Breach of Trust

A review of implementation of the NHS charging programme in maternity services in England

maternity action

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Maternity Action is the UK's maternity rights charity dedicated to promoting, protecting and enhancing the rights of all pregnant women, new mothers and their families to employment, social security and health care.

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Executive summary

This report investigates the degree to which NHS Trusts in England are complying with the regulations and guidance governing the NHS Migrant and Visitor Cost Recovery Programme ('the NHS charging programme'). The report draws on evidence from Maternity Action's Maternity Care Access Advice Service which delivers advice and legal representation to women affected by charging for NHS maternity care.

The NHS charging programme forms part of the Hostile Environment, a set of policies aimed at making life unbearable for undocumented migrants living in the UK. Women who are chargeable include refused asylum seekers and undocumented migrants who are destitute or living on very low incomes.

There is a growing body of evidence that charging for NHS maternity care is deterring women from attending for care. Migrant and asylum seeking women have long been recognised as a group at high risk of poor maternal health outcomes. There is increasing recognition in health policy documents and official data collection of the contribution of charging to maternal health inequalities.

The six Trusts selected as case studies in the report demonstrated significant failings in implementation of the charging regulations and guidance by NHS Trusts.

There were errors in assessing immigration status which resulted in women who were entitled to free NHS care wrongly receiving invoices. Many of these women were victims of trafficking or seeking asylum and highly vulnerable.

Department of Health and Social Care guidance supports debt write-offs for women who are destitute, however there were several Trusts which refused to write-off debts for women who were manifestly destitute. Several Trusts took an aggressive approach to demanding payment and used debt collection agencies to pursue debts from very vulnerable women. There were numerous instances where Overseas Visitor Officers rejected repayment plans as inadequate where women were manifestly unable to afford higher repayments.

Several Trusts showed an alarmingly poor understanding of the domestic violence provisions, rejecting sound evidence of abuse and making their own judgments about women's circumstances. There were a number of women who first heard about their NHS debts months or even years after they had given birth.

Where women challenged decisions, there was a consistent pattern of slow responses and resolution. Vulnerable women were left waiting for months for decisions on whether or not an invoice would be withdrawn or a debt written off.

These practices have a harsh impact on the pregnant women and new mothers subject to charging. Women reported high levels of stress and anxiety as a result of the charges and the difficulties in resolving them. Women were deterred from attending maternity care appointments and only attended after strong encouragement from Maternity Action advisers. Women were juggling very limited funds to make payments on their debt, foregoing food and essentials to do so.

The report challenges Government claims that 'extensive safeguards' are in place to protect the vulnerable, that charging is not deterring people from attending for care and that it has no impact on public health.

Women affected by charging include groups at high risk of serious illness and death during pregnancy, birth and postnatally. While NICE guidance and other health policy documents promote additional measures to improve access to care for these women, the NHS charging programme has the reverse effect, deterring women from attending for care, increasing stress and anxiety and exacerbating social and economic vulnerabilities.

Recommendations

Maternity Action calls for the immediate suspension of charging for NHS maternity care given the deterrent effect on women's access to maternity care.

In the interim, Maternity Action is seeking changes in the practice of Trusts to reduce the negative impact of charging on migrant women's access to maternity care. Maternity Action has worked with the Royal College of Midwives to develop guidance to assist NHS Trusts to make changes to various aspects of policy and practice. We ask:

1. That all NHS Trusts in England adopt the Maternity Action and Royal College of Midwives guidance, 'Improving access to maternity care for women affected by charging', and commit to implement the guidance.
2. That Trusts immediately undertake an audit of Overseas Visitor Manager files on women charged for maternity care to determine compliance with regulations and guidance, with Trust policy and with the Trusts' obligation to reduce health inequalities; and undertake swift remedial action where shortfalls are identified.
3. That Trusts release public reports on progress towards implementation of the guidance.

1. Introduction

An increasing area of work for Maternity Action in recent years has been supporting women whose access to essential NHS maternity care services has been compromised by the NHS Migrant and Visitor Cost Recovery Programme ('the NHS charging programme').

One of four advice lines offered by Maternity Action, the Maternity Care Access Advice Service (MCAAS) delivers specialised legal advice about NHS charges for maternity care. This service is open to all women who have been charged or are worried about being charged, their partners, friends and family, midwives, other health professionals, advice workers and community workers.

The service provides legal representation for undocumented migrant women who are destitute and are seeking a write off of their debt; legal representation for victims of trafficking, asylum seekers and refugees who have been wrongly charged for their care; and legal representation to undocumented women where the NHS Trust has not applied the "violence exemption". This legal representation, or casework, provides the evidence base for this report.

Minority ethnic women make up 85% of women using the MCAAS. This year alone, of the 220 women that the MCAAS has supported, 10% reported at least one form of gender-based violence, 85% had incomes below £10,000 and 40% of the women were single parents.

The service has been effective in improving the situation of the women who contact us. Amongst women receiving casework support, 95% reported increased awareness of their rights and 100% reported feeling less stressed. All women who were pregnant at the time of receiving casework reported that the service impacted on their attendance for NHS maternity care.

It is clear, however, that the problems with charging are systemic and cannot be effectively resolved by an advice service. The MCAAS is advising women who are often considering whether or not to attend for care out of fear of incurring a debt they cannot pay, and who are dealing with destitution, homelessness and violent and exploitative relationships. There are also hundreds of women each year who are not receiving support, either because they are not aware of the service or because they are focused on the more immediate questions of finding food and housing for themselves and their families.

Methodology

This report is based on a review of casework undertaken by the MCAAS in the period 2019-2020. The service delivered casework to 76 women in this time, a subset of the 732 service users who received one-off or short term telephone or email advice. Each casework client received legal representation from a Maternity Action immigration solicitor or adviser.

The researchers reviewed the casework data to identify those Trusts which were regularly appearing in the casework. Regularly appearing in the data does not necessarily demonstrate bad practice in and of itself, as some Trusts are better than others in signposting patients to support services.

The researchers undertook a focus group discussion with the legal advisers delivering the advice service. The discussion covered the sorts of problems encountered by advisers and the response from Trusts.

Advisers prepared anonymized case studies from those Trusts.

The six Trusts selected for the report were chosen on the basis of higher volume casework, a consistent pattern of incorrect decisions, and poor responses to representations from Maternity Action advisers. These are not exceptional Trusts, as casework records and feedback from advisers confirms that poor practice by Overseas Visitors Teams is widespread.

There are other NHS Trusts that demonstrate bad practice in charging women for their care that have not been highlighted in the following case studies. Furthermore, NHS Trusts do not necessarily apply charging practices uniformly and approaches to charging women for their maternity care differs amongst NHS staff members in each particular Trust.

All cases featured have been anonymised. Names, dates, nationalities and any identifying features have all been changed.

2. Background

2.1 The NHS Charging Programme

The NHS charging programme forms part of the Hostile Environment, a set of policies aimed at making life unbearable for undocumented migrants living in the UK.[1] In 2004, NHS Trusts in England acquired a statutory duty to determine the eligibility to health care of 'overseas visitors' and to apply charges to people not 'normally resident' in the UK. NHS Trusts are the organisational units within the NHS which deliver frontline health services. Since this time, charging regulations have become more stringent and exclusionary. Current charging regulations require Trusts in England to determine if a patient is chargeable and to issue an invoice for those charges, set at 150% of the standard commissioning tariff to NHS Clinical Commissioning Groups (CCGs).[2]

The programme is supported by dedicated Overseas Visitor Managers and other frontline staff within Trusts, detailed guidance from the Department of Health and Social Care (DHSC), and an oversight team within NHS England and NHS Improvement.[3] Maternity charging is just one aspect of charging policy, as charging regulations apply to all secondary (hospital) care (Department of Health and Social Care, 2021).

The NHS charging programme is used to limit access to NHS healthcare for individuals who are not 'ordinarily resident' in the UK. These include; those on short term visas of less than six months, such as fiancée visas or some student visas; destitute asylum seekers whose claims have been refused (and not in receipt of government support); and other 'undocumented migrants', such as women who left an abusive relationship and were dependent on their partner for their immigration status. Those affected by charging include some of the most vulnerable women living in the UK today, who live at the margins of society, without the ability to work or claim benefits.

