Evaluation of Department of Health Cost Recovery ID Checking Pilot

Final report

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Ipsos Public Affairs

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Introduction

- In July/August 2017, the Department of Health (DH) launched the ID Checking pilot, designed to help inform future policy decisions on how to improve eligibility checking in hospital settings.
- The core aim of the ID checking pilots was to establish whether introducing ID checking enables NHS staff to quickly, and more efficiently, identify who is and who is not eligible for NHS-funded care.
- The pilots will help DH to understand the potential benefits and barriers to introducing ID checks more widely across the NHS. Including, but not limited to, the impact on income from chargeable visitors and migrants, the burden on reception and administrative staff, whether patients readily carry identification and the impact on demand for services.
- Participating trusts were asked to run a pilot in two service lines for a period of three months. Where in place in the trust, it was decided (if possible) that one of the two pilot services should be Maternity. The other pilot service line was proposed by the trust.
- The pilot service lines were required to check IDs to establish the patient's identity (photo ID) and current residency status (proof of address) on the basis that this would assist the trust in its decision-making around chargeability.

Evaluation overview

- The Department of Health (DH) commissioned Ipsos MORI to undertake a process and impact evaluation of the ID Checking pilot.
- The aim of the impact evaluation was to assess the extent to which introducing ID checks leads to an increase in income from chargeable visitors and migrants; the impact this has on reception and administrative staff in terms of burden; and on demand for services.
- The aim of the process evaluation was to assess the feasibility of introducing ID checks at the point of access within A&E services; whether patients readily carry identification to make ID checks even possible; and what is the most effective point in the pathway to ask for ID.
- The evaluation also aimed to explore and assess any barriers or unintended effects of the pilots, as well as to provide learnings on how the introduction of ID checks could be refined for wider roll out.

Executive summary

Methodology

- The evidence required to answer the evaluation questions was primarily collected through five work strands:

  1. A survey of staff in the pilot services at two points in time: once before the ID Checks started (at baseline), and again once they were in place,

  2. A Time and Motion observation study at two points in time: once before the ID Checking pilot started (baseline), and again once the pilots were in place,

  3. Trust managed data collection: whereby trusts recorded data on the ID provided for each patient (photo ID and proof of address), and if they did not provide two valid forms of ID, why this was.

  4. Case studies at 6 of the 18 participating pilot trusts, and in-depth interviews with Overseas Visitor Managers or pilot leads in an additional four pilot trusts.

  5. Analysis of management information: both financial cost recovery data and non-financial activity data (cancellations and DNAs).

Pilot delivery

- In most instances the ID checks were undertaken at reception when patients checked in, whenever pilot services had clinics running.
- Almost all trusts decided to only request ID from those patients who were new to the service line. However the A&E pilots requested ID from all patients.
- All trusts wrote to patients informing them of the need to provide ID. Some trusts (including all A&E pilots) put posters up in reception waiting areas.
- There was variation in terms of trusts in following up patients who showed a form of ID which indicated that they were chargeable or if their status was unclear from the ID they provided. Some trusts focussed all resources on the pilot and did not have any capacity to follow up any patients.
- Recording systems for the IDs were also mixed. A few trusts took photocopies of the ID provided, whilst some A&E pilots simply asked patients if they had ID on them, rather than requesting to see it.
- Initial awareness of the pilot among staff was low with the exception of administrative staff. There was variation between trusts in terms of how the pilot was communicated with staff.

Executive summary

Assessment of pilot impact

Knowledge and attitudes

- Awareness of chargeability remained stable from the baseline and in the follow up survey of staff. Around two thirds of staff were aware that some people were chargeable for NHS care (66% in the baseline and 69% in the follow-up). However an increase in awareness was found among both nurses and healthcare assistants in the follow up survey.
- Staff were less able to provide specific details about exactly which patients this applies to and there were some misconceptions about exactly which services would be chargeable as well as confusion. The charging rules were described as 'ambitious' in the qualitative interviews, and as such staff questioned the appropriateness of administrative/reception staff to undertake the ID checks.
- At both the baseline and follow-up survey, the majority of all staff surveyed indicated support for the broad/overarching principles of cost recovery and the ID checks, and the findings suggest that the pilot generated further support. The qualitative interviews mirrored this support. However, support varied by staff group.
- Confidence in the ID checks was high in both the baseline and the follow up survey, although some groups (notably doctors) showed less support. A number of flaws in the ID checking process were aired in the qualitative interviews including a risk that patients will show false ID, a UK Driving Licence being an imperfect form of photo ID, and the fact that the two forms of ID are not necessarily sufficient in proving whether someone is eligible or not for free NHS care.

Cultural and behavioural changes

- There was an increase (in the follow up survey) across almost all staff who said that they have a role in cost recovery.
- There was concern, however, that the ID checks would place too much burden on staff. Whilst staff responsible for overseeing the pilot implementation reported that there had been an increase in understanding of cost recovery among staff and that the pilot had re-focussed attention on this area.
- Those who were aware of the ID checking pilot indicated higher levels of confidence in processes to maximise the recovery of costs in the follow-up survey compared to those who were not aware.
- Following the launch of the pilot, participants who said they were aware of the pilot were also more likely to find it easy to establish whether or not a patient is chargeable compared to those who were not aware.

Executive summary

Assessment of pilot impact

Effectiveness of the ID checking pilot

- Across non-emergency pilot trusts and services, overall nearly four in ten (39%) patients were recorded as providing both forms of ID to prove ordinary resident status (photo ID and proof of residence). In the A&E pilots, around a fifth of patients were able to provide both forms of ID.
- In all services, patients were more likely to provide photo ID than proof of address. Across A&E pilots, patients were nearly twice as likely to provide photo ID than proof of address.
- The most common form of photo ID provided – in both emergency and non-emergency services – was a driving licence. Where patients were able to provide proof of address – this was most commonly a utility bill, a council tax bill, or bank statements (in non-emergency services).
- In non-emergency services, the main reasons given as to why patients didn't bring the correct ID was that the letter didn't mention it, or that they didn't know to bring it. In A&E it was that they did not normally carry ID.
- Both the staff survey and the qualitative interviews indicated that staff were generally confident about the ID checking process and how this will improve the recovery of costs from chargeable patients.
- The key benefits of ID checking, reported by staff, centred around increased income for the trust, better, more efficient identification of chargeable patients and earlier identification of chargeable patients.
- In the qualitative interviews however, while staff were positive about the motives and principles behind the pilot overall, they also raised concerns around how the ID checking would work in practice.
- A number of practical difficulties around implementation of the ID checks were reported including using administrative and reception staff to verify whether ID is acceptable, some patients being entirely 'paperless' (i.e. not having access to paper documents) and patients not always owning the forms of ID requested.
- The most common financial cost associated with the ID checks reported by staff was the administrative cost of undertaking them.
- Several risks or negative implications of the ID checks were raised. Including concern about the difficulty of asking the ID check questions, and the worry that patients would not seek treatment they required if they were deterred by the ID checking.

Executive summary

Assessment of pilot impact

- A number of practical barriers in implementing the checks were also reported in the qualitative interviews including language related barriers, staff being unsure around whether or not to ask children for ID, and patients (particularly in A&E) being too unwell.
- While staff were initially very concerned about patient reaction to checking ID, they reported that most patients accepted the ID checks with the exception of a minority who were offended by them.
- There were some reports of patients being deterred from accessing treatment during the pilots because of the ID checks.
- Overall, for all trusts the checking in process took on average 16.9 seconds longer during the ID Checking pilot compared to before.
- However, excluding A&E observations, the process of checking patients in took on average 14.5 seconds longer during the ID Checking Pilot than before.
- During the pilot, the check-in process was on average 27.3 seconds longer in A&E than before the pilot, however undertaking the ID checking itself was actually fastest in A&E. This is because a higher proportion of patients in A&E than in other services were asked about ID.
- There was a significant degree of variability across services and trusts around the impact of conducting the ID checks on overall check-in times.

Overall perceptions of impact

- Participating trusts reported a number of benefits of undertaking the ID checks:
  1. Improved, more efficient processes for overseas teams and cost recovery
  2. Increased awareness and engagement with cost recovery
  3. Earlier communication with patients about cost recovery
  4. Increased awareness among patients that the NHS isn't free to all.
- Data for some trusts show promising signs in terms of the number of patients identified as chargeable and invoiced as a result of the pilot. The quality of the data provided for most trusts is poor, however, and we suspect it's still too early to say.
- We recommend that DH returns to trusts in three-four months time and requests access to their cost recovery data. At this point enough time should have passed for those trusts able to do so, to have caught up with their invoicing.

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Overall perceptions of impact continued

- Trusts highlighted several difficulties they had experienced in conducting the ID Checking pilot, relating to:

  1. Ambiguity around acceptable ID and which patients were exempt from charging
  2. Managing patient reaction
  3. Communicating effectively with patients

Going forward – future roll out

- Staff were asked about what improvements they felt could be made to the ID checking process and what they would need to be able to continue to run the checks. It was felt that these issues they identified, sometimes barriers, would need to be ironed out before the ID checks could be rolled out further, potentially across all services and within all trusts:

  1. The need for ID checks to be integrated within IT systems
  2. The provision of training and information regarding the ID checks (which ID is acceptable, the charging rules)
  3. The need to conduct the ID checks alongside asking the '12- months question'
  4. The need for a strong national communications strategy
  5. Clarity around the extent to which patients should be chased for ID
  6. Clarity around how to process IDs

- Support for roll out of the ID checks was relatively high among staff however there was more concern about the potential implications on existing workloads and resource among frontline staff.
- In terms of next steps, some trusts are continuing with the ID checks. Others are pausing for now, and will make a decision based on the outcome of the evaluation.

1. Introduction

This section sets out the background and rationale for the ID Checking Pilot. It provides an overview of the intended approach to implementing the Pilot during the period covered by the evaluation. Here we present the logic model for the ID Checking Pilot developed during the inception phase, setting out how the objectives of the Pilot would be achieved.

In addition, this chapter presents the objectives of the evaluation, the specific questions it has sought to address, and the methods through which the required evidence was collated.

1.1. Aims of the Pilot

The pilots have been designed to help inform future policy decisions on how to improve eligibility-checking in hospital settings.

The core aim of the ID checking pilots is **to establish whether introducing ID checking enables NHS staff to quickly, and more efficiently, identify who is and who is not eligible for NHS-funded care.**

The pilots will help the Department of Health (DH) **to understand the potential benefits and barriers to introducing ID checks more widely across the NHS**. Including, but not limited to, the impact on income from chargeable visitors and migrants, the burden on reception and administrative staff, whether patients readily carry identification and the impact on demand for services.

DH aims to increase the speed at which patients are identified as chargeable in order to potentially realise a range of benefits, including to:

- increase the number of chargeable patients identified
- increase the frequency of up-front charging and income realised
- increase the number patients whose eligibility is determined prior to treatment
- reduce the number of debts written off in the event of default

1.2 Rational for the ID Checking Pilot

Cost recovery – legislative overview

In 2014, the DH published implementation plans to deliver the Overseas Visitor and Migrant NHS Cost Recovery Programme, to improve cost recovery and ensure that the NHS receives a fair contribution for the cost of the healthcare it provides to non-UK residents[1]. The programme initially focused on two principle mechanisms for charging:

- the ability of the NHS to recover the costs of healthcare provided to European Economic Area (EEA) patients, non-resident in the UK, from their home member state through the European Health Insurance Card (EHIC) system, as well as S1 and S2 agreements; and,
- the statutory requirement of NHS providers to directly charge patients from non-EEA countries (or those from the EEA without an EHIC).

In addition, in April 2015, the Immigration Health Surcharge was launched, whereby recipients of UK visas (non-visitors) would be charged an annual fee upfront for each year of their visa, to allow them access to the NHS during their stay in the UK[2].

Most recently, since the 23rd October 2017, NHS Providers and non-NHS Providers have been legally required to recover charges that are not immediately necessary or urgent in full, in advance of providing them. The requirement for upfront charging has previously been recommended best practice.

Cost recovery performance to date

DH has recently estimated that since the Cost Recovery Programme was launched in 2014, the income identified from overseas visitors and migrants has risen from £89m (2012/13) to £289m (2015/16). The government has a stated ambition to recover up to £500million a year for the NHS, and plans are in place to implement the final stage of the Overseas Visitor and Migrant NHS Cost Recovery implementation plan: to extend charging to areas of healthcare currently free to all overseas visitors so that a consistent approach to charging is applied across the NHS.

The Government has committed to supporting the NHS to improve rates of cost recovery, including implementing an incentive scheme to overcome structural disincentives for NHS trusts to identify potentially chargeable patients. Nevertheless, implementation of the programme will require NHS trusts to adapt both systems and working cultures to ensure the details on the residency of patients required to establish chargeability are gathered at an appropriate point in time and transmit this information to the Overseas Visitor Manager (OVM) to enable charging arrangements to be put in place (or EHIC details to be uploaded to the OVT portal as appropriate).

[1]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/329789/NHS_Implentatation_Plan_Phase_3.PDF

[2]https://www.gov.uk/government/news/migrant-health-surcharge-to-raise-200-million-a-year

Rational for the ID Checking Pilot

Cost recovery barriers

As illustrated by Ipsos MORI's evaluation of the Cost Recovery Programme[3], NHS trusts face numerous challenges in putting in place the processes required to bring about improvements in cost recovery. Evidence collected shows that some issues stem from the level of priority that can be given to cost recovery at a board level and resistance from clinical staff to identify patients and to consider if treatment should be provided. Further, it has been found that a major problem in recovering costs is ensuring timely and effective identification of chargeable patients in trusts. In particular, trust practices often rely on patient honesty which potentially misses a large proportion of patients who they are treating.

The Department of Health and NHS Improvement have therefore recently introduced a programme of work to provide intensive support to trusts as well as gather best practice. Evidence suggests that a core element of successful cost recovery is ensuring that as much as possible (without affecting provision of treatment where urgent or immediately necessary) trusts are able to identify chargeable patients very early on in the care pathway. Ideally before any treatment has been provided. This ensures that patients and their families fully understand the cost of any treatment and can thus make informed choices on how they would like to proceed.

The Department of Health and NHS Improvement are supporting a number of pilots to look at innovative practices which may improve early identification and in particular exploring the effectiveness of collecting two forms of identification (ID) from patients on entry into secondary care, to allow staff to identify whether patients are considered Ordinarily Resident, and therefore eligible for free care. It is on this basis that the ID Checking Pilot have been designed.

[3]https://www.ipsos-mori.com/researchpublications/publications/1913/Overseas-Visitor-and-Migrant-NHS-Cost-Recovery-Programme.aspx

1.3 DH ID Checking Pilot

The DH ID Checking Pilot officially launched in early April, 2017, with participating trusts expected to implement ID checks in early June. However, following the announcement and subsequent June 2017 snap election, commencement of the pilot was delayed. Consequently, trusts began the pilots at varying times between late July and August 2017.

As part of launching the pilots, **trusts were asked to run a pilot for a three month period in two services lines**. Where in place in the trust, **it was decided that, if possible, one of the two pilot service lines should be the maternity service**. The trusts proposed the other clinical area. Only piloting in one service line was permitted in cases where trusts were able to facilitate a pilot in an emergency departments, however on launch of the pilot a handful of non-A&E participating trusts only launched in one service. Trusts were advised to consider expenditure on chargeable services, likelihood of service being used by chargeable patients and ease of delivery when considering their second pilot service line.

The service lines participating in the pilot were required to ask questions to all patients whose chargeable status was unknown to the NHS organisation or patients who had not had their ID checked since the start of the pilot. The ID checks needed to establish the patient's identity and current residency status on the basis that this would assist the trust in its decision-making around chargeability. Although having two forms of ID accepted by the pilot would not necessarily entitle the patient to treatment, they were felt to increase the number of patients identified and start conversations with patients about eligibility. All patients were to be asked for their ID to avoid discrimination.

It **was recommended to trusts that they make patients aware that they would be required to bring ID**, however how they did this in terms of communication with their patients, was open to their discretion.

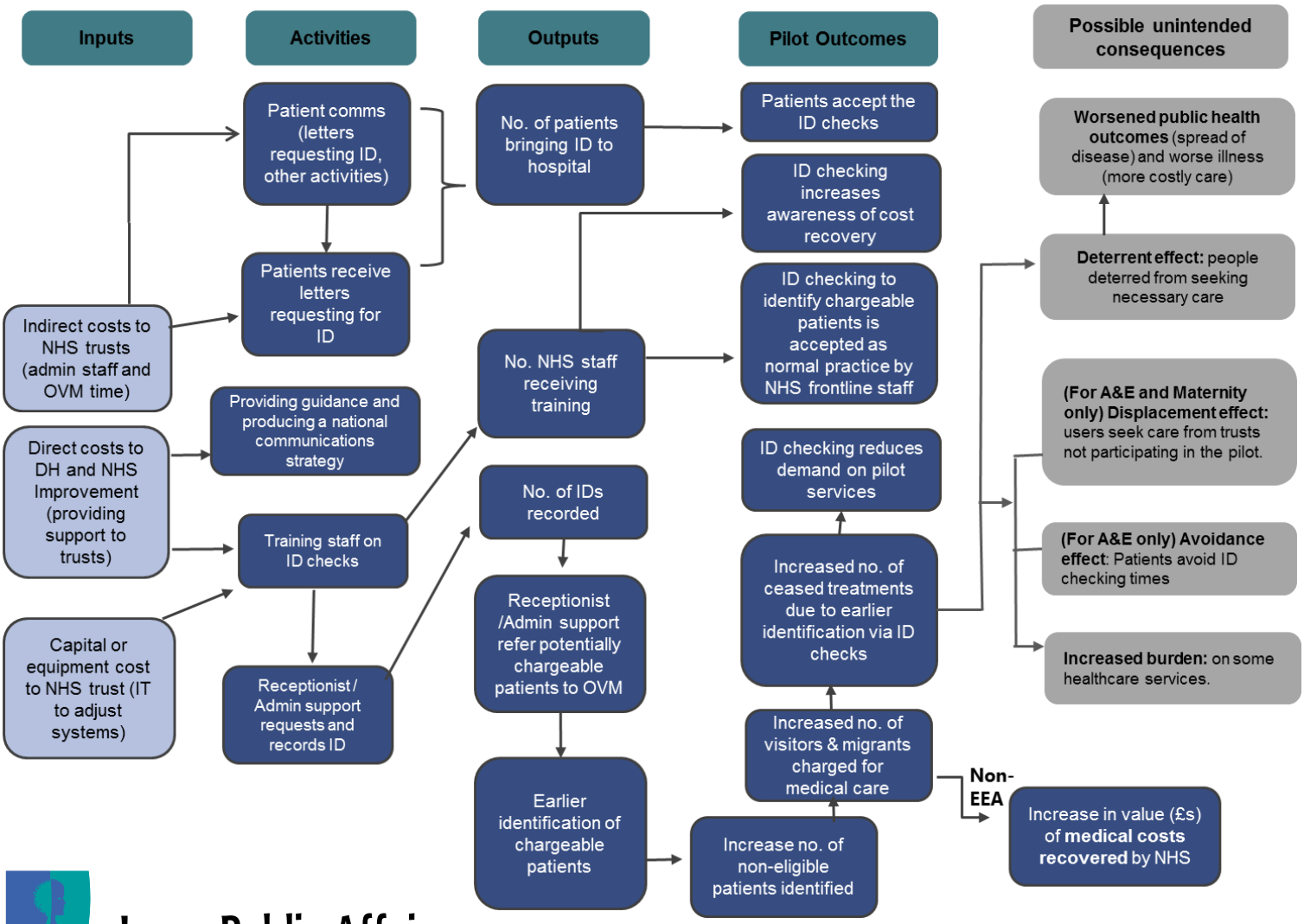
DH provided all trusts with a range of information around communicating the pilot and steps in the process of collecting ID from patients.

1.4 Pilot Logic Model

At the outset to the evaluation a Logic Model was created to help understand the vision of success for the pilot. The Logic Model for the ID Checking Pilot is set out in Figure 1.1. The purpose of this model was to clearly set out an analytical framework for the evaluation, defining the causal processes through which the ID Checking Pilot was intended to deliver its anticipated outcomes, framing the data that needed to be collected by the evaluation, and the issues that needed to be considered when evaluating it.

Throughout the evaluation, discussions were framed against the Logic Model to establish if the initial conditions expected to bring about change, have played out through implementation on the ground, and how effective this has been in the context of the pilot's aims and objectives. The Logic Model was open to amendment based on the evidence coming out of the evaluation with new assumptions being developed and defined. As such, the Logic Model was not fixed and was open to adaptation throughout the evaluation life cycle.

Figure 1.1 Pilot logic model



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Pilot Logic Model

Inputs

These are the resources necessary to put the pilot in place. The inputs for the ID Checking Pilot related to time and direct costs associated with undertaking the pilot in each participating trust. The costs relate to time spent by staff in each of the pilot trusts in introducing and implementing the ID check in the various service lines. It also relates to the staff time required by DH and NHS Improvement to support trusts with implementing the pilot and in monitoring their delivery. Finally, there are direct costs which relate to financial support and equipment needed by trusts to support them in adjusting their systems and processes in order to implement the checks.

Activities

A range of activities were involved in implementing the ID check in trusts. For DH, there needed to be ongoing support to trusts, including provision of guidance material around accepted ID and cost recovery, but also in terms of developing communication strategies. For trusts, the activities encompassed all those required to implement the ID checking in the pilot services. This included communicating to patients the need to bring in two forms of ID; making staff aware of the ID checking requirements and training them on how to approach collecting the ID; adapting systems and processes to allow for ID to be collected, recorded and acted on; and reception staff actively asking patients to provide ID. As the onus was on the trusts to undertake these activities, variation can be expected in the approach they took but it is assumed that these core activities will have needed to be undertaken in order for effective implementation.

Outputs

The activities are each intended to deliver a range of outputs, the realisation of which is anticipated to be crucial if the pilot is to deliver its intended outcomes. The delivery of these outputs represent the starting point for some of the metrics against which successful delivery of the pilot will be measured. The outputs related to:

- The number of patients who are reached by communication activities and bring ID
- The number of staff who are reached by, and engage with, the communication and training activities delivered
- The number of IDs recorded by staff
- The number of patients who are referred as potentially chargeable and the proportion who are identified earlier on as chargeable.

Pilot Logic Model

Outcomes

The outcomes are the expected effects of the ID Checking Pilot that will be achieved as a result of the inputs and activities described previously. It was anticipated that with the drive to increase awareness of ID checking in the medium-to-long term, patients would begin to accept being asked to provide two forms of ID and that the process would be normalised amongst both patients and staff.

Having earlier identification of patients, and staff buy-in, should then encourage earlier identification of chargeable patients allowing OVM staff to act on recovering costs more quickly. It was predicted that this in-turn should increase the number of ceased treatments, due to patients being approached before treatment commences and so meaning they could opt out of the treatment if they do not wish to pay. It was expected that with more ceased treatments there will be reduced demand on services. Further, with patients being identified earlier in the process, it was thought that this would extend the time in which OVM teams could work to recover costs from patients. This was expected to lead to increased numbers of visitors and migrants charged for medical care and ultimately increase the monetary value of medical costs being recovered by the NHS.

Possible unintended consequences

As well as the outcomes suggested above, the nature of the Pilot also provided the potential for the manifestation of a variety of unintended consequences. The first were deterrent effects, whereby people may have been deterred from seeking the care they needed, leading to worsened public health outcomes. The second are displacement and avoidance effects, whereby users sought alternate routes to access healthcare which were not routinely checking ID (e.g. using other services or trusts) or were non-chargeable (e.g. emergency or primary care services), leading to an increased burden on these healthcare services.

1.5 Evaluation Overview

Evaluation objectives

The Department of Health commissioned Ipsos MORI to undertake an **impact and process evaluation** of the NHS ID Checking Pilot being run in several NHS trusts which introduced identity (ID) checking at points of access in NHS services in secondary care.

The primary aims of the evaluation were:

1. **Impact evaluation:** An assessment of the extent to which introducing ID checks leads to an increase in income from chargeable visitors and migrants; the impact this has on reception and administrative staff in terms of burden; and on demand for services.
2. **Process evaluation:** An assessment of the feasibility of introducing ID checks at the point of access within A&E services: whether patients readily carry identification to make ID checks even possible, and what is the most effective point in the pathway to ask for ID.

Key research questions

The below table outlines the key questions this evaluation sought to answer:

Table 1.1 Evaluation questions

Maternity, A&E and elective care pilots	How many non-eligible patients attend services, and has this number increased throughout the pilots?
	Does requesting ID reduce demand for services?
	Does checking identifications of patients place a burden on administrative and reception staff?
	Does checking identifications of patients improve debt recovery or rates of up-front charging?
	Does checking identifications of patients increase rates of ceased treatment by trusts and by patients?
A&E pilots only	Do patients ordinarily carry sufficient ID to prove residency status? Does this change if there are local communications? Why are patients unable to carry ID?
	What is the most effective point in the patient pathway to ask for ID?

Evaluation Overview

Evaluation scope

The evaluation was concerned with:

- The 18 trusts who had introduced ID checking in selected services between July 2017 and October 2017
- Exploring how the implementation of ID checking in the selected services has worked
- The impact that the pilots have had on early identification of chargeable patients and recovery of costs
- Assessing any barriers or unintended effects the pilots have had
- Exploring how the introduction of ID checks could be refined for wider roll out

Methodology

The evidence necessary to answer the evaluation questions outlined in Table 1.1 was primarily collected through five work strands:

1. A survey of staff in the pilot services
2. Time and Motion Observations
3. Trust Managed Data Collection
4. Case Studies and in-depth interviews
5. Analysis of management information

18 NHS trusts participating in the pilot, however, not all trusts participating in full evaluation activities. **Four trusts did not participate in the time and motion. Three did not participate in the staff survey, although one of these trusts did participating in a case study interview**. All trusts collected the trust managed data and assisted with collecting data for the analysis of management information.

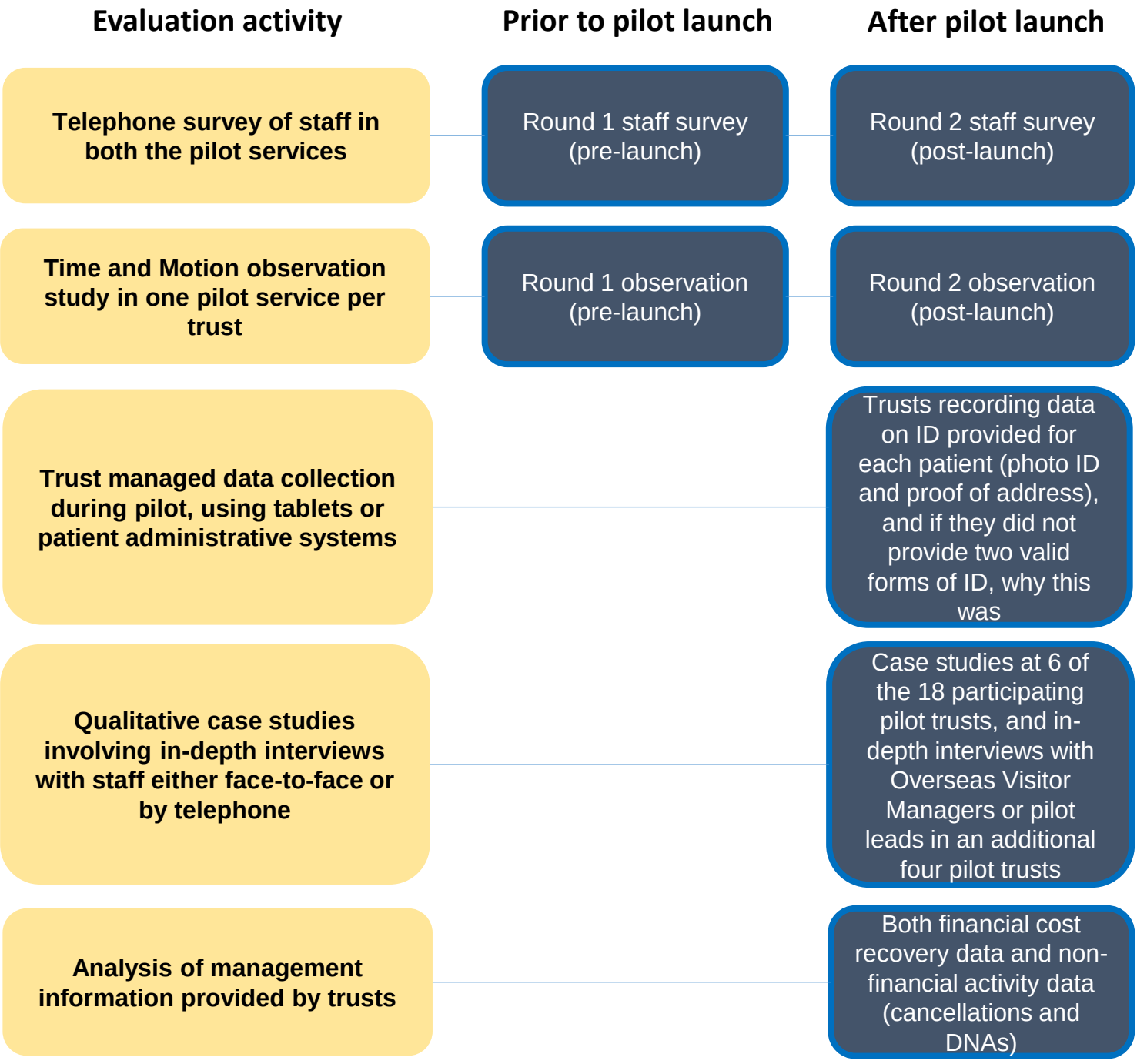
Evaluation Overview

Methodology

The figure below clearly outlines the activities undertaken throughout the evaluation and at what stage; some of these activities took place before the ID checking pilots launched in trusts ('baselining' activities) and others took place once pilots had started.

The following slides discuss each work strand in more detail.

Figure 1.2 Outline of methodology throughout the evaluation



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Evaluation Overview

Research questions and link to methodologies

The table below maps the research questions against methodologies used to address these.

Table 1.2 Evaluation questions and strands

RESEARCH QUESTIONS		Trust managed data collection	Time and motion observations	Staff survey	Case studies and in-depth interviews	Analysis of management information for cost recovery
MATERNITY A&E AND ELECTIVE CARE PILOTS	How many non-eligible patients attend services, and has this number increased throughout the pilots?	✓				
	Does requesting ID reduce demand for services?	✓		✓		✓
	Does checking identifications of patients place a burden on administrative and reception staff?		✓	✓	✓	
	Does checking identifications of patients improve debt recovery or rates of up-front charging?	✓				✓
	Does checking identifications of patients increase rates of ceased treatment by Trusts and by patients?	✓				✓
A&E PILOTS ONLY	Do patients ordinarily carry sufficient ID to prove residency status? Does this change if there are local communications? Why are patients unable to carry ID?	✓	✓	✓	✓	
	What is the most effective point in the patient pathway to ask for ID?	✓	✓	✓	✓	

Evaluation Overview

Pilot Staff Survey

- Quantitative data on awareness and views around the pilot, as well as indicators of cultural change with regards to ID checking, were collected through **telephone surveys of NHS staff working within the pilot sites and services**. Interviews covered frontline administrative staff, clinicians and senior trust management.
- Surveys were conducted **at two points in time**: prior to the implementation of the pilot (10th April – 18th August 2017[4]) and 3-4 weeks post implementation (29th August – 13th October 2017).
- **Quotas were set** to ensure that an equal distribution of interviews were achieved across staff groups and trusts.
- As different trusts launched their pilots at different times, **the closing dates for the staff survey were staggered across trusts depending on when they launched**. Early adopters were prioritised in the wave one survey to ensure their quotas were met before they launched the pilot. Late adopters in the wave 2 survey were focused on towards the end of the fieldwork period to allow for the pilot to bed in more before staff were contacted.
- All interviews were conducted using a Computer Assisted Telephone Interviewing (CATI) methodology.
- Full details of the questions asked and quotas achieved can be found in Appendix A.

A note on interpretation of staff survey data:

- Please note that due to small base sizes, results are not reported on at a trust level.
- Further, due to the different ways in which the samples were complied across trusts and staff groups, comparisons between staff groups are indicative rather than conclusive.
- All data are based on all participants within a staff group, unless otherwise specified. Where relevant individual base sizes are presented on charts.

[4] Please note during fieldwork a general election was called (Thursday 8th June) as such activities were slowed by a period of purdah.

Evaluation Overview

Time and Motion Observation

- The second strand of work feeding into this evaluation was a series of time and motion observations in one pilot service in each participating trust.
- **Two time and motion observations were conducted within one service line in 14 of the participating trusts**[5]. The observed services were chosen to represent the range and diversity of all services where the ID checks were taking place.
- One observation was conducted prior to implementation of the pilot (between 24th April and 23rd August 2017) and the other was conducted post implementation (between 7th September and 3rd October 2017).
- 936 patients were observed checking in at round 1. 754 patient were observed at round 2, in which **399 patients were observed having their ID check[6]**.
- As part of the time and motion observations, observers from Ipsos MORI undertook an in person visit (usually lasting 7 hours) to the participating service line. **These visits covered a variety of days and times across the different pilot services but were consistent within service for both visits** (e.g. if the baseline visit was undertaken on Monday between 9-4, the follow up visit would be undertaken on the same day and time). **Observers sat with those who check patients in and recorded the length of time it took to do this-** observing only one person at a time when multiple staff were working at reception. In the second visit observers were asked to separate out the time taken to check patients in and ask the ID questions (see Figure 1.2 overleaf). Full requirements for each observer when conducting the time and motion study are outlined within the observation tool provided to each observer (see Appendix B). Key however was that the time it took to check in each and every patient by receptionists and this was observed and recorded. Round 2, therefore recorded times for both patients who did have their ID checked (new patients) as well as those who did not (returning patients).
- **The observations were designed to assess the increased burden on reception and administrative staff** in asking the ID checking questions.

[5]Please note that four trusts did not participate in the time and motion due to late entry into the pilot and difficulties experienced when undertaking the checks.

[6]Please note that at both rounds the data was cleaned to remove cases which would skew results. The final figures reported here are the cleaned figures.

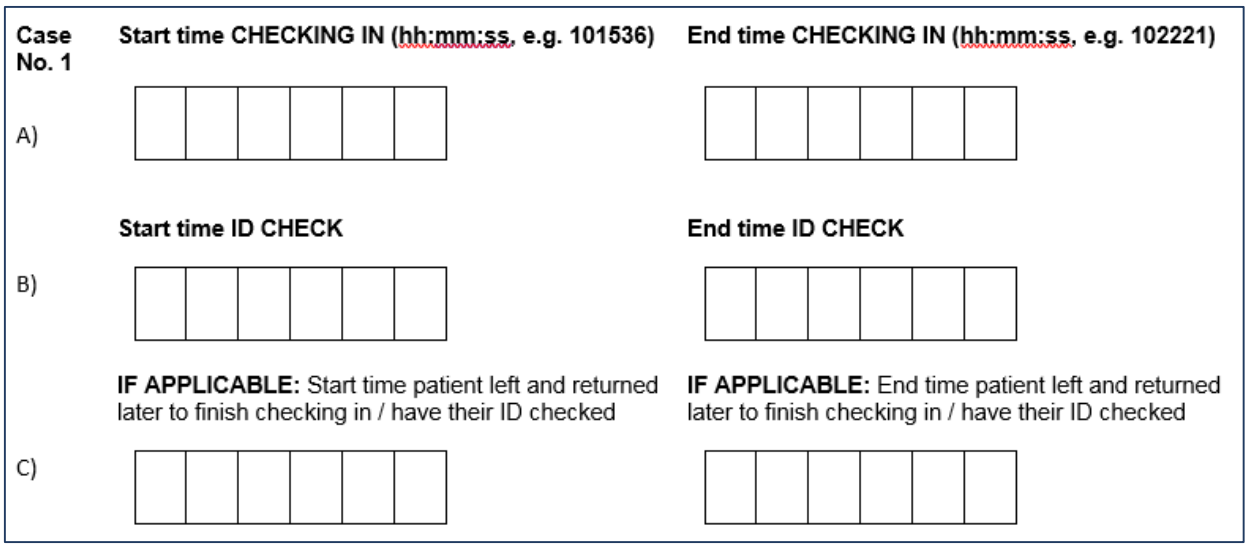
Evaluation Overview

Time and Motion Observation

Note on the analysis of the Time and Motion data

- Please note that these **results are not intended to be taken as an audit or a test of NHS trust staff** but as **an indication of how long it takes to check patients in for a medical appointment**.
- Observers were able to indicate irregularities in observations. Where irregularities, identified by the observers, are deemed to skew the results, these have been removed from the analysis. Irregularities removed from the final results included cases where:
  - The patient left the reception area and returned later on to finish checking in
  - The receptionist was interrupted during check-in
  - The check-in process was interrupted by an outside event
  - The patient was in the wrong location/ service
  - The check-n process was started but not completed
  - Other cases such as patients attending a reception desk to book future appointments.

Figure 1.3 Extract from the Time and Motion observation template (Round 2)



Evaluation Overview

Trust Managed Data Collection

- The third strand of the evaluation involved all participating trusts recording data on the ID provided, or not provided, by patients visiting the participating service lines during the three months of the pilot.
- Data was collected between 29th May and 10th November 2017.
- The **collection of this data has been essential in building a clear picture of the feasibility in undertaking ID checking**, both in terms of whether patients provide two forms of ID and what ID they are able to provide.
- Trusts were asked to collect the following information from every patient who presented at the pilot service line and who it was required, as part of the pilot, to ask for ID:
  - **Whether the patient provided valid ID.**
  - **Which photo ID they provided and which proof of address they provided.**
  - **If they did not provide two valid forms of ID, why they did not have this ID**.
- Trusts had two options for recording this data. They could incorporate the questions, which were designed to be answered by the person administering the check and not by the patient, into their existing Patient Administration Systems (PAS). Alternatively IPSOS MORI were able to supply them with a tablet which had the questions integrated into it via the Ipsos MOBILE App.
- For the exact questions trusts were asked to collect data on, and for more general information about the data collected, please see Appendix C.

Note on interpretation of the Trusts Managed data:

- It should be noted that the amount of recorded data varied across each trust. This is due to a range of factors which included:
  - General volumes of patients into the service lines
  - Different practices within each of the participating service lines in terms of which patients were checked for ID (for example only new patients in some trusts and all patients in others).

Evaluation Overview

Case studies and in-depth interviews

- The fourth strand of work feeding into this evaluation involved a series of full case studies and supplementary in-depth interviews conducted across ten of the pilot trusts between 25th September and 3rd November 2017.
- Full **case study interviews were completed with 6 pilot trusts**, with **supporting in-depth interviews conducted with Overseas Visitor Managers (OVM) or pilot leads in an additional four** pilot trusts.
- This qualitative strand was designed to **deliver a detailed and in-depth understanding of how the ID checks were perceived and working** in the participating trusts. The interviews carried out within this strand were hoped to uncover any issues with implementation with the ID Checking Pilot that may not have been possible with the observations and staff surveys alone. They were also used to explore with both staff directly involved in the ID checks, as well as those who were not, perceptions of the extent to which the ID checks had led to their anticipated outcomes.
- The findings of case studies and in-depth interviews have been included within this report to provide more detailed feedback on the pilot and its implementation. They also explore support for the future roll-out of ID checking more widely.
- **Interviews were conducted on site, in person, or via telephone** depending on availability and preference. They were conducted with a range of staff working within the pilot sites and included administrative staff, clinicians, general management, financial teams and trust board members.

Evaluation Overview

Analysis of management information

In order to evidence findings for a number of evaluation questions, publicly available secondary data was gathered and analysed where possible whilst data requests were submitted with pilot sites where granular information was not available publicly on the key areas of interest:

- Does requesting ID reduce demand for services?
- Does checking identifications of patients increase rates of ceased treatment by Trusts and by patients?
- Does checking identifications of patients improve debt recovery or rates of up-front charging?

The data requested from pilot sites can be broadly split into financial and non-financial data with the former encompassing cost recovery data for overseas patients. The latter covers the information on activity, cancellations and DNAs.

Activity data – DNAs and Cancellations

Motivating the analysis of activity, cancellations and did not attends is the potential for identification checking to have unintended consequences on patients. These may arise as a result of patients lacking the documents needed and therefore not seeking necessary treatment or cancelling/not attending an appointment should they need to provide some form of identification.

Data on activity rates across the various NHS healthcare providers is publicly available and refreshed on a regular basis, however quarterly publications pose a challenge for this analysis as when combined with potentially substantial publication delays, the data is unlikely to cover the full pilot period. In addition, for some pilot services, activity data focussed on an entire department, rather than the specific pilot service. For this reason, granular detail from sites has been requested for the pilot period and up to 3 years before to allow an assessment of change since the introduction of identification checks.

Figure 1.2 overleaf summarises the (non financial) activity sources and links with the research questions for both non-A&E services as well as A&E services.

