

Improving access to maternity care for women affected by charging



This guidance has been prepared to assist NHS Trusts to minimise the negative impacts of charging on migrant women's access to maternity care. Implementing the guidance won't ensure access for this group as there are significant barriers posed by the charging regime which cannot be compensated for by good local practice, however there is much that can be done to improve current practice.

The guidance will be of use to Overseas Visitor Managers, Directors and Heads of Midwifery, and NHS staff caring for migrant women. It covers various aspects of policy and practice within NHS Trusts. 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.

There is good evidence to show that charging acts as a barrier to accessing maternity care. This is outlined in Part 2.

The guidance complies with the law on charging for maternity care. Part 3 provides the references to the charging regulations and guidance, Care Quality Commission (CQC) regulations and guidance and Financial Conduct Authority (FCA) guidance.

Part 1: Guidance

Before women access maternity care

1. All information on charging for NHS care issued by the NHS Trust should explicitly state: 'Maternity care will not be refused or delayed for any woman, whether or not she is able to pay for her care.' This statement should be included in leaflets, posters and online information and should be in general information about charging as well as maternity-specific information. The information should be available in translation.
2. Where information on charging is sent to women in advance of their booking appointment, this should clearly state: 'Some women may be asked to pay for their maternity care. Maternity care will not be refused or delayed for any woman, whether or not she is able to pay for her care.' It should state the importance of maternity care for her health and that of her baby. The information should also signpost to sources of independent information and advice on charging for NHS maternity care.
3. All information on charging for NHS care issued by the NHS Trust should explicitly state: 'Terminations are considered 'urgent care' and will not normally be refused or delayed whether or not a woman is able to pay for her care.'

Commencement of care

4. Booking appointments and subsequent appointments should not be refused or delayed for any reason relating to charging. Any requests for documents or negotiations about payment should occur in tandem with delivery of maternity care but never within clinical appointments. This should be clearly understood by administrative staff as well as clinicians.
5. Women must be notified if they are chargeable by 12 weeks gestation or within two weeks of contact with maternity services. 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.
6. All women should be offered affordable repayment plans. These plans 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.
7. Women who are manifestly unable to pay for their care should have their debt written off by the Trust.
8. 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.

Resolving chargeable status

9. When women are notified that they are chargeable, they should be given a written statement outlining why charges apply, what the charge is estimated to be and how they can pay. They should also be advised how they can appeal the decision that they are chargeable and the amount charged.
10. Women should be given a name, job title, email and phone number for the officer responsible for making decisions about her chargeable status, the amount charged and affordable repayment plans.

11. The officer should respond swiftly to any phone calls or correspondence from women or their advocates.
12. 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.
13. If charges are withdrawn, the officer should provide the woman with written confirmation of this.

Dealing with debt

14. Women who find that they are struggling to maintain repayments should be signposted to independent debt advice. No notification should be made to the Home Office while women are seeking advice and changes to the affordable repayment plan are under consideration.
15. Debt recovery action should not commence until at least three months after the birth. This is to reduce the stress on the mother and her baby.
16. Debt recovery action should be suspended where 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.

Nature of charges

17. Women should be given an invoice which clearly states what they are being charged for. This should specify the relevant NHS tariff.
18. Women who use less than the standard package of maternity care should be charged only for the services which they use.

Independent advice

19. All chargeable women should be offered free, independent legal advice. This will assist them to resolve questions about chargeability and to obtain advice on any debt which may be incurred.

Role of clinical and financial staff

- 20.** No information about women collected by midwives or maternity support workers as part of routine clinical care should be used to assess migration status and chargeability. It is important that midwives can build a relationship of trust with the woman.
- 21.** Where women are chargeable, midwives should be asked if the woman falls within the exemptions for FGM, sexual violence, domestic violence or torture. The midwife's advice should be treated as definitive and finance staff should not request further evidence.
- 22.** Midwives and maternity support workers should not be asked to play any role in delivery of invoices or debt recovery.
- 23.** Finance staff should not, under any circumstances, attend antenatal or postnatal appointments or intrapartum care. Appointments are exclusively for the midwife to deliver clinical care to the woman.
- 24.** Finance staff should not seek to speak with a woman before or after her appointments. Such practices can deter women from attending appointments.
- 25.** Midwives should receive training about charging for NHS maternity care which supports access to maternity care by vulnerable migrant women. The NMC Code requires midwives to act as advocates for women and they should understand how NHS charging interacts with this requirement.

