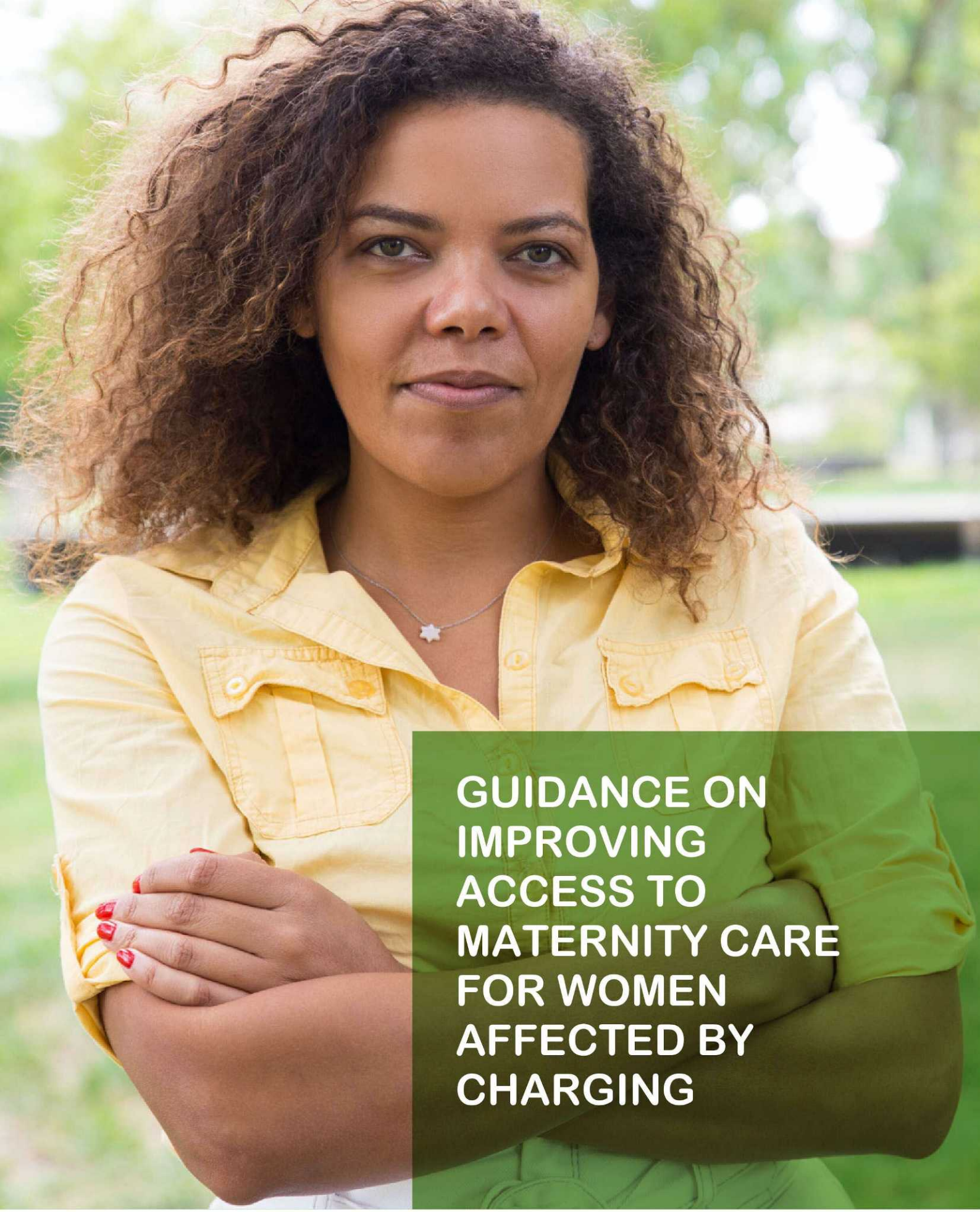

GUIDANCE ON IMPROVING ACCESS TO MATERNITY CARE FOR WOMEN AFFECTED BY CHARGING

Royal College of Midwives

Royal College of Obstetricians & Gynaecologists

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. We would like to thank the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists for their continued support on this project.

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This guidance has been prepared to assist NHS Trusts to minimise the negative impacts of charging on migrant women's access to maternity care.

