**The National Health Service (Charges to Overseas Visitors) Amendment Regulations 2017 Workshop**

**6th June 2018**

**Output from event**

1. **Ian Cameron Director of Public Health, Leeds City Council**

Ian Cameron opened the event and welcomed all.

* Noted there were concerns about migrant health in Leeds. Hence, a number of people from public health, the voluntary sector, the CCG and others got together through the Migrant Health Board to tackle this agenda.
* The first Migrant Health Board meeting was held and a view was raised that the charging regulations were the most important issue for us to tackle.
* Services commissioned by LCC are affected by these regulations, including public health services.
* Important to note that the health system is connected. One thing has an impact on another so the effect is visible. It also means we need to work together to make an impact and effect change.
* There are implications for the vulnerable groups.
* This event has been organised to give people the opportunity to share views on this agenda and start to find a way forward.
* We want to be a compassionate city and it is important that we support our communities to improve their health.
1. **Liz Maddocks and Aidan Hallett (Migration Yorkshire)**

Support role regionally.

* Patterns and numbers of asylum seekers supported in the city overtime have dropped, so in terms of charging, they are entitled to free treatment but may face barriers all the same as hospital staff may not understand their status/rights and the asylum seekers themselves may not be able to advocate for themselves. They may not speak English and there may not be an interpreter. Also they may not know their rights, or be in fear of authority figures due to their uncertain status in the UK.
* Dispersed asylum seekers-G4S find properties, these are usually in poorest areas of the city, reflecting lower costs.
* Population increases are generally due to births. Although it is often portrayed that the increase is due to migrants, in 2016 only 9% was made up of migrants.
* However, these are the stats we know about. What about those lost to the system - Gaps likely includes Roma/Kurds, Trafficked individuals, Refused asylum seekers who are destitute (key group), undocumented migrants, migrants who have come to join their families who are already in the UK and migrants who have left an area, region or the UK.
* Issues include language and literacy barriers and there have been examples of non-consistent practice leading to racial profiling.
* Important to have advocacy support to migrants so they know their rights/entitlements and can access the services they need and are entitled to.
1. **Ella Johnson (Doctors of the World)**
* Impact of charges.
* Doctors of the World founded in 1980 and consists of volunteer doctors who can provide vulnerable individuals with short term medical advice.
* The average length of time in UK before accessing Drs of the World service is 5.9yrs so this is a huge barrier. Much of this is because vulnerable people find it hard/cannot get registered with a GP to access primary care services.
* A very vulnerable group is the undocumented migrants-some do not seek asylum because they cannot get legal advice. Refused asylum seekers are also very vulnerable and are sometimes women, so adds an extra layer of vulnerability.
* Sometimes have come here on spousal visa and have since split, perhaps due to DV so status is compromised and so is entitlement.
* Charges have been extended into community services. There is a lot of confusion around the charges. Over half of patients coming to Drs of the World do not try to access the NHS due to perceived barriers-admin, lack of understanding and language barriers.
* Patients fear they cannot fund the cost of accessing services. This results in major health issues, as they present late.
* Access to healthcare is important. When conditions are caught sooner it costs less than when symptoms have persisted. However, there should not be any decisions made without a clinical assessment, but in a non-healthcare setting it is hard to see how this would work.
* The proportion of NHS budget that migrants cost is 1.83% according to Department of Health estimate. This is all migrants, including EEA migrants and not just undocumented individuals.
* A point was raised that information about ‘how migrants help the NHS’ was seldom seen. It was noted that this would be good to see as it is not currently documented.
* 1 in 3 vulnerable patients that Drs of the World see do not go to hospital because they fear they cannot pay. Many of those coming do not come with reciprocal agreements. Those who cannot make payments do have a number of options in order to make payments. However, if they slip behind with payment, after 2 months, debts of £500+ should be reported to the Home Office. This connection between health care and the Home Office department is also obviously unsettling for someone in a vulnerable position.
* Prescriptions is another issue. Some will be exempt from prescriptions but others will have to pay - Clinicians are encouraged to have honest conversations so it does not come as a shock when patients receive a bill.
* ‘Drs not Cops’ movement have done a lot to publicise the mismatch of this policy with their ethical beliefs and practice as doctors, and DOTW has worked with clinical partners including BMA, RCGP and Royal college of midwives.
1. **Corinne Lee Overseas Visitors Manager (**St James’s University Hospital Leeds)
* There is no one way to ensure treatment is provided and a case by case approach is required. Urgent care is accessible regardless and the Trust is fully committed to acting with compassion and empathy.
* If colleagues are aware of cases where this basic premise has been breached, Corinne would like to know about it, so she can follow it up.
* In her Trust, one question is asked of everyone **‘How long have you lived in the UK?’**
* If less than 12 months then they will ask the person to fill out an eligibility form, which covers date of entry to UK, Nationality and Residence. They will be asked for potential source (for infections) and the clinician’s advice will be sought for level of treatment.
* They will let the clinician know of chargeable status as a matter of courtesy, but the patient is led through the form and if it is obvious that the patient cannot pay, treatment should not be withheld, or the patient pressed for payment.
* Corinne felt that all is there to administer the scheme fairly, but it does depend on interpretation and how you apply it.
* Challenges - there are challenges to ensure patients get the right information- in high volume patient areas and also when patients cannot provide evidence of entitlement.
* However she said that only 2% are assessed and out of these, 80% are found to be exempt and 20% go on to be chargeable.
* A question from the floor-Are there any targets? Is it intended to raise income-this has not been done.
1. **Richard Jackson (Voluntary Action Leeds)**
* Charging is just another process / barrier. Important to have in mind the end result in terms of supporting the health of our population.
* Could take the view that there is lack of clarity – therefore, if in doubt don’t charge, or charge as little as necessary.
* The regulations are vague so you interpret as you see it?
* There are clear shared values in Leeds which is good to see.
* In Leeds we have Migrant Health Board and Health and Wellbeing Board and Migration strategy - all support this work.
* Public Health England has also been vocal and against health services sharing data with the Home Office.
* Richard feels from the discussions so far that there are 3 tangible actions around:
1. Systems
2. Communications
3. Values
* Local policy level to be adapted.
* CCGs involvement is key. There didn’t seem to be much representation- absence was noted.
* Need to discuss with Local authorities beyond Leeds – share best practice.
* It was suggested that we develop a proposition from Leeds, which other authorities could sign up to.
* Resource around communication should be shifted to those implementing the changes.
* Be clear about the amended regulations & what we’re charging before communicating. Make sure providers know the amended regulations exists.
* From the floor – colleague Amelia – will have conversations with CCG colleagues.
* The Migrant Health Board sub group will meet after this event to analyse output from today and feedback.
1. **Ian’s summary**
* Fantastic to hear contributions and the enthusiasm in the room. The regulations are clearly of concern to many and thanks to everyone for contributing so much to this debate.
* Presentations and write up will be shared with all attendees in due course.
* We are committed to our Migrant Health Board preparing proposed actions that can be shared across the system and so help us move this forward.