Since 2017 hospital Trusts are required to ask patients for advance payment for an estimated charge for treatment unless care is 'urgent' or 'immediately necessary'.[4] All maternity care is deemed 'immediately necessary' and must not be delayed or refused because of a woman's inability to pay in advance. However, women are ultimately charged for their care and get charged for the costs of scans, late miscarriages, stillbirths, C-sections and vaginal births. Bills commonly start at around £7,000 and can rise to tens of thousands of pounds for more complex care for women and additional care for new babies.

The consequence of an unpaid bill is serious. Under current regulations the NHS has an obligation to report to the Home Office any unpaid debt of £500 or more which has been outstanding for two months and for which no repayment plan has been agreed. This debt is

[1] The Joint Council for the Welfare of Immigrants (2020) *Windrush Lessons Learned Review Briefing*. JCWI, London https://www.jcwi.org.uk/windrush-lessons-learned-review
[2] National Health Service England (2017) (*Charges to Overseas Visitors*) (*Amendment*) *Regulations* (SI 2017/756)
[3] Department of Health and Social Care (2021) Guidance on implementing the overseas visitor charging regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf
[4] National Health Service England (2017) (*Charges to Overseas Visitors*) (*Amendment*) *Regulations* (SI 2017/756) https://www.legislation.gov.uk/uksi/2017/756/made/data.pdf

taken into account in consideration of future immigration applications, potentially impacting on women's ability to regularize their immigration status.

The current charging regulations include some exemptions for vulnerable patients. Refugees, asylum seekers awaiting a decision, refused asylum seekers supported by the Home Office and victims of modern slavery are all exempted from NHS charges (for more detail see Chapter 3, Legal Framework). The Department of Health and Social Care (DHSC) also offers guidance on how to execute the charging regulations. It stipulates how Overseas Visitor Managers and other frontline staff should deal sensitively with patients who have experienced gender based violence; acknowledge that there are significant complexities in identifying vulnerable patients who may not immediately disclose experiences of torture or ill-treatment; use their discretion in writing off debt for patients who are destitute; escalate concerns with safeguarding leads when they are concerned about the welfare of any patient (see Chapter 3, legal framework).

While regulations and guidance are developed at national level, implementation sits with NHS Trusts. In a response to a Parliamentary Question (reproduced in full in Appendix A), Stephen Barclay MP said:

> The Department does not mandate any specific processes to determine the residence or chargeable status of patients. In order to identify those who may not be entitled to NHS-funded treatment, and to do so in a way that avoids racial profiling and discrimination, all patients need to be asked baseline questions to indicate whether they are ordinarily resident in the UK or if they may be an overseas visitor who should be assessed for charges.
>
> However, it is up to providers of NHS care to assure themselves that they are doing everything reasonable to determine the eligibility of patients who are entitled to receive free NHS care, an entitlement based on residency not nationality.

Stephen Barclay MP made particular note of the exemptions applying to some vulnerable groups:

> It is also worth noting that that the Charging Regulations already have extensive safeguards in place for the most vulnerable. Refugees, asylum seekers, some state supported failed asylum seekers and victims of modern slavery are all exempt from the Charging Regulations.

The Government has taken very limited steps to assess the impact of the NHS charging pro gramme. The most recent completed review, in 2018, was limited to the 2017 amendments, not the regulations as a whole and was undertaken a scant twelve months after the regulations were made. Despite receiving detailed submissions from charities and health professional bodies, the review report consisted of a short ministerial statement which is reproduced in full in Appendix B. The statement, delivered by Stephen Hammond MP, declared that:

> The review is now complete, and the evidence received demonstrated that there is no significant evidence that the 2017 amendment regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health.
>
> I am pleased that the review has shown that the 2017 amendment regulations are largely working in the way they were intended.

In 2020, the Government invited 18 stakeholders to submit evidence to an internal policy review to assess the application of the Charging Regulations to the groups identified as representing the most vulnerable in society. These were; pregnant women, those supported under Section 17 of the Children Act 1989, destitute migrants, victims of gender-based violence and torture, children and others. In a witness statement, a Department of Health and Social Care officer said that the assessment would be concluded in September 2020. As of August 2021, no such report has been released.

2.2 The impact of charging for maternity care

There is a growing body of evidence that charging for NHS maternity care is deterring women from attending for care. Maternity Action's 2018 research report, 'What Price Safe Motherhood?' found that migrant women were withdrawing from antenatal, perinatal and postnatal care for fear of incurring huge debts that they cannot pay or suffering Home Office sanctions for unpaid debt. Maternity Action's 2019 report, 'Duty of Care', explored midwives' experiences of NHS charging. The findings were consistent with the 2018 research, and further flagged midwives' concerns that charging affected their ability to deliver high quality care.[5,6,7,8,9]

In 2018, the Equality and Human Rights Commission published research on the barriers to accessing healthcare faced by asylum seekers in the UK which found that the charging policy has made healthcare 'unaffordable' for many people refused asylum and caused confusion around who is eligible for free healthcare and who is not.[10] The research identified particular problems facing pregnant women, where fear of the possible cost meant women sometimes did not get antenatal and other maternity care early or often enough.

Deterring women from attending for maternity care increases the risk of poor health outcomes for mother and baby. A succession of Confidential Enquiries into maternal deaths have found that women who died were disproportionately likely to have commenced care late (after 12 weeks of pregnancy) and/or missed antenatal appointments. These gaps in care are of particular concern as many women affected by charging are at significantly higher risk of maternal mortality and morbidity due to poverty and destitution and to the additional risks associated with being a recent migrant or asylum seeker.

[5] Feldman, R. (2018) What Price Safe Motherhood? Charging for NHS Maternity Care in England and its Impact on Migrant Women, Maternity Action. https://maternityaction.org.uk/wp-content/uploads/WhatPriceSafeMotherhoodFINAL.October.pdf

[6] Shortall, C et al., (2015) Experiences of Pregnant Migrant Women receiving Ante/Peri and Postnatal Care in the UK: A Doctors of the World Report on the Experiences of Attendees at Their London Drop-In Clinic. London, Doctors of the World.

[7] Nellums, L et al. (2018) Access to healthcare for people seeking and refused asylum in Great Britain. A review of evidence. Equality and Human Rights Commission Research Report 121. https://www.equalityhumanrights.com/en/publication-download/access-healthcare-people-seeking-and-refused-asylum-great-britain-review

[8] Nellums, L et al (2021) "It's a life you're playing with": A qualitative study on experiences of NHS maternity services among undocumented migrant women in England'. Social Science and Medicine Vol. 270 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7895812/

[9] Feldman, R et al. (2019) *Duty of Care*? The Impact on Midwives of NHS Charging for Maternity Care. London. https://maternityaction.org.uk/wp-content/uploads/DUTY-OF-CARE-with-cover-for-upload.pdf

[10] Nellums, L et al. (2018) Access to healthcare for people seeking and refused asylum in Great Britain. A review of evidence. Equality and Human Rights Commission. https://www.equalityhumanrights.com/en/publication-download/access-healthcare-people-seeking-and-refused-asylum-great-britain-review

Maternity Action research found that charging for maternity care impacts on women's mental health, increasing stress and anxiety.[11] Women facing destitution, homelessness and deportation as well as additional health problems can experience acute anxiety when they receive an unexpected bill that they cannot afford. Anxiety and stress are recognised as having an adverse effect on immediate pregnancy outcomes such as pre-term birth and low birth weight.[12,13,14,15]

NHS charging increases women's vulnerability to domestic violence.[16] Women whose immigration status is dependent on their violent partner lose their entitlement to free NHS care if they leave the relationship. These women are not entitled to mainstream benefits and risk becoming homeless if they leave the relationship. Charging destitute women for maternity care increases their debts, and with few options to bring in an income, women are at increased risk of exploitation and abuse.

Recognising the severity of these risks to the health of mother and baby, a number of Royal Colleges and professional bodies have expressed concern about the impact of NHS charging. In 2018, the Royal College of Physicians, the Royal College of Paediatrics and Child Health, the Royal College of Obstetricians and Gynaecologists and the Faculty of Public Health published a joint statement calling for the suspension of NHS charging.[17]

In 2019, the Academy of Royal Colleges, the coordinating body for the UK and Ireland's 24 medical Royal Colleges and faculties, issued a statement calling on the DHSC to suspend the NHS charging regulations pending a full independent review of their impact on individual and public health.[18] The statement also called on the government to clearly separate the roles of the health care sector and migration authorities.