Evaluation Overview

Analysis of management information

Table 1.3: Activity sources and links with the research questions for both non-A&E services as well as A&E services

	Link to evaluation research question	What is publicly available	Data requested from pilot sites
Non-A&E activity			
DNA rates	Does requesting ID reduce demand for services?	This is available at Trust and CCG level on a quarterly basis.	Data at service level for piloted services during pilot and 3 years prior.
Cancellation rates	Does checking identifications of patients increase rates of ceased treatment by Trusts and by patients?	Available on a quarterly basis at a Trust level	Data at service level for piloted services during pilot and 3 years prior.
Demand/Activity **• Patients admitted** **• First attendances seen**	Does requesting ID reduce demand for services?	Available on a quarterly basis at a Trust level and monthly and quarterly basis at CCG level	Data at service level for piloted services during pilot and 3 years prior.
Maternity specific **• Number of maternities** **• Number of women who have had an assessment at any time during pregnancy**	Does requesting ID reduce demand for services?	Available on a quarterly basis at service level and Trust level	Data at service level for piloted services during pilot and 3 years prior.
A&E activity			
Attendances	Does requesting ID reduce demand for services?	Available on a monthly and quarterly basis at department and Trust level	-
A&E admissions	Does requesting ID reduce demand for services?	Available on a monthly and quarterly basis at department and Trust level	-

Analysis of management information

Cost recovery

Certain groups of overseas visitors and migrants are liable to cover the cost of some secondary care received while visiting the UK. NHS organisations providing secondary care services have a statutory obligation to identify potentially chargeable patients and recover this cost. The NHS (Charges to Overseas Visitors) Regulations have been in place since 1989, and were updated in 2011, and 2015, and cover charging of overseas visitors and migrants for their healthcare based on the principle that *a person who is ordinarily resident in the UK must not be charged for NHS hospital services,* and vary depending on the origin of the patient:

- **European Economic Area (EEA)** - where a patient (who is a visitor, including students) is able to provide a European Health Insurance Card (EHIC) – or a Provisional Replacement Certificate - the costs of NHS healthcare can be recovered directly from the Member State where the individual is resident. Some patients will not be eligible for an EHIC, in which case they are ineligible for free NHS care and should be charged. The S1 (for workers, dependants of worker in home state, pensioners, and people in receipt of other exportable benefits, and their dependants), and S2 (allowing patients to travel for medical treatments that are pre-arranged and approved), are different mechanisms for charging residents of other Member States for the costs of their healthcare.
- **Non-EEA** – patients who are not ordinarily resident in the UK are required to cover the cost of treatment themselves, or through insurance policies. Reciprocal arrangements are in place between the UK and some non-EEA states which also provide exemptions for urgent and emergency care, and exemptions also exist to extend free healthcare to patients based on other criteria, for example asylum seekers or those granted asylum, children taken into local authority care, and family members of exempt groups.

The checking of identification may have impacts on the number of patients for which costs are recovered should the process identify more ineligible patients; however, it may also have benefits in terms of efficiency should patients be identified earlier, though this could result in less income from cost recovery should patients choose to forego treatment. In practice, much of the costs sought from overseas visitors is written-off and it should be noted that it is unlikely that significant improvements in costs recovered are seen within the pilot period as it takes much longer to recover them. Lastly, costs are dependent on the treatment received and changes in the total costs recovered may reflect changes in the underlying treatments received by overseas patients. Therefore, the number of people identified as chargeable and invoiced as such are better measures of impact.

Analysis of management information

Table 1.4 Financial activity sources and links with the research questions for both non-A&E services as well as A&E services

	Link to evaluation research question	What is publicly available	Data requested from pilot sites
OVT Portal - EHIC & S2			
DWP - monthly reports	Does checking identifications of patients improve debt recovery or rates of up-front charging?	Monthly Trust level data collected through the OVT portal	Data at service/treatment level for piloted services during pilot and 3 years prior.
Directly Chargeable			
DH - Quarterly reports	Does checking identifications of patients improve debt recovery or rates of up-front charging?	Quarterly at a Trust level	Data at service/treatment level for piloted services during pilot and 3 years prior.

A note on data quality and availability

Data of some kind was received from 15 of the 18 pilot sites covering 23 services from a total of 34, however **only 4 trusts provided both cost recovery and activity data** (covering 8 services).

The lack of data from some trusts was due to a variety of reasons, including:

- **Lack of data collection:** some trusts did not have the data requested, particularly at a service level
- **Lack of computer systems:** some trusts collected some data manually, making it difficult to isolate the data required
- **Lack of follow-up:** some trusts had not followed up with any patients identified, due to the time spent overseeing the pilot, and therefore could not provide details on the chargeability during the pilot period.

The data provided varies also substantially in format between providers based on what they were able to provide at the time the request was submitted.

Figure 1.4 overleaf outlines the pilot trusts, services and data received for each. Appendix E provides the full details of this analysis for each trust.

Evaluation Overview

Analysis of management information

Table 1.5 Pilot trusts, services and data received for each

Trust	Service	Launch week	Launch month	3 month - end month	Cost recovery data	DNA/Cancellation data
Trust 1	Maternity	22nd May	May	August	Y	Y
	Dermatology	24th July	July	October	Y	Y
Trust 2 (London based)	Renal	17th July	July	October	-	N
	Maternity	17th July	July	October	-	N
Trust 3 (London based)	Maternity	28th July	July	October	Y	Y
	Neurophysiology	28th July	July	October	Y	Y
Trust 4	A&E	31st July	July	October	N/A	N/A
	Maternity	31st July	July	October	Y	N
Trust 5	Maternity	31st July	July	October	Y	Y
	Trauma Orthopaedics	31st July	July	October	Y	Y
Trust 6	Fracture	1st August	August	November	N	N
	Maternity	1st August	August	November	N	N
Trust 7	Urology	1st August	August	November	N	Y
	Maternity	1st August	August	November	N	Y
Trust 8 (London based)	Oral	7th August	August	November	N	Y
	Maternity	14th August	August	November	N	Y
Trust 9 (London based)	Renal	7th August	August	November	Y	Y
	Maternity	24th July	July	October	Y	Y
Trust 10 (London based)	Neurology	14th August	August	November	Y	N
Trust 11	ED	21st August	August	November	Y	N/A
Trust 12 (London based)	Ophthalmology	21st August	August	November	N	Y
	Orthopaedics	21st August	August	November	N	Y
Trust 13	Urology	24th July	July	October	Y	N
	Maternity	29th August	August	November	Y	N
Trust 14 (London based)	A&E	31st August	August	November	N	N/A
	Plastics	n/a (pilot stopped but data collected)	.	.	.	.
	Maternity	Cancelled	.	.	.	.
Trust 15 (London based)	Cardiology	21st August	August	November	N	Y
	Maternity	Pre-election	.	.	N	Y
Trust 16 (London based)	Assisted Conception Unit	24th July	July	October	N	Y
	Orthopaedics	back up service	.	.	.	.
	Diabetes - rapid access unit	Live in September	September	December	N	Y
Trust 17 (London based_	Maternity	TBC	.	.	.	.
Trust 18	A&E	4th September	September	December	Y	N/A

Evaluation Overview

Summary of evaluation activities undertaken by Trust

Table 1.6 Summary of evaluation activities

Trust	Service lines	Staff survey	Time and motion observation	Trust Managed data collection	Case study/ in-depth interview
Trust 1	Maternity	Completed	Undertaken in this service	Completed on tablet	Case study interviews
	Dermatology				
Trust 2	Maternity	Completed	Undertaken in this service	Completed on tablet	Case study interviews
	Renal				
Trust 3	Maternity	Completed	Undertaken in this service	Completed on tablet	
	Neurology				
Trust 4	A&E	Completed	Undertaken in this service	Completed on tablet	In-depth interview with pilot lead
	Maternity				
Trust 5	Trauma and Orthopaedics	Completed	Undertaken in this service	Completed on tablet	
	Maternity				
Trust 6	Maternity	Completed	Undertaken in this service	Manually collected but have not supplied	In-depth interview with pilot lead
	Fracture				
Trust 7	Maternity	Completed	Undertaken in this service	Collected via PAS	Case study interviews
	Urology				
Trust 8	Oral	Did not participate	Did not participate	Collected via PAS	
	Maternity				
Trust 9	Renal	Completed	Undertaken in this service	Completed on tablet	Case study interviews
	Maternity				

Summary of evaluation activities undertaken by Trust

Table 1.6 continued

Trust	Service lines	Staff survey	Time and motion observation	Trust Managed data collection	Case study/ in-depth interview
Trust 10	Neuro	Completed	Undertaken in this service	Completed on tablet	
Trust 11	A&E	Completed	Undertaken in this service	Completed on tablet	Case study interviews
Trust 12	Ophthalmology	No interviews achieved	Undertaken in this service	Collected vis PAS	
	Orthopaedics				
Trust 13	Urology	Completed	Undertaken in this service	Completed on tablet	
	Maternity				
Trust 14	A&E	Completed	Undertaken in this service	Completed on tablet	Case study interviews
Trust 15	Cardiology	Completed	Undertaken in this service	Completed on tablet	
	Maternity				
Trust 16	Diabetes-rapid access	Completed	Undertaken in this service	Collected via PAS but have not supplied	
	Assisted Conception				
Trust 17	Maternity	Did not participate	Did not participate	Completed on tablet	In-depth interview with pilot lead
Trust 18	A&E	Did not participate	Did not participate	Completed on tablet	In-depth interview with pilot lead

Evaluation Overview

Limitations of evidence

There are several limitations with the evidence gathered to inform this evaluation.

Staff survey:

- As data was not readily available on the proportion of staff working in each of the pilot services for the participating trusts, **it was not possible to ensure a representative sample** of overall staff working within each of the pilot services.
- Further, some trusts were unwilling or found it difficult to provide sample or allow Ipsos to draw sample from an external supplier to gather sample. As a result across participating trusts **a variety of approaches were used to contact staff to take part in the survey**. Some trusts provided staff contact details, others were contacted using an externally supplied sample, free-finding and snowballing from publically available contact details, and others opted in. It is therefore possible that in having to draw on a variety of approaches **some self-selection bias may be present** in the final achieved samples.
- **Quotas were set for each trust to ensure a good spread across participating services**. However, due to difficulties gaining access to some staff and low levels of engagement with the pilot in certain trusts, **the final sample has a greater representation of staff in some trusts compared with others**. As such results of the pilot staff survey are only discussed at the overall level (i.e. all trusts) and **should be considered indicative rather than representative**.
- In addition, during the first few weeks of the baseline pilot staff survey, a snap election was called. As such, fieldwork times were extended to take account of purdah. The uncertainty of this time may have impacted on willingness to participate, again potentially introducing some bias.

Time and motion:

- The time and motion was **completed by a range of observers who while instructed on how to use the tool, are likely to have interacted and approached the observation slightly differently**. The observation tool allowed for additional comments to be added and as such differences by observer, as much as possible, have been accounted for.
- It should also be noted that **the services observed varied greatly in the volume of patients they received**. Along with this, while a seven hour 'shift' was allocated to all service observations, not all services were seeing patients for the full seven hours. As such some services had a higher number of recorded observations. Because of these differences in services, results from the follow up observation will, in the main, only be compared against the previous observations for that particular service line.

Evaluation Overview

Limitations of evidence

Time and motion continued:

- During the shift being observed, there were changes of receptionists. In a number of cases, **the receptionist in the service line under observation changed shift in the seven hour observation period**. This change of receptionist is likely to have some impact on observed booking times due to different staff productivity rates, and/or familiarity with the ID checking process. Where receptionist changed this was recorded but should be born in mind when interpreting the results.
- Please be aware that it **may have been difficult for observers in certain cases, or at certain trusts, to establish what time the ID check started and what time it ended** because of the conversational nature of the interaction between the receptionist and the patient. Therefore care must be taken when interpreting the ID checking times.
- The data presented in this report do not contain all patients within a 7-hour shift. Observers were allowed to take short breaks as well as a 30 minute lunch break at their discretion, so some patients will have been missed from the observation. Additionally, outlying cases that may have caused a check-in to take much longer or shorter than typical have been removed on a case-by-case basis.

Trust Managed Data collection:

- Where trusts provided data via Ipsos MORI tablets data was collected in a consistent way across the trusts. However, a number of trusts recorded the data via their internal Patient Administration System. Where trusts collected the data this way, they did not always collect inform on ID provided in the same standardised way as the tablet – for example in some cases they used different question wording and answer options. As the questions were broadly similar it has been possible to merge the data. However, **there is potential that in asking the questions differently, some responses provided by trust may have been reported differently than if using the Ipsos tablets, potentially skewing some results**. Results should therefore be treated as indicative.
- Further, discussions with pilot leads revealed that **staff in some trusts did not feel comfortable ascertaining why a patient had not brought in the requested ID**. As such, the results presented in the report will likely under-report reasons why patients did not provide ID.
- In addition to the above, across the trusts **different approaches were taken in terms of which patients were asked for ID**. We are also aware that some trust did not record data about the ID checks at certain times when the service was running – e.g. out of core hours and during busy periods. We know that trusts took different approaches to administering the ID checks and had different rules around which forms of ID they accepted. As such, all findings need to be considered alongside the contextual information provided for each trust pilot service.

2. Pilot Delivery

This section provides a context in which the pilot trusts were previously operating, prior to the implementation of the ID Checking Pilot. It reviews how the trusts introduced and communicated the pilots and the key considerations that they made in doing so.

The section finishes with overall awareness of the ID Checking Pilot across staff, within participating pilot services. This is used to assess the effectiveness of communications about the pilot among staff.

2.1 Prior identification practices

Overview of practices

Prior to the implementation of the ID checking pilot, cost recovery and identification of chargeable patients varied widely both within and between the participating trusts.

The **most common approach employed by trusts to identify patients, was to ask and record whether the patient had lived in the UK more than 12 month when they first presented at the trust**. Other triggers used to determine whether someone was potentially chargeable included **patients providing temporary addresses or patients not being registered with a GP, and a new or no NHS number**. Often the overseas team would review recent admittance list to look for these triggers rather than staff actively highlighting them to the team.

Yet, **trusts would on the whole rely on frontline staff to flag potentially chargeable patients to the overseas team**. As such, this caused a degree of variability in cost recovery across services since identification relies heavily on having engaged members of staff. It also relies heavily on an overseas team's ability to communicate and build relationships with staff in order to make themselves known to staff and to highlight to them how to flag it if they suspect a patient to be chargeable.

Across a number of the trusts selected as part of the pilot, it was highlighted that **Maternity teams tended to have more established practices around cost recovery compared with other services.** It was not uncommon for trusts to say that their maternity team had electronic systems in place to flag chargeable patients and that a system was in place for staff to alert these to the overseas teams.

Barriers to identifying chargeable patients

Discussions with pilot leads and interviews as part of the case studies, highlighted a number of reoccurring barriers faced by trusts when identifying chargeable patients:

- The **12 months question was not always felt to be fit for purpose** – without the need to provide hard evidence, it is easy for people to provide incorrect information
- **Staff do not always ask the 12 months question**
- A **lack of awareness or distrust in the trusts' overseas teams** – meaning patients were not always identified to them
- The **lack of a structured system to identify chargeable patients** – and no clear process for passing these onto the overseas or central teams
- **Low engagement amongst staff** – staff not feeling it is their responsibility/part of their role, or not prioritising identification
- **Lack of IT systems to support overseas teams** – they were often relying on manual processes to track patients who need to be followed up on.

2.2 Pilot delivery

While **trust were given guidance about how to approach implementing the ID checks, this information was not prescriptive**. As such trusts had a degree of flexibility and freedom in the way in which they implemented the pilots. **This resulted in variation both within and across trusts in terms of how the pilots were implemented in the chosen service lines**.

Decisions around **where to implement the ID checks were largely based on willingness of staff to be involved** in the checks **and financial budgets**.

Where **pilot leads had a good and strong relationship with staff in the chosen pilot sites, they tended to be able to engage staff to undertake the ID checks** with patients they were checking in. Pilot leads who had only fragile relationships with staff working in the pilot sites, or who had requested additional funding from DH, tended to employ a separate person to undertake the checks or undertook the checks themselves. Where pilot leads had fragile relationships with service lines, or where trusts were concerned about capacity among existing staff to undertake the checks, they tended to opt to employ a separate person to do so. There was, in some cases, a fear of creating hostile relationships with staff through adding additional burden to their workload.

In **most instances the ID checks were conducted at reception when a patient checked-in**. In the instances when additional members of staff had been employed to do the check, the ID checking either happened at a separate desk or the person went round and spoke to patients sitting in reception.

In the **majority of cases checks were undertaken whenever the pilot services had clinics running**. However, there were some instances where checks did not run at certain times, this tended to be:

- In the hours outside of the working hours of those employed to do the checks
- In the evening or at the weekend, where evening staff had not been briefed or the trust struggled to find staff cover.

Nearly all trusts decided to only ask the ID checking questions of those who were new to the service line or who had not checked-in to the service line since the pilot began. Those trusts piloting the ID checks in A&E requested ID from all patients.

Outside trusts piloting in A&E, there were a small number of trusts who made the decision to ask all patients for ID each and every time they presented at the service. This decision was made either because the service line felt unable to accurately record when a patient had been asked to provide ID or because the reception desk served multiple services and it would have been too difficult to isolate the pilot service. These trusts did see a degree of backlash from patients who were asked the ID checking questions on a number of occasions.

Pilot delivery

Aside from A&E (where patients could not be communicated with in advance of their entry into the service), **all trusts opted to send patients letters to make them aware of the need to provide ID**. Information about the ID check was either added into or appended to existing appointment letters or sent out to patients as a separate letter. In addition some trusts put up posters in and around the reception areas of the pilot services lines (all A&E sites did this). **In a handful of cases trusts allowed patients to send the ID in advance and other trusts had an electronic system which allowed patients to email soft copies of their ID afterwards**.

Some trusts took photocopies of the ID or logged the ID on the patient's records however others didn't. Indeed, **some A&E sites simply asked patients if they had the ID on them** but did not actively seek to see the ID.

Where trusts took copies of the ID, some took hard copies to attached to patient records which, in part, acted as a means to prompt staff to chase for ID or flag the patient to the overseas teams. Other trusts only took copies of ID if they wanted to query it with their overseas team. However, it was only a minority of trusts where copies of ID were taken or recorded on a check list, most did not actively record this information.

Generally **staff alerted their overseas teams if they were shown a form of ID that indicated that the patient was chargeable or if they were uncertain about the charging status from the ID provided**. However, there were a few trusts who said that this was not happening. At these trusts it was suggested that resource barriers meant they were focusing on recording the ID and did not have the capacity to follow up any patients. In at least one trust, even where the overseas team were receiving ID information about patients, they were not able to look into these cases due to needing to resource the pilot.

In addition, while most trusts followed up with patients where it was clear that they were chargeable or there was uncertainty, chasing for ID was only actively done in a few trusts and usually where there were separate members of staff employed to do so. Trusts either lacked the resource to chase patients who had not provided ID or they did not have a clear system in place to record who had and had not provided ID.

Pilot delivery

Table 2.1 summarises the key activities undertaken by trusts when implementing the pilot:

Table 2.1 summary of pilot implementation activities

Trust	Service	Implementation of pilot	Comms and training
Trust 1	Maternity Dermatology	• Letter sent to patients in advance • Checking all patients • Using receptionist to check in dermatology and additional member of staff in maternity	• Have notified CCG and service managers have informed staff about the pilot
Trust 2 (London based)	Renal Maternity	• Letter sent out to patients in advance • Checking first appointment and those who haven't had ID checked before • Additional members of staff in both services doing the ID check	• Have done a poster campaign • Have communicated with all pilot services about the checks • Have provided training the service lines
Trust 3 (London based)	Maternity Neurology	• Letter sent out to patients in advance • Checking first appointment • Additional members of staff in both services doing the ID check	• Have put a note on their website about pilot • Have sent circular to GPs • Have spoken to CSY lead and CCG • Message on intranet for trust staff • Provided training to those doing check
Trust 4 (London based)	A&E Maternity	• In maternity letters sent out to patients in advance • In A&E posters up in reception • Checking first appointment for Maternity and all patients in A&E • Reception staff doing the ID check	• Posters in A&E • Communications with staff working in services • Training provided to admin staff
Trust 5	Maternity Trauma and Orthopaedics	• Letters sent out in advance • Checking first appointment only in Maternity, all patients in fracture • Additional members of staff in both services doing the ID check	• Have briefed staff undertaking the checks
Trust 6	Fracture Maternity	• Letters sent out in advance • Checking first appointment and those who haven't had ID checked before • Reception staff doing ID check	• Have used social media accounts to promote ID check • Had internal trust briefing with staff • Put pages on intranet • Training with front line staff
Trust 7	Urology Maternity	• Letters sent out in advance • Checking first appointment • Reception staff doing ID check	• Information on intranet • Training sessions with reception staff
Trust 8 (London based)	Oral Maternity	• Letters sent out in advance • Only checking those using a specific part of the service • Additional members of staff in both services doing the ID check	• Have done comms with clinical and non clinical staff working in pilot areas • Training sessions with staff undertaking checks

Pilot delivery

Table 2.1 continued

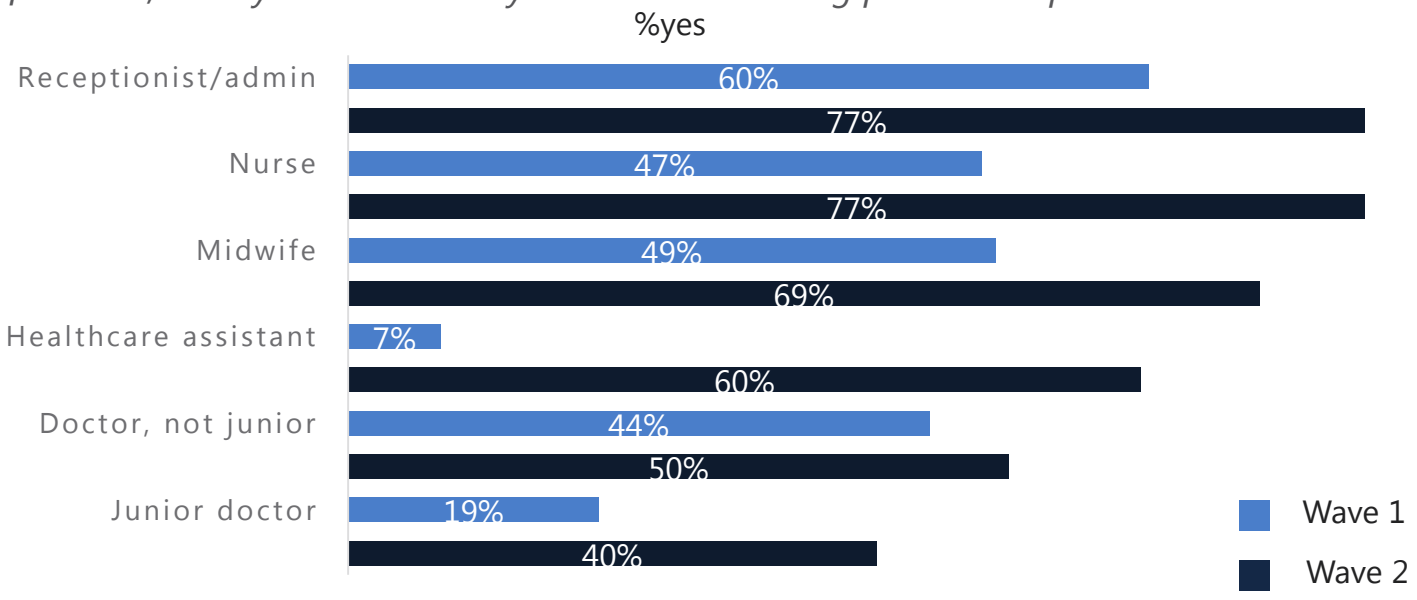
Trust	Service	Implementation of pilot	Comms and training
Trust 9 (London based	Renal Maternity	• Letter sent out in advance • Renal are checking all patients and maternity are checking first appointments • Reception staff doing ID check	• Poster have been put up • Have informed CCG and GPs • Training provided to all staff working pilot sites
Trust 10 (London based	Neurology	• Letters sent out in advance • Checking first appointment • Reception staff doing ID check	• Patient leaflet available • Promoted on website • Comms in Trust newsletter • CCG informed • Posters in staff rooms • Briefing given to consultants • Training provided to staff conducting checks
Trust 11	A&E	• Posters up in reception • Checking all patients • Reception staff doing ID check	• Posters in A&E • Have briefed staff in pilot site • Have met with clinical leads for additional briefing • Internal comms letter sent out • Training provided to those doing the checks
Trust 12 (London based)	Ophthalmology Trauma and Orthopaedics	• Letters sent out in advance • Checking new appointments • Reception staff doing ID check	• Posters in clinic area • CCG and GPs informed • Comms in internal bulletin • Training provided to those doing the checks
Trust 13	Urology Maternity	• Letters sent out in advance and explained over phone with emergency appointments • Checking first appointments • Reception staff doing ID check in Maternity and additional member of staff doing check in Urology	• GPs informed • Comms in internal magazine • Discussed in pilot service staff meetings • Training provided to those doing the check
Trust 14 (London based)	A&E	• No advanced warning • Checking all patients • Receptionist and additional member of staff doing ID check	• Small amount of comms done with staff working in pilot sites • Some training given to those undertaking the checks

2.3 Pilot awareness

- To asses the effectiveness of communication about the pilot within each trust, survey participants were asked if they were aware that their trust was taking part in the pilot.
- In the run up to its launch, the wave 1 **baseline survey found relatively low levels of awareness about the pilot** with less that half (45%) of staff within the participating sites reporting an awareness. **Following the launch of the pilot, awareness increased across all staff** with nearly seven in ten (69%) reporting an awareness in wave 2.
- Administrative staff (most likely to be directly involved in the ID checks) showed relatively high awareness both before and after the launch (60% in the baseline and 77% post launch). However, **even once the pilots were in place, nearly a third (30%) of staff were still unaware that their trust was taking part**. This was **most common amongst doctors** where only half of doctors (50%) working in the pilot service lines and only four in ten (40%) of junior doctors were aware of the pilot after it had launched in their department. While a number of trusts took active steps to ensure minimal involvement of clinical staff (and their role is less critical in delivery of the ID checks), this finding may give DH cause for concern. Previous research conducted by Ipsos MORI has shown that effective cost recovery requires buy in from doctors. Indeed, the case study interviews suggested that it is not uncommon for doctors to treat patients before chargeable status has been confirmed.

Figure 2.1 – Awareness of the pilot by staff group

Before now, were you aware that your Trust was taking part in this pilot



Bases: Wave 1:
All participants – (220)
Doctor, not junior (32)
Junior doctor (26)
Nurse (38)
HCA (15)
Midwife (41)
Receptionist / admin (65)

Bases: Wave 2:
All participants –(223)
Doctor, not junior (34)
Junior doctor (15)
Nurse (39)
HCA (15)
Midwife (39)
Receptionist / admin (69)

Pilot awareness

Those who were aware of the pilot, generally found out about it via **communication from management** (43% in both waves) **or through their trust OVM / pilot lead** (20% in baseline survey and 12% in follow-up). Just **over one in ten (12%) had heard about the pilot through word of mouth from colleagues before the pilot,** but nearly **one in five (18%) had heard through word of mouth by the follow-up survey**. Admin staff were more likely to have heard from the OVM/pilot lead in the follow-up survey (25% compared to 12% overall). There is a potential risk that understanding of the pilot and its aims amongst some staff groups may have become distorted if communicated incompletely or inaccurately (and could in turn have influenced staff commitment to the delivery of ID checking).

The case study qualitative interviews and discussions with pilot leads indicated that communication activities around the pilot varied widely across participating trusts.

In all trusts, **staff directly involved in the ID checks were made aware of the pilot through communication with the overseas teams, or via other managerial staff**. For some trusts, this was all the direct contact staff had about the pilot with subsequent communication either being cascaded down to them through various members of their team, or through emails and posters. **Frontline staff working in these trusts as well as other staff directly involved in the pilot frequently expressed a need for greater clarity around the check and requested further training** to help them undertake the checks more successfully in the future.

However, **there were trusts who took a more systematic approach to communicating the pilot to colleagues**. This included targeted training sessions and briefings for staff. Where trusts provided this level of communication staff were more likely to speak confidently about the aims of the pilot and indicated higher levels of support for it.

Indeed, **the impact in terms of different levels of communication was clearly evident in staff awareness of the aims of the pilot**. Staff who had been given more limited training and briefing on the pilot more generally assumed that the aims of the pilot was simply to see if patients could bring in ID and they were less likely to make the link to cost recovery compared to those who were more informed. **Very few linked the aims of the pilot with reduce pressure on the system and a more equitable way of treating patients** – only a handful of pilot leads were able to identify this aim and objective. This suggests that a stronger line could be taken if rolling the pilot out further to communicate with staff the more broad and system wide aims of the ID checks and their place within cost recovery.

Pilot delivery

Summary

- Prior to the ID Checking Pilot, there was great variation in cost recovery practices across trusts participating in the pilot. The most common approach to identifying chargeable patients was to ask patients whether they have lived in the UK for more than 12 months when they first present at the service within the trust.

- Trusts were previously very reliant on frontline staff to flag potentially chargeable patients to their overseas team.

- Maternity teams were said to have more established practices around cost recovery compared with other services.

- However, a number of barriers to identifying chargeable patients (prior to the pilot) were commonly reported. Including flaws with the'12-months question' as well as a lack of compliance among staff in asking it, a general lack of awareness or distrust in overseas teams, a lack of a structured system to identify chargeable patients, low engagement among staff and a lack of IT systems to support the overseas teams.

- While trusts were given guidance around how to approach the ID checks, they had a degree of freedom around the way in which they implemented this. This resulted in variation in how the pilot was implemented.

- Trusts either used existing reception/administrative staff to undertake the checks or employed additional staff to do so. In most trusts, the ID checks were undertaken at reception desks with just new patients being asked to provide ID.

- With the exception of the A&E pilots, all services within all trusts made patients aware of the need to bring two forms of ID via advance letters.

- A few trusts took photocopies of the ID provided, whilst some A&E pilots simply asked patients if they had ID on them, rather than asking to see it.

- Initial awareness of the pilot among staff was low with the exception of administrative staff. Indeed there was variation between trusts in terms of how the pilot was communicated with staff.

3. Assessment of Pilot Impact

This section considers the extent to which the Pilot has delivered the impacts anticipated at the end of its implementation (as described in the preceding chapters of this report). It assesses progress towards the achievement of overall Pilot objectives, and identifies any factors that may act as a barrier to any future role out.

This section draws on evidence gathered covering the pilot period, producing evidence collected across the five strands of the evaluation as detailed in Chapter One. It draws on the evidence generated during the most recent wave of fieldwork, to allow a thorough assessment of the progress made at the end of Pilot's implementation.

3.1 Knowledge and attitudes

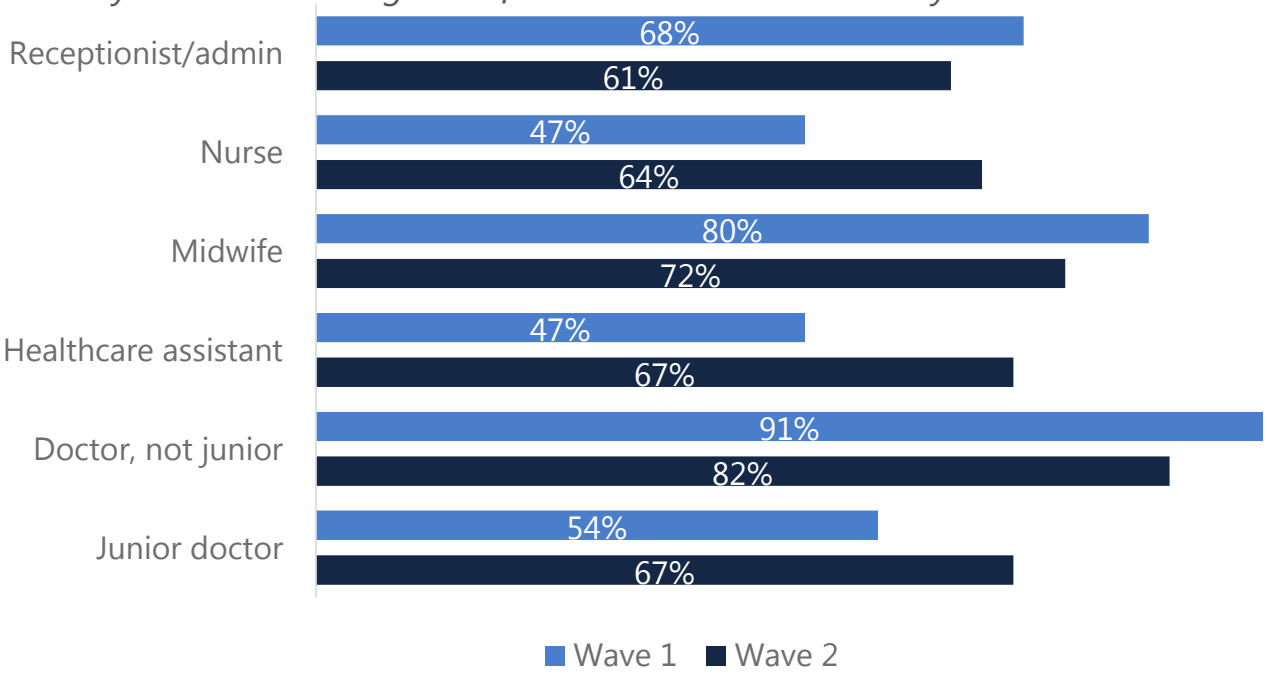
One of the intended outcomes of the ID checking Pilot was an increase, across all NHS staff groups, in the awareness of the need to identify and charge overseas visitors and migrants who are not eligible for free NHS care. The follow-up survey results, as well as evidence from the case studies interviews and interviews with pilot leads, show some encouraging signs of this targeted increase in awareness becoming a reality, however there remain some important gaps that would need to be addressed going forward.

Awareness and understanding of charging

Despite increased awareness of the pilot following its launch, awareness around chargeable status changed only minimally overall. Around **two thirds of staff who said they were aware that some people were chargeable for NHS care** (66% in the baseline and 69% in the follow-up). Around a quarter of staff continued to be unaware about chargeability (29% in the baseline and 24% in the follow-up). However, **findings for both nurses and healthcare assistants in the follow-up survey suggests increasing levels of awareness amongst these groups**. Around three in five nurses (64%) and slight more healthcare assistants (67%) were aware that some patients are chargeable.

Figure 3.1 – Awareness of chargeability by staff group

Thinking about services of than dental, optical and prescriptions, as far as you are aware, is there anyone who is chargeable for the NHS healthcare they receive?



Bases: Baseline:
All participants – (220)
Doctor, not junior (32)
Junior doctor (26)
Nurse (38)
HCA (15)
Midwife (41)
Receptionist / admin (65)

Bases: Follow-up:
All participants –(223)
Doctor, not junior (34)
Junior doctor (15)
Nurse (39)
HCA (15)
Midwife (39)
Receptionist / admin (69)

Knowledge and attitudes

Awareness and understanding of charging

Having an awareness of the criteria and exemptions for cost recovery, while not essential for undertaking ID checking, is useful in helping staff identify correctly when a case should be escalated to the overseas team.

Follow-up questions with those aware that some patients are chargeable show that awareness remained relatively stable around the reasons patients could be chargeable, the services they could be charged for and the reasons why some patients could be exempt. **When asked which patients are potentially eligible to be charged, the top answers reported related to being a visitor/having non-UK residency status.**

While many staff were aware that some patients may be chargeable, **they were less able to provide specific details about exactly which patients this applies to and there were some misconceptions about exactly which services would be chargeable.** For example, in the follow-up survey there were still small minorities among all groups who believe A&E services are potentially chargeable (7%), and around a third who reported 'everything except emergency services' (35%) and 'everything' (29%) to be chargeable.

While staff interviewed as part of the qualitative case studies and depth interviews showed a general awareness that some patients should be chargeable, **there was much confusion around who should be considered eligible and the exemption rules**. In some trusts it was suggested that **even the overseas team struggled with specific and more complex cases**.

Staff covering a range of roles spoke of how **the rules around chargeability are 'ambiguous'.** In particular, staff reported confusion regarding chargeability with regards to:

- Children
- Refugees
- British people who had moved abroad but still have an NHS number
- Those who have overstayed their visa

Given the perceived ambiguity around chargeability, a number of staff, particularly pilot leads, questioned the appropriateness of reception and administration staff carrying out the ID checks. In particular, they suggested that they did not feel it was appropriate for staff at this grade to be responsible for identifying the eligibility of patient for free care from ID provided. They felt that these staff were not paid enough to perform this role and it was felt that this should stay within the remit of overseas team. Certainly it was felt that if reception staff were to take on this role there would need to be much clearer guidelines about who is chargeable, and ways to successfully detect this from ID provided.

Knowledge and attitudes

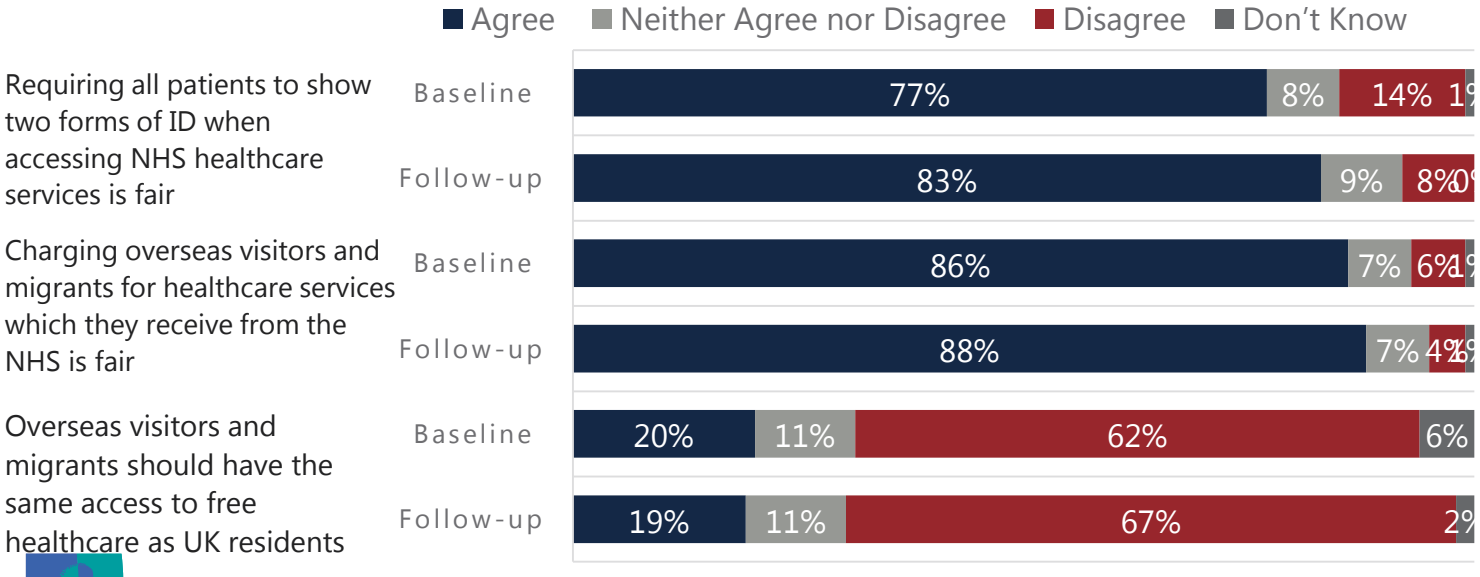
Buy-in to cost recovery and the pilot

The design of the pilot linked success, in encouraging questions to be asked of patients to allow for early identification of chargeable patients, to driving cultural change across staff groups. Specifically, **moving towards a culture where ID checking becomes 'normal practice'** (as outlined in the logic model in Figure 1.1) was identified as an outcome of the pilot. For normalisation to happen, there needs to be some degree of buy-in to the principles firstly of cost recovery and secondly, and importantly, to ID checking as a means of recovering costs. It is **important therefore, that staff understand and support the principles of fairness and entitlement which underpin cost recovery and the ID checks.**

At both the baseline and follow-up survey stage of the evaluation, the **majority of all staff surveyed indicated support for the broad/ overarching principles of cost recovery** and the pilot. In particular, there was a strong level of agreement across all staff groups, *that charging overseas visitors and migrants for NHS service fair,* and that *requiring all patients to show two forms of ID when accessing NHS healthcare services is fair*. At least two thirds in each staff group agreed with both statements. Indeed**, the follow-up survey indicated that the pilot generated a further increase in the support for the key principles of cost recovery, and the process of ID checking** with increasing proportions showing support for both statements (for example, 77% agreed in the baseline survey that it was fair to require all patients to show two forms of ID compared with 83% in the follow-up survey). In addition, at least half of each group, though often more, disagreed that *overseas visitors and migrants should have the same access to free healthcare as UK residents.*

Figure 3.2 – Support for cost recovery policy and practices

I would like you to tell me to what extent you agree or disagree with the following statement.



Base: Baseline: All participants (220); Follow-up: All participants (223)

Ipsos Public Affairs

Knowledge and attitudes

Buy-in to cost recovery and the pilot

The qualitative in-depth interviews and case study interviews also highlighted a degree of buy-in for the principles of cost recovery and the ID check. Staff in trusts identified a range of reason for why they agreed in principle. Staff acknowledged that:

- currently too many ineligible patients are 'slipping through the net' without being charged for their treatment
- people who do not pay tax should not be provided free healthcare
- the processes currently in place within the NHS are too soft and not effective
- cost recovery needs to be improved because of NHS debt.

However, despite this, staff support for the ID checks was variable across staff groups.

Table 3.1 – Support for ID checks by staff group

Staff group	% agreeing that requiring all patients to show two forms of ID when accessing NHS services is fair (Baseline)	% agreeing that requiring all patients to show two forms of ID when accessing NHS services is fair (Follow-up)
Senior doctors	56%	85%
Junior doctors	65%	67%
Nurses	79%	79%
Health care assistants	73%	87%
Midwifes	88%	87%
Receptionists / admin / non-clinical staff	85%	84%

Across participating trusts the maternity services tended to have an established history of costs recovery and so staff tended to be more engaged and bought in to the process. It is therefore expected that midwives would show the highest level of support. Yet **among midwives, concern was suggested (in the case study interviews) in terms of a potential ethical clash between ID checking and duty of care**. It was suggested that this was also a factor among other clinical staff showing lower levels of support for the pilot.