This group of women are at increased risk of poor maternal health outcomes and NICE guidance states that additional measures should be taken to promote access. Implementing the guidance will not ensure access for this group as there are significant barriers posed by the charging regime that cannot be compensated for by good local practice, however there is much that can be done to improve current practice.

This guidance covers all aspects of policy and practice within NHS Trusts, including in overseas visitor teams and finance departments. It is intended to support changes in organisational policies and practice.

Midwives, obstetricians and other maternity health professionals should read the guides for clinicians developed with the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. This will assist clinicians to support individual women affected by charging.

This guidance consists of guidance for Trusts on changes to policy and practice (Part A), evidence of charging as a barrier to accessing care (Part B) and a review of the law, policy and guidance which informs the guidance (Part C).

This guidance is based on legislation and guidance from the Cabinet Office, Care Quality Commission, Department of Health and Social Care, Financial Conduct Authority, National Institute for Health and Care Excellence, Nursing and Midwifery Council, Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. The guidance has been reviewed by Maternity Action's legal team.

This guidance relates to England only, as regulations and guidance differ in Scotland, Wales and Northern Ireland.

Part A: Guidance on changes to Trust policy and practice

General information about charging

1. It is a legal requirement for Trusts to provide maternity care for mother and baby without delay, whether or not the woman can pay for her care. This includes all antenatal, intrapartum and postnatal care.

2. The following text should be included in information targeting pregnant women and in any general information about charging provided by the Trust, including online information, leaflets, posters, pop-up stands or maternity notes:

   > 'Maternity care will not be refused or delayed for any woman, whether or not she is able to pay for her care. Abortions are considered 'urgent care' and will not normally be refused or delayed whether or not a woman is able to pay for her care.'

3. Wherever possible, information about charging should be translated into community languages.

4. Information targeting pregnant women should signpost to sources of independent information and advice on NHS charging, such as Maternity Action.

Maternity appointments

5. Booking appointments and subsequent appointments must not be refused or delayed for any reason relating to charging. This is a legal requirement. Any requests for documents or negotiations about payment should occur in tandem with delivery of maternity care.

6. No information about women collected by midwives, obstetricians and other maternity health professionals as part of routine clinical care should be used to assess immigration status and chargeability. This is to enable clinicians to build a relationship of trust with the woman. Health professionals are not obliged to make checks for chargeability or to share information about immigration status with financial staff for the purposes of charging.

7. If asked, midwives and obstetricians should advise the overseas team if the woman falls within the exemption for FGM, sexual violence, domestic violence or torture. This information can indicate that the woman is exempt from charges. Determining if a woman falls within these exemption categories may require additional sensitive enquiry by the clinician. If they do not feel confident in making the enquiry, they should contact their local Safeguarding Lead for Adults.

8. Midwives, obstetricians and other maternity health professionals should not be asked to play any role in delivery of invoices or debt recovery.

9. Finance staff should not, under any circumstances, attend antenatal or postnatal appointments or intrapartum care. Appointments are exclusively for clinicians to deliver clinical care to the woman. Finance staff should not seek to speak with a woman before or after her appointments, as such practices can deter women from attending appointments.

Advocating for women affected by charging

10. Midwives, obstetricians and other maternity health professionals can and should act as advocates for women affected by NHS charging. This is supported by Nursing and Midwifery

Council (NMC) Standards. NHS charging law is complex. Many women affected by NHS charging are vulnerable and find it difficult to self-advocate.

11. Clinicians should read the guidance for clinicians on charging for NHS care, available here from September 2024.

12. Maternity services should train clinical and non-clinical staff about NHS charging with the aim of improving access to care for vulnerable migrant women. Many women affected by NHS charging are at high risk of poor maternal health outcomes and NICE guidance states that additional measures should be taken to promote access. This training should be in addition to any delivered by the overseas visitor teams on charging procedures.

Resolving chargeable status

13. Determining a woman's immigration status can be complex, as status is not solely determined by information held by the Home Office and is subject to change. Women should be encouraged to seek independent advice about their chargeability.

14. In determining whether or not a woman is chargeable, the overseas visitor team should contact the woman's midwife or obstetrician to ask if the woman falls within the exemption for FGM, sexual violence, domestic violence, or torture. The clinician's advice should be treated as definitive and finance staff should not request further evidence from the woman. These are sensitive enquiries and should not be undertaken by non-clinical staff.