In the same year, the British Medical Association, published a report on the impact of NHS charging and a statement calling for a full and independent review into the impact of the regulations on individual and public health, the simplification of charging criteria and exemptions, and safeguards to ensure that vulnerable patients are not deterred from seeking care, are able to access the care they are entitled to and that necessary treatment is not denied due to difficulty or delay in proving eligibility.

[11] Feldman R. (2018) What Price Safe Motherhood? Charging for NHS Maternity Care in England and its Impact on Migrant Women, Maternity Action.
[12] Glover, V, Barlow, J. (2014) 'Psychological adversity in pregnancy: what works to improve outcomes' J Children's Services 9 (2): 96-108.
[13] Hobel, C., Goldstein, A. and Barrett, A. (2008), "Psychosocial Stress and Pregnancy Outcome" Clinical Obstetrics and Gynecology 51(2,):333–348.
[14] Mulder, E., Robles de Medina, P., et al. (2002) "Prenatal maternal stress: effects on pregnancy and the (unborn) child" Early Human Development 70: 3–14.
[15] Talge, N et al (2007) 'Antenatal maternal stress and long-term effects on child neurodevelopment: how and why?' J Child Psychiatry 48 (3-4): 245-61.
[16] Maternity Action (2019) A Vicious Circle: The relationship between NHS Charges for Maternity Care, Destitution, and Violence Against Women and Girls, Maternity Action https://maternityaction.org.uk/wp-content/uploads/VAWG-report-November-2019.pdf
[17] Joint Statement from the Royal College of Physicians, Royal College of Paediatrics and Child Health, Royal College of Obstetricians and Gynaecologists and the Faculty of Public Health (2020) https://www.rcplondon.ac.uk/news/royal-colleges-support-suspension-nhs-overseas-visitor-charges-pending-review
[18] Academy of Royal Colleges NHS charges to overseas visitors regulations; Academy statement (2019) https://www.aomrc.org.uk/statements/nhs-charges-for-overseas-visitors-regulations-academy-statement/

In 2021, the Royal College of Paediatrics and Child Health released a statement calling for an end to NHS charging. The statement cited the adverse effects of charging on child health and wider public health.[19]

2.3 Health Policy Frameworks

It is useful to consider charging policies within the context of the wider health policy frameworks. The National Maternity Safety Ambition set a target of halving the rate of stillbirths; neonatal deaths and maternal deaths by 2030.[20,21] There is widespread acknowledgement amongst policy makers that addressing health inequalities is essential for achieving this target. The NHS Long Term plan commits to roll-out the 'continuity of care' model of maternity care, with a target of 75% of women from Black and minority ethnic communities and 75% of women from the most deprived groups receiving this form of care by 2024.[22]

Migrant and asylum seeking women have long been recognised as a group at high risk of poor maternal health outcomes. The National Institute of Clinical Excellence (NICE) guidance CG110 'Guidance on Antenatal Care for Women with Complex Social Factors' identifies recent migrants, refugees and asylum seekers, and women who spoke or read little English as a distinctive group with 'complex social factors' and are more likely to experience 'high risk' pregnancy and birth.[23] NICE proposes that special efforts are made to improve access and engagement for these women. This includes ensuring that care involves early booking, more frequent antenatal appointments and continuity of care with a particular midwife. It is recognised that implementing the 'continuity of carer' model of care disproportionality benefits women with complex social needs.

Poor health outcomes for migrant and asylum seeking mothers form part of the disproportionately high rates of maternal mortality and morbidity of minority ethnic women. Confidential Enquiries into Maternal Deaths have shown an unabated trend for minority ethnic women, particularly black African and Caribbean women, to have significantly higher risks of maternal mortality than white British women.[24]

Racial disparities are also evident in data on miscarriage, stillbirth and neonatal deaths. The 2020 report 'Perinatal Mortality Surveillance Report on the death of babies before, during or

[19] Royal College of Paediatric and Child Health (2021) Access to healthcare for migrant and undocumented children; position statement. https://www.rcpch.ac.uk/resources/access-healthcare-migrant-undocumented-children-position-statement

[20] Department of Health and Social Care (2016) Safer Maternity Care: Next steps towards the national maternity ambition https://www.gov.uk/government/publications/safer-maternity-care

[21] Department of Health and Social Care (2017) Safer Maternity Care: Progress and Next Steps https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

[22] The National Health Service (2019) The NHS Long Term plan https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

[23] The National Institute of Clinical Excellence (2010) CG110 'Guidance on Antenatal Care for Women with Complex Social Factors' https://www.nice.org.uk/Guidance/CG110

[24] Knight M et al. (eds) on behalf of MBRRACE-UK (2019) Saving Lives, Improving Mothers' Care – Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17. Oxford: National Perinatal Epidemiology Unit, University of Oxford. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf.

soon after birth between Jan and December 2018' reported that Black and Black British and Asian and Asian British babies are up to twice as likely to be stillborn or die neonatally.[25]

There is increasing recognition in health policy documents and official data collection of the contribution of charging to maternal health inequalities. Public Health England has identified NHS charging for maternity care as one of the key issues that exacerbates poorer health outcomes for women and babies from BAME communities.[26] The 2019 Confidential Enquiry into Maternal Mortality reported that three of the 209 women who died between 2015 and 2017 were affected by charging for NHS maternity care and 'may have been reluctant to access care because of concerns over the costs of care and the impact of their immigration status'.[27] The National Child Mortality Database Programme recently introduced a new data item on NHS charging. This will enable them to pick up child deaths in the UK where the mother was subject to charges for care.

[25]Draper E S, et al. on behalf of MBRRACE-UK (2020) Perinatal Mortality Surveillance Report: UK Perinatal Deaths for Births from January to December 2018 https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_2018_-_final_v3.pdf

[26] Public Health England (2020) Maternity high impact area: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942480/Maternity_high_impact_area_6_Reducing_the_inequality_of_outcomes_for_women_from_Black__Asian_and_Minority_Ethnic__BAME__communities_and_their_babies.pdf

[27] Knight et al (eds) on behalf of MBRRACE-UK (2019) Saving Lives, Improving Mothers' Care – Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2015-17:p28.

3. NHS charging regulations and guidance

The various NHS charging regulations are made under Section 175 of the National Health Service Act 2006 (the 2006 Act), which allows the Secretary of State for Health to make regulations for the making and recovery of charges in relation to any person who is not ordinarily resident in Great Britain. It also gives the Secretary of State the power to calculate charges on any appropriate commercial basis.

Charging for NHS care is governed by the NHS (Charges to Overseas Visitors) Regulations 2015 ('the 2015 Regulations'), as amended by the NHS (Charges to Overseas Visitors) (Amendment) Regulations 2017, the NHS (Charges to Overseas Visitors) Amendment Regulations (EU Exit) 2020 and the NHS (Charges to Overseas Visitors) Amendment Regulations (EU Exit) (No 2) 2020.[28,29]

The 2015 Regulations place a legal obligation on NHS Trusts to make and recover charges from overseas visitors and provide that no charge can be made for individuals who are 1) ordinarily resident in the UK; or 2) who qualify for one of the exemptions. They also set out that certain vulnerable groups are exempt from NHS charges and include: asylum seekers and their dependents ('those with a current asylum claim'); refused asylum seekers supported by the Home Office under section 4 ('refused asylum seekers in receipt of Home Office support')**;** victims or suspected victims of modern slavery and their lawfully resident dependents ('victims of trafficking')**;** refugees and their dependents and unaccompanied children in the care of the local authority**.**

The exemptions do not offer protection from NHS charging for all vulnerable migrants. For example, migrant families supported by local authorities under the Children Act 1989 are not exempted from NHS charges, even though they are being supported by the local authority in order to avoid destitution.