For some clinical staff the ID checking was felt to clash with their responsibility to care. **Clinical staff felt that it was their duty to care for patients regardless of whether they were chargeable or not**, and so were uncomfortable refusing care when ID showed the patient should be charged. This was **especially the case where care provided was felt to be critical**. Clinical staff were also concerned about patients being put off using services if they thought they might be charged:

'Obviously one of our concerns in the service is that woman are identified and then that leads to women disengaging with care.'

(Head of Midwifery, Trust 1)

Knowledge and attitudes

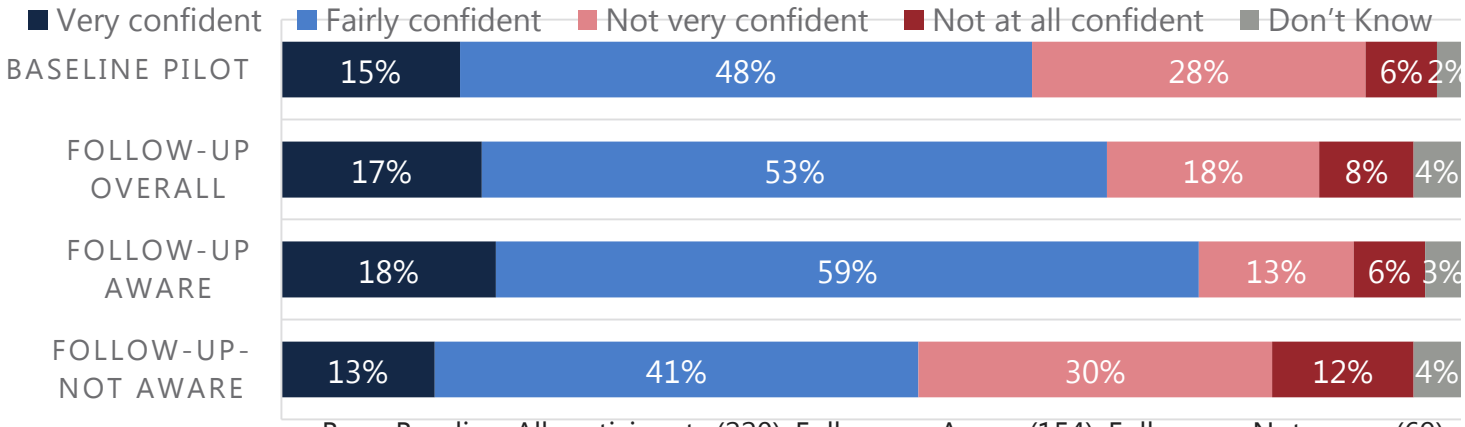
Buy-in to cost recovery and the pilot

Overall **confidence in ID checking as a means to improve cost recovery was high in both the baseline and the follow-up survey**. Indeed, where staff were aware of the pilot, nearly two in five (77%) in the follow-up survey reported confidence.

Again, however, some staff groups showed less confidence in ID checking as a means of recovering costs. Among those who were aware of the pilot, **nearly two fifths (39%) of hospital doctors, both junior and more senior, reported that they were not confident the ID checking would improve the recovery of costs**.

Figure 3.3 – Confidence in ID checks

How confident are you that the ID checking process will improve the recovery of costs from chargeable patients in your Trust?



Base: Baseline: All participants (220); Follow-up: Aware (154); Follow-up: Not aware (69)

During the case study and in-depth interviews, staff mentioned a number of perceived flaws in ID checking as a means of identifying potentially chargeable patients.

- Firstly, they spoke of how patients will find a way to 'work the system'. For example, even if they present two forms of ID, **they could well be using false identification**, and be ineligible for free treatment, but staff would never know.
- Secondly, **a UK Driving Licence is an imperfect form of photo ID**. A patient could have obtained a UK driving licence whilst living in the UK as an international student or on a work visa, and use this as a form of ID when accessing NHS care even though they are no longer a student, or their visa has expired.
- Thirdly, **the two forms of ID along may not necessarily be enough to prove someone is eligible.** As one Paying Patients officer put it: "*if someone, for example bought in a work visa and their proof of address, that would be fine but for us* [the overseas team] *to check that they are entitled, the person needs to be living within their visa rights which means that they'd have to be working which means we'd have to see proof of employment as well".*

Knowledge and attitudes

Summary

- Awareness of the chargeability remained stable from the baseline and in the follow up survey of staff. Around two thirds of staff who said they were aware that some people were chargeable for NHS care (66% in the baseline and 69% in the follow-up). However an increase in awareness was found among both nurses and healthcare assistants in the follow up survey.

- Staff were less able to provide specific details about exactly which patients this applies to and there were some misconceptions about exactly which services would be chargeable and confusion. The charging rules were described as 'ambitious' and as such, it was not always felt appropriate for administrative/reception staff to undertake the ID checks.

- At both the baseline and follow-up survey, the majority of all staff surveyed indicated support for the broad/ overarching principles of cost recovery and the ID checks, and the findings suggest that the pilot generated further support. The qualitative interviews mirrored this support. However, support varied by staff group.

- Confidence in the ID checks was high in both the baseline and the follow up survey, although some groups (notably doctors) showed less support. A number of flaws in the ID checking process were aired in the qualitative interviews including a risk that patients will show false ID, a UK Driving Licence being an imperfect form of photo ID, and the fact that the two forms of ID are not necessarily sufficient in proving whether someone is eligible or not for free NHS care.

3.2 Cultural and behavioural change

As well as aiming to increase general awareness of cost recovery, an intended outcome of the ID checking pilot was also to support a culture in which all NHS staff are aware of their responsibilities to identify and recover costs from overseas visitors and migrants. Alongside existing policies to promote cost recovery (predominantly the Costs Recovery Programme), the ID Checking Pilot aimed for an attitudinal and behavioural shift. A shift to a point where all those working in the pilot service line would feel some responsibility for recovering money from chargeable visitors and migrants and, were medically possible, would not treat patients until the eligibility for free NHS care had been established.

Understanding of roles and responsibilities

The **majority in all staff groups said that they felt that they had some role to play in relation to chargeable patients**.

Encouragingly, the follow-up survey suggested that there were some shifts in attitudes following the launch of the pilot. In particular**, a shift was seen in terms of needing to inform the overseas team about potentially chargeable patients** (30% of all those surveyed felt this was their role in the baseline survey where as 37% felt the same in the follow-up survey).

Across nearly all staff groups a decline in the proportion of staff who felt they did not have a role in costs recovery was seen between the baseline survey and the follow-up survey (see Figure 3.4). However, **while slightly more administration staff felt they had a role in identifying potentially chargeable patients in the follow-up survey (32% in baseline vs. 35% in follow-up), the proportion who did not feel they had a role rose from 15% in the baseline survey to 23% in the follow-up**. This potentially indicates a degree of backlash from administration staff who were more often than not required to perform the ID checks.

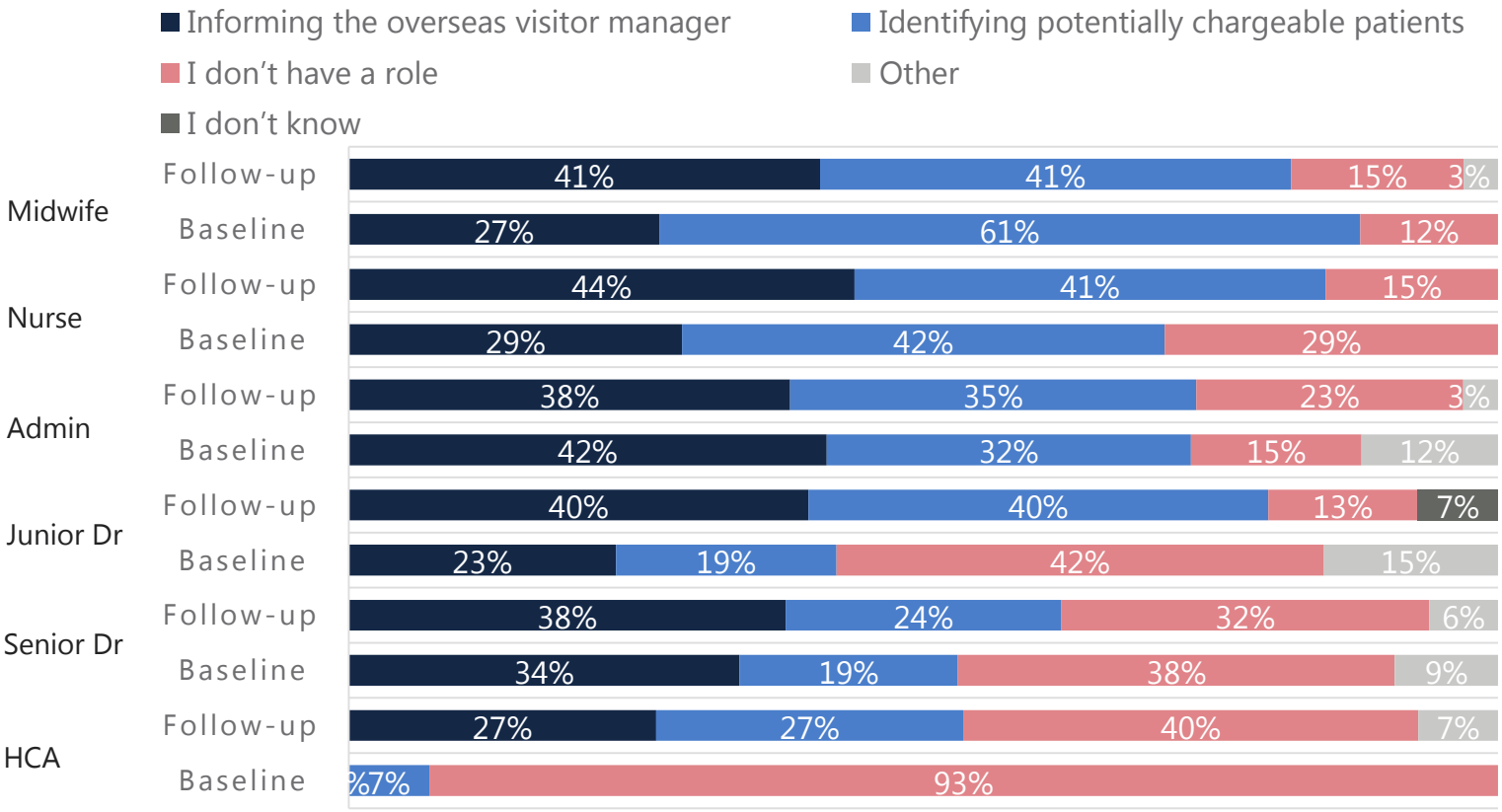
Interviews with administrative staff in the qualitative case studies demonstrated that while there was general support for the principle of identifying potentially chargeable patients and the motive behind the pilots, staff had some concerns with this being part of their roles. **Generally there were concerns that the ID checking would put too much burden on staff.** At the start of the pilots there were also concerns about how patients would react to being asked for ID and any awkwardness this could cause, although in practice administrative staff said this was usually not an issue. There **were also suggestions from administrative staff that the ID checking could or should be performed prior to patients visiting a trust** for an appointment – i.e. within GP practices.

This said and **staff responsible for organising and implementing the pilots felt as though there had been an increase in understanding of cost recovery amongst staff and the pilot had re-focussed attention on this area.**

3.2 Cultural and behavioural change

Figure 3.4 – Understanding of role regarding chargeable patients by staff group

What do you understand your role to be with regards to these chargeable patients?



Base: Baseline: Senior doctor (32); Junior Doctor (26); Nurse (38); Healthcare assistant (15); Midwife (41); Receptionist (65)
Follow-up: Senior doctor (34); Junior doctor (15); Nurse (39); Healthcare assistant (15); Midwife (39); Receptionist (69)

In the case study interviews, **views of staff roles regarding the identification of chargeable patients depended on the specific role of the interviewee**. Staff from the overseas team and other financial staff saw this as an integral part of their role, but administrative staff less so and clinical staff less still.

Prior to the pilot, within some trusts reception/admin staff did not have any processes in place to identify chargeable patients, or **if they did have such processes (such as asking the 12-month question), these did not typically occur in a standardised or systematic way**, meaning that patients would not always be identified. Staff generally felt that it was the responsibility of staff in the overseas team to investigate these cases but that it was their own individual responsibility to pass any suspected cases on to be dealt with.

Participation in the pilot did appear to have made frontline staff more aware of their role in relation to chargeable patients, and **in particular administrative staff** as a result of having to undertake the checks. Because of this, administrative staff may now be more likely to refer patients on to the overseas team.

Cultural and behavioural change

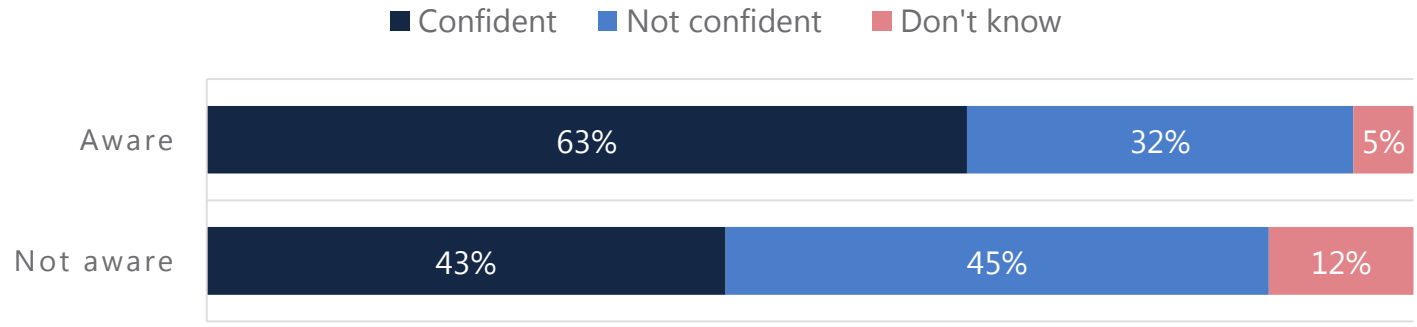
Changes in practice

The primary aim of the ID checking pilot was to encourage staff to flag potentially chargeable patients by introducing a systematic way of doing this.

Staff were asked about their confidence in the processes within the trust to maximise the recovery of costs. While there was little overall movement in terms of confidence (53% said they were confident at the baseline survey compared to 57% at the follow-up survey), **those who were aware of the ID checking pilot indicated higher levels of confidence in processes to maximise the recovery of costs in the follow-up survey compared to those who were not aware**. Around three in five (63%) of those who were aware of the pilot said they were confident compared with two in five (43%) who were not aware.

Figure 3.5 – Confidence in cost recovery practices within trust

How confident, if at all, are you that you have the processes in place in order to maximise the recovery of costs from chargeable patients in your trust?



Base: Follow-up survey: Aware (154); Not Aware (69)

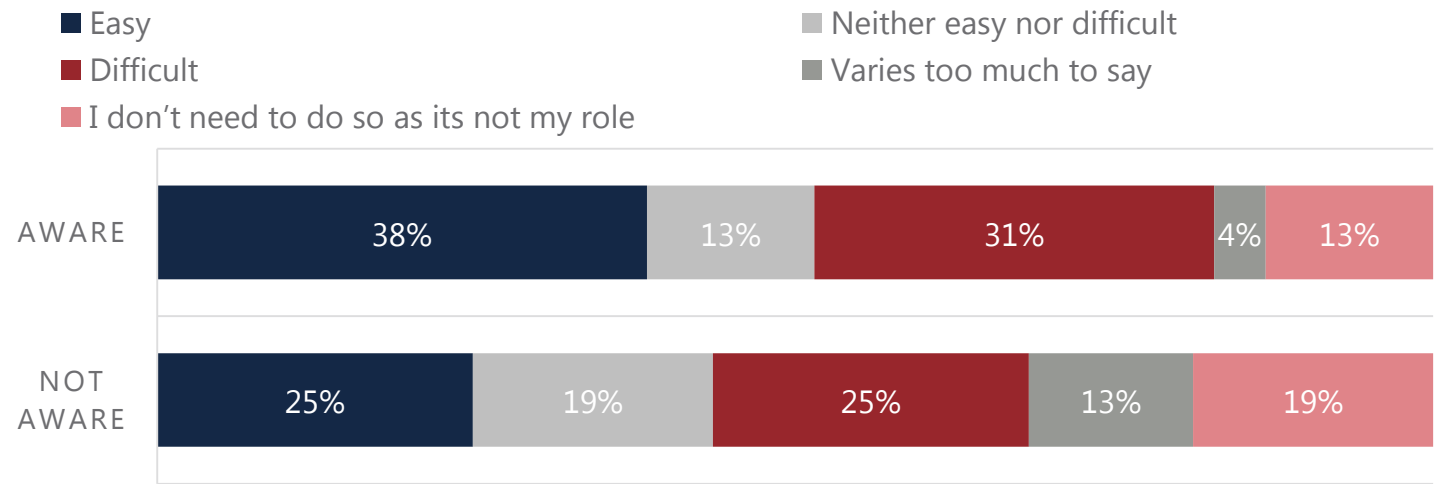
Cultural and behavioural change

Changes in practice

Further, **following the launch of the pilot, participants who said they were aware of the pilot were also more likely to find it easy to establish whether or not a patient is chargeable compared to those who were not aware**. Of those who were aware of the pilot 38% found it either very or fairly easy compared to 25% of those who were not aware of the pilot.

Figure 3.6 – Perceived ease in establishing a patient's chargeable status

In general, how easy or difficult, if at all, do you find establishing whether or not a patient is chargeable to be?



Base: Follow- up Survey: Aware (55); Wave 2 Not aware (16)

In the qualitative case study interviews, staff reported that prior to the pilot, the main method used for identifying patients was for administrative staff to ask patients whether they had lived in the UK for the past 12 months, and if the answer was no, to contact the overseas team. However, **there was acknowledgement that patients could lie at the 12 months question and 'slip through the net'**. It could be difficult for potentially chargeable patients to be identified where there was a lack of awareness among frontline staff about identification and cost recovery.

Administrative staff were initially concerned about asking patients for ID as part of the pilot, but once this was integrated within their daily practices they typically felt that it was easy enough for them to do. Overall the increased awareness resulting from the pilots, as well as having the ID checks systematically integrated into staff's work, resulted in staff feeling as though the pilot would make it easier to establish whether a patient is chargeable.

Cultural and behavioural change

Summary

- A cultural shift was observed among staff in the survey in relation to their perceived role in cost recovery, with a decline across almost all staff groups in those saying that they did not have a role in cost recovery.

- There was concern, however, that the ID checks would place too much burden on staff. However staff responsible for overseeing the pilot implementation reported that there had been an increase in understanding of cost recovery among staff and that the pilot had re-focussed attention on this area.

- Those who were aware of the ID checking pilot indicated higher levels of confidence in processes to maximise the recovery of costs in the follow-up survey compared to those who were not aware.

- Following the launch of the pilot, participants who said they were aware of the pilot were also more likely to find it easy to establish whether or not a patient is chargeable compared to those who were not aware.

3.3 Effectiveness of the ID checking pilot

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The ID check pilot required patients to provide two forms of ID, covering both photo ID and proof of address, which was intended to increase the identification of patients who were potentially chargeable and encourage this to happen earlier in the process. The extent to which patients were able and willing to provide two forms of ID, is central to the achievement of many of the pilot outcomes as outlined in the logic model.

While some of the outcomes could be achieved without full compliance (e.g. providing both forms of ID) **the pilot outcomes were largely predicated on the premise that generally patients would be able and willing to supply two forms of ID**. Where adherence is low, the ability of the pilots to increase identification of chargeable patients, recover costs, and lead to an increase in ceased treatments and decrease service demand will be limited. In addition, **whether or not patients provide ID when originally requested is a key indicator of the level of acceptance of the checks** and an indicator of how successful they will be if rolled out more widely .

In order to evaluate the feasibility of requesting that patients bring in two forms of ID, the participating service lines were asked to record the ID that patients supplied. In particular, they were required to record:

- Whether the patient provided ID
- The types of ID provided
- Where both forms of ID were not provided, the reason for this

The **ID supplied was recorded via a form on a tablet or on the trust's own patient administration systems (PAS).** The results for both these methods have been combined. For more details on the methodology, please see Appendix C.

Currently patients accessing accident and emergency services are eligible for free care. As such, the ID checking pilot was conducted in emergency services to establish the feasibility of patients spontaneously carrying two forms of ID with them. Other pilot service lines were able to provide patients with advance warning to bring ID to their appointment. Given the difference in prior awareness between A&E and other services, the results for A&E have been separated out in the following report.

Effectiveness of the ID checking pilot

Note on interpretation

From the case studies and conversations with trusts, it was clear that **some reception staff were uncomfortable carrying out the ID checks.** In the case studies, some participants mentioned that they were aware that the questions were not being asked of all patients, particularly where this was more difficult to track, for example for A&E patients. Further, data provided from trusts shows that often the full set of questions were not asked. For example, **staff indicated that they were often reluctant to establish why the patient had not brought in ID for fear of confrontation**. As a result, the data should be treated as indicative, rather than conclusive.

The finding in terms of reluctance to checking IDs, particularly establishing why ID was not provided, indicate that if similar requirements were to be expected as part of a wider roll-out, further work would be needed to ensure that staff feel comfortable doing so. It may be that due to the fact that it was a pilot, staff did not take the ID checks as seriously as they might if they were part and parcel of usual practice.

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Provision of ID in non-emergency services

Across non-emergency pilot trusts and services, **overall nearly four in ten (39%) patients were recorded as providing both forms of ID to prove ordinary resident status** (photo ID and proof of residence).

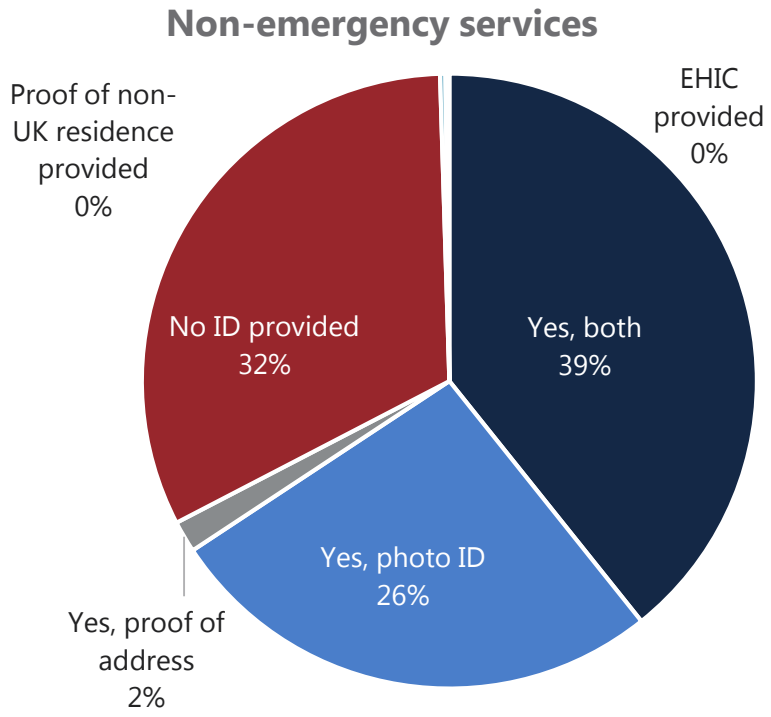
The proportion of patients who were able to provide at least one form of ID increased throughout the pilots as the checks became more established. For example, interim data (covering the launch of the pilot, and up until 10th September 2017) showed that around 38% of patients were not providing any form of ID. As the findings show here, by the end of the pilot this has now decreased to 32%.

Across all non-emergency pilots, **patients were more likely to provide photo ID than proof of address**. Two thirds of patients (66%) provided photo ID compared with around two fifths (41%) who provided proof of address. Amongst only those who provided ID, 97% provided photo ID while 60% provided proof of address.

Very few patients were recorded as providing an EHIC (64 of 22,698) or proof of residence of another country (46 of 22,698) - evidence which indicated that they were chargeable. Combined, these patients account for less than 1% of all patients (hence why 0% is stated in Figure 3.7 below).

Figure 3.7 – Percentage of patients who provided valid ID in non-emergency services

Did the patient present any valid identification (ID)?



Base: Non-emergency: 22,698 patients across 13 Trusts

Effectiveness of the ID checking pilot

Provision of ID in emergency services

In A&E pilot sites, where patients were not notified in advance about the need to provide ID, **overall around a fifth (22%) of patients were able to provide both forms of the ID required**.

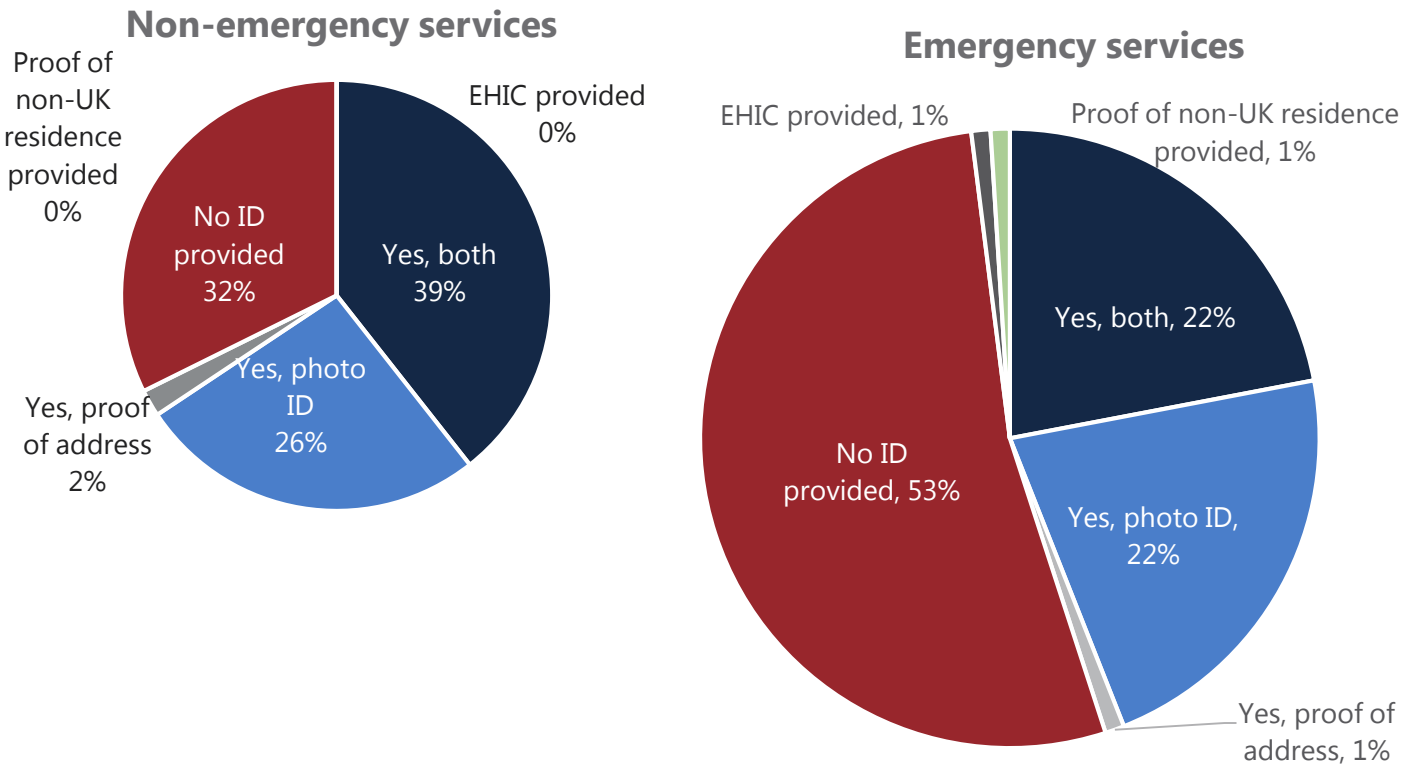
However, across the trusts, despite patients not being notified in advance, there was still variation between the levels of compliance, ranging between 17% and 34%.

As in non-emergency services, across all emergency sites, patients were **nearly twice as likely to provide photo ID than proof of address**, with 44% providing photo ID compared with 23% providing proof of address. Amongst only those who provided ID, 94% provided photo ID while 49% provided proof of address.

A slightly higher percentage of patients provided an EHIC or proof of non-UK residence in the A&E pilots than the non-emergency service pilots. Of the 6,860 patients who were asked to provide ID in A&E, 81 provided an EHIC and 49 provided proof of non-UK residence. However, this still only accounts for 2% of A&E patients overall.

Figure 3.8 - Percentage of patients who provided valid ID in emergency services

Provision of valid ID: Did the patient present any valid identification (ID)?



Base: Non-emergency: 22,698 patients across 13 Trusts; Emergency: 6,860 patients across 4 trusts

TRUST MANAGED DATA COLLECTION

Provision of ID - qualitative findings

In discussion with staff as part of the case study interviews, it was common for them to highlight that in their experience patients were generally only able to supply one form of ID. As the findings show**, patients were usually more likely to carry photo ID than proof residency**. This was largely because many patients tend to carry a driving licence on them, for example in their wallet, which they could use as photo ID.

Staff suggested that there were a variety of reasons for patients not providing two forms of ID. These included:

1. **Confusion around whether one ID would suffice**. There were examples of patients providing their driving licence as both proof of identity and of residency.
2. **Patients not fully reading information on their appointment letters** and missing that they would need to provide both proof of residency *and* photo ID.
3. **Older patients, in particular, not always owning passports or driving licences** (in these cases if they did provide a form of ID they were more likely to be benefit books, bus passes or bills).
4. **Students assuming that university cards could be used as proof of identity**.
5. **Other patients assuming that they could use cards or passes from their workplace as forms of ID.**
6. While still **other patients not bringing physical copies of ID**. For example showing their bank statement on their mobile phone or providing photocopies which were not accepted.
7. **Patients only having temporary residency or forms of identification** which were not accepted by the trust. These patients were often going through residency status and had not been sent the confirmation documents:

"Some who have not been here for 12 months, say that they have applied and that their documents are being held up – not sure where that happens. They say that they have the letter to say why they haven't got the documents but they don't actually have the ID."

(Administrator, Maternity – Trust 9)

Effectiveness of the ID checking pilot

Provision of both forms of ID varied widely across service lines and trusts, with 13% recorded as the lowest compliance rate and 68% compliance recorded as the highest compliance rate for providing both forms of ID.

This is likely to have been impacted by the local context and population demographics, as well as the effectiveness of any patient communications.

Table 3.2 Provision of ID by trust

Trust	Service line	Number of ID checks	Yes, both	Yes, just photo ID	Yes, just proof of address	Provided EHIC	Proof of residency for country outside UK / Not resident in UK	No
	Derma	1488	30%	13%	2%	0%	0%	55%
Trust 1	Maternity	1051	13%	22%	3%	0%	0%	62%
	Maternity	749	63%	17%	0%	0%	0%	19%
Trust 2	Renal	163	52%	10%	1%	0%	0%	37%
	Maternity	393	65%	23%	0%	0%	0%	12%
Trust 3	Neuro	172	38%	35%	0%	1%	0%	26%
	A&E	4631	17%	21%	0%	1%	0%	60%
Trust 4	Maternity	1926	38%	40%	0%	0%	0%	22%
	Maternity	1487	40%	30%	1%	1%	0%	28%
Trust 5	Trauma and Ortho	2254	12%	28%	1%	0%	1%	57%
	Urology	1240	63%	18%	3%	0%	0%	16%
Trust 7	Maternity	1664	60%	20%	1%	0%	0%	18%
	Oral	424	16%	70%	1%	0%	0%	13%
Trust 8	Maternity	643	14%	7%	1%	2%	0%	76%
	Maternity	1238	40%	31%	0%	0%	0%	29%
Trust 9	Renal	2726	41%	35%	4%	0%	0%	20%
Trust 10	Neurology	743	68%	12%	2%	0%	0%	19%
Trust 11	A&E	313	25%	12%	5%	1%	0%	57%
	Ophtha	424	50%	16%	3%	0%	0%	31%
Trust 12	Ortho	517	20%	48%	0%	0%	0%	32%
	Maternity	443	25%	37%	0%	0%	0%	37%
Trust 13	Urology	1051	32%	37%	5%	0%	0%	24%
Trust 14	A&E	1673	34%	23%	3%	2%	2%	35%
	Cardiology	621	41%	9%	1%	0%	0%	49%
Trust 15	Maternity	445	60%	23%	1%	0%	1%	15%
Trust 17	Maternity	836	62%	9%	1%	0%	0%	27%
Trust 18	A&E	243	18%	33%	1%	0%	1%	47%

Effectiveness of the ID checking pilot

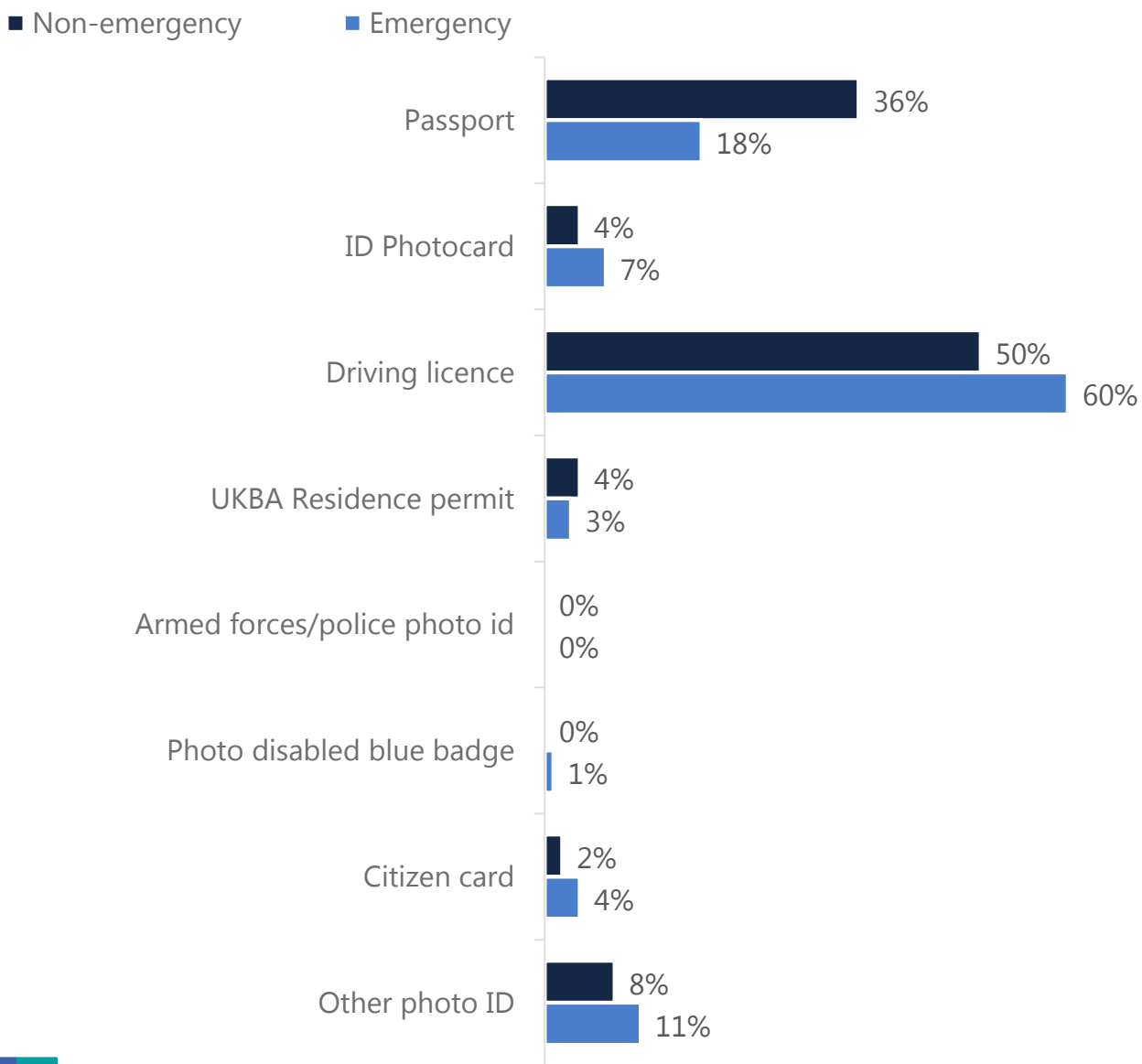
Provision of photo ID

As shown earlier where ID was provided, it was more likely to be photo ID - 66% of patients in non-emergency services and 44% in emergency services.

Amongst those who provided at least one form of photo ID, it was **most common to provide a driving licence.** This ID was used by over half of patients in both emergency and non emergency services (51% of emergency patients and 60% of non-emergency patients). The next most common form of photo ID provided was a passport (36% of non-emergency and 18% of emergency patients).

Figure 3.9 – ID provided by patients

What photo ID did they provide?



Ipsos Public Affairs Base: Emergency patients: 3,005; Non-emergency patients: 14,917

Effectiveness of the ID checking pilot

As with provision of all forms of ID, this varied by trust and service line. However, driving licence and passport remained the most common forms of Photo ID used across all trusts.

Table 3.3. Trust break down of type of photo ID where provided

Trust	Service line	Number provided photo ID	Passport	National identity photo-card (EU or Swiss)	Driving licence	Residence permit issued by UK Border Agency	Armed forces / Police photographic identity card	Photographic disabled blue badge	Citizen card	Other photo ID
	Derma	631	27%	2%	55%	0%	0%	0%	0%	18%
Trust 1	Maternity	367	50%	0%	47%	3%	0%	0%	0%	7%
	Maternity	603	43%	7%	41%	9%	0%	0%	0%	0%
Trust 2	Renal	101	57%	5%	21%	1%	0%	6%	0%	12%
	Maternity	346	51%	2%	45%	2%	0%	0%	0%	0%
Trust 3	Neuro	126	27%	2%	50%	2%	0%	4%	0%	14%
	A&E	1801	21%	6%	58%	3%	0%	1%	4%	7%
Trust 4	Maternity	1500	40%	4%	45%	7%	0%	0%	1%	6%
	Maternity	1041	31%	7%	54%	9%	0%	0%	0%	5%
Trust 5	Trauma and Ortho	914	29%	4%	64%	4%	0%	1%	0%	6%
	Urology	1002	36%	1%	57%	0%	0%	1%	6%	0%
Trust 7	Maternity	1345	37%	3%	56%	2%	0%	0%	4%	0%
	Oral	363	23%	1%	58%	1%	0%	1%	1%	14%
Trust 8	Maternity	129	59%	5%	16%	20%	0%	0%	0%	0%
	Maternity	872	51%	14%	30%	10%	0%	0%	0%	0%
Trust 9	Renal	2074	34%	1%	46%	2%	0%	1%	1%	15%
Trust 10	Neuro	590	42%	0%	47%	2%	1%	1%	3%	9%
Trust 11	A&E	117	13%	4%	46%	3%	0%	3%	3%	31%
	Ophtha	280	19%	0%	41%	0%	0%	0%	4%	37%
Trust 12	Ortho	351	23%	3%	49%	1%	0%	0%	0%	24%
	Maternity	276	14%	10%	82%	0%	0%	0%	0%	6%
Trust 13	Urology	732	15%	2%	65%	1%	0%	0%	1%	23%
Trust 14	A&E	963	13%	10%	62%	2%	0%	1%	5%	16%
	Cardiology	310	29%	0%	64%	2%	0%	0%	0%	4%
Trust 15	Maternity	366	70%	7%	12%	7%	0%	0%	13%	5%
Trust 17	Maternity	598	36%	6%	53%	3%	0%	0%	1%	3%
Trust 18	A&E	124	9%	4%	73%	2%	0%	1%	0%	16%

Effectiveness of the ID checking pilot

Provision of proof of address

Across patients, the provision of proof of address was lesson common.