15. Women should be notified if they are chargeable within two weeks of contact with maternity services and by 12 weeks gestation, at the latest. This is to enable them to take action which they consider appropriate. They may wish to refuse any further care, to have a termination, to seek care privately or to go abroad for care.

16. Notifying women that they are chargeable and the likely amount charged is a legal requirement. The notification must be in writing and provided prior to delivering care, so far as reasonably practicable.

17. When women are notified that they are chargeable, they should be given a written statement which states:

    - why charges apply
    - what the charge is estimated to be
    - how they can pay
    - how they can seek a review of the decision
    - the name, job title, email and phone number for the officer responsible for making the decision
    - signposting to sources of independent information and advice on NHS charging, such as Maternity Action

18. The named officer should respond swiftly to any phone calls or correspondence from women and their advocates. There is evidence that charging increases stress and anxiety in women. This increases the risk of poor maternal mental and physical health during

pregnancy and postnatally and can affect child health and development. Slow resolution of chargeable status adds to the woman's stress.

19. Overseas visitor teams and finance staff must exercise particular sensitivity when dealing with women who have experienced miscarriage, stillbirth or neonatal death. Officers should carefully review the chargeable status of the mother to avoid issuing an invoice in error. Where the baby received treatment, officers should also review the chargeable status of the baby, as mothers and babies may have different immigration status and chargeability. Women should be encouraged to seek independent advice, such as from Maternity Action. Officers should consider writing off the debt and should take the initiative to suggest this to the woman, as she may not be able to self-advocate at this time.

20. If the woman disputes the charges, the officer must consider the information she provides. If the charges are not withdrawn, the officer must provide written reasons for their decision. There is a common law presumption that a decision maker will provide reasons for a decision. If the charges are withdrawn, the officer must confirm this in writing.

21. The Trust should have an internal review process for women to use to challenge decisions made by the overseas visitor team. Charging regulations and immigration status are complex and a review process will reduce the likelihood of wrong decisions. An internal review process will also reduce the risk of legal challenge, which can be costly for Trusts. A review process is separate to any complaints process and women should not be referred to the complaints process when they are challenging decisions about charging. They should be referred to the complaints process when they are unhappy with the way they have been treated, such as discourtesy from staff or aggressive treatment by debt collection agencies.

22. Overseas visitor teams and finance officers should keep accurate records of meetings, phone calls and correspondence with women and the Home Office.

Invoices

23. As charges are 150% of the NHS tariff, women should receive an invoice which specifies the relevant NHS tariff.

24. If women are not notified that they are chargeable during the period of maternity care, then they should not be issued with an invoice at a later date. This is to avoid the situation where women receive invoices years after having given birth and therefore have been denied the right to make decisions about the pregnancy with all the relevant facts.

Dealing with debt

25. All women should be offered affordable repayment plans. These should be genuinely affordable, recognising that vulnerable migrant women may have extremely low or no income. No notification should be made to the Home Office regarding NHS debts for women with an affordable repayment plan in place. Where the Home Office has previously been notified of the debt, Trusts should swiftly notify the Home Office that a repayment plan is in place.

26. Trusts can and should write-off debt for women who are manifestly unable to pay for their care. Women may not be aware of the option of a debt write-off so Trusts should proactively consider writing off debt rather than waiting for women to make a request. Where women have been formally assessed as destitute, at imminent risk of destitution or

on very low incomes provided by other agencies, this should be accepted as satisfactory evidence of inability to pay. This includes provision of Section 17 support from the local authority, HC2 form and a fee waiver from the Home Office. Trusts should accept a wide range of evidence of inability to pay, recognising that many vulnerable women will not have documentary evidence of their situation.

27. As write-offs do not extinguish debt, Trusts are permitted to revisit the debt and consider re-commencing debt recovery. Trusts should consider excluding pregnant women and new mothers from review of debt write-offs so as to minimize the stress of repeated assessments.

28. Trusts should be sensitive to women in vulnerable circumstances. Many women who are chargeable are not entitled to access benefits, asylum support or other welfare payments. There is evidence of women on very low incomes going without food and essentials to make re-payments towards their NHS debt. The risk of destitution can leave women more vulnerable to exploitation and can make it very difficult for women to leave violent and exploitative relationships.