**Part B**

**The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 Workshop 6th June 2018**

**Notes from the table top discussions**

**Table top discussions 1**

LCH were present and their services are mixed in terms of whether they could be provided in a GP surgery. IAPT, podiatry etc.

* They asked if GP services are free, why couldn’t they services be considered as an extension of GP contract and provided free. It was recognised that funding implications would probably preclude this.
* Calculating a tariff is really hard as each service is a different price-at the moment LCH is looking at average cost across the lot, as a possible way to decide.
* Some are primary equivalent services some are not
* There was a view that the fact that the regs were difficult to interpret and make workable meant people were at liberty to put the patient/user first and not charge if there is any doubt as to eligibility
* We felt that although we disagreed with the regs and felt them the wrong thing to apply, we could do good work to improve the system as it is now e.g. raising awareness of community of their rights, raising awareness and training of service staff so they do not turn away eligible people and then ensure that people can go through the system and seek treatment early/be treated with compassion at hospital (the regs do seem to be applied reasonably here). Advocacy is a key part of this-some way of helping people through the system is required. It was suggested that church/faith groups might be able to help
* Ian - we could possibly just say we are not going to adopt the regs (we are not sure yet what response there would be from this). This was repeated during feedback from the floor-what would happen if we refused to implement?
* Doctors of the World are doing some work to see if they can get an idea of how many people are getting turned away from services