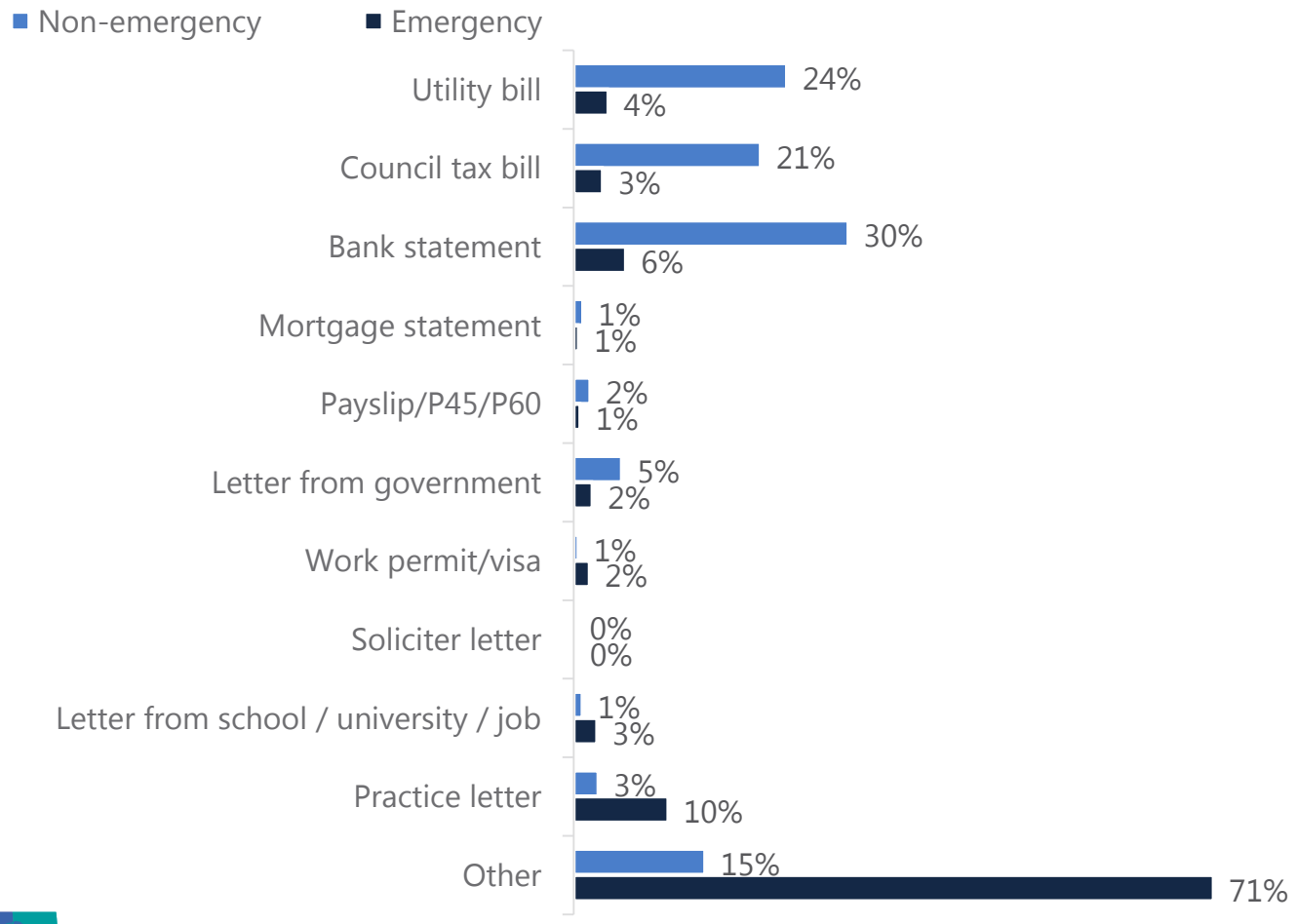
Where patients did provide proof of address, among non-emergency patients this ID was most likely to be either a utility bill (24%), a council tax bill (21%) or bank/building society/pension/ credit union statement (30%).

Emergency patients were less likely to carry more standard forms of proof of address, with more than seven in ten (71%) providing proof of address which had not been specified as one of the standard forms of proof of address.

Across trusts interviewed as part of the case studies, **there was less certainty around what would be considered acceptable ID compared to prove address**. Some trusts reported that as patients struggled to provide, or did not have on them some of the standard forms of proof of address, they often accepted non-standard forms of ID such as the patient's appointment letter or a driving licences. This was particularly the case where patients had another form of photo ID to provide in addition to their driving licence.

Figure 3.10 – Type of proof of address provided

What proof of address did they provide ?



Ipsos Public Affairs

Base: Emergency patients: 1,579; Non-emergency patients: 9,289

Effectiveness of the ID checking pilot

As with provision of all forms of ID, where proof of address was provided, this varied across trust and service line.

Table 3.4 Trust break down of type of proof of address where provided

Trust	Service line	No who provide proof of address	Utility bill	Council tax bill	Bank statement	Mortgage statement	Payslip/P45/P60	Letter from government	Work permit/visa	Solicitor letter	Letter from school / university / job	Letter from job	Practice letter
	Derma	474	25%	15%	10%	0%	0%	0%	0%	0%	0%	5%	45%
Trust 1	Maternity	162	20%	22%	29%	0%	2%	0%	15%	0%	1%	0%	14%
	Maternity	475	21%	18%	51%	3%	0%	7%	0%	0%	0%	0%	0%
Trust 2	Renal	86	24%	36%	41%	3%	0%	6%	0%	0%	2%	9%	2%
	Maternity	257	23%	24%	31%	0%	8%	9%	0%	0%	3%	0%	4%
Trust 3	Neuro	66	23%	24%	26%	0%	6%	11%	0%	0%	2%	2%	9%
	A&E	815	4%	5%	5%	1%	0%	3%	0%	0%	0%	5%	77%
Trust 4	Maternity	740	21%	27%	19%	2%	1%	10%	0%	0%	0%	1%	20%
	Maternity	608	10%	16%	24%	0%	2%	11%	0%	0%	1%	1%	36%
Trust 5	Trauma and Ortho	299	18%	22%	40%	1%	2%	8%	0%	0%	1%	1%	9%
	Urology	814	40%	23%	29%	1%	1%	6%	0%	0%	0%	0%	0%
Trust 7	Maternity	1021	17%	28%	45%	3%	2%	4%	0%	0%	0%	0%	1%
	Oral	73	19%	25%	40%	1%	0%	15%	0%	0%	0%	0%	0%
Trust 8	Maternity	96	23%	26%	50%	0%	0%	0%	0%	0%	0%	0%	1%
	Maternity	494	14%	20%	50%	2%	7%	4%	0%	0%	1%	0%	2%
Trust 9	Renal	1213	46%	24%	21%	1%	1%	4%	0%	0%	3%	0%	0%
Trust 10	Neurology	516	17%	17%	23%	0%	4%	8%	0%	0%	1%	1%	31%
Trust 11	A&E	94	5%	2%	5%	0%	0%	2%	0%	0%	0%	18%	68%
	Ophtha	223	9%	5%	82%	0%	0%	2%	0%	0%	0%	0%	1%
Trust 12	Ortho	105	25%	26%	32%	1%	0%	10%	0%	0%	0%	0%	7%
	Maternity	111	32%	19%	53%	0%	1%	0%	0%	0%	0%	1%	1%
Trust 13	Urology	396	19%	20%	20%	1%	1%	3%	0%	0%	1%	27%	14%
Trust 14	A&E	624	3%	1%	7%	0%	1%	1%	4%	0%	6%	16%	63%
	Cardiology	258	8%	5%	7%	0%	1%	0%	0%	0%	0%	1%	79%
Trust 15	Maternity	271	21%	20%	27%	0%	3%	3%	5%	0%	4%	10%	14%
Trust 17	Maternity	531	17%	11%	19%	1%	0%	2%	0%	0%	1%	10%	40%
Trust 18	A&E	46	7%	0%	0%	2%	4%	2%	4%	0%	4%	15%	61%

Effectiveness of the ID checking pilot

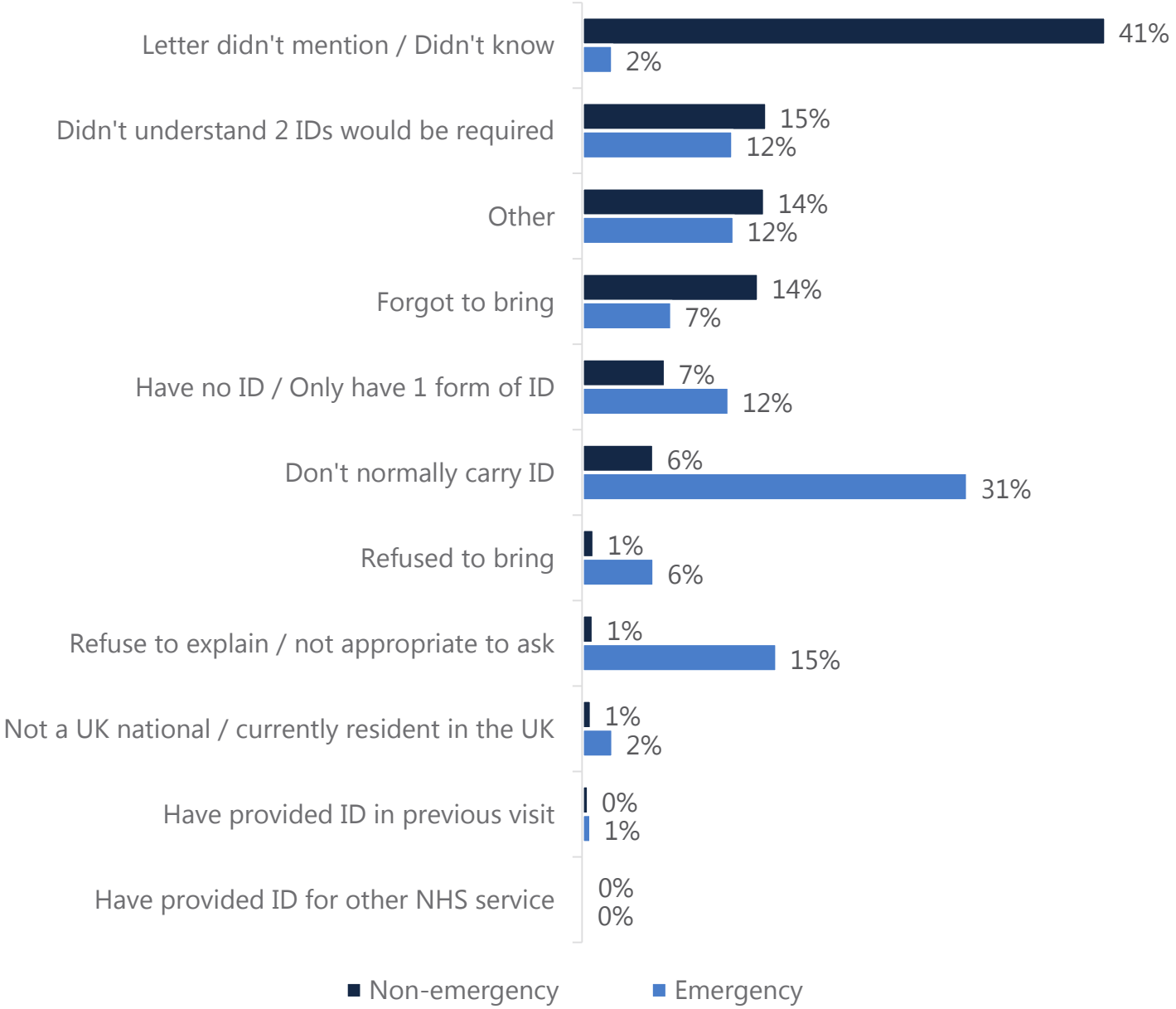
Reasons for not providing ID

Across the pilot trusts and services, around one in three (32%) non-emergency patients and more than half (53%) of emergency patients were recorded as not providing any form of ID during the check.

Figure 3.11 below shows the main reason given for not providing two forms of ID. This includes people who provided only one form of ID, or no forms of ID, to prove UK residency status.

Figure 3.11 – Reasons why patients did not provide two forms of ID

Why have they not brought two forms of ID?



Base: Emergency patients: 5,355; Non-emergency patients: 13,786

Ipsos Public Affairs

Effectiveness of the ID checking pilot

For non-emergency patients, the main reason given was that the letter didn't mention it, or that they didn't know (41%). **Some of the trusts interviewed suggested that they had experienced issues ensuring the correct letters were mailed out**, but largely **staff in case study interviews suggested that patients simply did not read the letters in full**.

For emergency patients, the most common reason provided was that they did not normally carry ID (30%). As patients had not been notified in advance this is to be expected. The qualitative findings from the case studies support this; it was reported that patients may carry photo ID such as a driving licence on their person but it was not typical for patients to carry other documents proving their residency such as council tax bills.

As mentioned earlier, staff were not necessarily comfortable establishing why ID had not been provided, which was often the case in A&E pilot sites. They mentioned that they did not feel comfortable asking patients who were very ill or potentially very hostile. This is evident in the emergency service results where 15% of emergency patients were recorded as *Refused to explain / Not appropriate to ask*.

Of those reasons listed as "Other", key themes that came up were:

- Patient was a child, and therefore they had no ID, or ID of a parent was used
- Patient was intoxicated
- Patient was a mental health patient or had a condition which made it difficult or inappropriate to ask for ID
- Patient did not speak English, so they were not able to ask for ID
- Patient assumed they could use driving licence as both proof of address and photo ID or assumed they could use their appointment letter as proof of address (where this was not being accepted)
- Patient was in the process of moving or had recently moved house

Overall, of those who did not provide two forms of ID, 3% of emergency patients and 1% of non-emergency patients were identified as being not a UK resident or having an EHIC card from the initial ID check.

Effectiveness of the ID checking pilot

Table 3.5 Trust break down of reasons for not providing two forms of ID

	Service line	No didn't provide both forms of ID	Not a UK national	Did not know	Didn't understand 2 IDs would be required	Forgot to bring	Refused to bring	Have given ID in previous visit	Have no ID / Only have 1 form of ID	Don't normally carry ID	Have given ID for other NHS service	Refuse to explain /Didn't ask	Other
	Derma	1043	1%	70%	4%	8%	1%	2%	3%	2%	0%	3%	6%
Trust 1	Maternity	917	1%	66%	3%	30%	0%	0%	1%	0%	0%	0%	0%
	Maternity	276	0%	4%	1%	58%	0%	0%	8%	0%	0%	0%	28%
Trust 2	Renal	79	0%	8%	3%	30%	0%	0%	3%	3%	4%	6%	44%
	Maternity	136	1%	45%	12%	37%	0%	1%	1%	0%	0%	0%	4%
Trust 3	Neuro	106	1%	42%	23%	25%	0%	4%	1%	1%	0%	0%	4%
	A&E	3824	1%	1%	13%	7%	8%	1%	12%	24%	0%	19%	15%
Trust 4	Maternity	1192	0%	2%	40%	6%	6%	0%	1%	40%	1%	1%	3%
	Maternity	895	1%	38%	13%	12%	0%	1%	8%	19%	0%	3%	5%
Trust 5	Trauma and Ortho	1975	2%	1%	7%	16%	1%	0%	8%	1%	0%	0%	64%
	Urology	464	0%	24%	1%	13%	1%	0%	53%	0%	0%	5%	3%
Trust 7	Maternity	659	0%	26%	7%	27%	0%	1%	33%	0%	0%	0%	5%
	Maternity	746	1%	1%	94%	1%	0%	0%	0%	0%	0%	0%	3%
Trust 9	Renal	1611	0%	99%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Trust 10	Neuro	239	0%	44%	31%	14%	0%	0%	4%	0%	0%	0%	8%
Trust 11	A&E	235	1%	30%	24%	15%	0%	0%	3%	17%	0%	1%	9%
	Ophtha	213	0%	47%	5%	14%	1%	2%	29%	0%	0%	0%	3%
Trust 12	Ortho	414	0%	16%	31%	40%	1%	0%	7%	1%	0%	0%	4%
	Maternity	333	1%	98%	1%	0%	0%	0%	0%	0%	0%	0%	0%
Trust 13	Urology	712	1%	72%	6%	9%	1%	2%	5%	1%	1%	1%	2%
Trust 14	A&E	1097	7%	3%	8%	8%	1%	1%	15%	46%	0%	7%	3%
	Cardiology	368	1%	73%	0%	15%	1%	0%	0%	2%	0%	1%	7%
Trust 15	Maternity	180	3%	44%	1%	28%	2%	1%	0%	1%	1%	2%	18%
Trust 17	Maternity	315	1%	36%	1%	21%	0%	0%	1%	0%	0%	0%	38%
Trust 18	A&E	199	2%	0%	6%	1%	1%	0%	1%	84%	1%	2%	4%

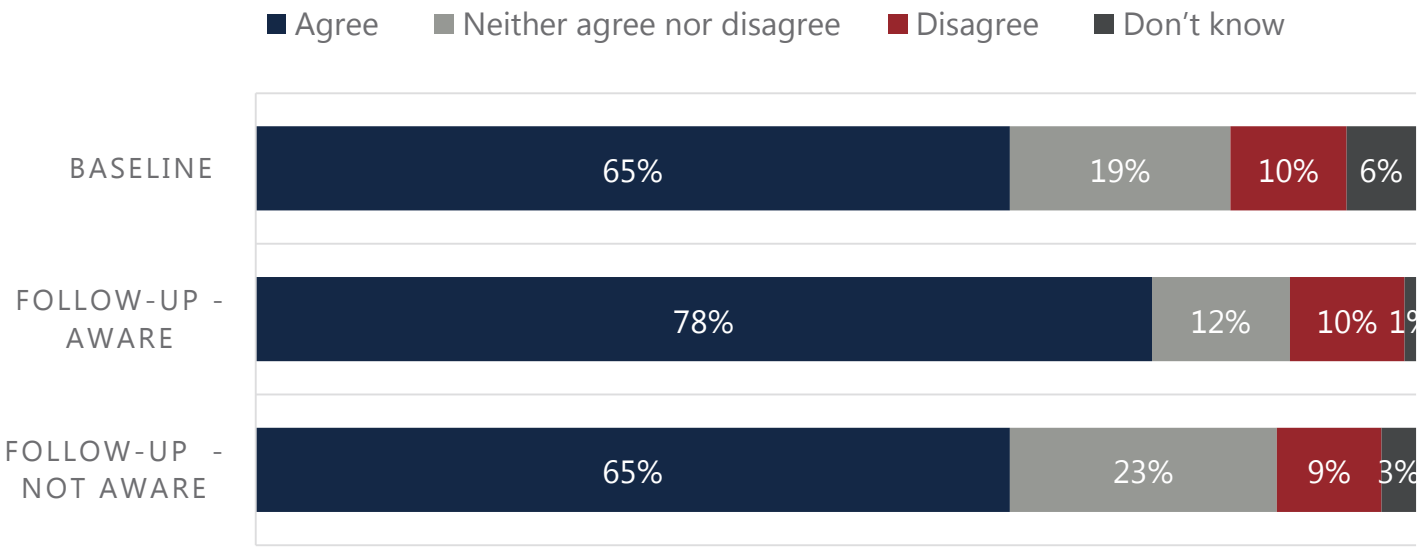
Effectiveness of the ID checking pilot

Overall perception of ID checking

In the **follow-up survey the majority of staff agreed that the benefits of checking for ID outweighed the costs.** Where participants indicated that they were aware of the pilot, the proportion agreeing with this increased from two-thirds (65%) of those who were not aware to nearly four in five (78%).

Figure 3.12

To what extent do you agree or disagree with the following statement: "The benefits of checking for ID, when using services, outweigh the costs to the NHS"



Base: Baseline: (220)
Follow-up: Aware (154) Not aware (69)

From the case studies and depth interviews, there were staff in trusts who were generally **confident about the ID checking process and how this will improve the recovery of costs from chargeable patients**. This was supported by the fact that they had witnessed **some level of increase in the number of identified patients throughout the pilot, even if this was just a few**. There was also confidence that this identification will continue to increase should the process be rolled out further in the future. Some trusts also said that **the identification of patients has occurred earlier than it did prior to the ID checks**.

There were other members of staff, within certain trusts however, who raised **concern that the amount of time and resource needed to conduct the ID checks (including chasing people for ID) would outweigh the costs recovered**.

Staff too spoke of how **the process for recovering costs from patients, even after they are identified is difficult and costly**.

Effectiveness of the ID checking pilot

Benefits of ID checking

The key benefits generally perceived by staff interviewed remained consistent across both waves. **More money for the trust, better more efficient identification of chargeable patients and earlier identification of chargeable patients were the top cited benefits.**

However, of potential concern for DH, the follow-up survey indicates notable differences between those who were aware of the pilot compared with those who were not. In particular, 'more money to the trust' was cited by a smaller proportion of those who were aware compared to those who were not (36% of those who were aware compared with 58% of those who were not aware). Higher proportion of those who were aware also cited that there were no benefits to the pilot (18% of those who were aware compared with 10% of those who were not aware). This suggests that **there a disconnect among staff in relation to ID checking identifying chargeable patients and actively bringing about greater cost recovery**.

Figure 3.13 – Benefits of ID checks

What benefits, if any, do you think this ID checking pilot will/has bring to your Trust?

Perceived / Experienced benefit	Baseline	Follow-up - Not aware	Follow-up – Aware
More money for the trust	52%	58%	36%
Better or more efficient identification of chargeable patients	36%	39%	34%
Earlier identification of chargeable patients	10%	17%	20%
No benefits	7%	10%	18%

Base: Baseline: (220)
Follow-up: Aware (154) Not aware (69)

In the case study interviews, staff recognised that there could be benefits to the ID checking and agreed with the pilot in principle. **Staff saw these benefits as being the earlier identification of chargeable patients and ultimately increased funds for their trust and the NHS as a whole**. Staff generally believed that ID checking would identify more patients in the future – not so much from these pilots themselves though.

Those with less awareness of the pilot, and with less involvement with the overseas teams, felt less confident in how the process would help identify chargeable patients.

Although **staff were positive about the motives and principles behind the pilot overall, they also raised concerns around how the ID checking would work in practice**.

Effectiveness of the ID checking pilot

Practical difficulties with implementation

As well as the potential benefits from ID checking, staff were asked about practical difficulties with implementation.

In both the baseline and the follow-up survey **staff indicated concern about patients' ability to bring in ID**. However, where participants suggested that they were aware of the pilot, the proportion who identified a concern with this was lower. Only around a fifth (19%) of those who had an awareness of the pilot in the follow-up survey, reported a concern about patients' ability to bring ID., compared to a third (33%) of staff in the baseline survey. This would seem to **suggest that following the launch of the ID checking pilot concern around patient ability to bring ID was reduced because patients *were* able to bring in ID**. However, caution should be applied to this conclusion. Both the trust managed data collection and qualitative research indicates that patients on the whole were able to provide at least one form of ID but struggled with two. A number of trusts in the research reported simply recording what ID was brought in, rather than chasing for both forms of valid ID. This explain why those who were aware of the pilot were less concerned about patients' ability to bring in ID.

Figure 3.14 – Difficulty experienced in implementing the ID checks

What difficulties, if any, do you see/ have been experienced in implementing the ID checking pilot in your Trust?

Perceived / Experienced practical difficulty	Baseline	Follow-up – Not aware	Follow-up– Aware
Patients won't bring ID / Patients will forget to bring ID / patients don't have the required ID	33%	19%	14%
Patients won't bring the correct ID	7%	16%	10%
Communicating the ID checks to the staff / staff training	5%	13%	3%
Causing delays	5%	12%	8%
Patients will be outraged by having to bring ID	11%	7%	10%
Staff won't ask for ID	7%	4%	1%
None	10%	6%	34%
Don't know	15%	9%	24%

Base: Baseline: 220
Follow-up: Aware (154) Not aware (69)

Throughout the qualitative case studies, concerns were raised regarding the practical implementation of the ID checks, including:

- The challenges around **using administrative and reception staff to verify whether ID is acceptable** or not –additional training would be required.
- Some **patients are entirely 'paperless'** (e.g. online banking) meaning hardcopy forms of ID are not necessarily going to be easy to provide.
- Certain **patients may not have the necessary forms of photo ID**, for example some older patients or low income people are unlikely to have a passport or a driving licence.

Effectiveness of the ID checking pilot

Costs and barriers of ID checking

Across trusts**, staff showed uncertainty around the financial costs associated with undertaking the ID checks**. In both the baseline survey and the follow-up survey around a third of staff reported 'No costs' or that they 'Don't know' (22% and 20% respectively in the follow-up survey). The **most common financial cost felt by staff, was the administrative cost of undertaking the checks**. Half of participants reported admin costs (52%) in the follow-up survey.

When exploring **potential risks and negative implications in participating in the pilot, overall concerns centred on patient relationships and treatment**. In both the baseline and follow-up survey **staff expressed a concern about the difficulty of asking the questions and the worry that patients would not seek treatment they required**.

The follow-up survey also showed that **a high concern for staff was the reaction of patients to being asked to bring ID**. Indeed around a quarter (24%) of staff in the follow-up survey who were aware of the pilot reported that a negative implication of participating in the pilot was 'patients unhappy to give ID/ to be charged'.

Figure 3.15 – Risks and negative implications of ID checks

What risks or negative implications, if any, do you think participating in this ID checking pilot will bring/ has brought to your Trust and the NHS more widely?

Perceived / Experienced negative implication	Baseline	Follow-up – Not aware	Follow-up – Aware
Patients unhappy to give ID / to be charged	5%	16%	24%
Awkwardness/ethical issues/risk of conflict for staff	21%	22%	21%
Patients not seeking treatment as in fear of being charged	20%	23%	18%
Risks of discrimination	4%	10%	8%
Reputational risks / adverse publicity	10%	6%	5%
Impact on vulnerable groups	10%	4%	1%
No risks	26%	23%	29%

Base: Baseline: 220
Follow-up: Aware (154) Not aware (69)

Effectiveness of the ID checking pilot

Costs and barriers of ID checking

Participants in the qualitative interviews highlighted the barriers and issues they experienced throughout the pilot. **Within particularly busy services, there were times when the ID checks did not take place when they should have done**. This was **mainly because of how busy the reception area got, and that it was unfeasible to do the ID checks** in addition to the other work involved in checking patients in. There were also instances where. **problems with computer systems within a trust meant that staff were unable to undertake the ID checks.**

There were barriers to the ID checking related to patients; for example, **staff mentioned language barriers making it sometimes impossible for them to do the ID checks**. In one trust **staff were unsure whether children were meant to be asked for ID** as part of the pilot – this caused some problems as young children did not have any documentation proving their identity or their residency that adults would typically have (such as a passport or driving licence). **Within A&E pilot sites in particular, it was impossible to ask patients for ID where they were too unwell**.

Initially, staff were particularly worried about the reaction among patients when they were asked for ID. In most cases, in practice **staff reported that most patients accepted the ID checking process and that it did not cause any problems**, particularly when staff took time to explain the pilot wherever patients had questions. However **there were still some patients who were offended by the ID checks**. Some patients felt as though they did not need to prove their residency or identification, particularly if they had been coming to the hospital for appointments for long periods of time.

In the case studies **a few cases were highlighted where overseas patients had been deterred from accessing treatment due to the ID checking.** A pressure group collected information from patients like these supporting the finding from the case study interviews. In these cases, patients had been put off from accessing care that they needed (in most cases Maternity services) due to worries about their ability to pay for care, the stress associated with being questioned about their eligibility status and fears of being detained or deported as a result. In the case studies where trusts mentioned such cases, staff reported trying as much as possible through communicating with the patient to ensure that they maintained attendance at their appointments.

The **secondary analysis carried out with available data does not indicate significant adverse impacts on service activity rates, cancellation rates or did not attends (DNA) rates**. However, significant variation in these rates over time means that the ability to isolate whether variation is caused by the ID checks or within expected norms is limited. Although the analysis suggests there was no large impact in these areas overall, a smaller impact could potentially have been masked by the variability in the data.

Administrative burden – Time and Motion Study

Guidance around ID checking suggests that the most appropriate point at which to request for a patient to provide ID is when they first register at the trust to use its services. As such, in the majority of trusts, existing reception staff undertook the checks. It was assumed that, if the checks were to be rolled-out more widely, the checks would be undertaken by staff within these teams. Where reception staff were not undertaking the checks in the pilot, the trust employed or seconded staff to do the checks.

Across staff involved in the evaluation activities, concern was therefore expressed around the potential burden on staff in checking patient's IDs, in additional to their usual responsibilities and tasks.

When discussing the potential roll-out of the ID checks**, it was suggested by many that it would only be possible or practicable for administrative and reception staff to undertake the ID checks if it placed minimal burden on them**. It was also suggested that senior buy-in would be reliant on this condition.

In order to understand the potential burden of ID checking on staff, a 'Time and Motion' observation study was conducted. This consisted of two rounds of observations in one service within each participating trust – one of which took place prior to the ID checking pilot, and the other following the introduction of the ID checking Pilot. The purpose of this was to capture changes to the check-in process as a result of the ID checks and to measure the impact on overall check-in times.

A note on the findings of the Time and Motion study

The time and motion only shows a snap shot of the checking-in process and was subject to a range of variables (see earlier discussion). **The findings presented here should therefore not be used as a robust measure for assessing and auditing check-in times**.

The first round of observations (Round 1) assessed only the time taken for a patient to check-in for their appointment.

The second round of observations (Round 2) assessed the time taken for a patient to check-in during the pilot. This also included the time to complete the ID checks. As such, the total time to complete the check-in process was recorded which included when patients stepped away from the desk to complete various check-in forms.

Administrative burden – Time and Motion Study

As can be expected **the time and motion findings show an increased time in checking patient in when the ID checks took place**.

Across trusts, the average (mean) checking in time for all observed patients at Round 1 was **81.2 seconds**, or just under **one and a half minutes**. The mean checking in time for all observed patients (which includes both those who were asked to provide ID, as well as those who were not) at Round 2 was **98.9 seconds**, or just over **one and a half minutes**.

A regression analysis was conducted to investigate the average difference in duration of check-in between Round 1 and Round 2. This analysis controls for differences in the number of patients checking-in across the different services at both rounds of the observation. **Overall, for all trusts the process took on average 16.9 seconds longer at Round 2 than at Round 1.**

Where most service lines targeted certain patients for the ID checks (e.g. new patients and/or patients who were checking in for the first time since the launch of the ID), A&E services were required to ask all patients who attended the service. Given therefore that a higher proportion of patients would have been asked to show ID when attending A&E, the regression analysis was run again removing A&E observations. **When A&E observations are removed from the analysis, the process of checking patients in at Round 2 took on average 14.5 seconds longer than Round 1.**

When looking at the overall time for A&E in isolation, the findings indicate that asking the ID check had a greater knock on impact on all check-in times compared to other services. **The Round 2 check-in process was on average 27.3 seconds longer than at Round 1 for A&E observations.**

Looking in more detail at the findings, at Round 1, the **majority of checking-in time (three-quarters of cases) lasted 108 seconds** or less. **For Round 2 this was 124.25 seconds.**

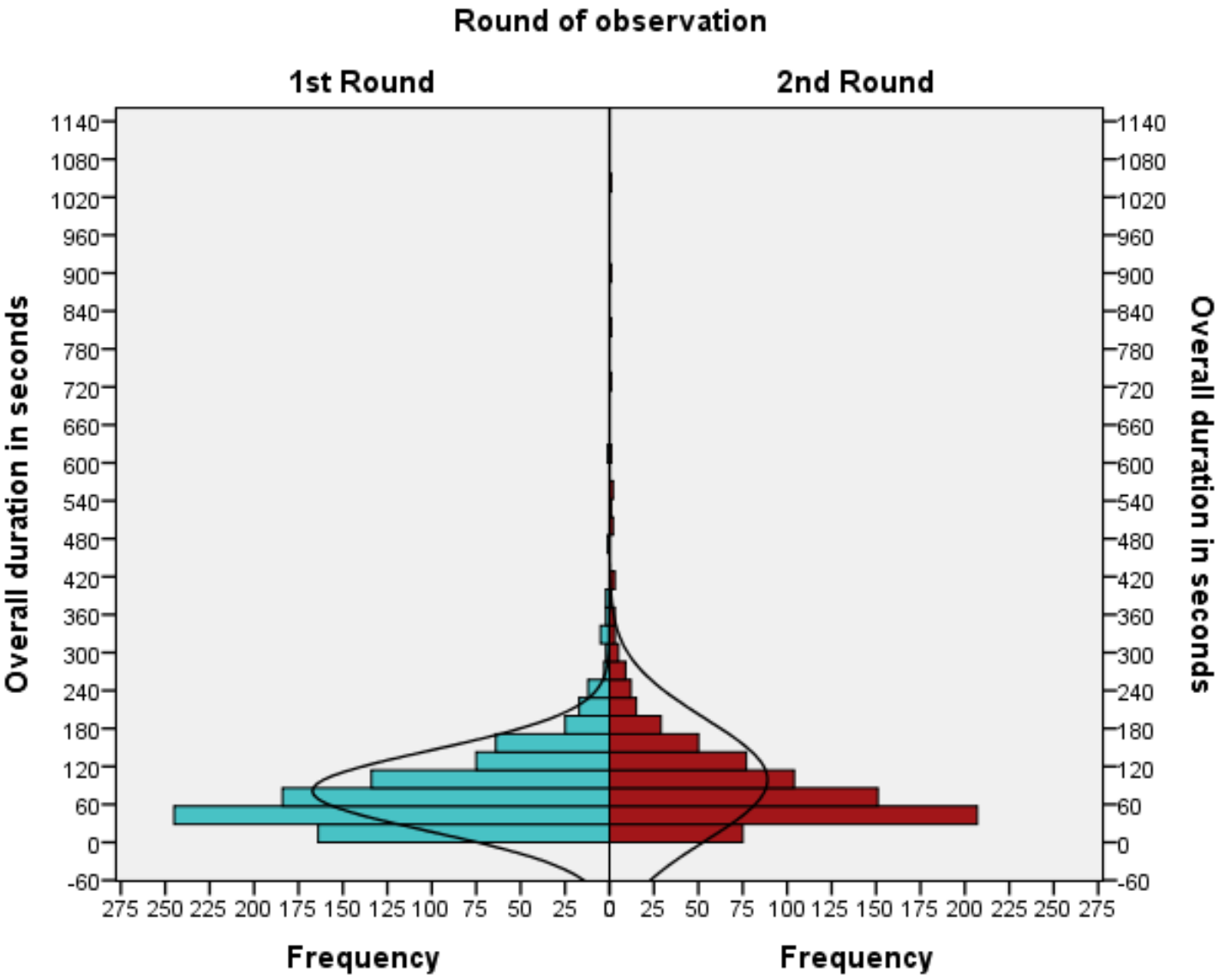
Table 3.6 Distribution of durations in percentiles by round

	Round 1	Round 2
25th percentile	37.25 seconds	46 seconds
50th percentile	66 seconds	73 seconds
75th percentile	108 seconds	124.25 seconds
100th percentile	602 seconds	1,038 seconds

Administrative burden – Time and Motion Study

Further at Round 1, the duration of cases ranged from 2 to 602 seconds. While at Round 2, the duration ranged from 1 second 1,038 seconds. The histogram below shows the spread in duration of check-in times across all trusts observed in Round 1 and 2:

Figure 3.16: Histogram of duration of all patients observed checking in at Rounds 1 and 2



Effectiveness of the ID checking pilot

Administrative burden – Time and Motion Study

Focusing on service line, table 3.7 shows the breakdown of average duration to check patients in by service type for both rounds of the observation. The majority of cases in the three A&E sites were asked for ID. For cases where ID was not asked in A&E, observers reported that patients that were too unwell to be asked, or were under 18, or staff forgot to do the ID check.

Table 3.7: Mean duration of patient check-in by service type and Round

Service type:	Average (mean) duration of check-in (seconds)		Difference in seconds	Number of cases observed		% of patients at Round 2 asked for ID
	Round 1	**Round 2**		**Round 1**	**Round 2**	**Round 2**
A&E	130.48	157.78	27.3	171	138	73%
Cardiology	34.7	107.46	72.8	73	28	14%
Diabetes outpatients	93.35	98.07	4.7	20	27	48%
Maternity	73.97	81.97	8.0	420	310	51%
Neurology	74.94	131.87	56.9	54	39	87%
Renal	60.49	65.94	5.4	71	65	77%
Fracture, Trauma and Orthopaedics	77.43	83.88	6.5	127	147	26%

As mentioned earlier, **A&E on average had the longest check-in time at Round 2 (158 seconds).** This would seem to suggest that any roll-out of the ID checks would likely hit A&E harder than other services. **Table 3.8 shows the durations of only the cases where ID was checked.** The table below shows that **undertaking the ID checks was actually fastest in A&E**. This is likely the result of A&E testing the feasibility of the ID check, rather than aiming to assess the impact on cost recovery. We know that A&E services were less stringent in the way the checks were undertaken and in some trusts patients were simply asked if they had ID, rather than being required to produce it. As such, it is likely that the volume of patients requiring check-in and the knock on impact this had, accounts for the higher increase in average duration time in A&E compared against other services.

Table 3.8: Mean duration ID check at Round 2[1]

Service type:	Average (mean) duration of ID checking (Round 2 only):	Number of cases where ID checking was observed
A&E	29.56	101
Cardiology	355.25	4
Diabetes outpatients	62.38	13
Fracture, Trauma and Orthopaedics	76.24	38
Maternity	33.30	159
Neurology	74.41	34
Renal	32.72	50
Total	**44.05**	**399**

1 Please treat these findings with caution as in some services ID checks were only carried out with a small number of patients.

Administrative burden – Time and Motion Study

Table 3.9 shows the Time and Motion observations by trust. Looking at the results across trusts it is evident that **there a significant degree of variability around the impact of conducting the ID checks on overall check-in times**. Appendix B contains more context about each observation. To illustrate the range in average ID check times:

- During one observation in a Cardiology department, 28 patients were observed, but only 4 had their ID checked as this trust was only checking patients attending their first appointment, meaning the average (mean) ID check time was 355 seconds.
- However in another A&E service, 65 patients were observed across the shift, with 41 having their IDs checked, giving a mean ID check time of 29 seconds.

The pilot certainly added time to the checking in process but discussions with staff in the trusts indicated that the impact this has on trusts largely depends on the processes put in place for the checks, the service line, and the way in which services are delivered.

For example of the variation:

- Trust 14 - undertook the pilot in A&E. This trust sees on average around 17,000 patients a month and the ID check questions added 31.5 seconds to average checking in time. If this time were to remain stable the service line would require an addition 169 hours a month or 42 hours a week.
- Trust 2 – undertook the pilot in Maternity. Data from June 2016 shows that 755 patients were treated in maternity during this period. Assuming a similar proportion of patients are treated each month, the average additional time for undertaking the ID check was 4 seconds, so this would equate to an extra 50 minutes a month.

There are a variety of external factors outside of the overall checking time which will impact on the burden associated with the checks:

- as the various examples discussed have shown, **volume of patients coming into the service is a key determinant** on burden and staff capacity to take on additional work;
- the **responsibilities of staff is also likely to impact on burden**, where staff use the time between booking patients in to complete other tasks as part of their job, any additional time spent on checking patients in will likely impact on their ability to perform these other roles; and
- **sophistication of IT systems and how the information from the ID check is passed on**. Staff who actively have to alert costs recovery teams about patients who have provided evidence showing they are chargeable or who were not able to provide ID will ultimately feel more burden to their time than those who have this process integrated into electronic systems.

Administrative burden – Time and Motion Study

Table 3.9: Mean duration ID check at for each trust

Trust name:	Service observed:	Round 1 fieldwork:	Round 2 fieldwork:	Observed time (both rounds)	Number of cases observed:	Mean check-in time Round 1 (sec):	Mean check-in time Round 2 (secs):	Difference in seconds:
Trust 1:	Maternity	28th April	8th September	9am - 4pm	Round 1: 65 Round 2: 62	50.43	48.19	-2.2
Trust 2 (London based):	Maternity	24th April	14th September	9.30am - 4.30pm	Round 1: 70 Round 2: 52	100.89	104.90	4.0
Trust 3 (London based):	Maternity	21st July	8th September	8.30am - 3.30pm	Round 1: 75 Round 2: 17	32.29	90.12	57.8
Trust 4 (London based):	A&E	13th July	7th September	2pm-9pm	Round 1: 47 Round 2: 65	141.91	177.74	35.8
Trust 5:	Fracture, Trauma and Orthopaedics	25th April	3rd October	9am - 4pm	Round 1: 127 Round 2: 147	77.43	83.88	6.5
Trust 6:	Maternity	11th July	19th September	9am - 4pm	Round 1: 108 Round 2: 94	76.66	74.21	-2.4
Trust 7:	Maternity	11th May	7th September	9am - 4pm	Round 1: 64 Round 2: 50	116.38	90.36	-26.0
Trust 9 (London based):	Renal	12th July	13th September	9am - 4pm	Round 1: 71 Round 2: 65	60.49	65.94	5.4
Trust 10 (London based):	Neurology	25th July	12th September	8.30 - 3.30pm	Round 1: 54 Round 2: 39	74.94	131.87	56.9
Trust 11:	A&E	9th May	19th September	12pm - 6pm	Round 1: 60 Round 2: 38	137.77	133.79	-4.0
Trust 13:	Urology	23rd August	27th September	9.30 - 4.30pm	Round 1: 38 Round 2: 35	67.84	112.66	44.8
Trust 14 (London based):	A&E	18th August	15th September	3pm - 10pm	Round 1: 64 Round 2: 35	115.25	146.74	31.5
Trust 15 (London based):	Cardiology	17th August	14th September	9am - 4pm	Round 1: 73 Round 2: 28	34.7	107.46	72.8
Trust 16 (London based):	Diabetes outpatients	19th July	20th September	9am – 11am	Round 1: 20 Round 2: 27	93.35	98.07	4.7

Administrative burden – Time and Motion Study

Finally it would be wrong to assume that the results as presented here are the absolute times that undertaking the ID checks add to completing the check-in process with patients.

It is possible to expect, and was identified by staff interviewed as part of the case study interviews, that **if the pilot was to be rolled out and given time to bed-in, the time to undertake the checks may reduce.** As well, as the ID checks become part of the normal checking in process within secondary care**, patients too will spend less time querying or commenting on them**. Interviews with staff as part of the case studies suggested that a lot of administrative and reception staff time was spent answering such queries during the pilot.

Key factors identified in discussions with staff, which may further reduce the overall time it takes to undertake the checks include:

- Staff become more in tune with undertaking the ID checks
- Patients become more aware of the requirement to bring ID and in turn becoming more willing to provide it.
- Technological developments to facilitate the ID checks, for example trusts embedding them in their PAS systems, patients being ask the questions through self-checking kiosk and patients being able to provide the ID prior to appointments.

Indeed, **staff interviewed as part of the case studies frequently advised that a strong communication programme would need to go along side the further roll out** of the ID checks to encourage greater awareness among both NHS staff and patients.