29. Trusts should signpost women who are struggling to make payments to independent debt advice. Trusts should defer notifying the Home Office while women are seeking advice or when changes to the affordable repayment plan are under consideration.

30. Trusts should notify women that they are chargeable by letter and not send an invoice alone.

31. Trusts should not pursue payment until after the woman has received her maternity care, including post-natal care. This is to reduce the risk of women avoiding care.

32. Trusts should only consider the use of debt collection agencies where the woman has not indicated that she is unable to pay her debt and where the Trust has exhausted its own debt recovery processes.

33. Trusts are responsible for the actions of debt collection agencies and should scrutinise debt collection agencies to ensure that they are not aggressively pursuing debt from vulnerable women. Correspondence from debt collection agencies should be carefully reviewed to ensure that the information is accurate. For example, unpaid debt does not affect asylum claims or result in detention on re-entry to the UK.

34. Debt recovery should not commence until at least three months after the birth. This is to reduce the stress on mother and baby.

35. Debt recovery action should be suspended when the woman is challenging the decision to charge her for care, is negotiating an affordable repayment plan or debt write-off, or is seeking independent debt advice when struggling to keep up with repayments.

Communication with the Home Office

36. Overseas visitor teams and finance staff should not inform the Home Office about outstanding debt where the woman is seeking independent advice or is seeking to negotiate an affordable repayment plan.

37. Overseas visitor teams and finance staff should not share with the Home Office any clinical information or any other information collected as part of routine clinical care.

Audit

38. Maternity services should audit clinical attendance and pregnancy outcomes of all migrant women charged for their care. This will help to determine the impact of charging on attendance for care and the risk profile of this group of women.

39. NHS Trusts should audit overseas visitor team files for women charged for maternity care. This is to ensure that the practices of overseas visitor teams and finance staff are in accordance with Trust policies, reflect the Trusts' obligation to reduce health inequalities and are accurate assessments of chargeability. There are many reasons why vulnerable women do not make complaints about poor treatment by NHS staff, so audits are necessary to identify any poor practice.

Part B: Charging as a barrier to accessing maternity care

Racial inequalities in maternal health outcomes are persistent. Maternal mortality rates amongst women from Black ethnic backgrounds are three times higher than white women and mortality rates amongst women from Asian ethnic backgrounds are twice those of white women.[1] Maternal mortality rates are higher amongst women experiencing deprivation. Women affected by charging are disproportionately likely to be from Black and minoritised ethnic backgrounds. Many vulnerable migrant women experience severe deprivation.

The Royal College of Obstetricians and Gynaecologists (RCOG) Position Statement, Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women, states that addressing additional barriers to a safe pregnancy experienced by migrant women is a vital part of ending the UK's persistent inequalities in maternal and perinatal outcomes. [2] The Royal College of Midwives (RCM) Position Statement: Caring for Migrant Women, similarly states that the RCM is committed to tackling health inequalities and agrees with other stakeholders that the lack of entitlement to NHS care due to migration status is a significant risk factor.[3]

Migrant women affected by NHS charging are at increased risk of poor maternal health outcomes. The RCOG position statement notes that:

> Migrant pregnant women are a diverse group at risk of disproportionately worse maternal and perinatal outcomes. They often face multiple barriers to care and are more likely to experience poverty or destitution, a higher burden of disease or poorer healthcare in their country of origin or transit, trauma, experiences of conflict, limited English proficiency, barriers to accessing support services, and limited social support network.[4] They are more

[1] MBRRACE-UK. 2023. Data brief: Maternal mortality UK 2020-22 January 2024 https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2020-2022

[2] RCOG. 2022. RCOG Position Statement: Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women. https://www.rcog.org.uk/about-us/campaigning-and-opinions/position-statements/position-statement-equitable-access-to-maternity-care-for-refugee-asylum-seeking-and-undocumented-migrant-women/

[3] RCM. 2022. RCM position statement: caring for migrant women. https://www.rcm.org.uk/media/5850/rcm_position-statement_caring-for-migrnt-women.pdf

[4] RCM, Caring for vulnerable migrant women (2021); Sonia Asif et al, The obstetric care of asylum seekers and refugee women in the UK (2015); WHO, Improving the health care of pregnant refugee and migrant women and newborn children (2018); Birth Companions and Revolving Doors Agency, Making Better Births a reality for

likely to access antenatal care later than the recommended first 10 weeks,[5] and the National Institute for Health and Care Excellence (NICE) identifies recent migrants, refugees and asylum seekers, and women who speak or read little or no English, as a group with 'complex social factors' requiring special efforts to improve access and engagement with maternity services.[6]