Communication with the Home Office

- 26.** Finance staff should not inform the Home Office about outstanding debt where the woman is not chargeable, where there is a dispute about whether the woman is chargeable, where the debt has been written off, where the woman has an affordable repayment plan in place or where the woman is seeking advice on debt. This advice may relate to negotiation of an affordable repayment plan or to changes to an existing affordable repayment plan.
- 27.** Finance staff must not share any clinical information or anything related to clinical information with the Home Office.

Quality control

- 28.** Finance staff should keep accurate records of meetings, phonecalls and letters to women and to the Home Office. This should cover all aspects of the charging process, including assessing the woman's chargeability, issuing an invoice, negotiation of an affordable repayment plan, debt recovery action and Home Office notification.
- 29.** Women should be informed about the process for making a complaint about clinical staff and finance staff. There are many reasons why vulnerable women do not make complaints about poor treatment by NHS staff. NHS Trusts should be conscious that the absence of a formal complaints does not mean the absence of poor practice.
- 30.** 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 finance staff are in accordance with Trust policy and reflect the Trusts' obligation to reduce health inequalities.
- 31.** NHS Trusts should audit clinic attendance and pregnancy outcomes of all migrant women, noting whether or not they were charged.

Part 2: Charging as a barrier to accessing maternity care

Many of the women who are chargeable for maternity care are undocumented migrants living in precarious circumstances with little or no income, and often speaking little or no English. Successive confidential enquiries into maternal mortality have shown that black and minority ethnic (BME) and migrant women are at higher risk of maternal mortality than the British born white population (1-4).

Such findings prompted the National Institute of Health and Care Excellence (NICE) to commission background research about the antenatal care needs of these and other disadvantaged women in order to provide appropriate guidance (5). This resulted in guidance on *Antenatal Care for Women with Complex Social Factors*, among whom it highlighted refugees, asylum seekers, recent migrants and women who speak little or no English (6).

Vulnerable women migrants are also more likely to have experienced domestic and sexual violence, have mental health problems and suffer from underlying physical health problems including diabetes, heart disease, HIV or hepatitis infections. They are also more likely to suffer from health conditions arising in pregnancy, especially gestational diabetes or high blood pressure (7).

The NICE guidance focused on the difficulties such women face in accessing maternity care and proposed that extra efforts be made to reach them and to maintain their attendance at appointments. It stressed the need for good history taking at first booking, more frequent antenatal appointments and continuity of midwifery care. The aim was to establish trust between vulnerable women and their midwives so that the women would feel safe and comfortable accessing maternity care (6).

Furthermore, because of the severe health risks associated with pregnancy, even before NICE guidance on antenatal care was published, Department of Health (DH) guidance on implementing charging in hospitals recommended

that maternity care should not be withheld if women were unable to pay in advance (8). Subsequent DH guidance and, in 2017, statutory regulations, stipulated that antenatal, intrapartum, and postnatal services were always 'immediately necessary services' and must not be delayed or denied even if the patient could not pay in advance (9,10).

Nevertheless, there is considerable evidence that charging remains a barrier to access, as women are still required to pay for maternity care, and can be reported to the Home Office if they have not repaid an invoice of £500 or over for two months (11). Maternity Action and other organisations have evidence of women delaying entry into maternity care or avoiding antenatal care altogether (12, 13).

In such circumstances, treatable underlying health conditions might go undetected and untreated, resulting in subsequent complex interventions incurring much greater costs for the NHS. For example, identifying and treating a urinary tract infection during standard antenatal care can prevent a woman developing kidney infection which may result in premature birth. Such a minor intervention could avoid over £50,000 in costs associated with treating a very premature baby (14). Similarly, routine antenatal HIV testing and prophylaxis, recommended to prevent mother to child HIV transmission, is likely to save the lifetime cost of HIV treatment for an affected child, estimated at around £300,000 (15).