Effectiveness of the ID Checking pilot

Summary

- Across non-emergency pilot trusts and services, overall nearly four in ten (39%) patients were recorded as providing both forms of ID to prove ordinary resident status (photo ID and proof of residence). In the A&E pilots, around a fifth of patients were able to provide both forms of ID.

- In all services, patients were more likely to provide photo ID than proof of address. Across A&E pilots, patients were nearly twice as likely to provide photo ID than proof of address.

- The most common form of photo ID provided – in both emergency and non-emergency services - was a driving licence. Where patients were able to provide proof of address, this was most commonly a utility bill, a council tax bill, or bank statement (in non-emergency services).

- In non-emergency services, the main reason given as to why patients didn't bring the correct ID was that the letter didn't mention it, or that they didn't know. In A&E it was that they did not normally carry ID.

- Both the staff survey and the qualitative interviews indicated that staff were generally confident about the ID checking process and how this will improve the recovery of costs from chargeable patients.

- The key benefits of ID checking, reported by staff, centred around increased income for the trust, better more efficient identification of chargeable patients and earlier identification of chargeable patients.

- In the qualitative interviews however, while staff were positive about the motives and principles behind the pilot overall, they also raised concerns around how the ID checking would work in practice.

- A number of practical difficulties around implementation of the ID checks were reported including using administrative and reception staff to verify whether ID is acceptable, some patients being entirely 'paperless' and patients not always owning the forms of ID requested.

Ipsos Public Affairs

Effectiveness of the ID Checking pilot

Summary

- The most common financial cost associated with the ID checks reported by staff was the administrative cost of undertaking them.

- Several risks or negative implications of the ID checks were raise, including a concern about the difficulty of asking the ID check questions, and the worry that patients would not seek treatment they required.

- As well, a number of practical barriers in implementing the checks were reported in the qualitative interviews. These included language related barriers, staff confusion around asking children for ID and patients (particularly in A&E) being too unwell.

- While staff were initially very concerned about patient reaction, they reported that most patients accepted the ID checks. However, they did describe a small minority who were offended by them.

- There were some reports of patients being deterred from accessing treatment during the pilots, and because of the ID checks.

- Overall, for all trusts the checking in process took on average 16.9 seconds longer during the ID Checking pilot compared to before.

- For non-emergency services, the process of checking patients in took on average 14.5 seconds longer during the ID Checking Pilot than before. For A&E sites, the check-in process was on average 27.3 seconds longer. However undertaking the ID checks was actually fastest in A&E.

- There was a significant degree of variability across services and trusts around the impact of conducting the ID checks on overall check-in times.

- Due to the length of time taken to follow-up, charge and bill patients, following their initial identification, following up with the pilot trusts a few months later may allow better identification of the number of patients identified, charged and billed from the pilot period.

Ipsos Public Affairs

4. Overall Perceptions of Impact

This section draws on information provided in case study interviews and discussions with pilot leads in relation to the perceived benefits of the ID checking pilot. It also summarises the difficulties experienced by trusts in implementing the ID checks.

The section also includes results from the analysis of cost recovery data that was provided by trusts. This is useful in terms of assessing any impact realised as a result of running the ID Checking pilot in relation to the number of chargeable patients identified and invoiced.

4.1 Overall perception of benefits and difficulties

Benefits of undertaking the ID checks

When speaking to pilot leads and staff within the case study interviews a number of key benefits were highlighted (some of which have been discussed elsewhere in this report):

1. Improved more efficient processes for overseas teams and cost recovery

In trusts which kept their own records of the IDs provided, overseas teams suggested that this had helped them when contacting potentially chargeable patients as it removed the step where they were required to chase the patient for this ID and meant that they already had information about the patient, which they would otherwise have needed to pursue.

Linked to this, staff from a number of trusts also suggested that the introduction of the ID checks has encouraged the services taking part in the pilot to consider their cost recovery processes. It was suggested that as a result they had become more stringent at putting details of chargeable patients on the network and established better working practices between services lines and the overseas teams.

The extent to which ID checking improved the identification of chargeable patients was debated across interviews and trusts. Some trusts felt their existing practices, particularly around the 12 month question and the flagging of patients to their overseas team, were already fit for purpose. As such these trusts did not feel they had identified more chargeable patients as a result of the ID checks. Other trusts suggested that more chargeable patients had been identified as a result of the checks but this tended to be based on anecdotal evidence. Only one or two trusts were able to provide any hard data to evidence this.

2. Increased awareness and engagement with cost recovery

A degree of communication about the pilot and its aims was required to be undertaking with staff before implementing the pilot. It was suggested by a number of pilot leads that this greater communication around costs recovery had fostered a greater awareness amongst staff working in the pilot sites around the charging of patients:

'I think everyone has become more aware, our clinicians, admin team are more aware, it has really brought it to the front of their minds and now they consider it where they hadn't before.'

(Pilot lead, Trust 2)

Overall perception of benefits and difficulties

Benefits of undertaking the ID checks

3. Earlier communication with patients about cost recovery

Another benefit drawn on by a number of staff within the pilot trusts was awareness raising with patients about cost recovery and chargeability. It was suggested by those working in the cost recovery team the ID check pilot had meant that patients were made aware earlier in the process that they could be charged for their care – particularly when letters were sent out prior to appointment. It was therefore felt that patients were given more warning time and removed the element of surprise when patients were billed for care:

'The problem is that previously you was accessing the care, you was having the first appointment with no letter, second appointment no letter, third appointment you owe money. So if it's done from the beginning, you was told, you can't give those responses 'I wasn't aware, you never told me I had to pay', and I think that's what we have done.'

*(*Service manager, Trust 9)

4. Ability to increase awareness among patients that the NHS isn't free to all

Finally, as well as increasing cost recovery awareness among NHS staff, and in addition to earlier communication with patients, staff also spoke of how ID checking has the potential to improve overall awareness among patients to the fact that the NHS isn't always free:

"***I think it would be good because, my personal view is, you start doing the ID checking across the trusts as a whole, this spreads a message to the patients, and that spreads a message to their friends and their neighbours... that message spreads and then hopefully, I see that as eventually people will realise NHS isn't free. They will forget ID checking... and begin to understand how that relates to overseas work, that they are there to identify people who are not eligible for free care and charge those people or talk to them about alternative options of treatment.***"

*(*Pilot lead, Trust 2)

Overall perception of benefits and difficulties

Benefits of undertaking the ID checks

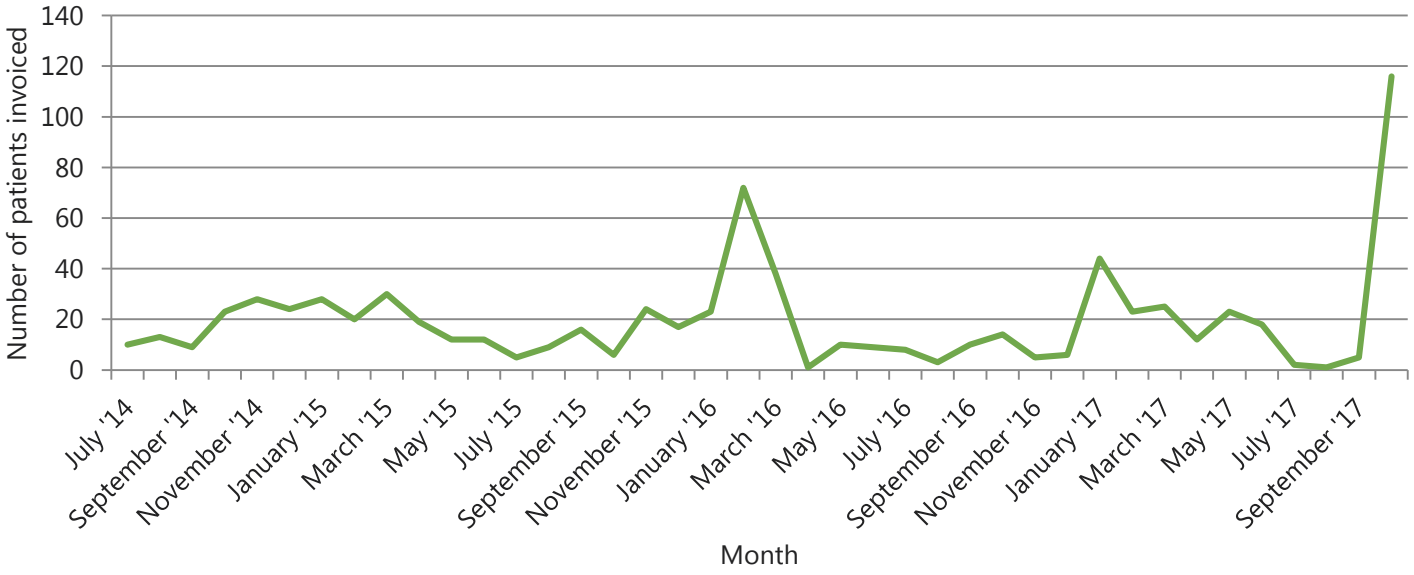
Evidence of improvements in cost recovery from secondary data analysis:

In terms of analysis of the cost recovery data available, significant variation is present in most of the data and **it has not been possible to identify any improvement or deterioration in the numbers of patients identified as chargeable or patients invoiced that is directly attributable to the programme**.

However, **some trusts do exhibit differences in the cost recovery data such as Trust 9 who show a more than doubling of invoices made during the pilot period than in the same months of 2016.**

Recent data provided by trust 9, for the maternity service, on the number of patients invoiced shows a spike in October 2017 in which 116 patients were invoiced. This may be explained by the introduction of a new process for invoicing overseas patients that the trust began to implement during the pilot and may not reflect an impact of the pilot. However, it is likely that the pilot may have has some effect on the ability of staff to identify patients for cost recovery.

Figure 4.1 – Number of maternity service patients invoiced, trust 9



The amounts invoiced follow an almost identical pattern to the numbers invoiced displayed above.

Overall perception of benefits and difficulties

Benefits of undertaking the ID checks

Data on cost recovery for the renal service was less comprehensive with only the number of patients invoiced available for analysis. In addition this data exhibited significant variation from month to month with many months in which no-one was invoiced. Similarly, EHIC data is sparse and no EHIC patients are recorded for either the pilot period or the same three months in 2016.

Figure 4.2 outlines the numbers of patients using the renal service at trust 9 that have been invoiced since January 2016 and illustrates the variability. However, there appears to be a consistently higher number of patients invoiced in 2017 than in in 2016 suggesting that other changes to the healthcare system and cost recovery are having an effect.

Figure 4.2 - Number of renal service patients invoiced, trust 9

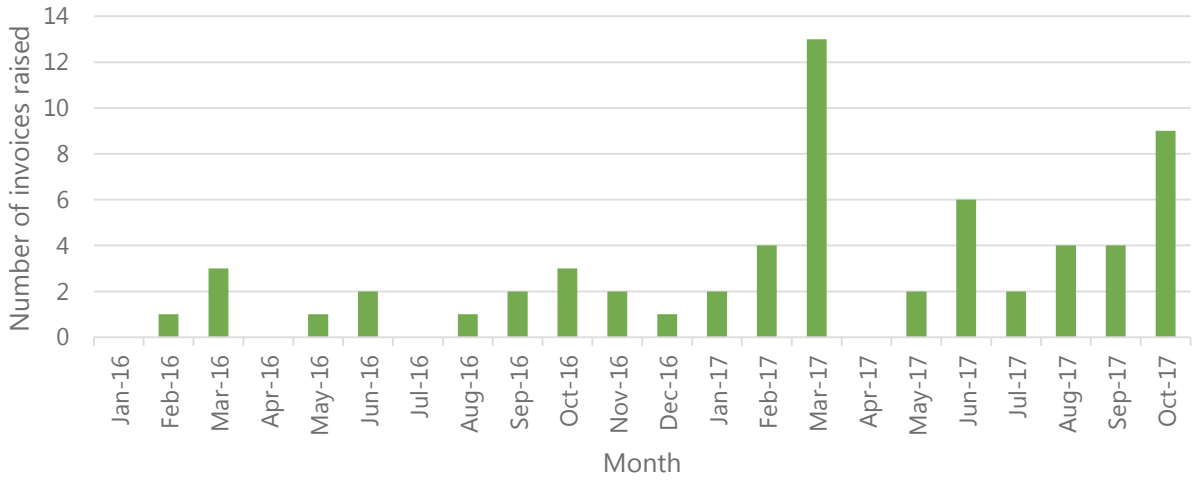
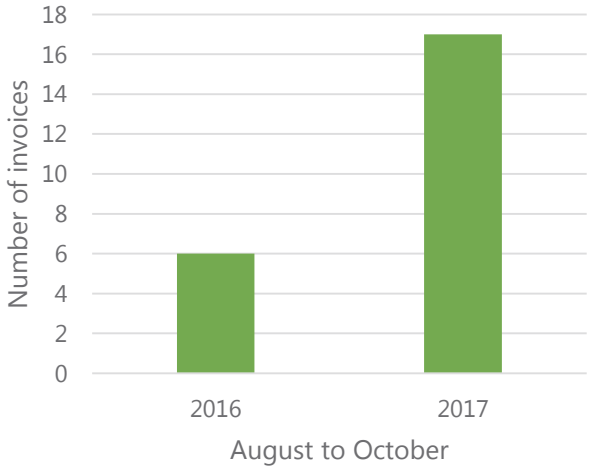


Figure 4.3 shows the difference between the same two periods in 2016 and 2017 from which the number of invoices rose to 17, a difference of 11.

Figure 4.3 - Renal service invoices, August to October 2016/2017, trust 9



Overall perception of benefits and difficulties

Difficulties associated with undertaking the ID checks

While those interviewed did outline benefits in undertaking the ID check, there also highlighted several difficulties they had experience. Across trusts the most frequently experience difficulties included:

1. **Ambiguity around acceptable ID and which patients were exempt from charging**

Across staff within the pilot trusts, a degree of uncertainty was felt about what appropriate ID would look like and who was eligible for free care. Indeed, trusts spoke of not knowing what some of the less common ID looked like (e.g. visa) and how to know if these were legitimate documents which also feel within the criteria for acceptable ID.

'You will get the conflicting thing when people will show there general working passes as photo ID. Do we accept that? Its got their name on.'

(Team leader, Trust 11)

Indeed, staff questions if it was right to place the responsibility for checking ID with reception staff:

'The problem is though receptionist's ability to interpret the IDs as someone could have shown their driving licence and proof of address but they could have been on a work visa that expired two years ago and they wouldn't know. The reception staff aren't always going to know what you need from someone.'

(Pilot lead, Trust 18)

2. Managing patient reaction

In some instances, frontline staff who were involved with asking the ID question suggested that they experienced difficulties with managing negative patient reaction. This sometimes lead to them avoiding asking certain patients for ID. As such, staff wanted greater support when dealing with difficult patients, particularly around what messages they should be communicating to them.

3. Communicating effectively with patients

A number of trusts spoke about having difficulties with communicating to patients the need to bring in two forms of ID. It was common for patients to say to staff that they had not seen on the letters that they were required to bring in ID. Indeed, one or two trust experimented with different ways of wording and providing the information on the letters. One trust also found that the initial letters which were sent were to patients about ID checks had gone out to early and had missed patients who were given last minute appointments. As such, they found that they had to provide details of ID required in letters a week before appointments.

Overall perceptions of impact

Summary

- Trusts involved in the ID Checking pilot reported a number of benefits of undertaking the ID checks:

1) Improved more efficient processes for overseas teams and cost recovery

2) Increased awareness and engagement with cost recovery

3) Earlier communication with patients about cost recovery

4) Increased awareness among patients that the NHS isn't free to all

- The quality of the information provided by trusts has made it difficult to assess any impact in terms of the number of patients identified as chargeable or the number of patients invoiced, as a result of the pilot. However some trusts' data do show promising signs.

- Trusts highlighted several difficulties they had experienced in conducting the ID Checking Pilot:

1) Ambiguity around acceptable ID and which patients were exempt from charging

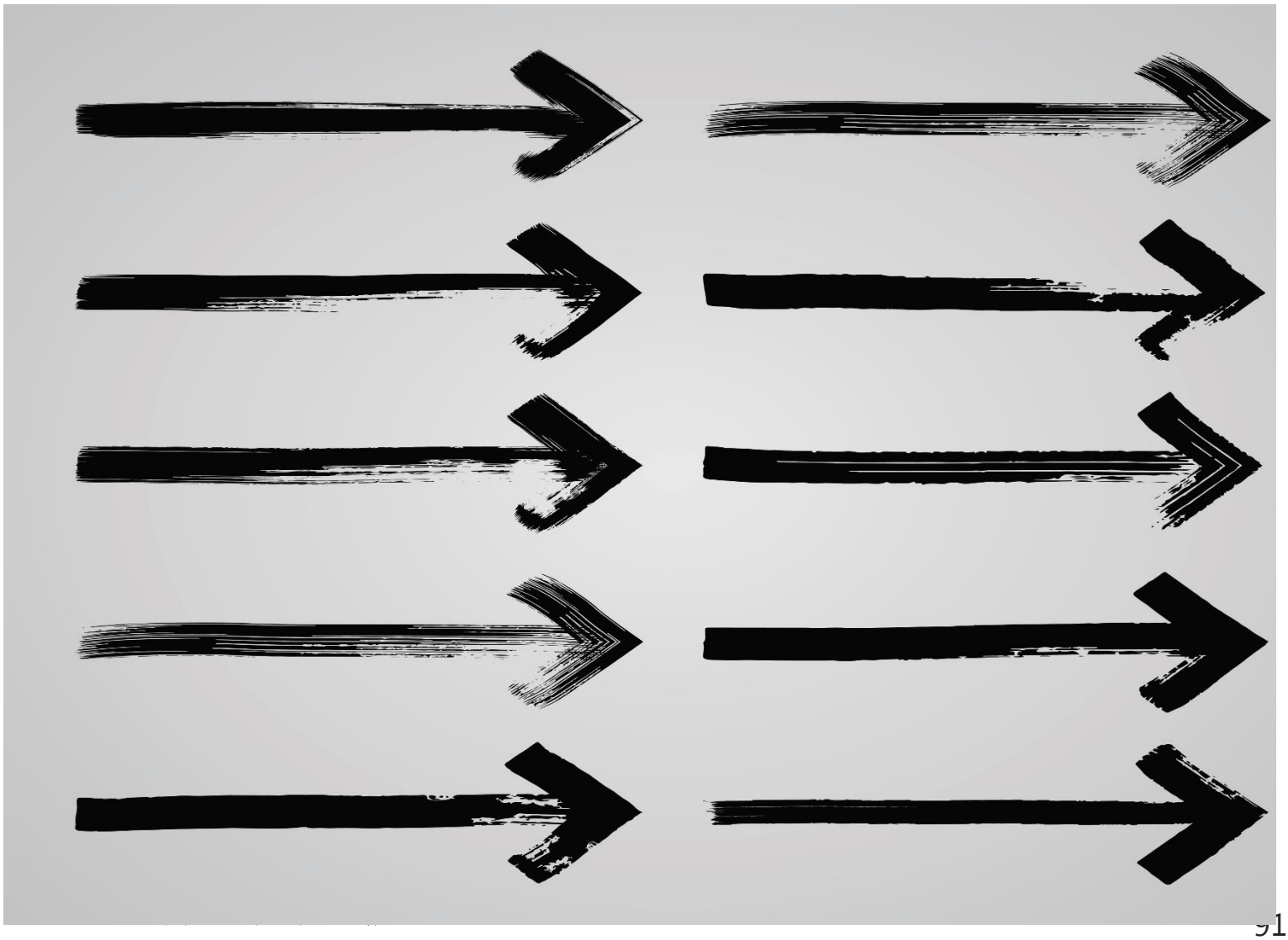
2) Managing patient reaction

3) Communicating effectively with patients

5. Going Forward

This final section focusses on the improvements to the ID checking process that would be needed if they were to be rolled out more widely. These issues experienced by trusts were reported during the case study interviews and also across general discussions with the pilot leads.

The section closes with staff reflections on potential future roll out, and provides more information with regards to the next steps for each of the participating trusts.



5.1 Suggested improvements for ID checking

During the in-depth and case study interviews, staff were asked about what improvements they felt could be made to the ID checking process and what they would need to be able to continue to run the checks. Across interviews several key suggestions were made.

It was felt that these issues, sometimes barriers, would need to be ironed out before the ID checks were rolled out further, potentially across all services and within all trusts.

1. Integration into IT systems:

Having to use a separate system to carry out the ID checks was felt by many to be burdensome and open to issues with data linkage. It was suggested by staff that to undertake the checks in the most efficient way, and to ensure that staff asked the questions of all patients, **the ID check would need to be built into existing electronic systems as mandatory fields**. In building the questions into the system it was also felt that it would ensure a record of the ID provided, or lack of, both allowing for easier identification of chargeable patients by the overseas team and to ensure against patients repeatedly being asked for their ID. It was also felt by some that this may remove the need for staff to flag chargeable patients to overseas teams, as flags could be built into the electronic system.

2. Training and information:

As has been discussed, across staff groups there was felt to be ambiguity around eligibility and acceptable ID. As such, it was suggested that to successfully undertake the ID checks, **staff would need to be provided with considerable training around what ID can be considered acceptable proof, what to look out for when being provided ID, what combinations of ID could be considered two forms of proof**, **and finally which patients are eligible for free care and which are not**. It was indicated that this information would need to come from DH – it was felt that even some overseas teams were not completely clear on all these points. As has been discussed, some trusts seriously questioned whether reception staff had the capacity to undertake the checks as such they wanted consideration around who would do this going forward and how it would be funded.

3. Integration with the '12 months' residency question:

One **particular concern around the ID check was the ability to capture patients who are chargeable but have the appropriate ID to hand – specifically ex pats**. It was therefore suggested that the '12 months question' would need to continue to be asked alongside the ID check.

Suggested improvements for ID checking

4. A strong national communication strategy:

A number of trusts experienced difficulties with communicating to patients about the ID check. Consequently, it was felt that going forward **they would need significant guidance from DH about how best to communicate with patients**. Further, it was also felt that the ID checks could only be successful if they were normalised amongst patients and staff. To achieve this there would need to be a serious programme of communication which included drawing on national media outlets to build general awareness.

5. Clarity around the extent to which patients should be chased for ID

Staff queried the process around chasing patients for ID if they do not provide it when first asked. For example would it be acceptable to allow patients to bring their ID to future appointments, or would there need to be a system in place whereby patients were given a certain amount of time (for example 48 hours) to produce their ID following the time when they are first asked. What would happen if patients didn't produce ID after being chased for it? What impact would this have on their ability to continue to access NHS care?

6. Clarity around how to process IDs

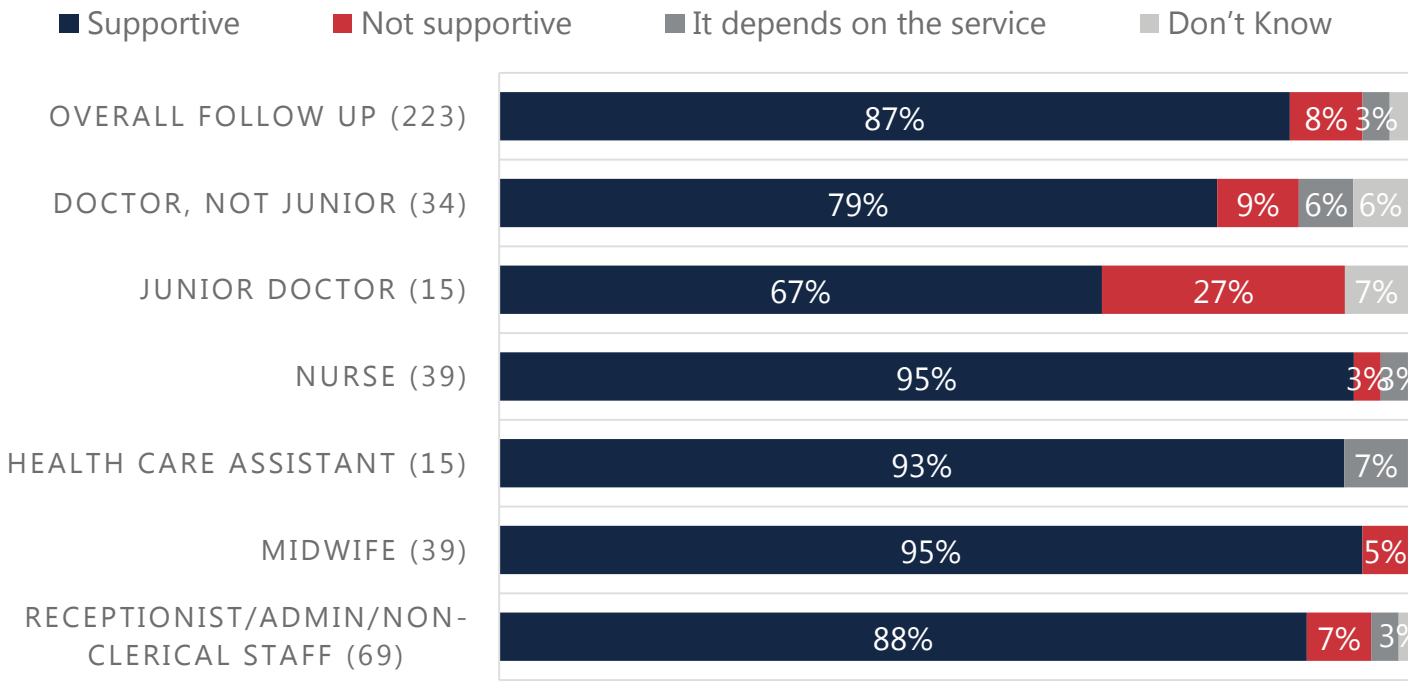
There was also some confusion around which system would be in place, in the absence of the tablets provided as part of the evaluation to record whether the patient had provided ID. It was assumed that the ID check would need to be integrated into the electronic systems within the trust, though some staff questioned whether this was enough to record the ID provided. As part of the pilot, few trusts took photocopies of IDs provided, though this was not considered acceptable practice by other trusts because of patient confidentiality and information governance.

5.2 Future roll-out of the ID checking

Reflecting the degree of buy-in shown earlier to the principles of costs recovery and ID checking, overall, staff were positive about the wider roll out of the pilot across the NHS and in other services. Nearly nine in ten overall (87%) in the follow-up survey reported that they would be supportive of its roll-out.

Figure 5.1 – Feelings about further roll-out of ID checks

How would you feel about the pilot being rolled out more widely across the NHS and in other services. Would you say you would be…



In the case studies, **staff overall were positive about an ID checking process being rolled out to other services** – but there were reservations about the practicalities of this, with staff mentioning that if the process were to be rolled out, certain issues would need to be addressed. This includes solving the issue of being able to resource the ID checking, as well as streamlining and standardising systems and processes to incorporate the ID checks.

There was a variation of opinions about the buy-in to the checking relating to staff roles. **Senior management and finance teams responsible for cost recovery in trusts were more positive about the ID checking being rolled out** to other services. Whereas **frontline staff were less sure** (although still typically saw the benefit of it). This was due to perceived potential implications on their workload and resources and concern that they were not equipped with the skills to establish eligibility.

On the whole staff viewed the potential roll out of ID checks within NHS services as a question of whether the time and effort needed for the ID checking process would be outweighed by the number of new patients identified and costs recovered as a result.

Future roll-out of the ID checks

Summary of next steps

Table 5.1 outlines what trusts plan to do next in terms of continuing with ID checking.

Table 5.1 Future roll-out of the ID checks in trust

Trust	Plans for ID checking after the pilots have ended
1	Pausing ID checks in pilot service lines, but intend to roll out Trust-wide at some point
2	Unknown
3	Pausing ID checks in pilot service lines until new 2017 regulations implemented in Trust
4	Pausing ID checks in pilot service lines, but intend to roll out Trust-wide at some point
5	Continuing to check identification in one service line only
6	Unknown - Likely pausing ID checks though
7	Pausing ID checks in pilot service lines and do not intend to roll out Trust-wide
8	Pausing ID checks in pilot service lines, but intend to roll out Trust-wide at some point
9	Continuing to check identification in one service line only
10	Intention to continue to check identification in both service lines but wait to roll out until the evaluation is available
11	Pausing ID checks in pilot service lines and do not intend to roll out Trust-wide
12	Pausing ID checks in pilot service lines, but intend to roll out Trust-wide at some point
13	Pausing ID checks in pilot service lines until evaluation of data is available
14	Unknown - Likely pausing ID checks though
15	Intention to continue to check identification in both service lines but wait to roll out until the evaluation is available
16	Intention to continue to check identification in both service lines but wait to roll out until the evaluation is available
17	Unknown
18	On Pause, waiting for evaluation and advice but no immediate plans to roll out

Going forward – future roll out

Summary

- Staff were asked about what improvements they felt could be made to the ID checking process and what they would need to be able to continue to run the checks. It was felt that the issues they identified, sometimes barriers, would need to be ironed out before the ID checks were rolled out further, potentially across all services and within all trusts:

  1) The need for ID checks to be integrated within IT systems

  2) The provision of training and information regarding the ID checks (which ID is acceptable, the charging rules)

  3) The need to conduct the ID checks alongside asking the '12-months question'

  4) The need for a strong national communications strategy

  5) Clarity around the extent to which patients should be chased for ID

  6) Clarity around how to process IDs

-Support for roll out of the ID checks was relatively high among staff however there was more concern about the potential implications on existing workloads and resource among frontline staff.

APPENDICES

Ipsos Public Affairs

APPENDIX A: Staff survey

Survey methodology

For both surveys Ipsos MORI conducted interviews using a Computer-Assisted Telephone Interviewing (CATI) methodology. For the baseline survey, 220 participants were interviewed between 10th April to 18th August 2017. For the follow-up survey, 223 participants were interviewed between 29th August and 13th October 2017.

Survey question topics

The questionnaire was designed to collect evidence prior to the launch of the ID checking pilots. In order to do this, questions were designed to cover a range of key themes as outlined in Table A.1.

The survey was targeted at seven core staff groups, with questions routed on the relevance to their role. Table A.1 outlines the question topics that were asked of each group as part of the survey and where additional questions were included in the follow-up survey.

A full copy of both questionnaires is included in the annex.

Table A.1 Staff survey topic areas

Questions	Staff group	Change to follow-up survey
Knowledge of charging rules	Asked of all staff groups	None
Roles and responsibilities in relation to cost recovery	Asked of all staff groups	None
Ease of establishing whether a patient is chargeable	Asked of admin staff only	None
Awareness and views on ID checking pilot programme	Asked of all staff groups	Where staff were aware of the pilots, questions asked about their experience, rather than expectations, of the pilots
Perception of roll-out of ID checking	Not asked	Added to the follow-up survey only
General perception of charging	Asked of all staff groups	None

APPENDIX A: Staff survey

Achieved sample profile

During fieldwork, quotas were set for each of the seven staff groups to ensure that the requisite number of interview were achieved. In addition, minimum quotas were set within staff group by participating trust and service line to ensure an equal spread across all pilot sites.

Tables A.2 shows the quotas set and final number of interviews achieved for both surveys. Please note that lack of sample provided by Trusts lead to a number of quotas being missed. As such, this has limited the ability of this research to discuss differences by staff group.

Table A.2: Achieved sample profile – Baseline survey

Trust	Service lines	Senior drs	Junior drs	Nurses	HCAs	Midwives	Admin staff	Total
Quotas set per service line		**2 (Min 1, Max 3)**	**2 (Min1, Max 3)**	**Where applicable: 4 (Min 2, Max 6)**	**1 (Min 0, Max 2)**	**Where applicable: 4 (Min 2, Max 6)**	**3 (Min 1, Max 4)**	
TOTAL		32	26	38	15	41	65	
Trust 1	Maternity	2	1	1	0	6	3	13
	Derma	0	0	4	0		4	8
Trust 2	Maternity	1	2		2	4	1	10
	Renal	2	4	6	0		4	16
Trust 3	Maternity	0	1		0	3	5	9
	Neuro	0	0	1	0		1	2
Trust 4	A&E	4	3	3	2		3	15
	Maternity	1	0	1	0	7	2	11
Trust 5	Trauma and Ortho	1	2	4	1		3	11
	Maternity	2	3		2	3	3	13
Trust 6	Maternity	1	0		2	3	3	9
	Fracture	0	0	2	1		3	6

APPENDIX A: Staff survey

Achieved sample profile

Table A.2 continued

Trust	Service lines	Senior drs	Junior drs	Nurses	HCAs	Midwives	Admin staff	Total
Quotas set per service line		2 (Min 1, Max 3)	2 (Min1, Max 3)	Where applicable: 4 (Min 2, Max 6)	1 (Min 0, Max 2)	Where applicable: 4 (Min 2, Max 6)	3 (Min 1, Max 4)	
TOTAL		32	26	38	15	41	65	
Trust 7	Maternity	2	3		1	4	3	13
	Urology	1	0	5	1		5	12
Trust 9	Renal	2	1	6	0		4	13
	Maternity	3	0		2	3	4	12
Trust 10	Neuro	1	0	0	0		2	3
Trust 11	A&E	1	1	2	0		2	6
Trust 12	Ophthal	0	0	0	0		0	0
	Ortho	0	0	0	0		0	0
Trust 13	Urology	2	2	3			3	10
	Maternity	4	2		1	6	2	15
Trust 14	A&E	0	0	0	0		0	0
	Maternity	0	0		0	1	0	1
Trust 15	Cardiology	1	1	0	0		3	5
	Maternity	0	0		0	1	2	3
Trust 16	Diabetes-rapid access	0	0		0	0	0	0
	Assisted Conception	0	0	0	0		0	0

Overall, 3 trust board members were also interviewed, at one trust. They were included in the overall results but, due to small numbers, were not able to be included for separate analysis.

APPENDIX A: Staff survey

Achieved sample profile

Table A.3 Achieved sample profile – Follow-up survey

Trust	Service lines	Senior drs	Junior drs	Nurses	HCAs	Midwives	Admin staff	Total
Quotas set per service line		2 (Min 1, Max 3)	2 (Min1, Max 3)	Where applicable: 4 (Min 2, Max 6)	1 (Min 0, Max 2)	Where applicable: 4 (Min 2, Max 6)	3 (Min 1, Max 4)	
TOTAL		34	15	39	15	39	69	
Trust 1	Maternity	0	1	3	0		3	7
	Derma	4	0	1	0	4	3	12
Trust 2	Maternity	3	1		1	3	1	9
	Renal	4	3	5	1		5	18
Trust 3	Maternity	0	1		0	4	3	8
	Neuro	0	0	1	0		3	4
Trust 4	A&E	2	2	2	1		3	10
	Maternity	1	0	1	1	5	3	11
Trust 5	Trauma and Ortho	0	0	4	1		2	7
	Maternity	2	0		2	5	3	12
Trust 6	Maternity	1	2		1	4	3	11
	Fracture	1	1	5	1		3	11
Trust 7	Maternity	2	1		1	4	3	11
	Urology	0	2	6	0		3	11
Trust 9	Renal	4	0	5	0		3	12
	Maternity	2	0		3	4	3	12
Trust 10	Neuro	0	0	0	0		0	0
Trust 11	A&E	0	0	0	0		2	2

APPENDIX A: Staff survey

Achieved sample profile

Table A.3 continued

Trust	Service lines	Senior drs	Junior drs	Nurses	HCAs	Midwives	Admin staff	Total
Quotas set per service line		**2 (Min 1, Max 3)**	**2 (Min1, Max 3)**	**Where applicable: 4 (Min 2, Max 6)**	**1 (Min 0, Max 2)**	**Where applicable: 4 (Min 2, Max 6)**	**3 (Min 1, Max 4)**	
TOTAL		34	15	39	15	39	69	
Trust 12	Ophthal	0	0	0	0		0	0
	Ortho	0	0	0	0		0	0
Trust 13	Urology	3	1	4	1		4	13
	Maternity	2	0		1	5	3	11
Trust 14	A&E	0	0	0	0		2	2
Trust 15	Cardiology	2	0	0	0		2	4
	Maternity	0	0		0	1	2	3
Trust 16	Diabetes-rapid access	0	0	2	0		3	5
	Assisted Conception	0	0	0	0		1	1

Overall, in the follow-up survey, 10 trust board members and 2 finance staff / overseas patient team members were also interviewed, across 7 trusts. They were included in the overall results but, due to small numbers, were not able to be included for separate analysis.

APPENDIX B: Time and motion observation

Observational details

The times of the observations were necessarily within clinic hours, as a result many were conducted between 9am – 4pm or similar. As the A&E clinics observed ran 24 hours, the observations conducted in these services were generally conducted outside of typical working hours.

Table A.1: Service lines observed at both rounds of observation

Service type	Frequency
A&E	3
Diabetes	1
Fracture, trauma and orthopaedics	1
Maternity	5
Renal	1
Urology	1
Neurology	1
Cardiology	1
Total	14

Table A.2: Shift times of observations at both rounds

Time of observation	Frequency	Service type
9am - 4pm	6	A mix of services including Renal, Fracture, trauma and orthopaedics and Maternity
9:30am - 4:30pm	2	Maternity, Urology
8:30am - 3:30pm	2	1 Urology, 1 Maternity
2pm - 9pm	1	A&E
3pm - 10pm	1	A&E
12pm - 6pm	1	A&E
9am – 11am	1	Diabetes
Total	14	

APPENDIX B: Time and motion observation

Round 1 overview

In all 14 trusts the observer sat with receptionists/administrative staff behind the reception desk to undertake their observations.

In the majority of observations there were two members of administrative staff checking patients in at the beginning of the observations – this was the case in 7 of the observations. In 1 of the observations there was only one member of staff checking patients in, and in another 2 observations there were three staff members. In 3 of the observations there were over three members of staff checking patients in. One observer did not record this information.

To ensure a consistent and accurate recording of time spent, only one receptionist was observed at a time. Over the course of their shifts, 2 observers recorded the checking in time of the same receptionist the entire time, 8 observed two different receptionists over the shift, and 3 observed three receptionists over the shift. 1 observer did not record this information.

APPENDIX B: Time and motion observation

Round 2 overview

Of the 14 observations, there were 7 cases where the observer reported that receptionists/administrative staff were conducting the ID checks as they were checking patients in. In 4 trusts the observer reported that additional/separate members of staff were undertaking the ID checking. In the remaining 3 trusts the observer reported the ID checking happening 'another way'. For detail on the processes at each trust, please see the contextual information for each trust on the following slides.

In 10 observations the observer sat behind a reception desk, with the receptionist/administrative staff when doing their observation. In 2 trusts the observer sat near to the reception desk but not behind it. In the other 2 trusts the observer sat somewhere else – in 1 of these cases the observer sat facing both reception and a self-check-in kiosk and in the other the observer observed the check in process with a receptionist and then followed patients around to a separate area where the ID checking was taking place.

As with the first Round of observations, it was most common for two members of staff to be checking patients in – this was the case in 7 observations. In 4 of the observations only one member of staff was checking patients in. In 2 observations there were three members of staff checking patients in and in 1 observation there were more than three members of staff.

There were additional members of staff (other than receptionists checking patients in) undertaking the ID checks at 4 of the trusts. At these 4 trusts, there was only one additional member of staff doing these checks.

In 3 of the trusts the same member of staff was observed checking patients in for the entirety of the observation. In 7 cases, two members of staff were observed during the observation period. In 1 trust three members of staff were observed during the observation. There was as two trusts where more than three members of staff were observed during the observation. 1 observer did not state how many members of staff they had observed over their shift.

In 6 of the Trusts at this Round of observations, observers noticed that there were materials in or around the reception area providing information for patients and making them aware about the ID checking process. These materials consisted of leaflets (in 2 cases), posters (in 3 cases), or a mixture of both leaflets and posters (in 1 case). In 1 of these Trusts these materials were about the importance of cost recovery more generally rather than specifically being about the ID checking process.

APPENDIX B: Time and motion observation

Contextual information on each trust observed

The observations differed slightly depending on the checking in procedures at each NHS Trust. The below information is taken from the additional quantitative and qualitative elements of the observations. This information may help to explain why some average check-in times were much longer or shorter than others.

Trust 1

Round 1: The cases here were split out into morning and afternoon appointments. The reception area closed over the lunch period at some point between 12pm and 1pm.

Round 2: This observation was unique as the ID checking of patients occurred at a separate desk before patients arrived at reception to check-in, rather than patients checking in before having their ID checked. The observer during this observation sat observing both a reception desk and a self-check in kiosk, unlike the first observation where only the receptionist was observed. The pilot lead estimates that around 90% of patients checked in via the receptionist rather than the self-check in kiosk.

Trust 2 (London based)

Round 1: Some patients were using a self check-in kiosk to check themselves in for appointments. The shift got quieter in the afternoon and staff mentioned to the interviewer that this had been an unusually quiet day. A consultant mentioned to the interviewer that the area was 'rife with fraud' and said that some patients were using false identities and/or NHS numbers.

Round 2: Patients were also using the self check-in kiosk at this Round of the observation, however the observer noted that patients still had to go through the same process of seeing a receptionist then having their ID checked whether they used the self-check in or not. Only patients arriving for their first appointment were asked to present ID. At this Trust, patients would check in at reception and then went around the corner to another desk to have their ID checked, which involved patients filling out a form. Because of this, our observer followed patients (with their consent) between the check-in desk and ID checking desk. Patients who did not bring ID with them to their first appointment were asked to bring it to their next one. If patients failed to bring ID to three appointments, they were referred to the Trust's Overseas Visitors and Migrants team.

APPENDIX B: Time and motion observation

Contextual information on each trust observed

Trust 3 (London based)

Round 1: There were fewer appointments in the afternoon than in the morning at this Trust. There was a receptionist acting as lunch cover between 2pm and 3pm who took slightly longer than the receptionists observed before/after this to check patients in for appointments.

