Directorate for Finance, eHealth and Pharmaceuticals
Health Finance Division

CEL 15 (2013)

August 2013

Dear Colleague

Revised Payment Verification Protocols – General Dental Services, Primary Medical Services; General Ophthalmic Services; Pharmaceutical Services

1. The attached document updates and supersedes the guidance on payment verification procedures for Primary Medical Services contained in CEL (2011) 24 and CEL (2012) 16 and outlines the arrangements for payment verification for 2013/14.

Background

2. This revision includes the following main changes:

Dental

The Protocol has been revised to detail the Level 1 – 4 checks being undertaken across each of the payment categories (Capitation & Continuing Care; Items of Service; Allowances).

A section on Retention of Evidence has been added.

The section on Capitation & Continuing Care has been augmented with an enhancement of the existing checking processes for patient registrations – principally the following up of the 5% of registrations which currently do not match to CHI.

An appendix detailing the processes applied for the Inspection of Patients by the Scottish Dental Reference Service has been added.

Medical

Outlines the arrangements for payment verification for 2013/14 which will review the achievement levels for Quality and Outcomes Framework for 2012/13 and reflects the changes contained within the GMS Contract Agreement in Scotland for 2013-14, in particular the introduction of Organisational Core Standard Payment for which a new guidance section has been added.

Ophthalmic

A section on Retention of Evidence has been added.

Wording in each section has been revised to be consistent with the Protocols for other contractor streams, including the addition of a section on the outputs from the PV process.

Addresses

For action
Chief Executives and Directors of Finance, NHS Boards

Chief Executive, NHS National Services Scotland

For information
Chief Executives and Directors of Finance, Special Health Boards

Auditor General

NHSScotland Counter Fraud Services

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Pharmaceutical

There are changes to the categories of payments included in the core reporting.

Action

3. Chief Executives are asked to:

- note the revised protocol and ensure that relevant staff within their Boards are familiar with this;
- ensure that their Audit Committee have sight of the protocol;
- work with Practitioner Services in ensuring implementation of the protocol;
- note that GP practices must retain evidence to substantiate the validity of payments; and
- note that tri-partite discussions should take place between Practitioner Services, NHSScotland Counter Fraud Services (CFS) and the relevant NHS Board where a concern relating to potential fraud arises in the course of payment verification, and that, where a tri-partite meeting is deemed necessary, this should take place within 2 weeks of the simultaneous notification of the concern to the Board and the CFS by Practitioner Services.

4. Where a family health service practitioner refuses to co-operate in the payment verification process, he or she may be in breach either of his/her contract or terms of service. In such cases, NHS Boards are asked to take appropriate action.

Further Information

5. Further information is available from Alasdair Pinkerton, Practitioner Services Division, NHS National Services Scotland:

- email: alasdair.pinkerton@nhs.net.
- tel: 0131 275 6682.

Yours faithfully

John Matheson
Director of Finance, eHealth and Pharmaceuticals

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Introduction

1.1 As the accountable bodies for FHS spend, NHS Boards are required to ensure that the payments made to contractors on their behalf are timely, accurate and valid.

1.2 With respect to the validity of the payments, as far as possible claims will be verified by pre-payment checks. The checking process will be enhanced by a programme of post-payment verification, across all contractor groups – Dentists, GP's, Optometrists and Community Pharmacists.

1.3 Accountability for carrying out payment verification ultimately rests with NHS Boards. Whilst the majority of payment verification will be undertaken by Practitioner Services (in accordance with the Partnership Agreement between Practitioner Services and the NHS Boards) there may be instances where it is more appropriate for payment verification to be undertaken by the NHS Board. Consequently, there is an onus on Practitioner Services and NHS Boards to agree the annual payment verification programme.

1.4 It is vital that a consistent approach is taken to PV across the contractor streams and this paper outlines the ways in which this matter will be taken forward across the various payment streams.

1.5 These requirements have been produced following consultation with representatives from NHS Health Boards, Practitioner Services and Audit Scotland and reflect the outcome of a comprehensive risk assessment process. The payment verification processes will be subject to regular review in respect of performance and contractual changes.