**Key points**

* It is a big ask for providers to sort out which services are in and which are out (but regs state providers should enquire of heir commissioners as to whether they are commissioned as a primary service)
* Could do more to improve the system for vulnerable people now, regardless of whether we implement the regs. Lots of people are already not getting the services to which they are entitled

**Table 2**

Noted low level of reps from some quarters.

- Pinderfields are not aware of the amendments - changes

- Are you/your organisation clear which (if any) of your services might be affected, and how?

* IAPT was thought to be potentially affected

- Do you know which of your services are chargeable and which ones are exempt?

* No e.g. IAPT – it is a bit muddy

- If so, have you tried to implement the charges? If yes, have you had any

 feedback in terms of people accessing your service?

* Pinderfields – yes in acute settings.

- What do you think Commissioners need to do to ensure a compassionate

 approach can be taken?

* Holistic approach.
* How do we make the most of working together to make all parts of the system as compassionate as possible

- What do you think providers need to do to ensure a compassionate approach can

 be taken?

* Issues – admin capacity – training
* No support to check real tensions

Our 3 main points we’d like to share to start helping us develop a plan for Leeds are:

**Communications**

1. Understand what we are talking about - clarity
2. Communicate effectively
3. Activate it in a way which is true to the values of the city

**Providers**

- System which delivers the best outcome for patients

- How to work better together

- Improving advocacy

- Supporting people demonstrating poor practice to do it better

- Collection of data which is not burdensome

- Communication – de-mystifying

- Support to enable organisations to know how much we should be charging

- Who will hold 3rd sector organisations to account.

- Responsibility to equip people with the knowledge and awareness – walking in

 peoples shoes Commissioners to Providers.

**System –** to bediscussed at policy level

Who might be missing?

* CCG and LA colleagues beyond Leeds

**Communications**

* Clarity re what is and what is not chargeable, prior to wider communications.

**Commissioners**

**1. Assessment of pathways**

- How does that work and questions asked

- Re mapping, no guidance in community healthcare settings

- Pro active

- Feasibility re questions

- Mapping journeys through healthcare

**2. Consistency of application** – to avoid postcode application

- Key clear messages to people accessing health.

- Current impact to understand activity v impact

- Positive narrative and managing re migrants contributions, numbers etc.

- Needs assessment re Advocacy

- Work between NHS hospitals – wider health economy

**Table 3**

- Who makes decisions?

- Barriers in budget interpretation

- Wakefield health not around table

- Yes. Have heard of these regulations before today?

- Wakefield challenges to linking services - Public Health Department don’t do

 anything on this at the moment

- Are you/your organisation clear which (if any) of your services might be affected,

 and how?

* Not clear, not commissioners, Public Health Dept wouldn’t be clear at all consultation came out after.

- Leeds are reasonably clear.

- Changes of contract using this policy - where’s money coming from – consistency

- VCSE was safe place for people - now changed if charging is implemented

- CCG as commissioner influencer.

**Table 4**

- Do you know which of your services are chargeable and which ones are exempt?

* Yes in terms of guidance, CCGs, clinicians, Primary care.

- If so, have you tried to implement the charges? If yes, have you had any feedback

 in terms of people accessing your service?

* Little evidence on implementation. Anecdotal, not implemented.

- What else does your organisation need to find out about charging?

* Local Authorities need to come together to have a consistent approach.
* Need to get CCGs views on implementing.
* Need to know how 3rd sector will be affected.

- **Migration Yorkshire** – all responsible for migrants. Those who work with

 migrants, but be aware, immigration status changes.

Our 3 main points we’d like to share to start helping us develop a plan for Leeds are:

1. Support for those who have responsibility to implement and for the navigators
2. People don’t know about current situation.
3. Commissioners need to be clear what’s important for them - health of people or get money in. Need to work better to enable everyone to have a chance to participate in consultations.