Round 2: Only a small number of appointments took place at this Trust throughout the day, which were evenly spaced in the shift.

Trust 4 (London based)

Round 1: This shift in A&E took place on a Thursday evening between 2pm and 9pm. The A&E department had two reception areas, one for major A&E and one for minor cases. The interviewer conducted their observations from behind the reception desk in the minor cases reception.

Round 2: The ID checking was done by receptionists at the end of the checking-in process in this Trust. Patients under the age of 18 were not asked to provide ID. The observer noted that sometimes receptionists would forget to undertake the ID check during the shift. Like in other A&E sites, receptionists would ask patients whether or not they were able to provide ID at this Trust, without actually conducting a check of the ID.

Trust 5

Round 1: This clinic in the Fracture, Trauma and Orthopaedics department was extremely busy. It started in the morning being very busy with long queues of patients and long waiting times in reception. The clinic became quieter in the afternoon. This interviewer photocopied additional sheets to conduct the observations, as they made over the 120 observations included in the observation tool.

Round 2: Patients were only required to show ID at their first appointment. As at the Round 1 observation, the 2nd observation in this Trust was exceptionally busy with over 160 observations made throughout the day. Also as with the 1st observation, the 2nd observation was busier in the morning than the afternoon. The ID checking here was being undertaken by a separate member of staff whose role was created as part of the pilot.

APPENDIX B: Time and motion observation

Contextual information on each trust observed

Trust 6

Round 1: There were two receptionists checking in patients for separate kinds of appointments on this day – one was checking patients in for general maternity clinics and another was checking patients in for pregnancy scans. There was also a diabetic clinic for maternity patients on the day of the observation. This was a busy clinic and the clinic ran late, which caused patients to become anxious.

Round 2: At the 2nd observation the observer noted that this Trust's computer system would crash and be slow throughout the day, meaning that patients were not always part of their 'standard' check in procedure. This may have influenced the duration of patients checking-in for appointments.

Trust 7

Round 1: This shift was very average according to the admin staff on the day. There were no appointments during the lunch hour. In the late afternoon (from 3:36pm) a second receptionist took over from the first. This second receptionist observed used a smart card in the computer as part of the checking-in procedure, which the observer was told slows down the checking-in procedure.

Round 2: Many of the patients observed checking-in for appointments were not asked for ID because at this Trust, patients were only being asked to provide identification at their first appointment. The observer remarked that the reception staff checking patients in were 'quite exceptional, efficient and remarkably speedy', which may help to explain why the average duration for this observation was much shorter at the 2nd observation than the 1st (by 26 seconds).

Trust 9 (London based)

Round 1: The interviewer moved to a different reception area within the same department (renal) in the afternoon. The clinic was busier in the morning up until 11am, after which it was quieter. The length of the check-in in this renal clinic depended on the type of appointment – urology appointments took less time to check-in than transplant appointments, which took longer because staff had to take patients' weight and give them a bottle which would be used to collect a blood sample. In the afternoon after 1pm the clinic had nephrology appointments, which had a slightly different check-in procedure as staff had to give patients a bottle to collect urine in.

Round 2: The interviewer noted that the observation was very quiet between 12:30pm and 1:30pm.

APPENDIX B: Time and motion observation

Contextual information on each trust observed

Trust 10 (London based)

Round 1: The clinics closed for lunch between 12:45pm and 1:30pm. The day was quieter than normal, particularly in the afternoon. In the afternoon, patients were also checking-in for genetics and paediatrics appointments.

Round 2: The observer noted that if a patient was unable to bring their ID to their appointment, it was acceptable for them to email copies of their ID into the service within 48 hours of their appointment. The observer also noted that the ID checks took a shorter length of time when a driving licence was presented by a patient, as this was taken as both proof of identity and of residence.

Trust 11

Round 1: This observation took place on a Tuesday afternoon/early evening in A&E.

Round 2: This observation was quieter in the mid-afternoon but got busier again in the evening. The observer noted that different receptionists were undertaking the ID checking in a different way; the first receptionist observed would ask for two forms of ID, but the others observed asked patients if they had any ID at all. The average check-in time was 4 seconds quicker at the 2nd observation (please be aware of the relatively low base size of 38 patients observed). The slightly faster duration at the 2nd round may be due to different working speeds of receptionists.

Trust 13

Round 1: This clinic was split out into a morning and afternoon session with a break for lunch. The afternoon clinic got busier than the morning clinic.

Round 2: As at Round 1, the clinic was split into morning and afternoon sessions. Although there were separate members of staff checking patients in and checking their IDs, they were both on the same desk.

APPENDIX B: Time and motion observation

Contextual information on each trust observed

Trust 14 (London based)

Round 1: This observation took place on a Friday night (3pm – 10pm) in A&E. There was a steady flow of patients being checked in throughout the shift.

Round 2: This Trust had an additional receptionist working during the pilot. All three receptionists were checking patients in and conducting the ID check as part of this process. Patients were asked whether they were able to provide ID but were not required to present it (however the observer notes that despite this, patients would voluntarily present their ID). The observer noted that although all patients were asked if they would be able to provide ID, the Trust's system picked up on new potentially overseas patients, who were required to complete a registration process during which their documents are checked and photocopied. Children being admitted to A&E as well as admittances via ambulance were being checked in separately and were not asked about ID. The ID checking process was happening here between the hours of 10am and 10pm, and a particularly busy period was between 5pm and 6pm, after GP surgeries had closed.

Trust 15 (London based)

Round 1: There was a self check-in kiosk at this service as well as receptionists checking patients in. The cardiology clinic was also shared with neurology patients checking in. Patients checking in for neurology appointments have been removed from the data.

Round 2: Only patients attending their first appointment were asked to provide ID here – patients returning for subsequent appointments were not required to present ID. The morning clinic at this Trust involved an ID check for new patients, whereas the afternoon clinic (any cases from 12pm) were all returning patients and did not have to present ID. The ID checking process here involved a member of staff giving patients a form to complete, either at or away from the desk. Every new patient had to fill in this form whether they had brought in ID or not. This may explain why this Trust had the longest average time for the ID check section of the observation (335 seconds; however please be aware of the very small base size of 4 this average is based on).

APPENDIX B: Time and motion observation

Contextual information on each trust observed

Trust 16 (London based)

Round 1: The morning of this shift was the diabetes outpatients clinic, the service where the ID checks are being piloted. After 11am the clinic completely changed to a maternity clinic within the same reception area. For this reason, all cases after 11am were removed from the analysis, as the ID checking will not be taking place within the maternity service at this Trust.

Round 2: The ID checking here was being done by receptionists during check-in. Only new patients were being asked to present ID. If patients failed to bring in their ID to their first appointment, they were asked to bring it to their next appointment instead. The shift lasted only in the morning (to match the Round 1 observation).

APPENDIX C: Trust managed data collection

Data collection method

Although the majority of trusts, collected data using tablets and the pre-programmed survey (13 of 18), three trust set up the questions in their own patient administration systems (PAS) and completed them there. Data for this strand was not provided by two of the trusts.

Table B.1 Data collection method

Trust	Tablets or PAS	Any notes
Trust 1	Tablets	
Trust 2	Tablets	
Trust 3	Tablets	These were collected on paper before being inputted into the tablets.
Trust 4	Tablets	
Trust 5	Tablets	
Trust 6		This data is currently missing, as it has not been provided by the trust
Trust 7	PAS	
Trust 8	PAS	As the reason why ID was not provided appears to have been optional, so there was data for very few cases. As a result, this has been removed for this trust.
Trust 9	Tablets	
Trust 10	Tablets	These were collected on paper before being inputted into the tablets.
Trust 11	Tablets	
Trust 12	PAS	
Trust 13	Tablets	
Trust 14	Tablets	
Trust 15	Tablets	
Trust 16		This data is not included in the report as it was supplied 4 weeks after the data was requested.
Trust 17	Tablets	
Trust 18	Tablets	

APPENDIX C: Trust managed data collection

Questionnaire

Regardless of the data collection method, all trusts were provided with the following questionnaire to collect this data.

Q0. Please enter Patient ID (NOT NHS number) e.g. unique trust ID

NOTES: This was used as a unique identifier in order to allow for analysis.

Q1. Did the patient present any valid identification (ID)?

NOTES: If they answered "Yes", the respondent was directed to Q2, to specify the type(s) of ID provided. If they answered "No", the respondent was directed to Q4, to explain the reason for the choice. If the respondent selected option 3 or option 4, the survey was completed.

1. Yes
2. No
3. Patient presented EHIC
4. Patient presented proof of residency for country outside the UK

Q2. What type(s) of Photo ID have they provided?

Please select all that apply. Please note the next question will ask about evidence of proof of address.

1. Current signed passport
2. National identity photo-card – (EU or Swiss)
3. Valid photo-card driving licence
4. Residence permit issued by UK Border Agency
5. Valid armed forces or police photographic identity card
6. Photographic disabled blue badge
7. Citizen card
8. Other photo ID
9. No Photo ID provided

APPENDIX C: Trust managed data collection

Q3. What type(s) of proof of address have they provided?

1. Utility bill (e.g. gas, electricity, satellite tv, water, phone, broadband bill)
2. Council Tax Bill / Payment book /statement
3. Bank / building society / pension/ Credit Union statement
4. Recent original mortgage statement from a recognised lender
5. Recent payslip / P45 / P60
6. Letter from Home Office / central or local government / government agency / local council –
7. Work permit or visa
8. Solicitor letter within the last three months confirming recent house purchase/ land registry confirmation of address
9. Recent letter from school / university / place of employment
10. NHS Medical card/ letter of confirmation from GP practice of registration with the surgery
11. Other
12. No proof of name / address provided

Q4. Why have they not brought two forms of ID?

NOTES: This was only asked of people who had not supplied both a Photo ID and Proof of Address.

1. Not a UK National / Not currently resident in the UK
2. Letter didn't mention / Didn't know
3. Didn't understand 2 IDs would be required
4. Forgot to bring
5. Refused to bring
6. Have provided ID in previous visit
7. Have no ID / Only have 1 form of ID
8. Don't normally carry ID
9. Have provided ID for other NHS service and assumed not needed again
10. Refuse to explain / not appropriate to ask
11. Other (PLEASE SPECIFY)

APPENDIX C: Trust managed data collection

Analysis

In order to analyse the data, variables were calculated in the following ways:

Table B.2 Analysis of trust managed data collection

Area of analysis	Variable	How the variable was calculated	Base for percentages
Provision of ID	Yes, both	Provided at least one of both forms of ID (codes 1-8 in Q2 and codes 1-12 in Q3)	All valid responses
	Yes, just photo ID	Provided at least 1 photo ID in Q2 (answer codes 1-8) (excluding those identified as non-UK resident from Q4)	
	Yes, just proof of address	Provided at least 1 proof of address in Q3 (answer codes 1-12) (excluding those identified as non-UK resident from Q4)	
	Provided EHIC	Answered "Provided EHIC" (code 3) in Q1	
	Proof of residency for country outside UK / Not resident in UK	Answered "Proof of residency outside UK" (code 4) in Q1 or "Not a UK National / Not currently resident in the UK" (code 1) in Q4	
	No	Total valid responses minus all other answers	
Type of photo ID provided	All variables	Answered this category in Q2.	Provided at least 1 photo ID in Q2 (codes 1-8)
Type of proof of address provided	All variables	Answered this category in Q3.	Provided at least 1 proof of address in Q3 (codes 1-12)
Reason for not providing ID	Not a UK national / currently resident in the UK	Answered this code in Q4, or selected "Not UK Resident" (code 4) or "provided EHIC" (code 3) in Q1	All those who brought only one form of ID, or who were identified as not bringing ID, "not UK resident"/ "provided EHIC" (codes 2-4) in Q1
	All other variables	Answered this category in Q4.	

APPENDIX D: Case studies and depth interviews

Additional information about the case studies

The 6 case study sites were chosen to reflect a range of regions and service lines:

Table C.1 Case study location

Location	Service line
London	Renal
	Antenatal
	Maternity
	Renal and Urology
	Maternity and Gynae
	A&E
North West England	ED
Yorkshire and Humber	Maternity
	Dermatology
East of England	Urology
	Maternity

Within each case study, 4-8 members of staff were interviewed about the ID checking pilot. Staff interviewed worked in a range of roles, including:

- The Trust Pilot lead, responsible for setting up the pilot within a trust
- Overseas Visitors Manager (OVM) and/or other members of the overseas visitor's team as applicable
- Frontline staff members that are involved in or responsible for establishing whether an individual is an overseas visitor – including both administrative and clinical staff
- Finance Directors
- Chief Executives or other senior level Board members
- Other relevant hospital management or frontline staff if appropriate.

Five of the case studies took place face-to-face with follow-up telephone interviews as necessary, and the sixth case study took place as a series of telephone interviews.

Most interviews were half an hour in duration, however interviews with the Trust Pilot Lead and OVM lasted for around one hour.

APPENDIX D: Case studies and depth interviews

Additional information about the case studies

Case study interviews covered the following topics:

- **Awareness of costs recovery and perceived role in recovering costs** – when interviewing OVM trying to understand the ways in which they have previously been identifying patients who are chargeable and any barriers they have experienced.
- **Awareness of the ID checks and their purpose** – knowledge, awareness and understanding of ID checks and its objectives. How do staff see this as fitting within current cost recovery activities?
- **The process for carrying out the ID checks:** for example, what process are the trusts following? Who is responsible for carrying out the checks? At what point do they ask for IDs and why? What is their experience of dealing with non-eligible patients?
- **Learnings for the implementation of ID checks:** for example, what has worked well when implementing the ID checks? What are the challenges and how have trusts overcome them? Also, how do trusts deal with patients not carrying their IDs (in the A&E setting)? What could be improved with the process? What additional support is needed?
- **The outcome of introducing ID checks:** for example, what is the impact on staff time and resource? What impact has it had on cost recovery, demand for services, and patient care? Any unintended consequences?
- **Perceptions of the ID checks:** for example, what do trust staff think of the ID checks? Do staff recognise the benefits, and what are the drawbacks?

In addition to the six case studies, four in-depth interviews were undertaken over the phone with OVMs from trusts not selected to take part in a case study.

APPENDIX D: Case studies and depth interviews

Individual case study write ups

Case Study 1 - Foundation trust in the South of England

Context

This large NHS trust chose to run the ID checks in the Maternity and Adult Urology Departments for the full three-month period. Prior to this, the identification of chargeable patients was facilitated by receptionists asking patients the '12-month question'. Staff in both areas are confident about asking patients this question, which is asked as a matter of course to all patients presenting for an appointment at the trust.

Some staff interviewed reported the following:

- A lack of awareness around charging rules among hospital staff
- Suspicion that staff were not always asking the 12-month question and/or were assuming that patients are not required to pay
- A notion that patients were not always honest in response to the '12-month question':

'I don't believe that everyone is honest about living here for 12 months...even if we don't believe them then paying patients can't interview them if they've said yes [to the 12 months' question]'

Setting up the pilot

The trust ran the pilot in the Maternity department and chose Adult Urology because it was felt that staff would be engaged and on board to run the checks. A decision was made to incorporate the ID check into the patient electronic system, hence a significant amount of work went into changing the system and the automatically generated appointment letters. Letters were sent out to all new patients: in Adult Urology they managed to include information about the ID check into the main body, however this was not possible in Maternity so a letter was stapled to the scan appointment letter and was printed on double sided paper. The trust had recently introduced patient check in kiosks, so throughout the pilot patients were still allowed to check in at the kiosk, if they wished, however a message was displayed on the kiosk screen instructing the patient to go to the reception desk to show their identification. A member of staff was seconded to project manage the pilot in both departments, train staff in the ID checks and be on hand to answer queries throughout. Staff were initially positive about the checks, with the only concern initially being that it would take up too much time.

APPENDIX D: Case studies and depth interviews

Implementation

The ID checks ran in all clinics within Maternity and Adult Urology with the exception of the sensitive clinics in Maternity (foetal abnormalities for example), around the clock on all days. Patients attending their first appointment in each clinic were asked to provide ID. Patients were only asked to produce their documentation on their new consultant visit if they had failed to produce the documentation at their first appointment.

When a patient reported that they had lived in the UK for the past 12-months and were able to present the correct ID, this was recorded in the system and no further action was taken. Patients who were not able to produce ID were given a slip telling them how to send in copies of their ID (by post or email) or bring copies to their next appointment. 723 follow up letters were posted to patients who had not fully or partly provided ID half way through the final month of the pilot, with a request to provide the ID by the end of the month.

Staff were confident that compliance rates for the checks were high. If patients were not asked for ID it was felt that staff were too busy or the patient had checked in at the kiosk and did not see the message to go to reception.

Staff and patient reaction and response

When reflecting on how they felt about conducting the ID checks, some of those directly involved in administering the checks reported feeling awkward and embarrassed about asking patients for ID. The addition of the ID check was also reported to add time to the check in process. The queues were said to be sometimes longer than before the pilot.

Patient reaction to the ID checks was mixed. Many patients found the checks acceptable, with some even supportive of them, however there were patients who were unhappy with the requirement to produce ID. Some older patients and long residing UK residents queried the need to prove their eligibility status. Problems with ID only being accessible online were reported.

Patient compliance rates remained relatively high throughout the pilot, with a drop in proof of address in October.

	Photo ID	Proof of Address
August	96%	89%
September	93%	84%
October	83%	65%

APPENDIX D: Case studies and depth interviews

Pilot learnings and impact

Reflecting on the pilot, hospital staff felt the pilot had gone well. There were a number of improvements to processes that were mentioned if the pilot were to be repeated, including:

• Information about the requirement to provide ID to be incorporated into the main body of the appointment letters

• A better organised drop down list in the electronic patient record system for recording the ID (the alphabetical list they had listed Driving Licence under 'U' – UK Driving Licence.

• Extending the pilots to for instance six or nine months would have allowed elective and maternity patients to reach the end of their pathways and in this respect it is likely that the compliance % figures would have been better and as a result it is possible we may have identified patients who were ineligible for free NHS care

The trust did not identify any chargeable patients during the pilot in either of the service lines. Sixteen patients were followed up, however none turned out to be ineligible for free NHS care. Some staff felt that it would be inappropriate to roll the ID checks out across the trust given that they did not identify one patient as chargeable throughout the pilot.

The trust is not continuing to undertake the ID checking within the pilot services and is waiting to receive the evaluation report of the 20 national pilot sites before deciding how to proceed.

Staff did recognise a number of benefits from participating in the pilot, however. The pilot was seen to have:

•increased the profile of the Private and Overseas Patient Team and what they do among hospital staff

•given off the message to patients that the trust takes the recovery of costs from those who are not eligible for free NHS care seriously

APPENDIX D: Case studies and depth interviews

Case Study 2 – Foundation Trust in the South England

Context

The ID checking pilot was undertaken in Maternity and Renal for the full three-month period within this large acute trust.

This trust has an overseas team who are responsible for the recovery of costs from chargeable patients. There are four members of staff on this team covering the whole of the trust. Identification of chargeable patients has historically fallen on frontline staff. On registration, staff aware of the overseas function, alert the overseas team to potentially chargeable patients. Frontline staff have been told to look for key triggers which included patients giving temporary addresses or who are not registered with a GP. In addition, to this, the OVM team also have access to patient records and on occasion identify people this way (maternity has a centralised system which helps the department identify chargeable patients).

As the onus is largely on staff to highlight chargeable patients to the OVM team, the trust has experience variation in how effective different service lines and departments have been in identification and recovery of costs:

'We realise that it is a very manual and not so much ad-hoc, but it works well with certain departments and then with other departments, perhaps there could be some room for improvement…we probably do miss some patients in identifying.'

Given the urgency of some treatment and delays in the process, most patients are treated within this trust before their chargeable status has been confirmed. It was also suggested that if they did not receive any ID it was unlikely that this would be followed up on:

'In following up on ID, if it wasn't presented in the first week we probably wouldn't have followed it up. There were a proportion of that who were followed up potentially by the overseas office, but probably a proportion of that which was lost. A lost opportunity, if you don't get in the first week I don't think you will get it.'

Staff at the trust also identified a number of additional difficulties with the way they currently recover costs:

• The OVM team are only available on weekdays and so patients who come in on the weekend are often lost as it takes a few days for OVM team to be alerted to them.
• It was suggested that there was generally a lack of clarity around the eligibility criteria for free care which caused difficulties in identifying chargeable patients.
• It was also suggested that more widely there is a lack of awareness of the overseas function and its importance. It was felt that cost recovery was not an embedded process at the trust.

It should be noted that the pilot lead suggested that recent media cover on chargeable patients had led to a greater awareness within the trust and increase general support for the overarching aims of cost recovery.

Setting up the pilot

The trust chose two of the more engaged Departments to undertake the ID checking pilot. In both Maternity and Renal it was agreed that checks would only be conducted with new appointments during the pilot period. Whereas Maternity rolled the checks in their antenatal clinics, Renal, which is a big and fragmented service within the trust, felt it would be impossible to roll it out in all renal wards and clinics and so chose to run it only in their dialysis clinics. Both Departments employed a separate full time member of staff to undertake the ID check (although admin staff were asked to do the check in one of the smaller renal wards located on a different site), it was felt that it would be too much burden on admin staff/other frontline staff to run the check.

In the run-up to the launch of the pilot, the pilot lead went to both departments and spoke to the managers about the ID checks. They worked closely with the managers to get the pilot up and running and to communicate with staff what was happening. Monthly updates were given at the overseas meetings with representatives from across the divisions within the trust. The pilot findings was also reported to the board. Training was given to those directly involved in the ID checks and the home office delivered some additional training on ID documentation to the maternity team.

APPENDIX D: Case studies and depth interviews

Staff reaction to the pilot was mixed. Staff who had been involved in the initial discussions around introducing the pilot (including clinical leads) were generally positive about the introduction of ID checks. However, those interviewed did speak of a more negative reaction from frontline staff who had not been involved in the early discussion around the pilot. Here staff were more reluctant to change. The pilot lead described some of the initial responses from staff:

'"That's not for me to do, that's not my job, I'm a nurse, I'm in the clinical profession to treat patients, it's now like border control, how can they ask for passports."'

Across staff interviewed it was felt that if the pilot was to be rolled out they would need:

- More material about how to undertake the ID checks for example, an FAQ document and also communication material such as posters.
- Great clarity about the policy around cost recovery – it was felt that there was a lot of ambiguity. In particular, staff suggesting it would be helpful to have some legal support around refugee status.
- More training on asking the questions was also suggested by those who were responsible for collecting the ID.
- The pilot leads also suggested that if it was to be rolled out, they would need clearer instructions from DH about what elements are mandatory. They wanted DH to provide a strong message about why the ID checks are important and what exactly the requirements of the trust would be – they did not want soft recommendations.

Implementation

In Maternity, the clerk employed to undertake the ID check was located at a side desk which patients were asked to go to following being booked in. The clerk explained that in the first week he had also worked reception but had not been able to manage checking in patients and asking for ID due to the volume of patients who attended the clinic. In renal, the clerk employed had a list of new patients admitted for dialysis and went around these patients and requested ID. As renal is split across hospital sites the clerk focused on one site. Renal was a 24 hour service and so when the clerk was not working staff were responsible for asking for ID, the clerk would follow up with staff about this. At the other, smaller site receptionist would ask all patients checking in for ID.

APPENDIX D: Case studies and depth interviews

Patients were informed of the need to bring two forms of ID in a variety of ways. In both services, letters were sent to patients in advance of their appointment. In renal they had originally sent letters out two weeks in advance but then they found that they needed to do it a week in advance as patients were being booked in last minute and so not receiving the letter. As well as providing letters, posters were also put up in the Departments to make patients aware. They had originally designed posters which used relatively firm language about providing ID but their Comms team had felt that they should soften the language and so the posters were adapted to reflect a lighter approach.

Staff explained that during the pilot they felt that some patients slipped through the net. This was largely attributed to:

• Evening staff in Renal not asking the ID checking question – It was explained that the dialysis team have around three minutes a patient so if a patient has not got their ID on them then they do not have time to follow up with this patient in that appointment or future appointments.
• Patients who come through A&E not having their forms completed correctly – Staff suggested that they have found instances where a patient is from overseas but has not been marked as such in the paperwork produced by A&E, so the right checks are not being done early enough.

The clerks themselves felt that they had asked all patient. They acknowledge that some patients can be more difficult than others to ask but they both felt able to deal with these patients. Patients which they thought were harder to ask for ID from were those whose first language was not English and those who were particularly hostile to the questions. It was suggested that those who were hostile sometimes turned out to be people who were chargeable.

Overall, it was indicated by those interviewed that they have largely found that patients can provide photo ID (passport/ driving license) but struggle, more often than not, to provide proof of address. They also found that a large number of patients do not fully read the letters sent to them and so miss the text around the need to bring ID to their appointment. One of the lead nurses also suggested that they have found a proportion of patients who do not bring ID because they know that they are not entitled to NHS care and so try to extend the process as long as possible. It was suggested that sometimes they suspect that patients they are speaking to are able to speak English or do have family who can, but who pretend that they cannot so as to avoid having to show ID. The admin clerk in Maternity suggested that some patients struggled to provide ID because they had move house recently, had electronic evidence only, their documents were with government organisations. As such, he suggested that it took some chasing of patients to get ID but generally he was able to get this information a few weeks later.

APPENDIX D: Case studies and depth interviews

In both Maternity and Renal, patients who were identified as having ID which showed they were chargeable (e.g. EHIC), were referred to the OVM team. In Renal where patients did not bring ID or the wrong ID they were chased a two further times and then no further action was taken. In Maternity, ID provided was documented and patient who failed to provide two forms of ID were given three chances to bring ID before their case was passed on the OVM team.

Staff and patient reaction and response

When discussing staff reaction following the launch of the pilot, there was a general sense that it had been broadly accepted by staff. It was felt staff appreciated the need to try and recover costs from patients. However, it was suggested that key to this acceptance was the distance frontline staff had from the process with clerks predominantly doing the checks. Indeed, when talking to clinical staff in renal about asking the ID checks they highlighted some concerns about their involvement in the process. Firstly, it was felt to clash with their duty of care, particularly around delaying care while chargeable status was decided. Secondly, there were concerns around the impact of patient relationships and patient's willingness to engage with them if they become the people asking the ID questions.

Staff who were directly involved with the setup of the ID checks suggested that they felt process had gone relatively smoothly which was in large linked to having separate members of staff employed to undertake the checks. Indeed, those directly involved in the pilot Departments suggested that they would have concerns about burden on staff and waiting times if the ID checking process was moved to admin or frontline staff.

In terms of patient reaction, a mixed reaction was described. Staff in both departments suggested that they have had some patients who have questioned why they are being asked for ID when they are tax payers/ have always been resident in the UK. Others who are already patients in other departments of the hospital, it was suggested, did not understand why they were being ask to show ID. Still other patients, they suggested, had not appreciated being chased to provide ID. Finally, they have also had patients who feel uncomfortable providing their ID. The clerks suggested that in the majority of cases where they explained why they were doing the checks, patients were fine with the process. However, the clerk in Renal did suggest that on a few occasions patients have not returned to use the service where they have been asked to provide ID.

Pilot learnings and impact

When discussing learnings and impact from the pilot, it was felt that having staff whose role it was to do ID checking had helped build the lines of communication with the OVM team in terms of identifying chargeable patients. The pilot lead and other members of staff suggested that the OVM team had already seen more referrals as a consequence of the pilot (it should be noted that not all agreed with this).

It was also felt that in introducing the ID checks staff had become more aware of cost recovery and were more actively taking steps to identify chargeable patients and inform the OVM team. It was suggested the clinicians were starting to feel more empowered to decide on treatment based on chargeability. The teams who had been brought in to help administer the ID checks spoke of the pilot as opening a 'can of worms' for them, it had lead them to investigate cost recovery process and the gaps in the system.

'Since the pilot I have learnt loads more - as long as we get these people before they start dialysis permanently, we can put a temporary line in for the time being until we find out if a patient is entitled or not. Also, the billing side of things, EHIC side of things that we didn't know about. There is all this stuff within the three months that we are now monitoring, so whether we get the EHICs or proper documentation.'

However, staff did also describe a range of barriers and difficulties with undertaking the ID checking pilot:

- There were some difficulties in communicating the ID checks appropriately to patients (this view was primarily based on difficulties they had within the trust on agreeing the format of posters).
- They also had difficulties with patients refusing to engage with staff around the ID checks and engaging patients who do not speak English.
- Further a lack of staff resource meant that the pilot could not be as wide ranging as initially hoped. It was suggested by those working in Renal that there was need for more resource to be put into asking the ID checking questions if they were to cover all sites and clinics in Renal.
- There was also concern around a lack of clarity in terms of acceptable ID and chargeable patients. It was felt that there was a need for more information to be provided and shared across all staff.

'I think there is some ambiguity, so some people think if you have a passport you are entitled which is not necessarily true etc. So, there is a lot of ambiguity and at the end of the day it is the clinician which accepts the patient formally and has ownership within the trust but they may not be privy to all the information which is available and we are trying to override that by getting all the information into the system. Probably of all the groups there is less awareness amongst the clinicians about entitlement'

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• Linked to this was a concern about patients who may come in for emergency care but then move to care which is chargeable. It was felt that the system, as it currently is, would mean these patients, while potentially being ID checked, could later be missed.

• Finally, these issues also meant that some were concerned about administrative staff's ability, going forward, to take on the ID checking questions and the level of training required:

'That goes into, "I'm not actually asking about your health conditions, and giving you information about how long it might take for you to be seen by a doctor, but talking about other things related to you when trying to register you" …but it's all to do with how much you can expect from the skill set for someone who is paid on a band 2 salary.'

Several improvements were suggested:

• It was felt the integrating the ID checks into the PAS system would make the process more efficient;
• as would allowing electronic proof of ID.

APPENDIX D: Case studies and depth interviews

Case Study 3 – Foundation Trust in the North of England

Context

ID check pilot undertaken was under taken in A&E for the full three months.

The trust currently does not have a cost recovery team (although plans are now in place to build one). As such, identification of chargeable patients has been very sporadic and relies on staff identifying and escalating to general office. There is no formal procedure in place for staff to identify patients, staff tend to flag patients when they have been actively provided with evidence which shows that they should be charged (e.g. EHIC or other documents showing that residence is abroad). The trust's Maternity Department is the only exception to the rule. This department has a proactive member of the team who had independently set up a system which ask the relevant questions to allow them to identify patients to recover costs from. It also allows them to do ad hoc reports on NHS numbers and patients without a GP.

Given the varying nature in the way that chargeable patients are identified and cost recovered, there was a strong sense amongst staff that more could be done to better address cost recovery. It was suggested that they required a core cost recovery team who could proactively target and follow up with patients. It was also felt that there was a need for more communication across the trust about cost recovery to build staff awareness and support.

Setting up the pilot

A&E was chosen to pilot the ID checks as it was felt that it would be good to run the pilot in a service with a high level of activity. The trust also felt that it would be beneficial to capture chargeable patients earlier in the process. It was felt that by recording chargeable status when attending A&E would make identification quicker and easier if the patient went on to be admitted. However, the trust did not have the capacity to integrate the ID checks into their own Patient System and so undertook the checks using tablets provided by Ipsos MORI. As such, the ID checking pilot in this trust was undertaken to check feasibility of asking for ID in A&E rather than to assess the impact of introducing ID checks. The pilot lead suggested that funding had to some extent hampered what they could do with the pilot both in terms of the integration of the checks into the trust system and in terms of the communication around it. The lead had found it very difficult to get budgetary support for the pilot and as such much of the work she had done for the pilot was treated as backfill on her existing workload.

APPENDIX D: Case studies and depth interviews

The receptionist at the trust were responsible for asking patients what ID they had available. Supervisors were provided with training around the ID checks and this was then cascaded down to the reception staff. A letter went out to all staff working in A&E to inform them that the pilot would be happening and why. The pilot lead also spoke to the clinical lead in A&E to ensure that they were on board with the process. Staff were initially positive about what the ID checks were trying to achieve but there was early concern about the impact undertaking the check would have on staff time to process patients.

Implementation

The ID check was set up to run 24hours a day, every day. As patients do not arrive to A&E on appointment, the first time patients were made aware that they would be required to provide ID was via posters in the reception area. Reception staff were also able to hand out small leaflets which provided further information about the pilot if this was asked for. Patients coming in to A&E were asked the ID checking questions by the receptionists when being checked in. The reception staff explained that they communicated the ID checks in terms of the trust taking part in a survey of patients to understand if they had two forms of ID and that this was just a temporary survey. They were keen to outline that there would be no impact if they did not have ID. The reception team also reported that while they asked the majority of patients if they had two forms of ID, they would not ask patients these questions if:

- they were very busy on the desk and did not feel they had time to ask
- they forgot to ask
- they felt the patient urgently needed care (e.g. presented with chest pains)
- the patient was drunk, hostile, or accompanied by the police
- the patient was old
- the patient came in with the ambulance team
- the patient's English was poor

Where the question was asked, the receptionists record the response on the tablets provided by Ipsos MORI. No action was taken regardless of the answers the patient provided to the ID check questions. One receptionist did mention that if a patient provided ID which indicated that they were chargeable (mainly EHIC) then this information was recorded on their system.

Across staff it was suggested that very few patients could provide two forms of ID. The receptionists suggested that in most cases, patients were able to provide photo ID (usually driving license) but were unable to provide any form of proof of address.

APPENDIX D: Case studies and depth interviews

All the reception staff spoken to as part of the case study indicated that they relied on the question lists provided within the tablets to understand what ID they should be asking for. It was highlighted by the pilot lead that going forward, if the pilot was to be rolled out, there would be concern around reception staff's capacity to identify whether ID presented was valid (e.g. out-of-date passports) and their confidence in challenging a patient about their provision of evidence.

Staff and patient reaction and response

Staff were largely positive about introduction of the ID checks. There was a sense across those interviewed that the NHS needed to do more to recover costs and that recovering costs from patients who should be charged was a reasonable way to approach closing the deficit. However, those who were directly involved with conducting the ID checks showed a degree of reservation around requesting patients show ID as a means of recovering costs. A key concern amongst staff was the additional burden they felt it put on their time. As seen in the quote below, some of this concern came out in part as a result of having to record the ID provided in a separate system to their PAS. Indeed, it was mentioned across interviews that for the ID checks to be effective it needed to be integrated within the normal patient booking system:

'It's just so time consuming - when we are short staffed and there is a bit of a queue at the desk - it is just a bit annoying to be constantly having to go to the tablets and fill it in. Then sometimes you will forget, especially when the phone is ringing. I know it doesn't seem like it but when you are on that desk you have got everyone coming into you and you have this IPad on you and it is time consuming.'

In the run-up to the launch of the pilot, the pilot lead had expected a degree of patient backlash and briefed both the security team and the comms team in advance. However, the lead suggested that in reality there had been limited backlash, highlighted by a lack of complaints escalated to them during the running of the pilot. Staff on the ground also suggested that they had received less backlash than they had expected. They in part attributed this to the way in which they were asking the questions – it was explained to patients that the questions were only being asked part of a national survey to see if patients do carry the required ID normally. Primarily, staff suggested that patients showed curiosity about being asked for ID with some actively indicating support for its introduction. However, they did experience some patients who were concerned about who their details were being shared with more widely, and others who were openly hostile (largely amongst patients who were ordinary resident and did not feel it was necessary to ask them for ID).

APPENDIX D: Case studies and depth interviews

Pilot learnings and impact

Reflecting on the pilot, hospital staff were uncertain of the impact it would have. The pilot lead felt the pilot had certainly spearheaded further improvements to the cost recovery process and brought it higher up on the trust agenda (when interviewing happened, the trust was recruiting an OVM lead). The pilot lead indicated that they thought the ID check may have picked up a few chargeable patients but they did not have any evidence to support this. Front line staff were also uncertain around if any chargeable patients had been identified, although reception staff suggested that they had picked up on a few patients who had brought EHICs to their appointments. They were uncertain if any action had been taken with these patients.

When exploring the further roll out of the pilot, staff were generally positive about this but several improvements were suggested to the process:

• It was felt strongly that the ID check questions would need to be streamlined and integrated into their PAS system. It was felt that in doing this it would create less suspicion with patients as would seem part of the natural process of checking in, would reduce the amount of time needed to programme in ID brought and, if it was made a mandatory field, would help to ensure that staff asked the questions to all patients.
• For a PAS approach to be effective, staff also felt that the questions ask around ID would need to be kept to an absolute minimum and not go beyond those asked as part of the pilot.
• Staff also wanted further guidance around acceptable ID, as it was generally felt that they were unclear about this.

'Credit cards don't have any address on, whether your driving license is up to date is another thing. You will get the conflicting thing when people will show there general working passes as photo ID. Do we accept that? It's got their name on.'

Indeed, as mentioned earlier, there was some concern about the appropriateness of reception staff doing the ID check linked to concern about time and capacity to identify valid and invalid ID. The reception staff themselves indicated that they would rather a system where they put in the ID provided which is flagged automatically if there is a concern and then followed up by someone else. They wanted a system which involved minimal input from them.

• The pilot lead suggested that more detailed guidance and supporting material (including comms material) from DH would be needed if the pilot was to be rolled out more widely.

Going forward

The trust is pausing the ID checking within the pilot services and does not intend to roll the ID checking out to other service lines.

APPENDIX D: Case studies and depth interviews

Case Study 4 – Foundation Trust in London

Context

This large acute trust ran the ID checking pilot in their Emergency Department for the full three-month period.

Prior to this, patients who answered the '12-month' question or who identified themselves during treatment as being eligible for charging (e.g. by saying they were currently on holiday) had this recorded on their notes. Patients were also asked if they had an EHIC card during check-in – which would be photocopied if they did. This had been introduced in the last couple of years. During standard office hours, potentially chargeable patients were highlighted directly to the overseas team, and out-of-hours, a sticker would be added to the notes as a flag, so that if patients received any care that was chargeable, that they were able to be charged for this.

As A&E is not chargeable for overseas visitors and migrants, staff described this as not being a priority for them, but rather something that was important to support other areas of the hospital when patients were admitted from the Emergency Department. However, staff described an increasing awareness and improvement in links with the OVM office, recently, and were currently reviewing their procedures to increase identification.

The small number of OVM staff compared to the patient population was described as potentially making it harder to follow up with patients who were identified.

Setting up the pilot

The trust was asked by the Department of Health to run the pilot in the Emergency Department. Because of concerns about increased workload for reception staff and the potential for impact on waiting times (including in relation to the four-hour waiting time target), an additional member of staff was recruited to work on the front desk while the pilot was being run. Although the trust had more than one Emergency Department, it was agreed to focus on the larger site where there were more concerns that patients were not being identified. It was also only run in the adult Emergency Department.

Implementation

The ID checks ran from 10am to 10pm Monday to Friday. Because it was being run in the Emergency Department, it was run as a survey of patients when they got to the front desk, asking if they were currently carrying ID, and what type of ID if they were, but not asking to see it. Posters were put up around the department to warn patients they would be ask, but they emphasised that patients would not be asked to show ID and that this was a pilot. Staff also said patients rarely engaged with the signs prior to attending the reception desk.

However, staff mentioned that there were certain occasions when patients were not asked whether they carried ID, including:

- When patients were admitted by ambulance
- When patients were particularly seriously ill
- Where there was a language barrier that would have made asking the questions particularly difficult

It was also mentioned that there had been occasions where reception staff had forgotten to, or had not been set up, to ask the pilot questions, particularly where there was no supervision at the beginning or end of a shift.

Staff and patient reaction and response

Patients were described as having either a positive or neutral response to the ID checks – and a more positive response than expected by staff, who had been concerned patients would object. They were seen as generally willing to answer questions and provide ID. However, staff were describing this as a survey and not asking to see the ID, just asking if patients were carrying any, which was felt could have had an impact.

Staff reactions to the pilot, and cost recovery in general, were mixed.

There had been deliberately limited communications more widely to staff before the pilots came into place, to avoid controversy. Some staff mentioned not knowing about the pilot, or not knowing about the link between ID checking and cost recovery, until the pilots had already begun. Those in more clinical or nursing roles, also mentioned limited knowledge of what the process entailed, as they were not involved in asking the questions.

When describing the benefits of ID checking, staff particularly emphasised the benefits of limiting fraud by encouraging patients to bring ID, so staff knew exactly who they were treating, and potential benefits for other departments if patients were identified earlier.

Generally staff were positive about the potential for recovering costs from chargeable patients, particularly considering the current stresses on NHS finances. Staff described instances where American patients had asked where to go to pay, following treatment, and had had to be told that, because it was Emergency care, they were not chargeable.

However, concerns were raised about ensuring that changes to increase cost recovery were based on clear evidence of cost effectiveness, and ethical implications due to the potential impact on patients' health if they avoided treatment.

APPENDIX D: Case studies and depth interviews

Pilot learnings and impact

From staff descriptions, the pilots themselves were felt to have limited impact on services or cost recovery. However, this was felt to be at least in part because patients were only being asked the question and IDs were not being seen, so it was not able to help patients be identified and patients could simply say 'No' when asked for ID without being followed up.

Due to the additional staff member, there was also not felt to have been an impact on workload from asking the additional questions.

However, the following key pieces of learning were shared by staff:

- Although patients were generally found to carry Photo ID, they rarely carried proof of address, which was felt to be a potential barrier to ID checking in this type of setting.
- Patient response to the questions was generally more positive than expected.
- Where there was a language barrier, it was suggested a summary sheet with the questions translated into different languages would make it easier for receptionists to ask these questions to all patients.
- It was felt better communication beforehand, so more staff were aware and on-board with the pilots in advance, would have been beneficial.
- There was some confusion among staff about what classified as valid ID – for example whether a Driving Licence could be considered both Photo ID and Proof of Address. It was felt that more clarity about this early on would have been helpful.