Even if women continue their care in the face of maternity care charges that they will almost certainly not be able to repay, the additional anxiety this causes is already known to have a very damaging effect on their mental health (12). These issues raise serious concerns about how charging may impact on maternal health and health inequalities (13,16).

Migrant support organisations and advice agencies have also come across questionable charging procedures such as harassment of pregnant women and new mothers by debt collection agencies. As occurred during the recent Windrush scandal, there have also been reports of hospitals erroneously charging pregnant women who were actually entitled NHS maternity care (12).

Trusts need to take special care to attempt to mitigate the potentially damaging effects of charging on maternal and newborn health and take into account that many chargeable women live in precarious and vulnerable situations.

Part 3:

Compliance with law, policy and guidance

The guidance complies with the law on charging for maternity care. This section reviews the relevant charging regulations and guidance, Care Quality Commission (CQC) regulations and guidance and Financial Conduct Authority (FCA) guidance.

The following references are used in the text.

- **‘the Charging Regulations’**
The National Health Service (Charges to Overseas Visitors) Regulations 2015, as amended in 2017
- **‘DHSC guidance’**
Department of Health and Social Care, ‘Guidance on implementing the overseas visitor charging regulations’ December 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/771515/Guidance_on_implementing_the_overseas_visitor_charging_regulations.pdf
- **‘DHSC upfront charging guidance’**
Department of Health and Social Care, ‘Upfront charging operational framework to support identification and charging of overseas visitors’, Updated at 5 January 2019
<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>
- **‘DHSC guidance on administration and data sharing’**
Department of Health, ‘Overseas chargeable patients, NHS debt and immigration rules: Guidance on administration and data sharing,’ March 2019 (Note that this guidance was withdrawn in October 2018 pending review for compliance with the General Data Protection Regulations (GDPR) 2018) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793132/overseas-chargeable-patients-nhs-debt-and-immigration-rules.pdf
- **‘the CQC registration regulations’** Care Quality Commission (Registration) Regulations
Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended)
- **‘the CQC regulated activities regulations’** means the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended)
- **‘CQC guidance’**
Care Quality Commission, ‘Guidance for providers on meeting the regulations,’ March 2015
https://www.cqc.org.uk/sites/default/files/20150324_guidance_providers_meeting_regulations_01.pdf
- **‘RCOG guidance’**
Royal College of Obstetricians and Gynaecologists, ‘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>
- **‘FCA guidance’**
Financial Conduct Authority Consumer Credit sourcebook (CONC), as at 31 July 2018
<https://www.handbook.fca.org.uk/handbook/CONC/7/>

Before women access maternity care

1. All information on charging for NHS care issued by the NHS Trust should explicitly state: Maternity care will not be refused or delayed for any woman, whether or not she is able to pay for her care. This statement should be included in leaflets, posters and online information and should be in general information about charging as well as maternity-specific information.
2. Where information on charging is sent to women in advance of their booking appointment, this should clearly state: Some women may be asked to pay for their maternity care. Maternity care will not be refused or delayed for any woman, whether or not she is able to pay for her care. It should state the importance of maternity care for her health and that of her baby. The

information should also signpost to sources of independent information and advice on charging for NHS maternity care.

DHSC guidance explicitly states that no one must ever be denied, or have delayed, maternity services due to charging issues (at 8.6). It further states that 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. The DHSC guidance reflects the Charging Regulations (Regulation 7 and Regulation 1A).

We recommend that this principle of clear communication about entitlement to maternity care is extended to leaflets, posters, online information and information sent to women in advance of their booking appointment.

- 3. All information on charging for NHS care issued by the NHS Trust should explicitly state: 'Terminations are considered 'urgent care' and will not normally be refused or delayed whether or not a woman is able to pay for her care.'**

DHSC guidance states that terminations should be considered 'urgent 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 them (at 8.11). The guidance specifically refers to refused asylum seekers and undocumented migrants as examples of women for whom terminations are considered 'urgent care'.