- Consistency of application – how we communicate effectively

- Advocacy

- Public patient facing services

- Mandatory learning

**Table 5**

- Have you heard of these regulations before today?

* Yes

- Are you/your organisation clear which (if any) of your services might be affected,

 and how?

* Yes, some people – No for others

- Do you know which of your services are chargeable and which ones are exempt?

* No

- If so, have you tried to implement the charges? If yes, have you had any feedback

 in terms of people accessing your service?

* GP and 3rd sector reps = No

- What do you think Commissioners need to do to ensure a compassionate approach can be taken?

* Patient on family group as the focus.
* What do you think providers need to do to ensure a compassionate approach can be taken?
* Listen and offer clear options

Our 3 main points we’d like to share to start helping us develop a plan for Leeds are:

1. Need more clarity – awareness raising across the board
2. Aware there are charges but not “what” or “how”
3. Comparison/material guidance/statutory

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 Balance

**Table 6**

**Current situation**

- Mixed awareness re primary care and costs – confusion re registration guidance.

- Too much policing in primary care (not immigration officers).

- Clinicians – confidence re what’s chargeable / how to access advice.

**Commissioner actions:**

- Increase awareness to migrants re access to services / what costs…

- Increase awareness to primary care and beyond re ‘compassionate approach’.

- Public Health campaigns.

- Clear guidance available.

- Patient facing campaign.

What do providers need to do to ensure a compassionate approach can be taken?

- Awareness campaign.

- Educate workforce.

- Send messages to primary care / 3rd sector re what secondary care is doing to

 manage this.

- Underlying - ? Referral pathways re how both / all areas work.

- Consistent approach from all.

- Mandatory e-learning for staff.

- Safe surgeries in Leeds.

- What services are chargeable in the third sector?

- CCGs commissioned work – social prescriber?

- Public Health commissioned work – PH contract states NONE chargeable?

- Where do charges go? Make service private – additional sessions.

- 150%

- Tariffs?

- Clarity of regulations.

- What service is included?

- If explicit as a compassionate city we should deem as exempt.

- Improve system for most vulnerable.

VCSEs

* Contracts
* Training
* Clinical decisions

Best practice areas exemplars?

**Questions from the floor**

* How do we know what to charge and where does it go?
* The regs assume a team of people to administer the system-how does a small organisation of 6-7 people do this, alongside running their service?
* Many organisations are not aware of the regulations and more awareness raising is necessary. Also consistency of message is essential. We all need to be clear of message and saying the same thing. We are an interdependent system and what happens at one level affects the others
* Staff should be aware of the regulations and applying correctly and consistently (colleague in CCG can help with primary care-a meeting with her and other colleagues to discuss Safe Surgeries training)
* Corinne would like to know from others when the hospital system is reported to not be working as can then pick up to see where things are going wrong
* How is it possible to have a compassionate approach with a bad policy? Agree but is room for improvement for system as it is now anyway
* Commissioners need to be honest about which side they are on-to be clear on what is most important, the patient or the regs/collecting the money!
* When asked to commit to 3rd Sector doing some follow up-was a view that it needed resourcing and that those responsible for it should do it (but in the regs, onus is on providers).
* In terms of getting messages out this was agreed as necessary, but to see what the national consultation says first and then work with that-but do what we can to work together to make the system more functional.
* Richard picked up little support for the Regs and three levels that we need to work on Communications, Systems and Values.
* We need a proposition (agreed) but decided that this would come from the Migrant Health Board, after analysing the output from today.
* We need to share impact info and pass back to policy level.
* Small organisations need to know if service is chargeable and if in doubt to be able to not charge.
* Third Sector happy to play their part get messages out and raise awareness, but would like a commitment from commissioners to push back on bad policy.
* We can develop a Leeds wide across service approach/template and share with our closest neighbours e.g. Wakefield colleagues Yorks and Humber and beyond.

**Missing partners**

It was felt that Leeds CCG was not well represented (in terms of numbers) and should be encouraged to attend further meetings/engage.