The current charging regulations state that all maternity care is statutorily deemed '*immediately necessary'*. This means that it must not be refused or delayed if a woman is unable to pay for her care in advance. Main guidance explains that:

> 'Due to the severe health risks associated with conditions such as eclampsia and pre- eclampsia, and in order to protect the lives of both mother and unborn baby, all maternity services must be treated as being immediately necessary. Maternity services include all antenatal, intrapartum and postnatal services provided to a pregnant person, a person who has recently given birth or a baby. No one must ever be denied, or have delayed, maternity services due to charging issues'.[30]

[28] National Health Service England (2017) (*Charges to Overseas Visitors*) (*Amendment*) *Regulations* (SI 2017/756) https://www.legislation.gov.uk/uksi/2017/756/made/data.pdf
[29] National Health Service England (2020) (*Charges to Overseas Visitors*) (*Amendment*) *Regulations* https://www.legislation.gov.uk/uksi/2020/59/made/data.pdf
[30] Department of Health and Social Care (2021) Guidance on Implementing the Overseas Visitor Charging Regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf

Regulation 9 of the NHS (Charges to Overseas Visitors) Regulations provides exemptions from charging for services that treat physical or mental illness caused by torture, female genital mutilation or domestic and sexual violence. This exemption is not limited to maternity services.

The exemption relies upon establishing a causal link between the violence suffered by the patient and the treatment received, which in reality is difficult for clinicians and patients to ascertain. For example, it is very difficult to separate out maternity care which is 'caused' by FGM and what was incidental to it. There is a higher risk of caesarean section for women who have been subject to FGM, which then results in the NHS charges being significantly higher than for a vaginal birth. The same applies for care women receive when they are in a violent partnership. It is hugely difficult to separate out care as 'caused' by domestic abuse when the patient's care pathway will be informed by disclosure of violence in the first instance.

DHSC Guidance

The DHSC has also issued 'Guidance on implementing the Overseas Visitor Charging Regulations' (2021) ('the main guidance') and 'Upfront charging operational framework to support identification and charging of overseas visitors' ('the upfront charging guidance').[31,32] The guidance complies with the law on charging for maternity care. There are also a number of guidance documents available to NHS trusts from the Care Quality Commission (CQC), the Royal College of Obstetricians and Gynaecologists (RCOG) and the Financial Conduct Authority (FCA).[33,34,35]

Main DHSC Guidance explicitly states that no one must ever be denied, or have delayed maternity services due to charging issues (at 8.6). Furthermore, it stipulates that Trusts should not discourage women from attending their maternity appointments:

> 'Although a person must be informed if charges apply to their treatment, in doing so they should not be discouraged from receiving the remainder of their maternity treatment. OVMs and clinicians should be especially careful to inform pregnant patients that further maternity healthcare will not be withheld, regardless of their ability to pay.' - section 8.6 (the main guidance).

DHSC guidance also prescribes additional protective measures for vulnerable women:

> It is very important that the OVM/patient-facing administrative teams and clinicians consider the position of vulnerable patients who may not be eligible for free care, may be unaware that they are exempt from charging or who may have difficulty

[31] Department of Health and Social Care (2021) Guidance on Implementing the Overseas Visitor Charging Regulations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf

[32] Department of Health and Social Care (2021). Upfront charging operational framework to support identification and charging of overseas visitors. https://www.gov.uk/government/publications/overseas-nhs-visitors-framework-to-support-identification-and-upfront-charging/upfront-charging-operational-framework-to-support-identification-and-charging-of-overseas-visitors

[33] Care Quality Commission (2015) Guidance for providers on meeting the regulations: Guidance for providers on meeting the regulations Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended) Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended) https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

[34] Royal College of Obstetricians and Gynaecologists (2015), 'Best practice in comprehensive abortion care' Best Practice Paper No. 2, June 2015. https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper-2.pdf

[35] Financial Conduct Authority Consumer Credit sourcebook (CONC), as at September 2021 https://www.handbook.fca.org.uk/handbook/CONC/7/

> providing documentary evidence of their eligibility ... If at any point a maternity patient ceases to attend planned appointments, safeguarding procedures should apply, with immediate action taken to locate and speak to the individual to discuss any concerns they may have and their options for provision of care. It is important that providers work with other stakeholders in their local communities to embed and enforce effective safeguarding procedures and communicate with potentially vulnerable patients.' section 3.3 (upfront charging guidance)

The main DHSC guidance refers Trusts to the Home Office's non-statutory cross-government definition of domestic violence and abuse which is:

> 'Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members … regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; emotional behaviours … Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.[36]

Overseas Visitor Managers may be able to obtain confirmation from a medical professional (who is aware of the patient's health record) that violence has occurred and that the treatment being accessed is directly attributable to domestic violence. Otherwise, it states, an Overseas Visitor Manager should accept confirmation from a medical professional who could most appropriately identify signs and symptoms of domestic violence. When discussing patients who have been subjected to torture, the main DHSC guidance acknowledges that there are significant complexities in identifying patients who may be reluctant to disclose humiliating and degrading experiences of torture and ill-treatment.

In recent years, other statutory agencies have adopted guidance acknowledging the particular vulnerability of those with insecure immigration status and 'no recourse to public funds' to gender based violence. A woman's immigration status may be used as a way to further perpetrate abuse, including reproductive control, or may be used as a way of preventing her from reporting the behaviour to the midwife.[37] A combination of social and cultural factors, communication difficulties, lack of information in their own language and lack of access to informal and formal support may make it difficult for victims to disclose domestic abuse. Although the domestic violence exemption will apply almost exclusively to women with insecure immigration status, the DHSC guidance is silent on the particular vulnerability of this group.

Issuing Invoices and pursuing debt

DHSC Guidance also requires trusts to conduct 'reasonable enquiries' into a patient's liability for charging and states that chargeable patients should be advised of the estimated cost of care 'at the earliest opportunity'.

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[36] Department of Health and Social Care (2021) Guidance on Implementing the Overseas Visitor Charging Regulations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf

[37] Maternity Action (2019) A Vicious Circle: The relationship between NHS Charges for Maternity Care, Destitution, and Violence Against Women and Girls https://maternityaction.org.uk/wp-content/uploads/VAWG-report-November-2019.pdf

The invoice for treatment should clearly set out the reasons for the charge and 'a high-level explanation'of the charge. The DHSC upfront charging guidance states that trusts must communicate all payment options to them, such as affordable payment plans (at 5.6). The guidance does not explain what is meant by an affordable payment plan.

Trusts are required to pursue outstanding debts and are encouraged to consider using debt recovery agencies. There is no provision in the Regulations for NHS Trusts to waive or cancel correctly issued invoices for care. DHSC guidance confers the only discretion available to Trusts, which is to write off debt where the individual is destitute:

> 'Where it is clear that a person is destitute or genuinely without access to any funds, a relevant body can conclude that it is not cost-effective to pursue payment and write it off in their accounts. This is not a waiver nor extinction of the debt and the written-off debt remains on the relevant body's records and can be recovered'.[38]

Writing off a debt does not extinguish the debt or prevent the Home Office being notified of that debt. It merely provides that the debt no longer appears on the Trust's accounts and is generally no longer pursued by the Trust finance staff or debt collectors. Debts must be cancelled entirely if the charges they relate to are found not to have applied in the first place. When the NHS Trust accepts that a woman has been incorrectly charged for her maternity care, the Trust withdraws the invoice. The effect is that the woman has never received an invoice. Conversely, where the NHS Trust accepts that the woman is financially destitute and is unable to repay the debt on grounds of destitution, the invoice is written off. The effect is that the debt remains, and the NHS Trust can seek to recover the debt in the future. Currently, there does not appear to be a standard practice amongst NHS Trusts of how to recover the debt in the future.

[38] Department of Health and Social Care (2021) Guidance on Implementing the Overseas Visitor Charging Regulations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf

4. Findings

The six Trusts examined in this report were chosen on the basis of higher volume casework with Maternity Action's MCAAS service and a consistent pattern of incorrect decisions and breaches of guidance. They also demonstrated poor responses to representations from Maternity Action's MCAAS advisers. These are not exceptional Trusts, as casework records and feedback from advisers confirm that poor practice by Overseas Visitors Teams is widespread.

NHS Trusts do not necessarily apply charging practices uniformly and approaches to charging women for their maternity care differs amongst NHS staff members in each particular Trust.