DHSC guidance further states that the decision on whether or not treatment is urgent is only for clinicians to make (at 8.13). Assessment by a clinician should never be refused or delayed because a woman is chargeable or because the Trust is unsure if she is chargeable (at 8.16).

Commencement of care

- 4. Booking appointments and subsequent appointments should not be refused or delayed for any reason relating to charging. Any requests for documents or negotiations about payment should occur in tandem with delivery of maternity care but never within clinical appointments. This should be clearly understood by administrative staff as well as clinicians.**

DHSC guidance explicitly states that no woman must ever be denied, or have delayed, maternity services due to charging issues (at 8.6). It further

states that 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. This reflects the Charging Regulations (Regulation 7 and Regulation 1A).

The DHSC guidance specifically addresses circumstances where it is possible to assess charges and request payment before a course of immediately necessary treatment (at 8.27). The guidance states that relevant bodies should make clear to the patient that treatment will not be withheld or delayed if they do not pay in advance or provide an appropriate EEA healthcare form.

- 5. Women must be notified if they are chargeable by 12 weeks gestation or within two weeks of contact with maternity services. 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.**

If women are not aware that accessing maternity care will result in a debt of several thousand pounds, they are unable to make decisions about the care which is most appropriate to them. The NHS Constitution includes the following pledge to patients: 'You have the rights to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences.'

Women who are considering an abortion require time to consider their options. Royal College of Obstetricians and Gynaecologists best practice states: 'Abortion is safer the sooner it is done. Services should be able to meet the local demand for abortion so that women can have their abortion at the earliest possible gestation...' Women can access less invasive abortion procedures prior to 14 weeks gestation.

All NHS Trusts have a legal obligation to provide each chargeable pregnant women with a written statement of the cost of their care (regulation 19 of the CQC registration regulations). This statement must include the amount of the charges and the method of payment. The statement must, as far as reasonably practicable, be provided prior to the commencement of services. CQC guidance states: '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). The CQC can prosecute for a breach of this regulation, regardless of whether there is any harm or risk of harm arising from the breach.

All NHS Trusts are also under a regulatory obligation to provide each chargeable pregnant woman with the information she would reasonably need to enable her to understand the care or treatment choices available to her, and to make, or participate in making decisions about that care or treatment to the maximum extent possible (regulation 9(3)(g) of the CQC regulated activities regulations). CQC guidance states that this information must include the costs, fees or tariffs associated with the care or treatment (at page 32). The CQC can take regulatory action for breach of this requirement, which could include imposing conditions, or suspending or cancelling a trust's registration.

- 6. All women should be offered affordable repayment plans. These plans should be genuinely affordable, recognising that vulnerable migrant women may have extremely low incomes. No notification should be made to the Home Office regarding NHS debts for women with an affordable repayment plan in place.**
- 7. Women who are manifestly unable to pay for their care should have their debt written off by the Trust.**

The DHSC upfront charging guidance states that 'it is critical that women are supported to continue with their maternity care' (at 5.6). This acknowledges the significant health risks associated with women missing antenatal appointments, not receiving care during the birth and avoiding postnatal care (see Part 2 of this guidance.)

The 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. The former DHSC guidance on administration and data sharing states that a *reasonable* repayment plan allows for the debt to be repaid within a realistic timeframe (at 3.6). However it goes on to say that NHS bodies 'need to consider the individual's particular circumstances such as amount of disposable income against the amount of the debt to decide whether a repayment plan is reasonable.' (The DHSC guidance on administration and data sharing has been withdrawn pending review for compliance with the General Data Protection Regulations 2018.)

Many women who require maternity care are on very low incomes. For these women, repayments would

need to be very low to be affordable. For women who are in paid work, their household income is likely to drop dramatically from late pregnancy through to the child's early years, as they are likely to cease work to care for a new baby or for health and safety reasons during their pregnancy. Repayment plans should accommodate these circumstances.

The former DHSC guidance on administration and data sharing states that the Home Office is not to be informed about the debt where an affordable repayment plan is in place (at 4.1).