APPENDIX D: Case studies and depth interviews

Case Study 5 – Foundation Trust in the North of England

Context

This acute trust chose to run the ID checks in the Maternity and Dermatology departments for the full three-month period. Before the pilot, potentially chargeable patients were identified if they were missing an NHS number, if their NHS number was new or didn't look quite right. At this point, the OVM would step in and look into the patient's case. The process before the pilot was described as 'efficient' by senior staff in Maternity:

'the process is quite robust…not many slip through the net'

Setting up the pilot

The trust was asked by the Department of Health whether it would be possible to run the pilot in the Maternity department and chose Dermatology as its second service line. Initially the trust intended to run a pilot in their Cardiology department alongside Maternity, however this proved infeasible as many Cardiology appointments took place out in community settings; therefore, Dermatology was identified as a suitable replacement service. Dermatology is a single site service; therefore, it was felt that the pilot would be easier to manage.

Staff responsible for the overall organisation of the pilot thought that the aims of the pilot had changed from what was initially intended. At first the aims were considered to be to increase the early identification of chargeable patients and to improve cost recovery from those patients. However, it was soon considered that these aims would not be practical as it would require reception staff undertaking the checks to be able to verify the IDs being presented – which was infeasible. Therefore, staff saw the aim of the pilot as having changed to being about the feasibility of asking patients to bring in two forms of ID.

'At the start the objectives seem to be different from when we actually began the pilot…my understanding of it was that we were going to be asking for ID but we were actually going to be verifying. And that proved to be such a difficult thing that by the time we got started the objective was just to collect information about what ID people bring'

Staff not responsible for the set-up of the pilot but involved in the implementation (for example the receptionists) understood this aim of feasibility. However, some also thought that the introduction of two forms of ID was to ensure that those who should be charged are easily identified. Some staff mentioned upfront charging too, however it was pointed out that this is unlikely to be implemented in the same way in Maternity due to the fact that it is classed as emergency care.

Staff reported that pilot awareness was high in middle management however that it had not been communicated across the trust, due to the fact that it was seen as irrelevant to staff in other areas.

In both service lines, communication about the ID checks was facilitated via letters to patients. In one service line, these letters were generated by the system as part of the appointment letter, whereas in the other separate letters had to be sent. Receptionists undertook the ID checks in the Dermatology service line and a clerk specifically employed as part of the pilot did so in Maternity.

Staff were initially quite positive about the motive for the checks, however a number of concerns were raised including fear of negative reaction among patients (including potential harassment), as well as the impact on reception staffs' workload (another thing for them to have to do). Some staff voiced that they felt that ID checks should be taking place at an earlier stage in the process; in GP practices rather than in hospitals.

Implementation

The ID checks ran in all Dermatology clinics and in the scanning clinic for Maternity, around the clock on all days that the clinics were open. The scanning clinic in the Maternity service was chosen because all patients attend at least once for a scanning appointment. This might be the only time at which patients attend the hospital. Therefore, it was decided that this should be the point at which patients are asked for ID.

Patients attending their first appointment in each clinic were asked to provide ID. Staff reported high compliance rates in doing the checks and gave no examples of when they were unable to check patient's ID.

Where patients didn't bring ID, or the correct ID, this was recorded in the data collection on tablets provided by Ipsos MORI, however this was not generally flagged to the OVM department any differently from how existing processes ran pre-pilot. This is because in this trust, the pilot was used as a way of seeing how feasible asking patients to bring IDs in is, rather than having an aim of increasing identification of overseas patients or recovery of costs. The trust did not focus on the latter due to difficulties with receptionists being able to verify forms of ID provided, which was considered to be out of the remit of the roles of receptionists undertaking the ID checking.

The trust accepted a Driving Licence both as a form of photo ID, and as proof of residence.

APPENDIX D: Case studies and depth interviews

Staff and patient reaction and response

Staff did not raise anything particularly negative in relation to their experience of the process of ID checking. The addition of the ID check was reported to add time to the check in process however ('*Slowed us down slightly*'). Staff did mention that there had been queues at times.

Senior staff members talked about the concern the service lines have had in putting patients off from coming in for care and treatment:

'It's also carried a bit of a clinical risk especially in the maternity one, we have had letters and correspondence from our commissioners about the risk that pregnant mums won't turn up and had quite a lengthy debate about a particular case to-ing and fro-ing with the patient saying please come in and that the baby and her health is of the up-most concern, the fact that she has been flagged as a chargeable patient is what we will continue to pursue the charge, but we just want the baby and the mum to be healthy'

Patient reaction to the ID checks was mixed. Some patients accepted the checks, whilst others were unhappy about them. There was a minority of patients who had reacted aggressively or had seemed insulted by the check. Trust staff reported receiving phone calls from patients, having received the letter, querying whether they needed to bring ID if they had been 'born and bred' in England. Typically, these patients were understanding once the pilot had been explained to them by staff.

Patient related barriers were reported in relation to the feasibility of the ID checks, including:

- The difficulties in asking for ID among babies and children (they don't have ID so what is the process for them)
- Language barriers

Pilot learnings and impact

Reflecting on the pilot, hospital staff felt the pilot had gone well. The trust identified one patient as a result of the pilot, who had received the information letter instructing them to bring their ID to their appointment and had subsequently called the trust and was picked up by the OVM. The trust also reported a situation that they have had with one of their Maternity patients – which actually occurred after the pilot but was still of concern to them:

'This is a high risk pregnancy, and we have had to work very hard to persuade her [the patient] for maternity care and to make sure her and her baby are safe. and although this didn't happen during the pilot [it was afterwards], the potential is there and it does still give me anxiety. I think we are going to see more and more of this. So how we manage that situation, I have absolutely no idea at the moment. It is a real issue for us.'

APPENDIX D: Case studies and depth interviews

Staff members commenting on this concern talked about this potentially being quite common. Fortunately, there is an existing process in place within the trust for capturing vulnerable maternity patients and escalating these to the appropriate clinician and manager so that care can be managed appropriately. However, staff may still require further support and guidance from DH about how to deal with pregnant patients who are not eligible for free care but don't have the means to pay for it, and/or are put off attending the hospital.

Staff were positive about further roll out, however made the point that they would need to assess the resource implications of doing so. Self-check in kiosks were raised as a potential barrier to conducting ID checks, because reception staff would still be needed to conduct the check.

Towards the end of the pilot period, the trust implemented a new Electronic Patient Record (EPR) system. This system includes more mandatory checks for receptionists to undertake with patients to help to identify more potentially chargeable patients. The EPR has been 'future proofed' to incorporate the ID checking should it be rolled out in future, although it is not continuing for the time being.

Staff did recognise a number of benefits from participating in the pilot, however. The pilot was seen to have increased awareness: the pilot has made more staff aware of what they need to look for to identify potentially chargeable patients and report this to the OVM.

APPENDIX D: Case studies and depth interviews

Case Study 6 – NHS trust in London

Context

This large London trust chose to run the ID checks in the Maternity and Renal departments for the full three-month period. Prior to this, the identification of chargeable patients was facilitated by receptionists asking patients the '12-month question' and involving the paying patients team where they thought someone might be chargeable – either because the patient had answered 'No' to the 12-month question, and/or because they had no NHS number or a new NHS number. Staff in the Renal department had lower awareness of the 12-month question and of paying patients more generally.

Trust staff we interviewed suspected that some reception staff (in Maternity and Renal) would only ask the 12-month question if the field in the system was blank and they needed to get past it. Receptionists in Renal would also sometimes assume the answer to this question, given how frequently the patient came in for their appointments, and especially if the receptionist knew them. The paying patients team recognised that they were not catching patients until much further down the line in their treatment pathways. They also said that referrals from staff in these service lines were infrequent (especially from the Renal reception team) however they relied heavily on staff to flag people to them. A number of difficulties in identifying chargeable patients were reported:

- Often patients were entitled to free care at some point but no longer are (i.e. a British person who has moved abroad but still has a live NHS number; someone from abroad who was here on a visa but the visa has now expired and hence they are overstaying their visa).
- The regular nature of Renal outpatient appointments (up to three times a week for some) means it is often difficult to identify patients until they have already received a lot of care, which can equate to a large sum of money.

The trust had discussions last year where it was flagged that it only recognises around 50% of chargeable patients. This percentage is higher in Maternity (75-80%), however patients are often identified and charged later in their pathway, or even after they have given birth.

Setting up the pilot

The trust ran the pilot in Maternity and chose Renal as the second service because it was identified as another service (like Maternity) where the trust knew that they had a through flow of ineligible patients accessing the services. The Renal department had been identified before the pilot as an area to further explore, since the Home Office had contacted the trust to notify them that there were patients who had been receiving free treatment when they shouldn't have been for quite a number of years. This frequent treatment (of dialysis for example) would have been costing the trust a significant amount of money.

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Information about the pilot was circulated around the trust via the intranet and also in trust wide email communications. Posters were also displayed in reception areas informing patients of the requirement to bring in ID. Letters were sent to patients notifying them that they needed to bring ID to their appointment, however unlike Renal (who eventually managed to change the letters so that the ID check information was incorporated into the main body of the letter), Maternity continued to staple a piece of paper to the appointment letters throughout the pilot.

No extra staff were employed on the frontline to assist receptionists in checking patients in, however a bank staff member was employed to input the data required for the Ipsos evaluation.

Staff in the two departments had different initial reactions to the ID checks. In Maternity, the administrative and reception staff were generally quite positive, although the Midwives had concerns around the impact of checking IDs on their clinics (starting on time for example). In Renal, a few more issues were raised. Some of the senior managers were unhappy about the pilot going ahead and there was more of a reluctance to participate in the ID checking pilot. In Renal, staff told us that some of the consultants were worried that the trust would be turning patients away, that DNAs would increase and/or that people would end up in A&E in a worse condition which would then cost the trust more money. Staff across both service lines reported feeling concerned about the reaction among patients and the impact on their already busy workloads.

Implementation

A decision was made to ask all new patients in Maternity for ID. In practice this meant that the ID checks took place at the patient's first booking in/history appointment or at their first scan (if they had transferred over from another hospital). Maternity staff additionally took photocopies of the IDs and stapled these to the paper checklist forms, which were completed for every patient across both service lines involved.

In Renal, a decision was made to ask all patients for ID (new and repeat) because it was felt that it would be the most straightforward approach given the high numbers coming through the door each day, and so that patients would not feel like they were being singled out. This was particularly relevant given that the Renal reception team check patients in for several other service's clinics too. Part way through the pilot, the manager of one of these services found out about the pilot and stopped patients (for Neurology) being asked ID as it was felt inappropriate given some of the conditions that these people have.

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Staff in Maternity were confident that compliance rates for the checks were high, and when they were missed this was rare and because they were very short staffed (and physically couldn't photocopy the ID). Where it was not possible to check IDs at the same time the patients were checked in, reception staff talked about how they would check all patients in and then ask them to sit down and call them back, one by one, to check their IDs. Occasionally the Midwives called a patient in for their appointment during this time, in which case the reception staff would need to enter the consulting room to complete the ID check.

In Renal, staff were fairly confident that the ID checks had always taken place. However, during one period of time, staff were not recording the IDs on the paper checklist forms but instead on a note pad. This was sent in error to the central booking team. During this week, 525 patients had appointments but the IDs for just 225 patients had been checked. It was assumed that this must have been a week when the team was short staffed and either existing receptionists didn't have time to do the checks, and/or cover staff were not instructed to check IDs.

Patients who did not have the correct ID in Maternity, as well as those who had no ID, were given a slip of paper informing them to email their ID to the paying patients team within the next 48 hours. In Renal, patients were told to bring theirs to their next appointment or to send it in via email (as in Maternity).

Staff and patient reaction and response

Staff in both services talked about how it was quite "awkward" asking patients for ID, reporting that they had come up with lines that they would use with particularly inquisitive or unhappy patients to justify the process. Staff would often play on the fact that it was part it a pilot, for example, or use humour to win patients round ('there's nothing special about you, we are doing this for everyone').

Staff reported that most patients had been able to provide photo ID. Proof of residence had more issues, however. Patients had either not been providing it because they had assumed that their photo ID would suffice as proof of residence (a Driving Licence for example), or because they didn't have proof of residence or forgot to bring it with them. Some patients genuinely may not have known about the requirement to bring ID. If, for example, they had been booked in on the previous day for an appointment by phone and were not told at that time.

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Staff (non-clinical and clinical) reported some of the knock on effect of requesting IDs:

• Queues were longer because staff were spending time checking the IDs and also talking to patients who had queries or comments for example

• Clinics start times were delayed due to patients spending longer at the reception desks

• The first part of the appointments (especially in Renal) was often dominated by the patient wanting to talk about the ID checks:

'Patients came to clinic in August and the first thing they verbalise to us is why are they doing this…it takes time because you have to calm them down first before you start'.

• The backlog in Renal increased because the long queues put patients off from returning to the desk after their appointment to book their next one. In these instances, reception staff had to call patients and book them in, which meant that on occasions staff had to do overtime.

• The ID checks occasionally distracted staff from the other tasks that they were supposed to be doing. A staff member in Renal, for example, reported that another member had forgotten to put the notes through which could have risked the patient not being seen.

Staff also reported a number of barriers to conducting the ID checks. Firstly, language problems meant that patients did not always understand the concept Nationality, so the trust had to change a question to ask instead about the current passport that each person holds. Secondly, some patients out rightly refused to provide ID (especially those who had been visiting the trust for some time). Thirdly, not only was the process of checking IDs resource intensive but so too was the process of following patients up. In fact, the overseas team had only been able to conduct their basic checks on people during the pilot. They had not been able to look into people's circumstances as they would have liked to have done, because of time. Finally, the Renal department experienced one patient who was wearing a burqa and this had cause them difficulty checking the patient's identity.

Patient reaction was described as very mixed. Some were very accepting of the ID checks, and even showed support for this as a policy, whilst others were less comfortable or content with it. In Renal, and because they were being asked to bring their ID each time, staff spoke of patients who were really annoyed by having to repeatedly show their ID (sometimes up to three times per week).

Staff reported that patients in both departments, especially those born in England, often queried the requirement:

'Some of the British people are at first very taken back by it, well I'm born and bred here I don't understand why you are asking me. But again, the same thing is said to them that is said to everyone else. It's not about me identifying whether you were born here or not, I need to know where you were in the last 12 months because if you weren't in this country, then you were not eligible for NHS care, it's as simple as that'.

Pilot learnings and impact

Reflecting on the pilot, hospital staff in Maternity and Renal had different opinions on the success of the pilot. In Maternity, the staff were fairly positive about the pilot, and have agreed to continue with the checks, whilst in Renal staff expressed relief that the pilot had come to an end.

Renal staff members reflected on the decision to ask every patient for ID, and thought that this was probably the reason why the ID checks had had a negative impact on the service. If the ID checks were to continue in Renal, which they won't be for the time being, staff agreed that it would only be feasible to ask new patients.

In terms of the impact of the ID checks, the paying patients team reported that because of the sheer number of patients in Renal, they have not been able to follow any of these up- but do plan to do so. In Maternity, however, the overseas team reported that they have definitely identified more patients (176) than they would have done in a usual 3-month period (around 145) and that there had been four patients who had decided not to continue with their treatment, but said that they would return to their home country for this instead, because they found out that they were chargeable.

'It's not a huge gain but it's definitely a gain, but what is also useful is that capturing them earlier has been good for the culture definitely and as a whole I think perhaps patients are taking the invoices coming through a big more seriously because they don't have the excuse of we should have been told about this sooner'.

Staff did recognise a number of benefits from participating in the pilot, however. The pilot was seen to have:

- An increase in patient awareness that not everyone is entitled to free NHS care (Renal)
- Patients are being informed at their first appointment that they may have to pay for their care (Maternity)
- A cultural change in that staff are much more aware of charging rules now.

APPENDIX E: Analysis of management information

Secondary data analysis

This note outlines the approach to the analysis of secondary data collection in addition to the findings from this analysis. It covers the analysis of cancellation, did not attend, activity and cost recovery data where it has been provided. It should be noted that the format and provision of data varies significantly across pilot sites and consequently has been analysed on a trust by trust basis.

1.1 Summary of findings

Findings from the secondary data analysis carried out with the data available do not indicate any significant adverse impacts on service activity rates, cancellation rates or did not attends rates. However, significant variation in cancellation and DNA rates limits the extent to which analysis can unpick effects. This would suggest that the pilot has largely avoided impacting the overall activity of the service and that patients have on average not been deterred by the need to present identification.

In terms of cost recovery, once again significant variation is present in most of the data and it has not been possible to identify any improvement or deterioration in the numbers of patients identified as chargeable or patients invoiced that is directly attributable to the programme. However, some trusts do exhibit differences in the cost recovery data such as trust 9 who show a more than doubling of invoices made during the pilot period than in the same months of 2016. In conjunction with limited data, it appears unclear as to whether the introduction of identification checks has led to more patients identified as chargeable and invoices raised and it is likely that this would require further data collection in the near future to explore.

1.2 Data

In order to evidence findings for a number of evaluation questions, publicly available secondary data was gathered and analysed where possible whilst data requests were submitted with pilot sites where granular information was not available publicly on the key areas of interest:

- Does requesting ID reduce demand for services?
- Does checking identifications of patients increase rates of ceased treatment by Trusts and by patients?
- Does checking identifications of patients improve debt recovery or rates of up-front charging?

The data requested from pilot sites can be broadly split into financial and non-financial data with the former encompassing information on activity, cancellations and DNAs. The latter covers the cost recovery data for overseas patients.

1.2.1 Activity, DNAs and cancellations

Motivating the analysis of activity, cancellations and did not attends is the potential for identification checking to have unintended consequences on patients. These may arise as a result of patients lacking the documents needed and therefore not seeking necessary treatment or cancelling/not attending an appointment should they need to provide some form of identification.

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Data on activity rates across the various NHS healthcare providers is publicly available and refreshed on a regular basis, however quarterly publications pose a challenge for this analysis as when combined with potentially substantial publication delays, the data is unlikely to cover the full pilot period. For this reason, granular detail from sites has been requested for the pilot period and up to 3 years before to allow an assessment of change since the introduction of identification checks.

Table 1.1: Secondary data sources and research questions (non-financial)

	Link to evaluation research question	What is publicly available	Data requested from pilot sites
Non-A&E activity			
DNA rates	Does requesting ID reduce demand for services?	This is available at Trust and CCG level on a quarterly basis.	Data at service level for piloted services during pilot and 3 years prior.
Cancellation rates	Does checking identifications of patients increase rates of ceased treatment by Trusts and by patients?	Available on a quarterly basis at a Trust level	Data at service level for piloted services during pilot and 3 years prior.
Demand/Activity • Patients admitted • First attendances seen	Does requesting ID reduce demand for services?	Available on a quarterly basis at a Trust level and monthly and quarterly basis at CCG level	Data at service level for piloted services during pilot and 3 years prior.
Maternity specific • Number of maternities • Number of women who have had an assessment at any time during pregnancy	Does requesting ID reduce demand for services?	Available on a quarterly basis at service level and Trust level	Data at service level for piloted services during pilot and 3 years prior.
A&E activity			
Attendances	Does requesting ID reduce demand for services?	Available on a monthly and quarterly basis at department and Trust level	-
A&E admissions	Does requesting ID reduce demand for services?	Available on a monthly and quarterly basis at department and Trust level	-

1.2.2 Cost recovery

Certain groups of overseas visitors and migrants are liable to cover the cost of some secondary care received while visiting the UK. NHS organisations providing secondary care services have a statutory obligation to identify potentially chargeable patients and recover this cost[1]. The NHS (Charges to Overseas Visitors) Regulations have been in place since 1989, and were updated in 2011, and 2015, and cover charging of overseas visitors and migrants for their healthcare based on the

[1] www.legislation.gov.uk/uksi/2011/1556/made and www.legislation.gov.uk/uksi/2012/1586/contents/made

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principle that *a person who is ordinarily resident in the UK must not be charged for NHS hospital services*[2], and vary depending on the origin of the patient:

- European Economic Area (EEA) - where a patient (who is a visitor, including students) is able to provide a European Health Insurance Card (EHIC) – or a Provisional Replacement Certificate - the costs of NHS healthcare can be recovered directly from the Member State where the individual is resident[3]. Some patients will not be eligible for an EHIC, in which case they are ineligible for free NHS care and should be charged. The S1[4] (for workers, dependants of worker in home state, pensioners, and people in receipt of other exportable benefits, and their dependants), and S2[5] (allowing patients to travel for medical treatments that are pre-arranged and approved), are different mechanisms for charging residents of other Member States for the costs of their healthcare.

- Non-EEA – patients who are not ordinarily resident in the UK are required to cover the cost of treatment themselves, or through insurance policies. Reciprocal arrangements are in place between the UK and some non-EEA states which also provide exemptions for urgent and emergency care, and exemptions also exist to extend free healthcare to patients based on other criteria, for example asylum seekers or those granted asylum, children taken into local authority care, and family members of exempt groups.

The checking of identification may have impacts on the number of patients for which costs are recovered should the process identify more ineligible patients; however, it may also have benefits in terms of efficiency should patients be identified earlier, though this could result in less income from cost recovery should patients choose to forego treatment. In practice, much of the costs sought from overseas visitors is written-off and it should be noted that it is unlikely that significant improvements in costs recovered are seen within the pilot period as it takes much longer to recover them. Lastly, costs are dependent on the treatment received and changes in the total costs recovered may reflect changes in the underlying treatments received by overseas patients. Therefore, the number of people identified as chargeable and invoiced as such are better measures of impact.

Table 1.2: Secondary data sources and research questions (financial)

	Link to evaluation research question	What is publicly available	Data requested from pilot sites
OVT Portal - EHIC & S2			
DWP - monthly reports	Does checking identifications of patients improve debt recovery or rates of up-front charging?	Monthly Trust level data collected through the OVT portal	Data at service/treatment level for piloted services during pilot and 3 years prior.
Directly Chargeable			
DH - Quarterly reports	Does checking identifications of patients improve debt	Quarterly at a Trust level	Data at service/treatment level for piloted services

[2] Guidance on implementing the overseas visitor hospital charging regulations 2015, Department of Health, p.2, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418634/Implementing_overseas_charging_regulations_2015.pdf
[3] Ibid. p.4
[4] A certificate of entitlement issued by the member state to insured persons. S1 forms should be sent to the Overseas Healthcare Team in DWP, although it is expected that staff in both primary and secondary care may come into contact with patients with S1s that have not yet been sent to DWP and may collect and send these to DWP on behalf of the patient. A fixed annual amount is charged to the member state for as long as the patient with the S1 remains in the UK (with the exception of Worker S1s where actual costs will be recouped from the member state).
[5] An S2 form represents a payment guarantee from the issuing country for planned treatment.

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	recovery or rates of up-front charging?		during pilot and 3 years prior.

1.2.3 Data quality and availability

Data of some kind has been received from 15 of the 18 pilot sites covering 23 services from a total of 34, however only 4 sites have provided both cost recovery and activity data (covering 8 services). What has been provided varies substantially in format between providers based on what they were able to provide at the time the request was submitted.

Table 1.3 outlines the pilot sites, services and data received for each.

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Table 1.3: Data summary table

Trust	Service	Launch week	Launch month	3 month - end month	Cost recovery data	DNA/Cancellation data
Trust 7	Urology	1st August	August	November	N	Y
	Maternity	1st August	August	November	N	Y
Trust 4	A&E	31st July	July	October	N/A	N/A
	Maternity	31st July	July	October	Y	N
Trust 2	Renal	17th July	July	October	-	N
	Maternity	17th July	July	October	-	N
Trust 9	Renal	7th August	August	November	Y	Y
	Maternity	24th July	July	October	Y	Y
Trust 13	Urology	24th July	July	October	Y	N
	Maternity	29th August	August	November	Y	N
Trust 5	Maternity	31st July	July	October	Y	Y
	Trauma Orthopaedics	31st July	July	October	Y	Y
Trust 1	Maternity	22nd May	May	August	Y	Y
	Dermatology	24th July	July	October	Y	Y
Trust 15	Cardiology	21st August	August	November	N	Y
	Maternity	Pre-election	.	.	N	Y
Trust 11	ED	21st August	August	November	Y	N/A
Trust 3	Maternity	28th July	July	October	Y	Y
	Neurophysiology	28th July	July	October	Y	Y
Trust 10	Neurology	14th August	August	November	Y	N
Trust 6	Fracture	1st August	August	November	N	N
	Maternity	1st August	August	November	N	N
Trust 12	Ophthalmology	21st August	August	November	N	Y
	Orthopaedics	21st August	August	November	N	Y
Trust 16	Assisted Conception Unit	24th July	July	October	N	Y
	Orthopaedics	back up service	.	.	.	.

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	Diabetes - rapid access unit	Live in September	September	December	N	Y
Trust 14	A&E	31st August	August	November	N	N/A
	Plastics	n/a (pilot stopped but data collected)	.	.	.	.
	Maternity	Cancelled	.	.	.	.
Trust 17	Maternity	TBC	.	.	.	.
Trust 8	Oral	7th August	August	November	N	Y
	Maternity	14th August	August	November	N	Y
Trust 18	A&E	4th September	September	December	Y	N/A

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1.3 Methodological issues

As the majority of the secondary data analysed has primarily been provided by each trust, there was not an opportunity to introduce a control group for comparison. This limits the extent to which the analysis can attribute changes in any of the outcomes of interest to the pilot as it cannot be known for sure if other factors have influenced any observed changes.

In addition to this, data on cost recovery and DNA/Cancellation rates often exhibits significant variation due to either the uncommon nature of overseas patient identification or the small bases from which percentage rates can be based for some services. This poses issues for the analysis and may preclude identification of changes resulting from the pilot's introduction without further data over covering a longer time period into the future.[6]

In light of these limitations, wherever possible, the analysis has compared the general trend over the last year or so and has also compared outcomes of interest over the same 3-month period in 2016 and 2017. The trend should give some indication as to whether there is a discontinuous change once the pilot starts which would imply that it has had some effect whilst the same period in 2016 should exhibit the same seasonal trend and therefore be more comparable.

* We have 3 months of data at most.

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2 Analysis by trust

2.1 Trust 9

Trust 9 provided activity data for both their maternity and renal services for the pilot period and 3 years prior to the pilot starting in addition to cost recovery data for each service separately.

For the primary analysis of activity rates and cost recovery for trust 9, data from August to October 2017 was compared to the same period in 2016 on the basis that these periods should exhibit similar seasonal trends.

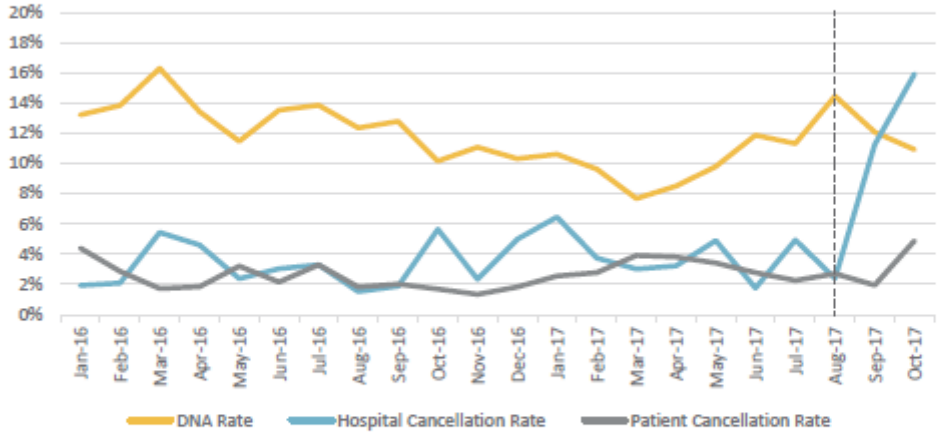
2.1.1 Maternity

Across the maternity service at trust 9, the total number of appointments including cancellations and other data increased by 164, from 2108 in August to October 2016 to 2272 in August to October 2017.

DNAs/Cancellations

Analysis shows an increase in the cancellation rate over the months of interest compared to the previous year, driven primarily by service cancellations, increasing by 6.6 percentage points to 9.64 percent. Cancellations by patients also rose by 1.4 percentage points to 3.26 percent but this remains in line with the yearly average patient cancellation rate for 2016. It seems plausible that there is something else driving the increase in hospital/clinic cancellations since it is not likely that the introduction of identification checking would affect these. DNAs, however, fell over the same period with a 1 percentage point drop on the previous year.

Figure 2.1: Trust 9 maternity service DNAs and cancellations



Cost recovery

Recent data provided by the trust on the number of patients invoiced shows a spike in October 2017 in which 116 patients were invoiced. This may be explained by the introduction of a new process for invoicing overseas patients that

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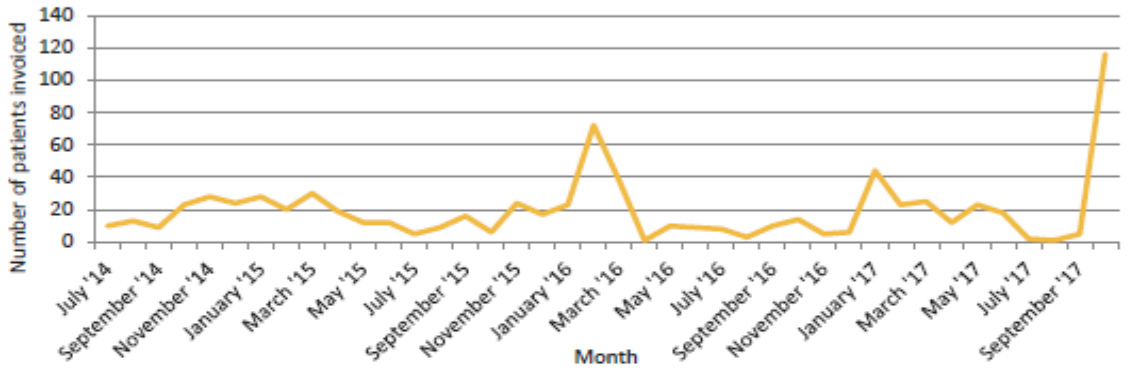
the trust began to implement during the pilot and may not reflect an impact of the pilot. However, it is likely that the pilot may have has some effect on the ability of staff to identify patients for cost recovery.

Figure 2.2: Trust 9 maternity service patients invoiced



The amounts invoiced follow an almost identical pattern to the numbers invoiced displayed above.

2.1.2 Renal

The total number of appointments for the renal service at trust 9, including cancellations and other data, fell by 1347 from 9679 in August-October 2016 to 8332 in the same period this year.

DNAs/Cancellations

The overall rate of attendance for the renal service at trust 9 rose in comparison to the previous year from 61.79% to 66.77% whilst the overall cancellation rate was lower despite a small increase in the proportion cancelled by patients. Figure 2.2 plots the various rates of interest over time and does not suggest a significant impact as a result of the pilot with rates broadly similar to preceding months.

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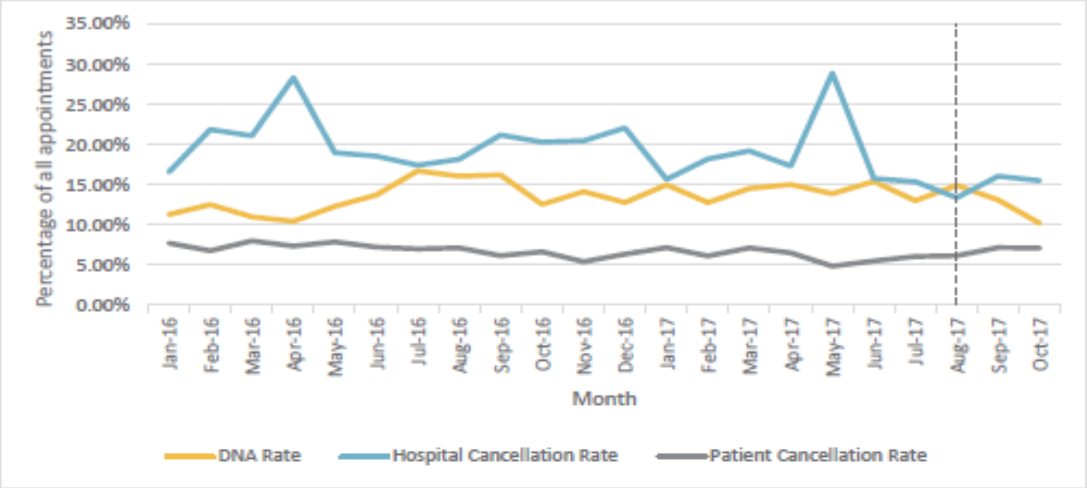
Figure 2.3: Trust 9 renal service DNAs and cancellations

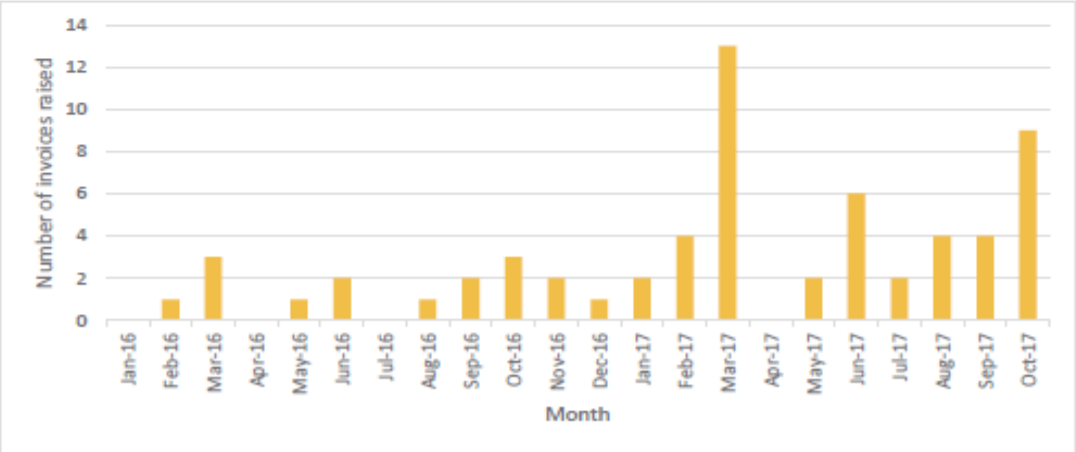


Cost recovery

Data on cost recovery for the renal service was less comprehensive with only the number of patients invoiced available for analysis. In addition, this data exhibited significant variation from month to month with many months in which no-one was invoiced. Similarly, EHIC data is sparse and no EHIC patients are recorded for either the pilot period or the same three months in 2016.

Figure 2.3 outlines the numbers of patients using the renal service at Trust 9 that have been invoiced since January 2016 and illustrates the variability. However, there appears to be a consistently higher number of patients invoiced in 2017 than in in 2016 suggesting that other changes to the healthcare system and cost recovery are having an effect.

Figure 2.4: Trust 9 renal service invoices



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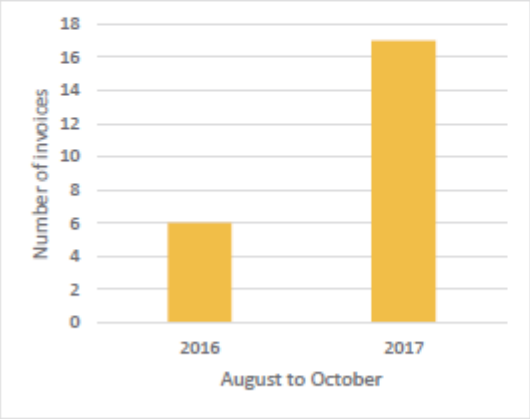
The figure below shows the difference between the same two periods in 2016 and 2017 from which the number of invoices rose to 17, a difference of 11.

Figure 2.5: Trust 9 renal service invoices, August to October 2016/2017



2.2 Trust 1

For trust 1, we have access to activity data for both their maternity and dermatology services for 3 years prior to the pilot starting but only 1 month of the pilot period itself, August 2017. This is also split by new and follow-up appointments. Cost recovery data for trust 1 is available but is not separated by service limiting the extent to which analysis can provide insight.

For the primary analysis of activity rates and cost recovery for trust 1, data from August 2017 was compared to the same month in 2016 on the basis that these periods should exhibit similar seasonal trends.

2.2.1 Dermatology

Total new appointments were higher in August 2017 at 866 in comparison to 790, however this is in line with a relatively stable trend over 2016 and 2017 with an average number per month of 824. For follow up appointments, the total number was 11.2 percent down in August 2017 on August 2016 and 20 percent down on July 2017. This decrease is not consistent with the relatively stable trend over the last two years but it is impossible to rule out other actors that may have led to this decrease.

DNAs/Cancellations

For new appointments, the cancellation rate was significantly higher in August 2017 than 2016 at 17.2 percent compared to 10.1 but the DNA rate was lower at just 6.8 percent compared to 12.5. However, the figures for August 2017 are not out of line with those for earlier in 2017 which shows an average cancellation rate above that of 2016 whilst the DNA rate has continued to fall since September 2016.

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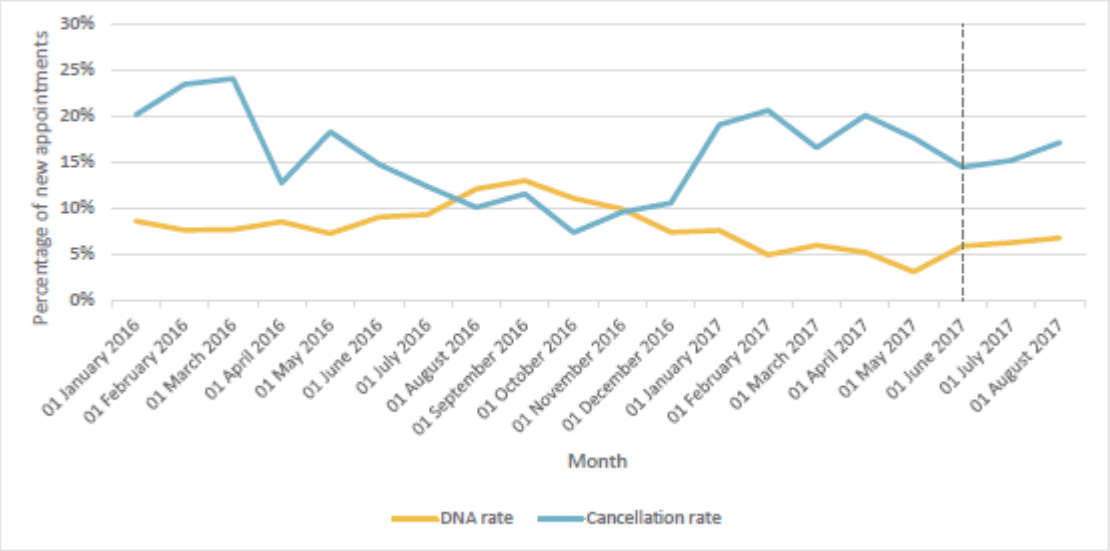
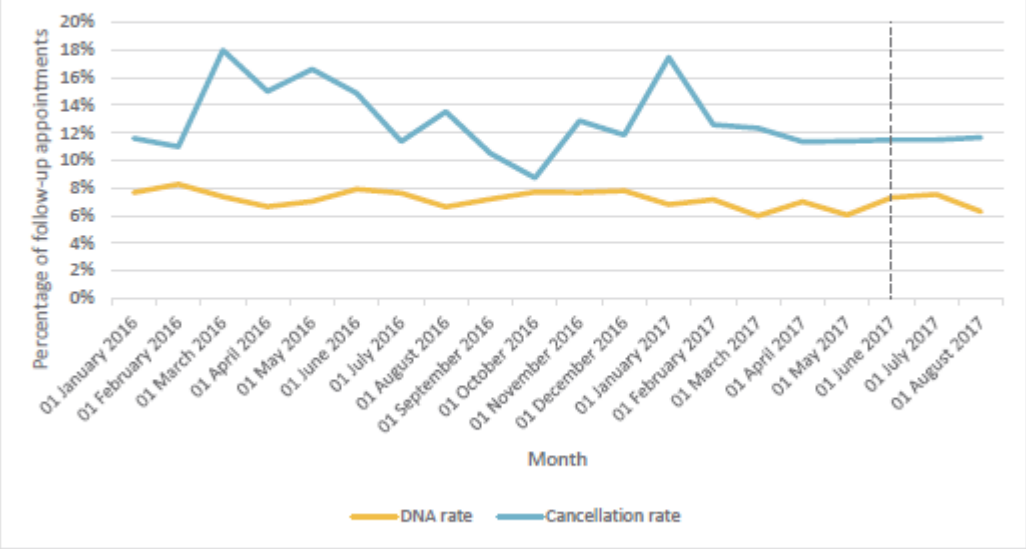
Figure 2.6: Trust 1 dermatology service new appointment DNAs and cancellations



When looking just at follow-up appointments, there are very few differences between August 2017 and 2016 when the cancellation rate was 13.5 percent and DNA rate 6.6 percent. In August 2017 the cancellation rate was 11.7 percent and the DNA rate was 6.3 percent.

There is once again a very consistent pattern to these rates over the last two years as evidence in figure 2.6.

Figure 2.7: Trust 1 dermatology service follow-up appointment DNAs and cancellations



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2.2.2 Maternity

During the pilot period, 9,557 appointments were made with the maternity service, a substantial decrease of 45 percent on the same period in 2016. It is clear that there is sharp decline in the number of follow-up appointments being made from April 2017 reaching its lowest point in May before stabilising throughout the pilot period, however, it is unclear what is driving this decline in appointments but it is unlikely to be the pilot given that it begins 2 months in advance of it starting.