All cases featured have been anonymised and names, dates and nationalities have all been changed.

4.1 Trust A

Mary

Mary came to the UK from Uganda and claimed asylum shortly after arriving. Mary's baby was born at a hospital under the remit of Trust A in 2017. At the time of the birth, she was told that she would be charged for her care. In 2019 she was contacted by the Trust and invoiced for over £3500. Mary offered to pay £10 a month towards the debt but was told by the Trust that this was not enough. Mary was very worried about how she was going to repay the debt as a single mother of two children.

When Mary contacted Maternity Action we told her that, as she had a pending asylum claim, she should not be charged for her care and that the hospital in question had in fact made a legal error in charging her. Maternity Action contacted the hospital Trust to rectify the issue. Neither Mary nor Maternity Action received any response from the Trust for just under three months, which meant that Mary had to endure an extended period of uncertainty over the charges. Eventually, the Trust cancelled the charges and accepted that Mary was exempt. Mary was eventually recognised by the Home Office as a Refugee.

Bernice

When Bernice first contacted the advice line in 2019, she was being housed and supported under the National Referral Mechanism (NRM) for trafficked persons. Bernice was in the third trimester with her due date imminent. Bernice told Maternity Action that she had been receiving bills for her NHS care and had several letters demanding payment.

She had attended her antenatal appointments and had found her midwife to be supportive of her difficult situation. Maternity Action wrote to the Trust to point out that Bernice was not chargeable under the regulations because she had been trafficked to the UK, had received a positive reasonable grounds decision from the Home Office and had been in the National Referral Mechanism for some time. The Trust agreed to withdraw the invoice.

Commentary

Women with outstanding asylum claims or who have received decisions confirming that there are reasonable grounds to believe that they are victims of trafficking are exempt from charging under Regulations 15 and 16 of the charging Regulations. These cases highlighted above are representative of the poor practice within this Trust and indicate that the Trust did not 'conduct reasonable enquiries' into a patient's liability for charging. In both cases, the woman's immigration status could be easily determined by a review of their documentation.

The NHS Trust relies on patients providing information about their trafficking status in order to establish their right to an exemption. However, women are not necessarily informed that being a trafficking victim exempts her from NHS charging. Women may well be generally unaware of the entitlements and services available to them because they have been trafficked. This lack of information means that there is a strong likelihood that other vulnerable women like Mary and Bernice have been charged when in fact they are entitled to free care.

One common impact of being wrongly charged was the evident increase in stress and anxiety experienced by these women. Many women accessing care at this Trust experienced long delays in hearing back from the Trust once a query has been made about the charges. This increases stress and anxiety and also affects attendance for care, as women are reluctant to attend appointments when their chargeability is still being established or challenged. Maternity Action advisers regularly encourage women to attend their appointments, despite the charges.

4.2 Trust B

Patricia

Maternity Action wrote to this NHS Trust asking that Patricia's debt be written off on grounds of her destitution. Patricia's family were being supported under Section 17 of the Children Act, 1989. The NHS Trust refused to write off the debt.

Marta

Marta disclosed ongoing domestic violence to her midwife whilst she was receiving maternity care and was supported to leave the violent relationship. Marta was not notified of the Regulation 9 domestic violence exemption and was charged for her care. Maternity Action made submissions to the Trust asking that they apply Regulation 9, however the Trust refused. Marta is now seeking advice about challenging the decision by Judicial Review.

Commentary

Women in receipt of Section 17 support have been assessed as destitute by their Local Authority. As part of a Section 17 referral, a very thorough assessment is carried out to determine a family's financial situation, which in this case was deemed precarious enough to require ongoing subsistence payments, as provided by the local authority. The Trust's failure to understand that Maternity Action had requested that the debt be written off based on grounds of destitution (and provided a detailed explanation of the rationale) raises concerns that the trust has not written off debts for women supported under Section 17 Children Act 1989 before.

Main DHSC guidance states that '*where it is clear that a person is destitute or genuinely without access to any funds, a relevant body can conclude that it is not cost-effective to pursue payment and write it off in their accounts*'.[39] Yet this particular Trust refused to write off the debt in accordance with the guidance, which makes it extremely difficult for women to navigate this system without legal representation.

In both cases mentioned above, the Overseas Visitor Manager stated that they would need to contact the DHSC for input about the cases. This raises new concerns about the administration of the charging programme. It is unclear what additional expertise the DHSC can contribute to the assessment of destitution for Section 17 recipients, given that the Local Authority has already undertaken a comprehensive assessment. The Children's Society found that in some cases, families supported under Section 17 of the Children's Act were living on less than £3 per person per day.[40]

It is also clear that women are not being made aware of their entitlements and the exemptions afforded to them from the regulations. Overseas Visitor Managers should endeavour to increase a patient's awareness of the charging regulations. If a woman has disclosed domestic violence to her midwife, the midwife's advice should be treated as definitive and Overseas Visitor Managers or finance staff should not request further evidence. As one of Maternity Action's advisors notes:

> 'the workability of the [domestic violence exemption] depends on victims knowing that the exemption exists and knowing the process, as well as feeling safe enough to disclose the violence to hospital staff'. - Maternity Action legal advisor.

4.3 Trust C

Marissa

Marissa gave birth during the first wave of the Covid-19 pandemic. She received an invoice of over £10,000 for her maternity care which she could not repay as she was undocumented and destitute. Marissa and her children were facing homelessness and Maternity Action referred her for specialist advice on her housing situation.

Maternity Action notified the NHS Trust of Marissa's destitution and asked that her account be put on hold. The Overseas Visitor Team agreed to put her account on hold for 20 days. Following the 20 day period, Marissa received a letter from the debt collection company informing her that this was the third and final reminder and that her account was being prepared for legal action. Maternity Action requested that the NHS Trust agree to write off the debt on grounds of Marissa's destitution. Marissa and her children were by this time supported by the Local Authority under Section 17 of the Children Act, 1989 following a detailed financial assessment which had concluded that Marissa and the children were destitute and homeless. Marissa has been waiting for a decision about whether they will agree to write off the debt from the Trust for 11 months despite frequent requests from Maternity Action requesting a decision.

[39] Department of Health and Social Care (2021) Guidance on Implementing the Overseas Visitor Charging Regulations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/977345/Main_Guidance_post_February_2021_v3.pdf

[40] The Children's Society (2020) A Lifeline for All Children and Families with No Recourse to Public Funds https://www.childrenssociety.org.uk/sites/default/files/2020-11/a-lifeline-for-all-report.pdf

Esi

Esi is a Ghanaian national who was 26 weeks pregnant with her third child when she contacted Maternity Action. At that time, Esi was temporarily living with a family member with her other children following the breakdown of her relationship. She was relying on her local church and a food bank for food and support. As an undocumented migrant, Esi had no means to earn an income or receive benefits. Maternity Action referred Esi for advice about her entitlement to receive support from Social Services under Section 17 of the Children's Care Act 1989, and following a detailed assessment, the Local Authority agreed to support Esi and her children.

Before Esi had given birth, the Trust began writing to her requesting that she pay over £9,000 for her maternity care. The hospital proceeded to pass her details onto a debt collection company to chase Esi for the debt. Despite Maternity Action requesting that the debt collection company should pause chasing Esi for money while she and her children were homeless and destitute, the company still issued a final notice reminder letter.

Esi became so scared about accruing more debt that she said that she was afraid to attend an antenatal appointment. Maternity Action encouraged her to attend the appointment and eventually she decided to attend. Maternity Action contacted the Trust and requested that the debt be written off because she did not have the means to pay the charges. Esi's mental health deteriorated and she struggled to care for her children, living in difficult circumstances.

The NHS Trust made a decision to write off the debt twelve months after Maternity Action's request. The Trust agreed to write off the debt only for a period of six months, and therefore, Esi will have to shortly begin the process again.

Ilona

Ilona, a Romanian national, approached Maternity Action's advice line with a bill more than £3,000 from this particular Trust. Ilona was trafficked to the UK in 2020 via Europe. Ilona did not claim asylum immediately on arrival to the UK due to the ongoing Covid 19 pandemic, language barriers and a lack of knowledge of the immigration system. She first accessed maternity care when she was in her second trimester.