Fears of incurring debts they cannot pay and of being reported to the Home Office deters women from attending maternity appointments. MBRRACE-UK reports have found that late booking and fewer antenatal appointments are associated with poor maternal health outcomes, including maternal deaths. The 2019 MBRRACE-UK report found that three of the women who died in the period 2015-2017 may have been reluctant to access care because of concerns over the costs of care and the impact of their immigration status.[7]

NHS charging also increases women's vulnerability to domestic abuse and exploitation.[8] There is also evidence that charging increases stress and anxiety, which is linked to poor maternal mental health and poor birth outcomes, such as low birth weight. [9]

The RCM position statement notes that charging practice, including data sharing beyond the NHS, can undermine the essential trust and confidentiality that is needed between women and midwives.

Maternity Action's report, *Breach of Trust*, documented failings by NHS Trusts in implementing the NHS charging regulations.[10] A number of Trusts made 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. While DHSC guidance supports debt write-offs for women who are destitute, 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.

The report found that 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

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women with multiple disadvantages (2019) Birthrights and Birth Companions, Holding it all together: Understanding how far the human rights of woman facing disadvantage are respected during pregnancy, birth and postnatal care (2019)

[5] Gina Marie Awoko Higginbottom et al, Experience of and access to maternity care in the UK by immigrant women: a narrative synthesis systematic review (2019); Sonia Asif et al, The obstetric care of asylum seekers and refugee women in the UK (2015)

[6] NICE, Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors [CG110] (2010)

[7] MBRRACE-UK. 2019. Saving Lives, Improving Mothers' Care. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

[8] 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/vawg-report-december-2019/

[9] Lima, Silvana Andréa Molina et al, Is the risk of low birth weight or preterm labor greater when maternal stress is experienced during pregnancy? A systematic review and meta-analysis of cohort studies (2018); Breach of Trust (2021)

[10] Maternity Action. 2021. Breach of Trust: a review of the implementation of the NHS charging programme in maternity services in England. https://maternityaction.org.uk/breach-of-trust-report-2021/

months or even years after they had given birth. Further, the report also found that 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.

Part C: Law, policy and guidance

Reducing health inequalities

The National Health Service Act 2006, as amended, requires NHS England to have regard to the need to reduce health inequalities in access to health services and in health outcomes (section 13G). A similar duty applies to the Secretary of State for Health in the exercise of their functions in relation to health services (section 1C). This duty applies in relation to all pregnant women, whether or not they are chargeable for NHS care.

Provision of treatment without delay

The National Health Service (Charges to Overseas Visitors) Regulations 2015, as amended ('the charging regulations'), state that maternity care for mother and baby is classed as an immediately necessary service. This includes antenatal, intrapartum and postnatal care (regulation 3(7)). An immediately necessary service must not be refused or delayed for any reason related to charging (regulation 3(1A)).

This legal requirement is reflected in Department of Health and Social Care (DHSC) Guidance on implementing the overseas visitor charging regulations 2023 ('DHSC charging guidance'), which states (at 86):

> Maternity services are chargeable but must be treated as being immediately necessary, with no patient having them denied or delayed based on their status as an overseas visitor or due to charging-related issues…. It is crucial that you take all reasonable steps to encourage the patient to continue with their maternity care. [11]

There are a number of exemptions from charging in the Charging Regulations. Women are not chargeable if they have paid the Immigration Health Surcharge, have an outstanding asylum claim, have made a claim for temporary protection such as an Article 3 claim, have refugee status, or are a child in care. This is not an exhaustive list.

Torture, FGM, domestic abuse and sexual violence

Women are not chargeable for maternity or other healthcare where it is treatment of a condition caused by torture, female genital mutilation, domestic abuse or sexual violence, provided that the overseas visitor has not travelled to the United Kingdom for the purpose of seeking that treatment (regulation 9, Charging Regulations).