If a woman has insufficient income to be able to enter into an affordable repayment plan, then it is unlikely to be cost effective to pursue the debt. The DHSC guidance provides for debts to be written off where, given the woman's financial circumstances, it would not be cost effective to pursue the debt (at 13.77).

There are some women who have been formally assessed as destitute or on very low income by other agencies. We recommend that these assessments be accepted as satisfactory evidence of inability to pay. These include:

- women in receipt of Section 17 support from their local authority;
- women who hold a HC2 form;
- women who have obtained a fee waiver from UK Visas and Immigration (which is normally accompanied by a waiver of the Immigration Health Surcharge) for their application for leave to remain;

Women whose asylum claim has been refused and who are not in receipt of asylum support are at high risk of destitution as they are not entitled to work or to access mainstream benefits. Those who received asylum support during their asylum claim will have passed a destitution test. We recommend that women whose asylum claim has been refused be treated as destitute in the absence of evidence to the contrary.

Where women have not been formally assessed as destitute or on low incomes by other agencies, it is up to the NHS Trust to make this assessment.

The DHSC guidance also provides for debts to be written off where all reasonable steps have failed to recover the debt (at 13.77). The guidance provides, as an example, where there are no further practical means of pursuing debt recovery.

8. If women are not notified that they are chargeable during the period of maternity care, then they will 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 have been denied the right to make decisions about the pregnancy with all the relevant facts.

The CQC registration and regulated activities regulations require Trusts delivering services to chargeable women to provide those women with a timely statement of the charges, including a written statement of the cost of care and method of payment (regulations 9(3)(g) and 19 respectively). The written statement must, as far as reasonably practicable, be provided prior to the commencement of services. CQC guidance states: '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'. The CQC can take regulatory action or prosecute for a breach of this regulation.

Issuing a late bill of which the chargeable woman was not previously aware puts the Trust at risk of regulatory action, prosecution or judicial review for maladministration (based on illegality or procedural unfairness). This is noted in the DHSC guidance (at 11.36). Further, the Charging Regulations state that the Trust has an obligation to make reasonable enquiries in order to determine whether a person is liable for charges (regulation 3). These enquiries must relate to the time at which the maternity care was provided, rather than the date on which the late bill was issued. Women's immigration status and personal circumstances can change over time, so Trusts cannot assume that a woman's current status and chargeability applied at the time the maternity care was provided.

We are recommending that the Trust write off debts where the women were not advised that they were chargeable during the period of maternity care.

Resolving chargeable status

9. When women are notified that they are chargeable, they should be given a written statement outlining why charges apply, what the charge is estimated to be and how they can pay. They should also be advised how they can appeal the decision that they are chargeable and the amount charged.

10. Women should be given a name, job title, email and phone number for the officer responsible for making decisions about her chargeable status, the amount charged and affordable repayment plans.
11. The officer should respond swiftly to any phone calls or correspondence from women or their advocates.
12. 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.
13. If charges are withdrawn, the officer should provide the woman with written confirmation of this.

The staff who assess chargeability are not infallible. Women can pursue a legal challenge against decisions about their liability for charges, the amount charged and how the debt is handled. Trusts can reduce the legal costs and administrative burden of responding to legal challenges by establishing and clearly communicating processes for women to appeal decisions about charging. Providing reasons for decisions will facilitate swift resolution of disputes. Where charges are withdrawn, swift, written confirmation of this will reduce the risk of legal action.

Dealing with debt

14. Women who find that they are struggling to maintain repayments should be signposted to independent debt advice. No notification should be made to the Home Office while women are seeking advice and changes to the affordable repayment plan are under consideration.
15. Debt recovery action should not commence until at least three months after the birth. This is to reduce the stress on the mother and her baby.
16. Debt recovery action should be suspended where 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.

The DHSC upfront charging guidance states that ‘it is critical that women are supported to continue with their maternity care’ (at 5.6). This principle should inform the way in which Trusts deal with debt.

We recommend that debt recovery action not commence until at least three months after the birth. This allows for women to complete post-natal care prior to any debt recovery actions, including women whose discharge from postnatal care is delayed due to poor health. This also recognises that debt recovery increases women’s stress and that stress and anxiety during pregnancy increases the risk of poor health outcomes for mother and baby (see Part 2).