Ilona received multiple late payment letters and contacted Maternity Action for advice. After checking her immigration status with the Home Office, the Trust agreed to cancel one invoice in full, recognising that Ilona had an outstanding asylum claim at the time of the birth. However, an additional invoice was outstanding because Ilona had received care before claiming asylum. The Overseas Visitor Manager requested that a repayment plan be set up for the remaining amount. Maternity Action requested that the NHS Trust put her account on hold until she received a decision regarding her refugee status. Following negotiations, the NHS Trust agreed to cancel the charges in full.

Elizabeth

Elizabeth contacted Maternity Action for advice as she had received a bill from the Trust for her maternity care. As Elizabeth had made an asylum claim, she was exempt from charges. Maternity Action wrote to the Trust asking that they cancel the invoices.

The Trust refused, explaining that Elizabeth was chargeable for her care as the ARC card issued to her by the Home Office evidencing that she had claimed asylum was issued after the date she claimed asylum. Maternity Action wrote back to the Trust explaining the Home Office's procedures for issuing ARC cards and providing further evidence of the date she

made her asylum claim. Two months after Maternity Action first wrote to the Trust, they confirmed that they had checked with the Home Office and agreed to cancel the invoice issued to Elizabeth.

Zenia

Zenia is a single parent who had recently fled a violent relationship with her children. She was accommodated by the Local Authority under Section 17 of the Children Act, 1989 on account of her destitution. Maternity Action provided evidence of the violence to the Trust including a letter from her Domestic Violence advocate.

Maternity Action requested that the NHS Trust apply Regulation 9 of the charging regulations and exempt Zenia from over £8000 of charges for her maternity care. The NHS Trust refused to apply the exemption giving the reason for refusal that Zenia did not notify her GP or midwife of the domestic violence. The letter provided to the Trust from the Domestic Violence advocate setting out the history and the involvement of Social Services was ignored.

The Trust also instructed a debt collection agency, which sent a letter to Zenia containing threatening language and legally incorrect implications for her immigration applications because of the NHS debt. Zenia was told that all future visa applications for the lifetime of the debt will be refused unless she agreed an acceptable repayment plan. The letter threatened Zenia that if she had an outstanding asylum claim in the UK, the debt will be taken into consideration affecting her legal status. Maternity Action referred Zenia to a public law solicitor for advice about challenging the decision by way of Judicial Review.

Commentary

Maternity Action has had 19 clients from this Trust since the beginning of 2019 and it has a particularly aggressive culture towards vulnerable migrant women seeking maternity care. This Trust does not, as a whole, adequately explore the exemptions as detailed in the current regulations. The failure of the Trust to exempt asylum seeking patients from NHS charges is of real concern and means that women who should not be charged are getting charged and are then having to fight the Trust for the charges to be cancelled. Two of the above cases took a high level of input from the legal advisers who had to explain to the Trust the significance of the documents issued to the women by the Home Office, such as ARC cards. Furthermore, failure to consider trafficking when deciding chargeability, increases the risk of women being re-trafficked due to their increased economic vulnerability.

This Trust does not adequately consider writing off the debt for accounting purposes when it is clear that a patient is manifestly unable to repay debts due to her financial situation or destitution. As mentioned before, DHSC guidance states that Trusts have the discretion to write off debt. In the case of Esi, this particular Trust decided to write off the debt but only for six months, which means that she continues to contend with debt and destitution simultaneously. Because of the debt, Esi was becoming increasingly fearful of accessing any further maternity care at the Trust. Women will continue to avoid accessing maternity care when they are attending maternity appointments that push them further into debt, poverty and economic vulnerability.

Women who access maternity care at this Trust can wait months to hear the outcomes of their queries, which in turn, increases the likelihood that women will avoid attending appointments until late into their pregnancies. The Trust also uses the services of a debt collection company that has been known to reference the law incorrectly and threaten women if they do not agree a repayment plan suggested by the Trust (which is illustrated further in Trust D,

below). Pushy communications from Trusts and debt collection agencies, the use of threatening language and final reminder notices only serves to scare women and put an additional strain on their mental health. As in the case of Zenia, trying to negotiate satisfactory proof that she experienced domestic violence started to feel Kafkaesque in its complexity and added to her stress levels, having to navigate pregnancy, violence, debt, and legal action at the same time.

4.4 Trust D

Rene

Rene was 34 weeks pregnant at the time of first contacting Maternity Action and was receiving antenatal care at this particular Trust. The Trust invoiced Rene for over £4,000 for the antenatal care which she was still receiving. Rene was undocumented and destitute and as a result had no means to repay the debt that had been issued. The demands for repayment had caused significant distress for Rene, especially given that she was already considered a '*high risk pregnancy*.'

When she was unable to pay the debt, the Overseas Visitor Management team instructed a debt collection company to pursue the debt on behalf of the Trust despite the fact that they had been made aware that Rene was destitute and that she was still receiving her antenatal care. At the beginning of 2021 Rene received a letter from the debt collection company which included the following text in bold red writing:

> '**Unless an acceptable repayment arrangement is in place all future Visa applications (if applicable), for the lifetime of the debt, will be denied. If you already have a visa or are from a country that does not require a visa to enter the UK you may be detained by the UK border Agency while entering the UK. If you have an asylum or residency application with the Home Office the outstanding account will be taken into consideration, which may affect your legal status to remain in the UK**'**–** Letter received by client early 2021

Upon receiving this letter, Rene was extremely distressed and her GP referred her for some counselling support. Eventually the Trust agreed to cancel the invoice that had been sent to Rene to prevent her experiencing any more distress. Again, this took time, effort and input from Maternity Action advisors. It is worrying to think about women who do not access services to help them navigate the charging programme and who try to do this alone, with minimal resources or expertise at their disposal.

Commentary

The letter sent by the debt collection company misrepresents the law. The Immigration Rules and associated guidance does not state that the Home Office will refuse *all* future visa applications unless an acceptable repayment arrangement is in place.[41] Secondly having an outstanding debt will not *under any circumstances*, affect the decision as to whether an indi-

[41] ***Immigration Rules*** state that the Secretary of State for the Home Department *may r*efuse the application for leave to enter or remain of a person subject to immigration control with outstanding debts of over £500 for NHS treatment. *Refusal on the basis of an outstanding NHS debt in these categories is discretionary*, not mandatory and the Secretary of State for the Home Department policy guidance states that there must be no 'compelling, compassionate circumstances or human rights considerations which would make refusal inappropriate...'

vidual seeking asylum in the UK is granted asylum or international protection. To say otherwise is misleading, inaccurate and is threatening to individuals who are made vulnerable by their immigration status.

We are finding that the language used in communications to patients are overtly hostile, and not in the spirit of patient-centred care of which the NHS strives to achieve. This particular debt collection company is used by a number of Trusts.

4.5 Trust E

Joan

Joan is a Cameroonian national who was issued a bill for over £10,000 by a hospital under the remit of Trust E. During her pregnancy, she was subject to domestic violence. After one particularly violent attack when she was heavily pregnant, she was hospitalised. Upon getting in touch with the Trust regarding Joan's experience of domestic violence, the Overseas Visitor Manager responded that the definition of domestic violence needed 'further investigation'. In a follow up communication, the Overseas Visitor Manager decided that the incident described above would not be classified as domestic violence for their purposes as it was a 'one off event'. Joan was referred by Maternity Action to a public law solicitor for advice about challenging the decision by Judicial Review.

Carolina

Carolina, a single mother, was billed just over £3,000 for her maternity care. It was established that Carolina was chargeable but that, as with anyone who receives an NHS debt for their maternity care, was entitled to enter into an affordable repayment plan. At the time of contacting Maternity Action Carolina had no income and was being financially supported by friends and a local charity. The Trust followed up with Carolina in 2018 and demanded that she pay an initial instalment of £1,000 followed by around £80 per month. Carolina had no realistic way of paying the proposed repayment in the context of her dire financial situation. Carolina was encouraged to contact the Trust again to say that she is entitled to negotiate an affordable repayment plan.