The Domestic Abuse Act 2021 defines domestic abuse as abusive behaviours occurring in the context of a marriage, partnership or intimate personal relationship. Abusive behaviours consist of physical or sexual abuse, violent or threatening behaviour, controlling or coercive behaviour, economic

[11] DHSC. 2023. NHS cost recovery - overseas visitors: Guidance for NHS service providers on charging overseas visitors in England. https://assets.publishing.service.gov.uk/media/650d852b2f404b0014c3d7bc/nhs-cost-recovery-overseas-visitors_september2023.pdf

abuse, psychological, emotional or other abuse. The legislation states that this behaviour may consist of a single incident or a course of conduct. Maternity Action is of the view that a pregnancy in the context of a coercive relationship should be treated as a condition caused by domestic violence.

Termination of pregnancy

DHSC charging guidance (at 90) states that the treating clinician can determine that a termination of pregnancy is urgent or immediately necessary care where a woman cannot reasonably be expected to leave the UK before the date at which an abortion may no longer be a viable option for her. It states that this may include refused asylum seekers or undocumented migrants who are unlikely to leave the UK in the short term. Under the charging regulations, urgent treatment must not be refused or delayed for any reason related to charging (regulation 3(1A)).

Women who are considering a termination of pregnancy require time to consider their options. Royal College of Obstetricians and Gynaecologists guidance, Best practice in abortion care, states: 'Abortion is safer the sooner it is done. Services should be able to meet the local demand for abortion so that people can have their abortion as early as possible and as close to home as possible.'[12] Medical abortions can be undertaken at home up to 9 weeks and 6 days gestation.

As charging for maternity care may affect a woman's decision to have a termination, they should be informed of chargeability as swiftly as possible.

Whether or not the woman is considering a termination, Care Quality Commission (CQC) Guidance ('the CQC guidance') states that 'Providers must give people using the service information about the costs, terms and conditions of the service, so that they can make decisions about their care, treatment or support (at page 102).[13] As this guidance is based on Regulation 9 of the Care Quality Commission (Registration) Regulations 2009, as amended ('the CQC regulations'), the CQC can prosecute for a breach of this regulation, regardless of whether there is any harm or risk of harm from the breach.

Promoting access

The DHSC Upfront charging operational framework to support identification and charging of overseas visitors states (at 3.3, italics added):

> Although a person must be informed if charges apply, in doing so they should not be discouraged from receiving any part of their maternity treatment. *It is critical that they are supported to continue with their care…*

This is reflected in DHSC charging guidance, which states that women who are chargeable should not be discouraged from receiving maternity care (at 86). Further, it states that OVMs and clinicians should be especially careful to inform pregnant women that further maternity healthcare will not be withheld, regardless of their ability to pay.

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[12] RCOG. 2022. Best practice in abortion care. https://www.rcog.org.uk/media/geify5bx/abortion-care-best-practice-paper-april-2022.pdf

[13] CQC. 2015. Guidance for providers on meeting the regulations March 2015. https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf

Clinician role in charging assessments

The British Medical Association, in its statement: *BMA view on charging overseas visitors*, rejects a role for doctors in the process of assessing chargeability:

> It is our strong and longstanding view that doctors should not have a role in assessing patients' immigration status or eligibility for free NHS care. The policy of charging some migrants for NHS care puts doctors in a difficult position and takes vital clinical time away from caring for their patients. We believe that the single role of doctors is to care for the patients in front of them, and that their clinical judgement must take precedence over any other considerations.[14]

Clinicians acting as advocates

The Nursing and Midwifery Council Code sets out the professional standards of practice and behaviour for nurses, midwives and nursing associates and states (at point 3):

> Make sure that people's physical, social and psychological needs are assessed and responded to. To achieve this, you must... act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care[15]

Auditing impacts of charging

The RCOG Position Statement, *Equitable access to maternity care for refugee, asylum seeking and undocumented migrant women* emphasizes the importance of auditing the impacts of charging:

> It is impossible to understand the full impact of NHS charging policies on maternal and perinatal outcomes without the routine collection of quantitative data relating to the care and outcomes of those affected.

This is undertaken by individual Trusts, pending any decision to adopt RCOG recommendations for national data collection on the impacts of charging for NHS maternity care.

Notification of chargeability and charges

The CQC regulations require health care providers charging for services to give service users a written statement which states that they will be charged, the amount charged and the method of payment (regulation 19). The CQC guidance states that an estimate of costs should be provided where a fixed price is not known. This requirement is so that people using the service can make decisions about their care, treatment or support (at page 102). The CQC can prosecute for breach of this regulation.

