administrative managers); A&E staff (receptionists, supervisors, operational managers) and Ward staff (patient service coordinators, ward clerks, discharge managers). Every effort was also made to consult frontline clinical staff, although this was not possible across all the case study sites due to difficulties experienced in securing access to this group.

Year Two case studies

Building on the experiences, and in particular, difficulties of conducting the case studies during Year One of the evaluation, a revised approach to the case studies was agreed with DH for Year Two. Year One case studies proved useful in understanding the barriers faced at a Trust-level, with little evidence of progress being bade throughout the first year of the Programme. As such, a single round of case studies was to be undertaken across Trusts identified by DH as being examples of good practice, in order to allow the collection, and sharing, of best practice case studies. However, significant issues were again experienced by both DH and the evaluation team in securing agreement from Trusts to take part in the case study work. As such, case study visits were only possible to two Trusts. To supplement the evidence collected here, in-depth telephone interviews were conducted with the OVM (or Overseas Visitors Officer in one case) in five additional Trusts.

Josh Keith
Associate Director, Policy and Evaluation Unit
josh.keith@ipsos.com

Anna Carluccio
Research Director, Health and Social Care
anna.carluccio@ipsos.com

Chris Hale
Director, Policy and Evaluation Unit
chris.hale@ipsos.com

For more information

About Ipsos MORI's Social Research Institute
The Social Research Institute works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. This, combined with our methods and communications expertise, helps ensure that our research makes a difference for decision makers and communities.