DNAs/Cancellations

Cancellations and DNAs for new appointments remain similar throughout the pilot period and in comparison to the same period a year earlier, however for follow-up appointments the cancellation and DNA rate is higher. At 6.6 percent during the pilot period, the cancellation rate is 3.2 percentage points higher than the same period in 2016 and at 11.6 percent the DNA rate is 6.4 percentage points higher. Coincidently the rise in the DNA and cancellation rate for follow-up appointments coincides with the drop in follow-up appointments in April 2017.

Figure 2.8: Trust 1 maternity service new appointment DNAs and cancellations

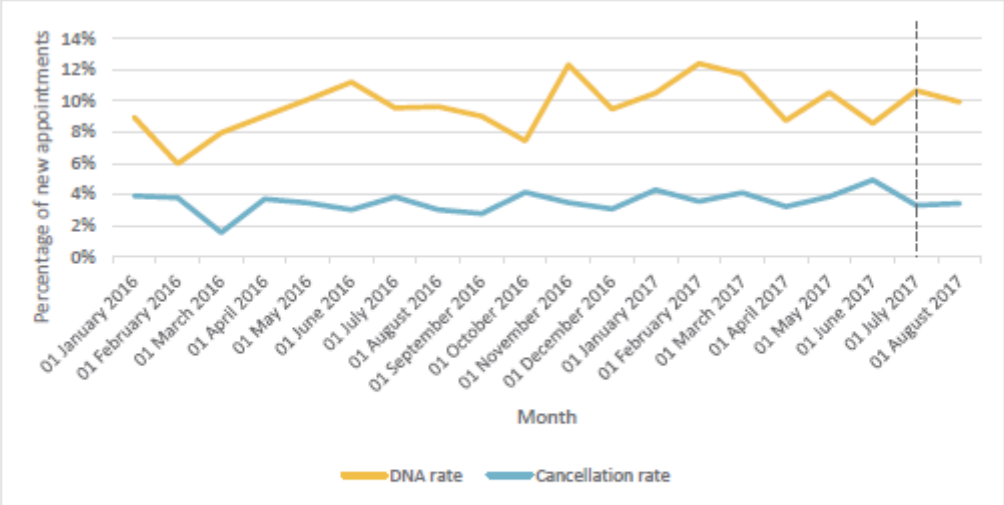

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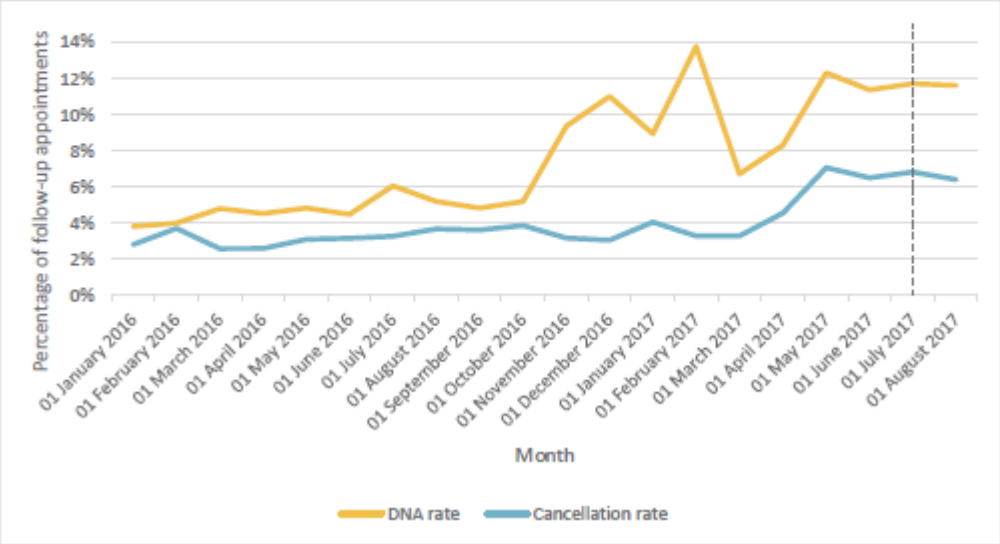
Figure 2.9: Trust 1 maternity service follow-up appointment DNAs and cancellations



2.3 Trust 7

Trust 7 provided activity data for both their maternity and urology services, however only for the pilot period for the maternity service. We have data for 2 years prior to the pilot starting for urology. We do not have access to any cost recovery data for trust 7.

For the primary analysis of activity rates and cost recovery for trust 7, data from August to October 2017 was compared to the same period in 2016 on the basis that these periods should exhibit similar seasonal trends.

2.3.1 Maternity

The data suggests that there were 1818 appointments with the service between August and the end of October, the pilot period. This compares to just 1014 in the same period in 2016 but remains I line with a steadily rising number of appointments since April 2017.

DNAs/Cancellations

DNAs for the maternity service are lower in two of the three pilot months than the equivalent months in 2016 with only the October 2017 DNA rate higher than its equivalent.

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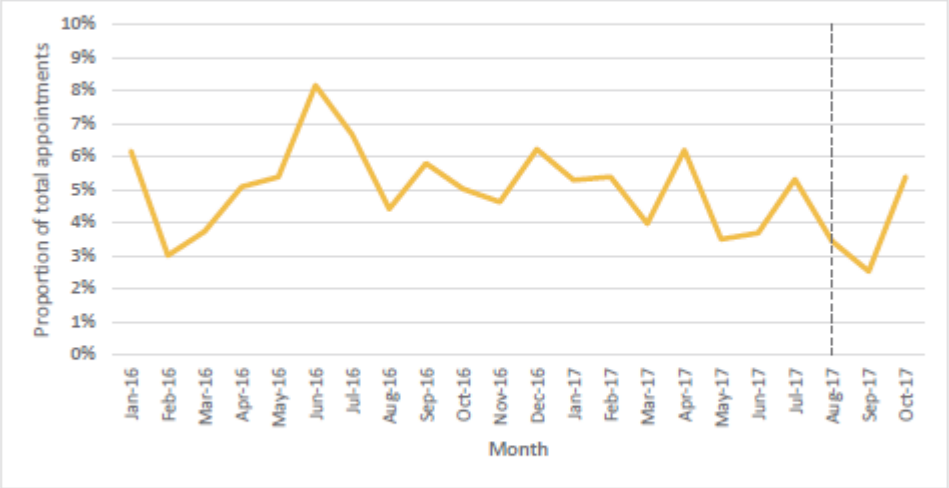
Figure 2.10: Trust 7 maternity service DNAs



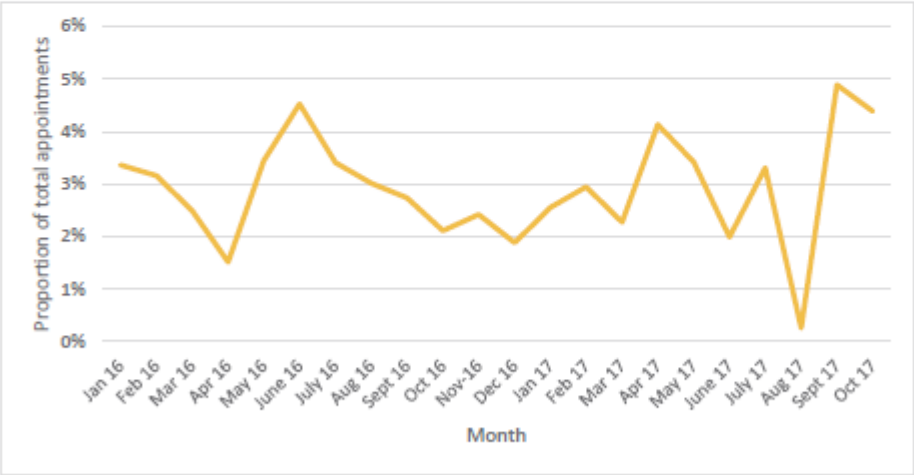
2.3.2 Urology

The total number of urology appointments fell by 61 to 1355 in 2017, however this is a relatively small difference and remains in line with the trend for 2017.

DNAs/Cancellations

The data suggests that there were only 10 cancellations in urology between August 2015 and July 2017 but 633 during the pilot. This seems implausible and may be a result of a change in the way information has been recorded especially given that the DNA rate remains similar in 2017 at 3.39 percent, an increase of just 0.9 percentage points from the same period in 2016. It may also be the case that service disruptions were the cause of this drastic change with 94 percent of cancellations made by the clinic itself and not patients.

Figure 2.11: Trust 7 urology service DNAs



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2.3.3 Cost recovery

On cost recovery, data on the number of patients interviewed by the overseas team only during the pilot period is available which indicates a total of 26 patients having been interviewed. It is not clear if this relates specifically to the services piloted or the trust as a whole.

2.4 Trust 16

For trust 16, we have access to activity data for both their Assisted Conception Unit (ACU) and diabetes clinic for 4 years prior to the pilot starting but only 1 month of the pilot period itself, September 2017 for diabetes, and the majority of the pilot period for the ACU. This is also split by new and follow-up appointments. Cost recovery data for Trust 1 is available but is not separated by service limiting the extent to which analysis can provide insight.

For the primary analysis of activity rates and cost recovery for trust 16, data from the plot periods in 2017 were compared to the same months in 2016 on the basis that these periods should exhibit similar seasonal trends.

2.4.1 Assisted Conception Unit

There was a total of 522 appointments for the ACU between August and September 2017 compared to 652 in the same period in 2016. However, the overall rate of attendance was slightly higher at 92.3 percent instead of 90.3 percent last year.

DNAs/Cancellations

The general trend in cancellation and DNA rates for the ACU exhibits significant seasonal variation, however when looking just at the same period in 2016 and 2017, there is very little difference in either rate. In 2016, the cancellations accounted for 6 percent of total appointments and DNAs 1.7 percent. The majority of these cancellations were from the patient cancelling, accounting for 77 percent of total cancellations.

In August and September 2017, the cancellation rate was only 0.04 percentage points lower and the DNA rate just 0.5 percentage points lower. More data would be required to form any firm conclusions from this but there is no evidence of a significant impact to date.

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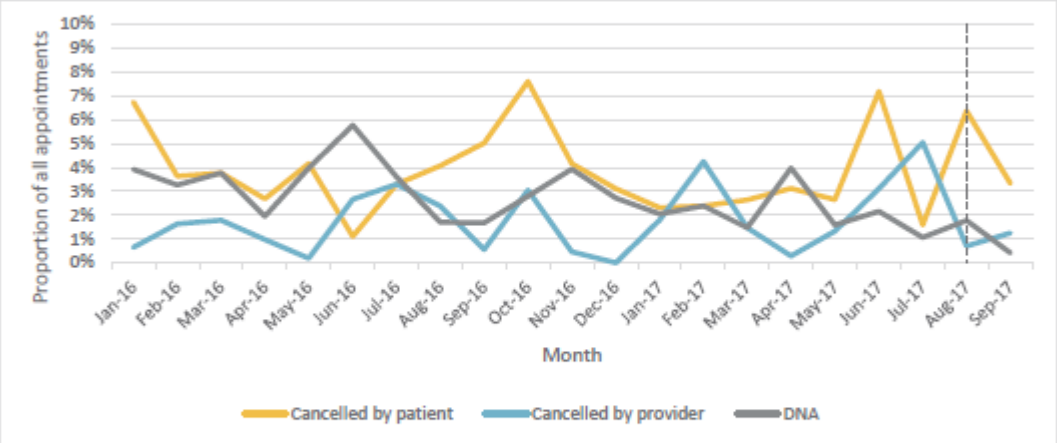
Figure 2.12: Trust 16 ACU cancellations and DNAs



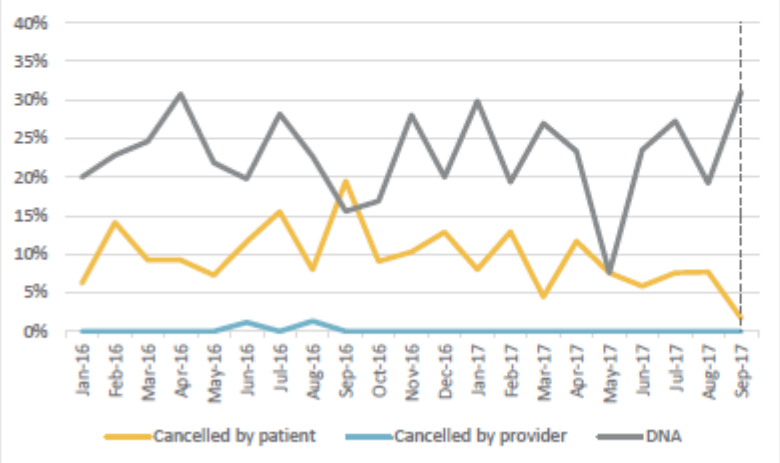
2.4.2 Diabetes

Overall appointments for the diabetes service at trust 16 were relatively similar in September 2017 at 58 compared to September in the previous year and were also in line with the general trend for 2017, averaging at 66 appointments a month.

DNAs/Cancellations

As data was available for just one month of the pilot period for trust 16's diabetes service, comparisons were only made with the same month in 2016 and considerable variation in rates may complicate interpretation with potential for simple comparisons to be misleading. However, there was a substantial jump in the DNA rate from 15.6 percent in September 2016 to 32.7 percent in September 2017. The opposite trend was evident for cancellations with the majority made by patients but falling from 19.5 percent in September 2016 to just 1.8 percent in September 2017.

Figure 2.13: Trust 16 diabetes cancellations and DNAs



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2.4.3 Cost recovery

No cost recovery data was available from trust 16 at the time of the analysis.

2.5 Trust 8

Of the two services piloted by trust 8, data was only available for activity on the Oral pathway and not for maternity. No cost recovery data was available for analysis.

For the Oral pathway, data covers the pilot period (August to November 2017) and two years prior.

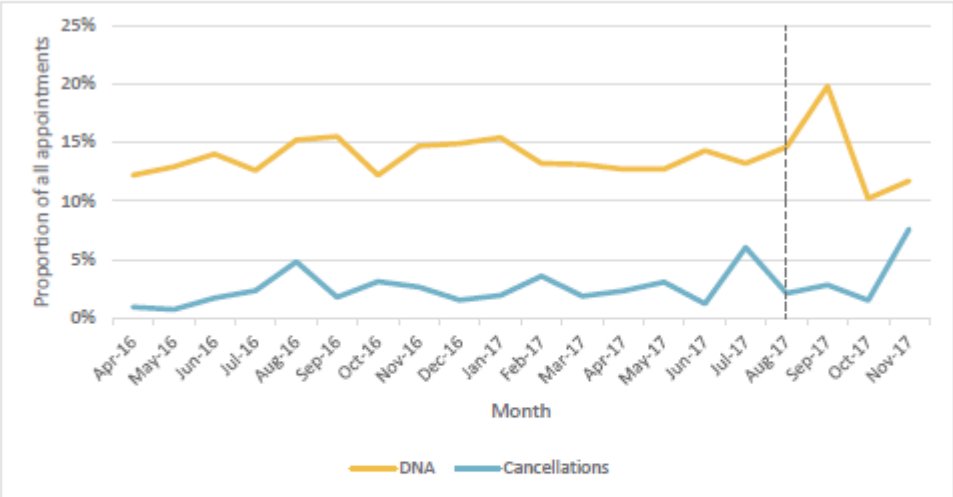
2.5.1 Oral pathway

There was a rise of around 18 percent in the total number of appointments along the pathway to 3099 appointments in the pilot period compared to the same time last year. However, this is in line with a steady increase in overall appointments throughout 2017.

DNAs/Cancellations

Compared to the same period in 2016, the DNA and cancellation rates both fell by 0.08 and 1.5 percentage points on average respectively. These represent very small differences and are do not suggest any adverse impact on oral surgery activity. Plotting the DNA and cancellation rate over time though does suggest an irregularity in September 2017 with the DNA rate spiking before falling back below its long run average.

Figure 2.14: Trust 8 oral surgery cancellations and DNAs[7]



[7] Note: November based on incomplete data

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2.6 Trust 13

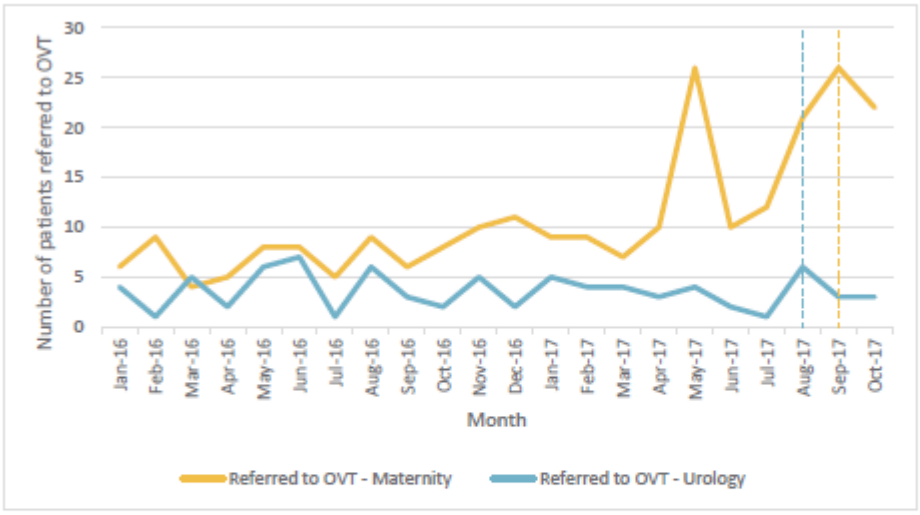
Data has been provided by trust 13 on cost recovery split across the two services piloted, maternity and urology. This stretches back three years prior to the pilot staring, all of the pilot period for urology and two thirds of the pilot period for maternity.

For the primary analysis of activity rates and cost recovery for the urology service, data from the pilot periods (August, September, October) in 2017 were compared to the same months in 2016 on the basis that these periods should exhibit similar seasonal trends. For maternity, the pilot began at the very end of August and only September and October contain relevant data.

2.6.1 Cost recovery

For maternity at least, there is a clear increasing trend towards referral to the OVT with these increasing since June 2017, however lack of data precludes an assessment of change since the introduction of the pilot. For Urology, far fewer patients are referred to the OVT and consequently fewer directly chargeable patients are invoiced, zero urology patients were invoiced in the pilot period compared to five from maternity. Only one patient was invoiced for maternity treatment in the same period in 2016.

Figure 2.15: Patients referred to OVT from maternity and urology services



There were also very few patients presenting an EHIC across both services during the pilot period with just two eligible, 1 for maternity and 1 for urology. This compares to four patients in total across both services in the same period in the previous year. It should be noted that EHIC numbers are extremely small and there were no S2 eligible patients between October 2017 and April 2014.

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2.7 Trust 5

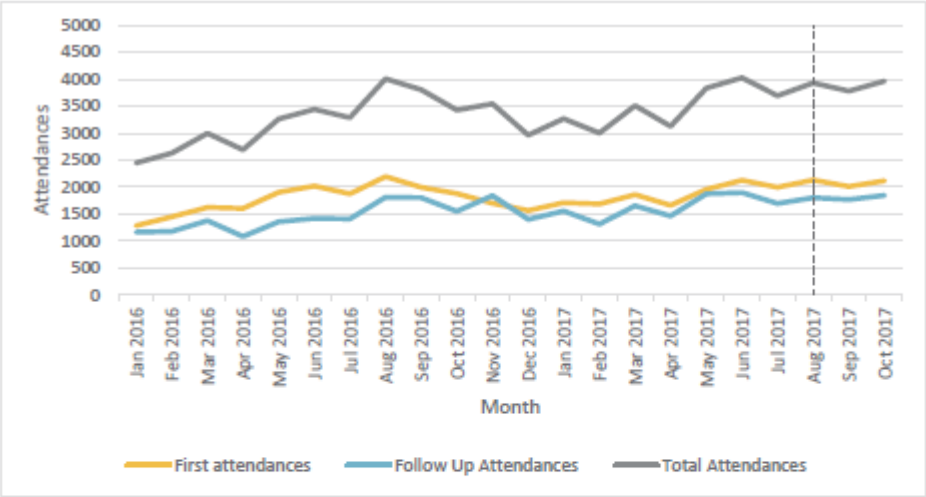
For trust 5, we have access to both activity data and cost recovery data for the two services piloted as part of the project, Trauma and Orthopaedics and Maternity.

For the primary analysis of activity rates and cost recovery for trust 5, data from the pilot months in 2017 were compared to the same months in 2016 on the basis that these periods should exhibit similar seasonal trends.

2.7.1 Trauma and orthopaedics

Total appointments for the Fracture clinic have risen steadily at trust 5 since the beginning of 2016 and there is no obvious change in this trend since the pilot began in late July 2017. The service recorded 11681 attendances during the pilot period and a further 3133 DNAs or cancellations. This compares to 11244 attendances in the same period of 2016 and 3211 DNAs or cancellations.

Figure 2.16: Fracture attendances at trust 5 since January 2016



DNAs/Cancellations

The cancellation rate was lower during the pilot period than the equivalent timeframe in 2016. Both cancellations instigated by the hospital and those by the patient fell by 1.2 and 0.2 percentage points respectively. The DNA rate remained the same at 6.3 percent of all appointments.

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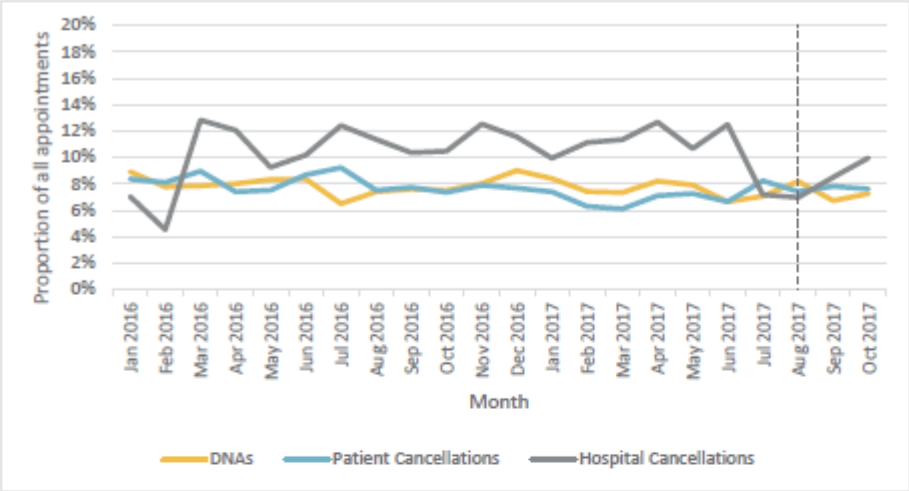
Figure 2.17: Trust 5 trauma and orthopaedics cancellations and DNAs

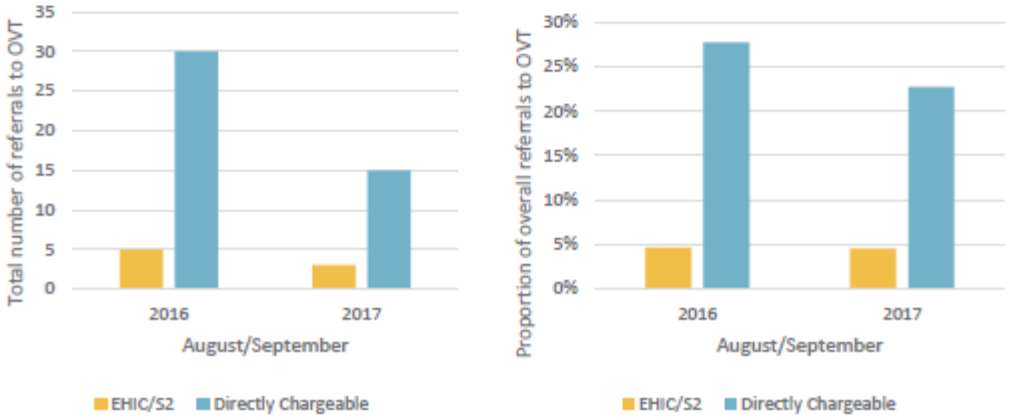


The general trend for cancellations has been steady since January 2016 and there is no indication of a departure from this since the pilot began. DNAs show a more erratic trend but no significant increase is evident since August 2017.

Cost recovery

Data on cost recovery for the fracture clinic appears to be incomplete for October and so the analysis has been focussed on comparison of the data for August and September. This shows fewer referrals to the Overseas Visitor team, down from 108 in 2016 to 66 in 2017 and also fewer patients identified as EHIC/S2 or directly chargeable. However, the proportion identified as EHIC/S2 and directly chargeable remain relatively similar albeit with the proportion identified as directly chargeable higher in 2016. This indicates that despite referring fewer patients to the Overseas team, a similar proportion of patients are still being identified as chargeable however it is not clear whether the pilot has caused any change.

Figure 2.18: Fracture clinic patients identified as chargeable



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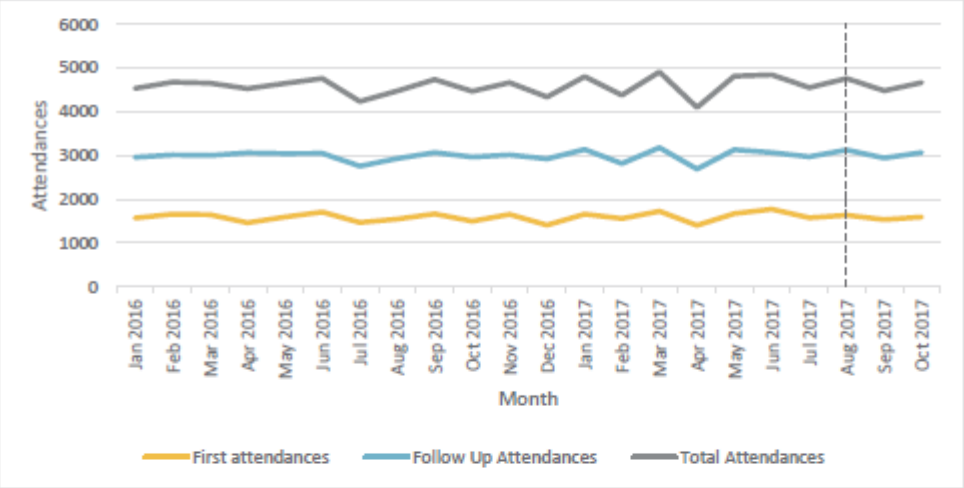
Where a patient was identified as directly chargeable, it is assumed that an invoice will be raised.

2.7.2 Maternity

Total appointments for the maternity service have remained steady at trust 5 since the beginning of 2016 and there is no obvious change in this trend since the pilot began in late July 2017. The service recorded 13691 attendances during the pilot period and a further 2324 DNAs or cancellations. This compares to 13691 attendances in the same period of 2016 and 2297 DNAs or cancellations.

Figure 2.19: Maternity attendances at trust 5 since January 2016



DNAs/Cancellations

Analysis suggests that there has been no impact on the overall, patient instigated or hospital instigated cancellation rate since the pilot began, nor does it indicate any impact on the DNA rate. The trend remains steady since January 2016 and comparisons to the same period in 2016 indicate only minor differences (less than 1 percentage point).

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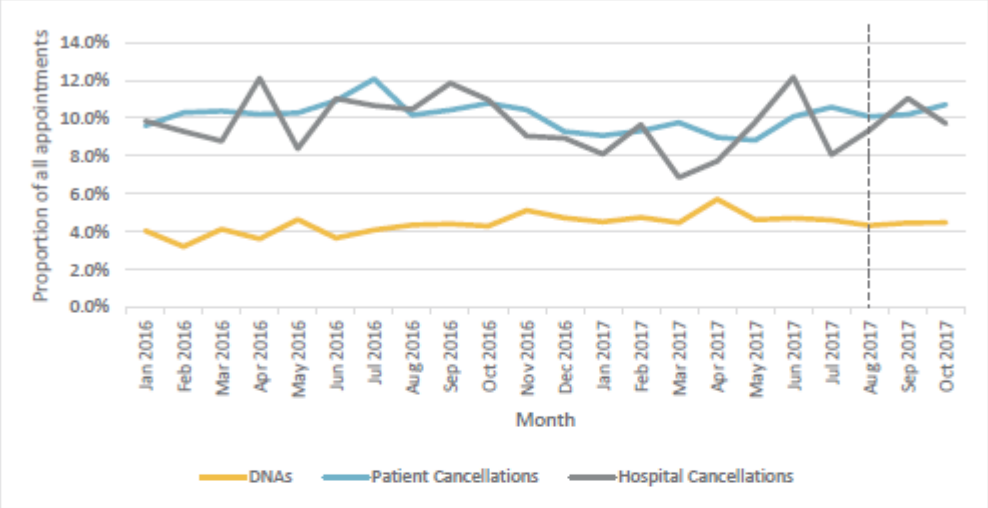
Figure 2.20: Maternity cancellations and DNAs

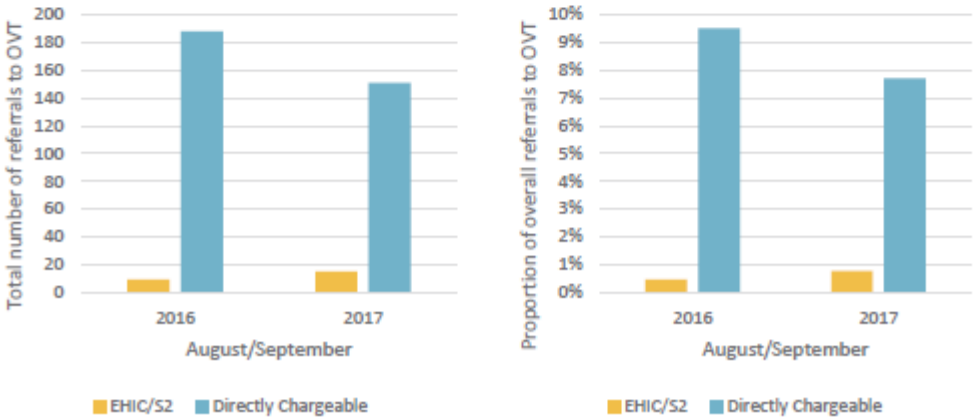


Cost recovery

As with the fracture clinic data, Octobers data appears incomplete and has been excluded from the below analysis.

For maternity, the number of referrals made to the overseas team remained similar over the two periods with 1,979 referrals in August and September 2016 and 1,960 in 2017. The number of patients identified as EHIC/S2 and directly chargeable also remain similar between periods. The figures below illustrate few differences.

Figure 2.21: Maternity patients identified as chargeable



APPENDIX E: Analysis of management information

2.8 A&E sites

A&E departments at four trusts piloted identification checks as part of the pilot and it is our understanding that these were specifically within their major A&E (type 1) departments. As such, the following analysis has focussed on exploring A&E activity within type 1 departments as defined in the monthly NHS England statistical data releases.[8]

The four trusts of interest here are:

1. Trust 4;
2. Trust 14;
3. Trust 11; and
4. Trust 18

Data on the number of attendances attending type 1 departments for each trust has been analysed in order to assess any effect of the pilot on the number of people attending A&E whilst data on the proportion of patient's seen at these departments in under four hours has also been looked at to assess any potential delays in patients receiving treatment as a result of the pilot.

2.8.1 A&E attendances

The total number of A&E attendances has continued to rise across England throughout the past two years, however A&E attendances at the major A&E departments of the four trusts piloting ID checks with A&E services appear to show much more stable numbers attending. In each of the four trusts, the difference from month to month appears relatively small with only two trusts showing a higher number of attendances in October 2017 than January 2016.

Examination of the number of attendances both either side of the pilot start date and with the same months in the previous year do not show any meaningful differences. This is not unexpected as A&E services included in the pilot did not request identification but instead only asked whether a patient would be able to provide it. Patients would also likely be unaware that this was going to be requested prior to attending and so this may not have factored into someone's decision to attend. Lastly, a requirement to provide identification is unlikely to play a major part in influencing someone to not access urgent treatment even if they are aware the question will be asked.

[8] Data available here: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/

APPENDIX E: Analysis of management information

Figure 2.22: A&E activity, Trust 4

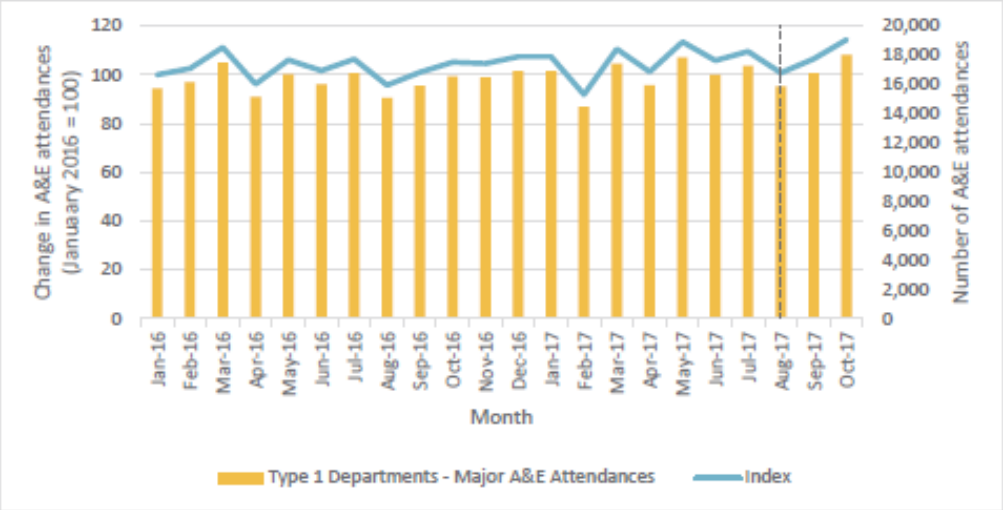


Figure 2.23: A&E activity, Trust 11

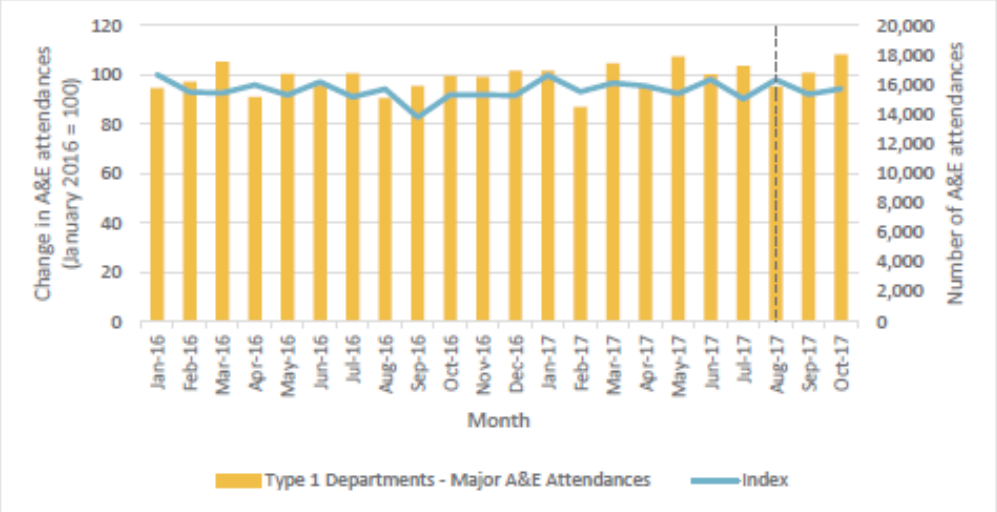


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Figure 2.24: A&E activity, Trust 18

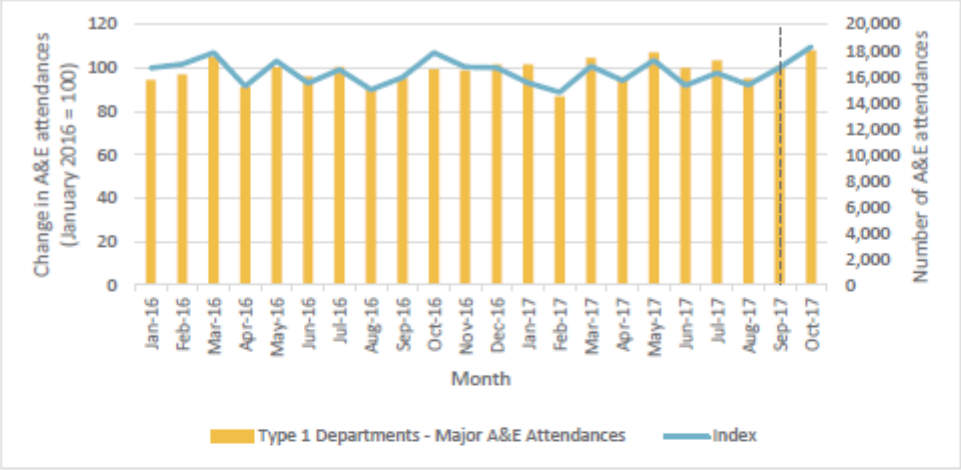
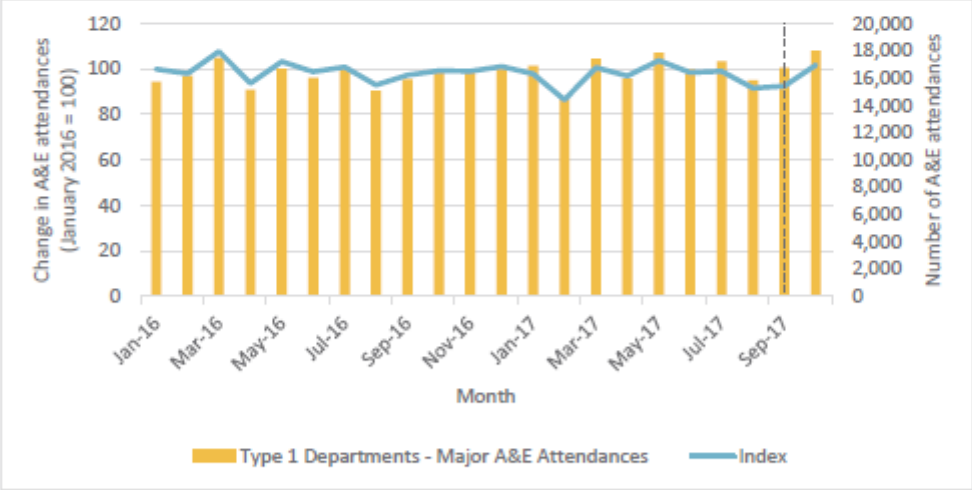


Figure 2.25: A&E activity, Trust 14



2.8.2 A&E attendances seen in under 4 hours

Analysis of type 1 A&E department performance against the four-hour waiting time target in each of the four trusts does not find any evidence of worsening performance during the pilot period. In general, the most recent month for which data is available (October 2017) shows an improvement from the previous month and in each case performance against the target is similar or better in the pilot period than in the same period in 2016.

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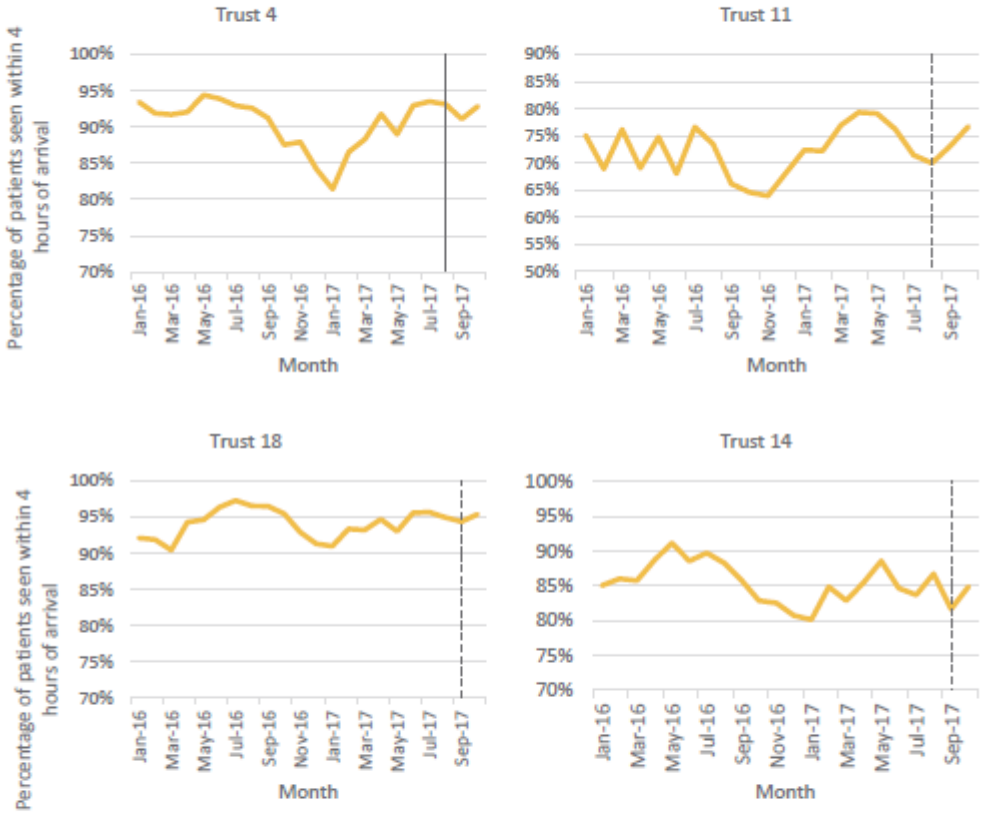
Figure 2.26: A&E waiting time target



2.9 Other sites

Some data was received from a further six sites, however the quality of the information provided meant that it was unusable. One further site did not provide any information at all.

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