The Charging Regulations state that the amount charged for a service is 150% of the NHS tariff for that service (Regulation 7). NHS Trusts do not have the discretion to change the amount charged. It is for this reason that NHS Trusts should state the relevant tariff on invoices.

Pursuing debt from vulnerable women

The DHSC charging guidance states (at 150) that Trusts may consider debt write-off if a person is destitute or is at risk of imminent destitution. The guidance provides examples of the evidence

[14] BMA. 2022. BMA view on charging overseas visitors. https://www.bma.org.uk/advice-and-support/ethics/refugees-overseas-visitors-and-vulnerable-migrants/bma-view-on-charging-overseas-visitors
[15] NMC. 2018. The Code Professional standards of practice and behaviour for nurses, midwives and nursing associates. https://www.nmc.org.uk/standards/code/

which may be provided to demonstrate destitution or imminent destitution (at 149). These include a statement from the person that they are staying with a friend and cannot remain there, and recent letters from organisations providing support, including local authorities and charities.

The guidance states (at 133) that debt collection agencies should not be employed in relation to persons who are either destitute or at risk of imminent destitution. The guidance confirms (at 133) that NHS Trusts are responsible for ensuring that any debt collection services provided by a third party is delivered to a satisfactory standard.

The Debt Management Vulnerability Toolkit for service and policy managers V2[16], developed by the Cabinet Office Fairness Group, is intended to support public sector agencies engaged in recovering debt to identify and support vulnerable customers. NHS Trusts are public sector agencies engaged in recovering debt. The definition of 'vulnerable customer' used in the guidance would encompass migrant women affected by NHS charging.

The guidance states that organisations need to ensure that they give customers appropriate support and flexibility, to help them achieve a positive outcome. Examples of this support are:

> Forbearance: allowing people longer to pay; waiving late fees or charges; adjusting payment rates and repayment plans; payment breaks; putting the account on pause/hold (e.g. until circumstances stabilise or while customer seeks wider support, including debt advice)
>
> Expert support: referral to internal support team; signpost/referral to external support (e.g. debt advice, foodbank, housing advice, gambling support); working with an authorised third party who is also supporting the customer.

The guidance emphasises the importance of monitoring and continuous improvement by public sector agencies engaged in recovering debt from vulnerable customers. It states: 'Monitoring outcomes for customers who are vulnerable to harm is critical in understanding where your policies and processes are working well, and where there are areas for improvement.' It further refers to the Vulnerability Guidance, released by the Financial Conduct Authority, which states that clear monitoring and feedback strategies allows organisations to identify where:

- they do not fully understand vulnerable customers' needs
- the performance of staff has led to poor outcomes for vulnerable customers
- services (or processes) unintentionally cause harm to vulnerable customers
- customer service processes are not meeting vulnerable customers' needs

Affordable repayment plans and write-offs

DHSC charging guidance states (at 150) that Trusts may write-off debts where the patient is destitute or at risk of imminent destitution. The guidance states that debt collection in these circumstances is unlikely to be cost effective. The guidance (at 154) states that debts may also be written off where the patient has died and the costs are unlikely to be recovered from their estate; or where all reasonable steps have failed to recover the debt.

[16] https://www.gov.uk/government/publications/public-sector-toolkits/debt-management-vulnerability-toolkit-for-service-and-policy-managers-v2-html

It is important to note that write-offs do not extinguish debt. Trusts must report this debt to the Home Office and the debt can affect future immigration applications. An invoice which is wrongly issued should be cancelled rather than written off.

The DHSC Guidance on Administration and Data Sharing[17] explicitly provides for Trusts to negotiate repayment plans with chargeable patients (at 3.5):

> Where an invoice is particularly large, or where the patient is genuinely willing to provide payment for services provided but cannot meet repayment in full, then Trusts should agree with the patient, at the earliest opportunity, a reasonable repayment plan…

DHSC charging guidance (at 143) states that repayment plans must be appropriate and have due regard to safeguarding financially vulnerable individuals. This guidance should be read in the context of the Cabinet Office Debt Management Vulnerability Toolkit.

[17] DHSC. 2019. Overseas chargeable patients, NHS debt and immigration rules Guidance on administration and data sharing March 2019.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793132/overseas-chargeable-patients-nhs-debt-and-immigration-rules.pdf