In cases of standard commercial debt, it is common for creditors to agree to a period in which debt recovery is suspended while the debtor seeks advice. This may be a period of 30 days or may be longer. FCA guidance, which covers regulated debt such as credit cards, requires firms to suspend the active pursuit of debt for a reasonable period where the customer informs the creditor that the customer, a debt counsellor or other person acting on the client’s behalf is developing a repayment plan (CONC 7.3.11). This ‘reasonable period’ is generally 30 days and can be extended for a further 30 days (CONC 7.3.12). We recommend that Trusts adopt this approach, recognising that women who do not have recourse to public funds may require additional time to sort out their situation.

Signposting women to independent debt advice provides women with the support to document their financial situation and propose an affordable repayment plan. Trusts should be aware that some debt agencies do not offer advice to women who do not have leave to remain in the UK, so this should be checked prior to signposting. Referring customers to free and impartial debt advice is a standard element of FCA guidance, which covers regulated debt. Firms are required to refer customers to a not for profit debt advice body where a customer in default or arrears (CONC 7.3.7A).

Nature of charges

- 17. Women should be given an invoice which clearly states what they are being charged for. This should specify the relevant NHS tariff.**

Where a woman is chargeable, the Charging Regulations state that the charges should be 150% of the value of NHS tariff for that service (regulation 7). The regulations provide for local variations on

this price only in very limited circumstances. A local decision on the amount to be charged to chargeable patients is not one of the circumstances specified in the regulations.

CQC regulations require Trusts delivering services to chargeable women to provide those women with a written estimate of the cost of care (regulation 19). As charging is on the basis of the NHS tariff for the service, Trusts should state the relevant tariff. This does not preclude the Trust from subsequently charging on the basis of a different tariff if the woman requires care which is more or less complex than that anticipated at the time the estimate was provided. If this is the case, this should be specified on the invoice issued to the woman.

Clearly communicating the tariff which forms the basis of charges for maternity care will reduce the risk of legal challenge.

- 18. Women who use less than the standard package of maternity care should be charged only for the services which they use.**

Pregnant women visiting the UK may require a check-up or a standard maternity appointment while in the country. The Charging Regulations provide for Trusts to charge a proportion of the tariff where the woman uses only some of the bundle of services which make up a tariff (regulation 7). For example, a woman who attended only antenatal appointment or one scan should be charged a proportion of the tariff for antenatal care.

Clearly communicating the tariff which forms the basis of charges for maternity care and the proportion which is being charged for will reduce the risk of legal challenge.

Independent advice

- 19. All chargeable women should be offered free, independent legal advice. This will assist them to resolve questions about chargeability and to obtain advice on any debt which may be incurred.**

Signposting to free, independent legal advice will assist women to resolve any concerns which impact on engagement with maternity services, including chargeability and debt management.

The DHSC upfront charging guidance states that ‘it is critical that women are supported to continue with their maternity care’ (at 5.6).

Many women who are chargeable are in very vulnerable situations and require a significant level of support to make a complaint or otherwise exercise their rights. CQC Guidance states that: 'Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested' (at page 61).

There are a number of exemptions from charging which require disclosure of sensitive information, including torture, FGM, sexual assault and domestic violence. Women are unlikely to be aware of the exemptions. It is not appropriate for OVMs and other finance staff to ask women about these issues in the course of assessing chargeability. Access to independent advice increases the likelihood that women who are covered by these exemptions are made aware of their rights and supported to exercise them.

Role of clinical and financial staff

- 20.** No information about women collected by midwives or maternity support workers as part of routine clinical care should be used to assess migration status and chargeability. It is important that midwives can build a relationship of trust with the woman.
- 21.** Where women are chargeable, midwives should be asked if the woman falls within the exemptions for FGM, sexual violence, domestic violence or torture. The midwife's advice should be treated as definitive and finance staff should not request further evidence.
- 22.** Midwives and maternity support workers should not be asked to play any role in delivery of invoices or debt recovery.
- 23.** Finance staff should not, under any circumstances, attend antenatal or postnatal appointments or intrapartum care. Antenatal appointments are exclusively for the midwife to deliver clinical care to the woman.
- 24.** Finance staff should not seek to speak with a woman before or after her appointments. Such practices can deter women from attending appointments.