Menna

Menna is a single mother with two children, both born in the UK. At the time of the births Menna was a refused Asylum Seeker although she was later granted leave to remain. This means that Menna was chargeable for her maternity care. However she was not notified about the debts by the NHS at the time of the births. Menna first heard about the NHS debt in 2020 when she was questioned by immigration officers at a UK airport. She was shocked, especially since several years had passed since the birth of her first child. Maternity Action contacted the Trust to enquire about negotiating a repayment plan. The Trust said that they would not provide a letter to the Home Office to say that a reasonable repayment plan had been agreed unless Menna had paid at least half of the bill upfront. This was not possible for Menna, who was living on a very low income and a single mother.

Delores

Delores was trafficked to the UK and had a reasonable grounds decision from the Home Office. She had not been interviewed by the Overseas Visitor Team when she received maternity care and had not been notified that she was chargeable for her maternity care, nor of any possible exemptions such as that for trafficking victims. When Maternity Action initially

made contact with the Overseas Visitor Manager, the incorrect decision to charge Delores was maintained. Further representations were required before the Trust would accept that the charges were raised incorrectly.

Jenna

Jenna contacted Maternity Action for advice as she did not know what to do about her NHS bill for her maternity care. Jenna was undocumented and destitute. She and her child had recently been supported by the local authority under Section 17 of the Children Act, 1989. Jenna disclosed to Maternity Action previous labour and sexual exploitation however she decided against a referral to the National Referral Mechanism for victims of modern slavery.

Maternity Action wrote to the NHS Trust and asked that the Trust agree to write off the debt in accordance with the DHSC guidance on account of Jenna's destitution. The Trust agreed to put debt recovery on hold for 12 months but refused to agree to write off the debt. This approach left Jenna with an unsatisfactory conclusion to the outstanding NHS charges with no real clarity how this would affect her immigration application.

Commentary

This Trust has taken an aggressive approach towards charging vulnerable migrant women. As we have seen with other trusts, the Overseas Visitor Managers have demonstrated a profound misunderstanding of the regulations and guidance, especially pertaining to domestic violence, writing off destitution and the negotiation of repayment plans.

DHSC upfront charging guidance states that trusts must communicate all payment options to them, such as affordable repayment plans (at 5.6). The guidance does not explain what is meant by an affordable repayment plan, which leaves a grey area for the trust and the women being charged. Maternity Action regularly advises women to go back to a Trust and spell out their entitlements to affordable repayment plans that are based on what they can reasonably afford. Chargeable women tend to live on very low incomes and as a result, in many instances repayments need to be very low in order to be affordable. It is also crucial that women enter repayment plans when possible because not doing so may impact on any current and future immigration applications.

Affordable repayment plans, based on what a woman can afford over and above her basic costs of living, should be made available to all low income women who are chargeable for their care and embedded into the practices and procedures of the NHS charging programme.

It is common practice for Trusts to chase debts (or even issue the first invoice) years after the birth or other maternity care treatment took place. Some women are informed of existing debts only when they come into contact with the hospital for unrelated treatment or immigration officials at UK airports. It is noted in the main DHSC guidance that issuing a late bill of which chargeable women were not aware puts the Trust at risk of regulatory action, prosecution or judicial review for maladministration (at 11.36). Maternity Action recommends that Trusts should write off debts where women were not advised that they were chargeable during the period of maternity care.

4.6 Trust F

Lydia

Lydia is a single parent with one child. At the time of her maternity care she was on Section 17 support following the breakdown of her relationship with the child's father who was physically abusive towards her during her pregnancy. Lydia received invoices for over £9,000 for the birth of her child. She contacted the hospital and offered to pay monthly instalments once she was able to work. Lydia received a letter from a debt collection company which stated that the Trust had instructed them to recover the debt despite the fact that she was in the process of negotiating a repayment plan and had been told that her account was on hold. She was then notified by the company that the proposed repayment plan was too small an amount. Maternity Action highlighted to the Trust the client's vulnerability, history of domestic violence and low income. The Trust eventually acknowledged that Lydia's situation made it almost impossible for her to pay the debt and eventually raised two credit notes to cancel the invoices issued.

Patience

Patience overstayed her visitor visa and therefore is chargeable for her care. Her baby spent several weeks in NICU before being discharged. At the time of the birth Patience did not receive any invoices for any charges and was not told that she was due to pay for any of the costs of the maternity care that she received. It was not until several years later that she was notified of the charges, having attended to the hospital for an unrelated appointment. At this time Patience received a bill for over £30,000 for the birth.

Patience has been extremely anxious about receiving this bill and her stress compounded by not having enough money make an upfront payment for her child's care. Eventually Patience agreed a repayment plan with the Trust and managed to proceed with her child's care. She started to fall behind on her repayments as she is relying on family and friends for all her living expenses, does not receive any benefits, and is not entitled to work.

Rosa

Rosa entered the UK on a visitor visa. Her children were all born in the United Kingdom. She is separated from her partner and has no means to earn income due to her immigration status as a visa over-stayer. Rosa was not notified of any charges until after the birth of her youngest child, when she was given a bill for her maternity care of over £9,000. Rosa could not ascertain which child the bill related to, since the bill did not break down the charges or offer any information about what care they were for. Rosa was eligible to pay for her care and set up a repayment plan despite the fact that she had no income and no means of repayment. She received a barrage of emails and daily calls from the hospital when she didn't make the repayments which made her anxious and afraid.

Commentary

A total of 15 women contacted Maternity Action about charges for maternity care received at Trust F. Of these 15 women 12 were offered legal representation. Five out of the fifteen women who contacted us for advice from this Trust disclosed that they had been subject to domestic violence or sexual violence by their partners. Nine of the women represented in 2019 and 2020 were also destitute.

This particular Trust, as we have also seen in other examples, does not have the safeguarding systems in place to identify and support chargeable women who are destitute and manifestly unable to pay the debt. Women like Rosa are currently pursued by NHS Trusts without

fully acknowledging the impossible financial burden this places on low or no income households. This ultimately means that women are making impossible decisions about whether to try and repay the debt or provide adequately for their family.

Furthermore, as we have seen with great frequency, women experience significant delays in reaching a conclusion to their complaint or query. In fact 50% of the women represented by Maternity Action at this Trust had to wait longer than six months for a decision. As previously noted, a delay in decision making adds to the anxiety experienced around charging.

5. Conclusions and recommendations

The case studies document a series of failings in implementation of the charging regulations and guidance by NHS Trusts. Errors in assessing immigration status resulted in women who were entitled to free NHS care wrongly receiving invoices. Many of these women were victims of trafficking or seeking asylum, indicating a high level of vulnerability. Determining immigration status can be complex, however it is imperative that Trusts have a swift and effective process for resolving this prior to issuing bills rather than relying on individual women to challenge bad decisions.

While the DHSC guidance supports debt write-offs for women who are destitute, there were several trusts which refused to write-off debts for destitute women. The decision by some Trusts to write-off debts for six months and then re-assess the write-off is increasing the stress placed upon vulnerable women, without any likely increase in income to the Trusts.

Aggressive demands for payment from NHS finance staff are similarly likely to increase women's distress, without any financial return. The use of debt collectors in pursuing debts from very vulnerable women is of enormous concern. It is extraordinary that several Trusts continue to use a debt collection agency which misrepresents the law on NHS debts. It is extremely worrying that these strategies compel women to make payments to the NHS rather than buy food and other essentials for themselves and their children.

The case studies include numerous instances where Overseas Visitor Officers refused repayment plans as inadequate, where women were manifestly unable to afford higher repayments. This leaves women with a significant barrier to regularising their immigration status, as the debt will be on the Home Office records and taken into consideration in future immigration applications.

Several Trusts showed an alarmingly poor understanding of the domestic violence provisions, rejecting sound evidence of abuse and making their own judgments about women's circumstances. While the domestic violence exemption has been poorly drafted, the implementation falls well short of acceptable standards.

There was a consistent pattern across the different case studies of the Trusts making inadequate efforts to inform women of their entitlements or to determine if the various exemptions applied. Given the vulnerability of the women affected by charging, it is not acceptable to leave it up to individual women to review the regulations and guidance in order to identify any relevant exemptions.

There were a number of women who first heard about their NHS debts months or even years after they had given birth. This prevented women from challenging the charges at the time they were incurred and had a number of flow-on effects for women, including substantial delays in obtaining medical care for a child.