The DHSC upfront charging guidance states that 'it is critical that women are supported to continue with their maternity care' (at 5.6). A key element of maternity care is the development of a relationship of trust between the woman and her midwife (see Part 2). The actions of staff tasked with assessing chargeability, issuing invoices or pursuing payment should not impact on women's relationship with her midwife or deter her from accessing care.

- 25.** Midwives should receive training about charging for NHS maternity care which supports access to maternity care by vulnerable migrant women. The NMC Code requires midwives to act as advocates for women and they should understand how NHS charging interacts with this requirement.

Training which supports access to maternity care by vulnerable migrant women is not the same as the training provided by OVMs on the administration of charging. Training to promote access to services is consistent with the DHSC upfront charging guidance, which states that 'it is critical that women are supported to continue with their maternity care' (at 5.6).

Communication with the Home Office

- 26.** Finance staff should not inform the Home Office about outstanding debt where the woman is not chargeable, where there is a dispute about whether the woman is chargeable, where the debt has been written off, where the woman has an affordable repayment plan in place or where the woman is seeking advice on debt. This advice may relate to negotiation of an affordable repayment plan or to changes to an existing affordable repayment plan.

Notification of the Home Office of outstanding debt creates significant difficulties for women seeking regularise their immigration status, so should only take place when any disputes about chargeability have been resolved and the option of an affordable repayment plan or debt write-off have been fully explored.

As discussed above, in cases of standard commercial debt, it is common practice for creditors to agree to a period in which debt recovery is suspended while the debtor seeks advice. This may be a period of 30 days or may be longer.

We recommend that Trusts adopt this approach, recognising that women who do not have recourse to public funds may require additional time to sort out their situation.

- 27.** Finance staff should not share any clinical information or anything related to clinical information with the Home Office.

The former DHSC guidance on administration and data sharing states that personal clinical information relating to treatment provided must not be included in information provided to the Home Office (at 6.2). It further states that care should also be taken not to provide information from which the clinical history of the patient can be deduced.

Quality control

- 28.** Finance staff should keep accurate records of meetings, phonecalls and letters to women and to the Home Office. This should cover all aspects of the charging process, including assessing the woman's chargeability, issuing an invoice, negotiation of an affordable repayment plan, debt recovery action and Home Office notification.

CQC Guidance states that: 'Information and guidance about how to complain must be available and accessible to everyone who uses the service. It should be available in appropriate languages and formats to meet the needs of the people using the service' (at page 61). It further states that: 'Providers must tell people how to complain, offer support and provide the level of support needed to help them make a complaint. This may be through advocates, interpreter services and any other support identified or requested.'

- 29.** Women should be informed about the process for making a complaint about clinical staff and finance staff. There are many reasons why vulnerable women do not make complaints about poor treatment by NHS staff. NHS Trusts should be conscious that no formal complaints does not mean absence of poor practice.

- 30.** 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 finance staff are in accordance with Trust policy and reflect the Trusts obligation to reduce health inequalities.

Trusts face external scrutiny of their administration of maternity charging. Women can pursue a legal challenge to decisions about their chargeability, the debt and how the debt has been handled. Women can complain to internal complaints mechanisms and to the Parliamentary and Health Service Ombudsman or share their experience with the Care Quality Commission. Women can also seek media attention for their concerns.

Trusts can reduce the risk of legal challenge, complaints and negative media attention if they have good records in place about interactions with women affected by charging. As with any aspect of service delivery, regular audits of files relating to charging increases the likelihood that Trusts will pick up and remedy problems in service delivery prior to external scrutiny.

- 31.** NHS Trusts should audit clinic attendance and pregnancy outcomes of all migrant women, noting whether or not they were charged.

NICE guidance on caring for vulnerable women outlines how specialist dedicated support is needed to secure healthy outcomes for mothers and babies. Research into maternal and neonatal death across the UK finds that poor outcomes are socially-determined. The various quality improvement programmes in Trusts across England, based on the Secretary of State's ambition to make England the safest place to have a baby, should be taking into account vulnerabilities experienced by migrant women. Trusts should investigate the clinical consequences for their implementation of the Cost Recovery Programme Regulations.

References

- Lewis, G (ed.). 2007. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003–2005. The Seventh Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. London: CEMACH. <http://www.publichealth.hscni.net/sites/default/files/Saving%20Mothers%27%20Lives%202003-05%20.pdf>
- Knight, M, Tuffnell, D, Kenyon, S, Shakespeare, J, Gray, R, Kurinczuk, J. (eds.) on behalf of MBRRACE-UK. 2015. Saving Lives, Improving Mothers' Care. 2015. Surveillance of Maternal Deaths in the UK 2011-13 and Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. National Perinatal Epidemiology Unit, University of Oxford, Oxford: MBRRACE-UK. <https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202015.pdf>
- Knight M, Nair M, Tuffnell D, Shakespeare J, Kenyon S, Kurinczuk J. (eds.) on behalf of MBRRACE-UK. 2017. Saving Lives, Improving Mothers' Care – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15. Oxford: National Perinatal Epidemiology Unit, University of Oxford. <https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202017%20-%20Web.pdf>
- Nair M, Kurinczuk J, Knight M (2014) Ethnic Variations in Severe Maternal Morbidity in the UK– A Case Control Study. PLoS ONE 9(4): e95086. doi:10.1371/journal.pone.0095086
- National Collaborating Centre for Women's and Children's Health, 2010, Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. London: Royal College of Obstetrics and Gynecology. https://www.ncbi.nlm.nih.gov/books/NBK62615/pdf/Bookshelf_NBK62615.pdf
- NICE, 2010, Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. <https://www.nice.org.uk/guidance/cg110/resources/pregnancy-and-complex-social-factors-a-model-for-service-provision-for-pregnant-women-with-complex-social-factors-pdf-35109382718149>
- Maternity Action and Asylum Support Appeals Project, 2015, Advice briefing: Housing and financial support for pregnant women who have been refused asylum. https://www.maternityaction.org.uk/wp-content/uploads/ma-asap-briefing_v4.pdf
- National Health Service, 2004, Implementing the Overseas Visitors Hospital Charging Regulations. Guidance for NHS Trust hospitals in England. <http://tinyurl.com/zhjz5z6>
- National Health Service, England, 2017, The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations (SI 2017/756) http://www.legislation.gov.uk/uksi/2017/756/pdfs/uksi_20170756_en.pdf
- Department of Health, 2018, Guidance on implementing the overseas visitor charging regulations https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767905/guidance-on-implementing-the-overseas-visitor-charging-regulations.pdf
- Department of Health, 2016, Overseas chargeable patients, NHS debt and immigration rules: Guidance on administration and data sharing, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793132/overseas-chargeable-patients-nhs-debt-and-immigration-rules.pdf
- Maternity Action, 2018, What Price Safe Motherhood? - NHS Charging for Maternity Care in England and its Impact on Migrant Women. www.maternityaction.org.uk/wp-content/uploads/WhatPriceSafeMotherhoodFINAL.October.pdf
- Doctors of the World, 2017, Deterrence, delay and distress: the impact of charging in NHS hospitals on migrants in vulnerable circumstances. https://www.doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/Research_brief_KCL_upfront_charging_research_2310.pdf
- Mangham L, Petrou S, Doyle L, Draper E, and Marlow N, 2009, The cost of preterm birth throughout childhood in England and Wales. Pediatrics 123(2): e312-27. doi: 10.1542/peds.2008-1827
- Public Health England, 2013, HIV in the United Kingdom: 2013 Report. PHE, London
- Feldman, R. 2017, The Impact on Health Inequalities of Charging Migrant Women for NHS Maternity Care. London, Maternity Action, <https://www.maternityaction.org.uk/wp-content/uploads/ChargingReportMarch2017FINALcompressed.pdf>