Another consistent pattern was in the slow process of responding to correspondence. Maternity Action employs skilled immigration lawyers and advisers who are able to clearly communicate the issues of concern and to reference the relevant law and guidance. It is extremely worrying that Trusts are leaving an asylum seeking woman waiting for two months for a bill to be withdrawn and taking more than 11 months to respond to a destitute, homeless woman seeking a debt write-off.

The case studies show the widespread failures of Trusts to follow the charging regulations and guidance, and also show the harsh impact of these poor practices on women affected by charging. Women report high levels of stress and anxiety as a result of the charges and the difficulties in resolving them. Many women were deterred from attending maternity care appointments and only attended after strong encouragement from advisers. These women were juggling very limited funds to make payments on their debt, foregoing food and essentials to do so.

It is clear that the Government's claims that 'extensive safeguards' are in place to protect the vulnerable are not accurate. Neither are their claims that charging is not deterring people from attending for care and has no impact on public health. The case studies outlined in this report are consistent with evidence presented by Maternity Action to the various formal and informal consultations undertaken by the Government over past years, and also consistent with evidence provided by other charities working in this area. This raises questions about the Government's continued insistence that the programme is working as intended and its refusal to undertake a satisfactory review of its impact.

Women affected by charging include groups at high risk of serious illness and death during pregnancy, birth and postnatally. While NICE guidance and other health policy documents promote additional measures to improve access to care for these women, the NHS charging programme has the reverse effect, deterring women from attending for care, increasing stress and anxiety and exacerbating social and economic vulnerabilities.

Recommendations

Maternity Action calls for the immediate suspension of charging for NHS maternity care given the deterrent effect on women's access to maternity care.

In the interim, Maternity Action seeks changes in the practice of Trusts to reduce the negative impact of charging on migrant women's access to maternity care. Maternity Action has worked with the Royal College of Midwives to develop guidance to assist NHS Trusts to make changes to various aspects of policy and practice. The guidance, 'Improving access to maternity care for women affected by charging', works within the constraints of the charging legislation and guidance and complies with Care Quality Commission requirements.[42]

The guidance is based on the following set of objectives:

- Women should not be deterred from seeking maternity care by the charging practices of NHS Trusts.
- Women should not be refused maternity care or face delays in accessing care for any reason relating to charging practices.
- Women who are able to pay for their maternity care should be offered realistic repayment arrangements, which can be revisited when their circumstances change.
- Women who are not able to pay for their maternity care should have their charges written off, without negative impacts on any future immigration applications.
- Women affected by charging should have access to free, independent legal advice.

[42] Maternity Action (2021) Improving access to maternity care for women affected by charging. https://maternityaction.org.uk/accessguide2019/

A critical requirement of the guidance is that NHS Trusts should regularly audit files relating to the treatment of women who are charged for their maternity care. This is to ensure that the practices of Overseas Visitor Officers and other finance staff are in accordance with the regulations and guidance, with Trust policy and reflect the Trusts' obligation to reduce health inequalities.

Recommendations:

1. That all NHS Trusts in England adopt the Maternity Action and Royal College of Midwives guidance, 'Improving access to maternity care for women affected by charging', and commit to implement the guidance.

2. That Trusts immediately undertake an audit of Overseas Visitor Manager files on women charged for maternity care to determine compliance with regulations and guidance, with Trust policy and with the Trusts' obligation to reduce health inequalities; and undertake swift remedial action where shortfalls are identified.

3. That Trusts release public reports on progress towards implementation of the guidance.

Appendix A

Parliamentary Question on NHS charging

Question for Department of Health and Social Care
UIN 169657, tabled on 3 September 2018
Preet Kaur Gill MP, Labour, Birmingham Edgbaston

To ask the Secretary of State for Health and Social Care, pursuant to Answer of 10 July 2018 to Question 160799 on Health Services: Foreign Nationals, what processes his Department has put in place to monitor the effectiveness of NHS care providers in relation to determining the eligibility of patients; and what steps he has taken to ensure that the eligibilty criteria does not result in discrimination.

Stephen Barclay MP, Conservative, North East Cambridgeshire
Answered on 11 September 2018

The National Health Service is a residency-based healthcare system, with a requirement to be ordinarily resident in the United Kingdom in order to access NHS-funded healthcare. Providers of relevant NHS services are required to make and recover charges from overseas visitors where relevant services have been provided to them and no exemption applies.

The Department does not mandate any specific processes to determine the residence or chargeable status of patients. In order to identify those who may not be entitled to NHS-funded treatment, and to do so in a way that avoids racial profiling and discrimination, all patients need to be asked baseline questions to indicate whether they are ordinarily resident in the UK or if they may be an overseas visitor who should be assessed for charges.

However, it is up to providers of NHS care to assure themselves that they are doing everything reasonable to determine the eligibility of patients who are entitled to receive free NHS care, an entitlement based on residency not nationality.

The Department has published extensive guidance on implementing the overseas visitor charging regulations. This guidance is for use by all frontline staff providing National Health Service funded services, as well as the providers and commissioners of those services. It is available at the following link:

https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations(opens in a new tab)

The guidance clearly sets out that urgent or immediately necessary care must never be withheld, regardless of an individual's ability to pay for the treatment. Clinicians are required to make the decision on whether treatment is urgent or immediately necessary for those patients identified as not eligible for NHS-funded care, taking into account a realistic expectation of when the individual is expected to leave the UK. As a result of the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017 patients are required to pay in advance if treatment is decided by a clinician to not be non-urgent. The Department has been carrying out a review of these Amendment Regulations, with evidence submitted by 31 organisations or individuals representing vulnerable migrants. The evidence is currently being considered and stakeholders will receive an update in due course.

It is also worth noting that that the Charging Regulations already have extensive safeguards in place for the most vulnerable. Refugees, asylum seekers, some state supported failed asylum seekers and victims of modern slavery are all exempt from the Charging Regulations.

Appendix B

Ministerial Statement on the NHS Overseas Charging Regulations Review 2017

The Minister for Health (Stephen Hammond)

On 16 November 2017, the Under-Secretary of State for Health and Social Care, my hon. Friend the Member for Winchester (Steve Brine) announced to the House that my Department would be conducting a review into the impact of amendments made to the NHS charging regulations in 2017, with particular regard to any impact on vulnerable groups and those with protected characteristics.

The review is now complete, and the evidence received demonstrated that there is no significant evidence that the 2017 amendment regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health.

I am pleased that the review has shown that the 2017 amendment regulations are largely working in the way they were intended. These changes were, amongst other things, made to enshrine in law that overseas visitors not eligible for free care must pay for any non-urgent treatment upfront, to help reduce the need to chase up charges, and to remove the anomaly whereby the healthcare setting or provider type could determine whether services would be charged for or not.

Some case studies presented did reveal that there is more to do to ensure some groups of vulnerable overseas visitors understand their entitlements and treatment options, and that providers of NHS care consider fully when a patient can be reasonably expected to leave the UK before deciding if treatment should be safely withheld if payment is not provided.

We will continue to work to ensure that these issues are addressed, so that the charging regulations are implemented in as fair a way as possible. We will improve information and support for NHS staff and patients and work with stakeholders and interest groups to ensure that key messages and safeguards are understood by all.

To ensure clinicians, NHS and community care staff fully understand our guidance and how it should be implemented in practice, we will revise and relaunch our focused e-learning training programme, and work with NHS Improvement's support teams to promote it. This will ensure that all relevant aspects of overseas visitors' personal circumstances are taken into consideration when clinicians decide whether treatment is immediately necessary.

To combat any misconceptions around how the cost recovery regulations affect access to care, the Department and NHS Improvement will continue the close partnership with community groups and stakeholders representing vulnerable individuals to develop user-friendly, culturally-appropriate guidance, and ensure this reaches those who may be impacted by this policy.

Finally, we will continue to work closely with NHS Improvement and frontline staff to keep the impact of the regulations and these further actions under very close review, and to provide additional support and guidance to organisations implementing the regulations in different settings in the best interests of patients.

NHS Overseas Charging Regulations Review 2017. Hansard Volume 651: debated on Wednesday 12 December 2018

[HCWS1174]