1.6 Payment verification of the exemption/remission status of patients (Patient Checking) is dealt with within a Partnership Agreement between CFS and the NHS Boards.

Contractor Checking

2.1 Ophthalmic, Pharmaceutical and Dental Payments

2.1.1 It is intended that payment verification checks will take place on 4 levels:

2.1.2 **Level 1** Routine pre-payment checking procedures carried out by PSD staff, including automated pre-payment checking by Optix/MIDAS/DCVP, with reference to the Community Health Index (CHI) where appropriate.

2.1.3 **Level 2** PV Teams will undertake a trend analysis and monthly/quarterly sample testing, where:

- The results of level 1 checks indicate that this would be beneficial;
- The results of statistical trend analysis indicate a need for further investigation;
- The formal assessment of the level of risk associated with a particular payment category indicates a need for more detailed testing.

2.1.4 **Level 3** PV Teams will, as appropriate, undertake extended sample testing, send out patient letters, or conduct targeted inspection of clinical records in order to pursue the outcome of any claims identified at Levels 1 and/or 2 as requiring further investigation.

2.1.5 **Level 4** PV Teams will undertake a random assessment of claims, which may require an inspection of clinical records and/or patient examination.

2.2 GMS Payments

2.2.1 Due to the different nature of the GMS contract, payment verification will use various techniques such as:

- validation of data quality;
- checking of source documentation and activity monitoring. The purpose of this is to reduce the requirement to access patient medical records during practice visits; and
- Payment verification practice visits.

2.3 Inspection of Clinical Records

2.3.1 Inspection of clinical records may or may not necessitate a practice visit, depending on the contractor type and also on the implementation of PV protocols at local NHS Board level.

The methodology of actual practice visits is detailed further in Appendix B of the Medical and Appendix A of the Ophthalmic Annexes.

Risk Assessment

In order to ensure that maximum use is made of the finite resources available for payment verification, it is imperative that PV work is targeted at the areas of highest risk. Risk Matrices have been developed and applied to facilitate the appropriate risk assessment of the payment areas and targeted use of payment verification resources.

In order to ensure that these Risk Matrices continue to reflect both the materiality of, and the risks relating to, all contractor payment types, it is intended that the application of the risk assessment methodology will be subject to an annual review.

This review will be undertaken by the appropriate PV Contractor Group, and shall be subject to approval by the PV Governance Group.

Reporting to NHS Boards

NHS Boards also require assurance on the level of payment verification checking carried out in their respective areas, in relation to the guidance set out in this document.

In order to support this, the Practitioner Services PV teams will produce quarterly reports for each of the contractor streams, providing information on the level of checking carried out in each NHS Board area and highlighting any specific issues of interest.

In addition, for all categories of payments it is important that any matters of concern, arising from the payment verification work undertaken, are acted upon quickly and appropriately. In such circumstances the procedures noted at Section 6 below will be followed.

Countering Fraud

NHSScotland CFS has the responsibility of working with others to prevent, detect and investigate fraud against any part of the NHS in Scotland. Under Scottish Governments Strategy to Combat NHS Fraud in Scotland, everyone within NHSScotland has a part to play in reducing losses to fraud and, to increase deterrence, effective sanctions will be applied to all fraudsters. Professional bodies representing all FHS Practitioners have signed a counter fraud charter with CFS, committing their members to assist in reducing fraud against the NHSS.

Where either Practitioner Services or an NHS Board, through the application of their internal control systems, pre- or post-payment, identify irregularities which could potentially be fraud, they shall make their concerns known to CFS. Where necessary tri-partite discussions will be held to determine the best way forward in accordance with the Counter Fraud Strategy and the NHS Board/CFS Partnership Agreement.

Adjustment to Payments

All proposals to make additional payments or to seek recoveries of overpayments from contractors as a result of PV investigations will be the subject of discussion and agreement between Practitioner Services and the relevant NHS Board. Although any recovery is officially in the name of the NHS Board and any formal action to recover will have to be taken in their name, it is important that recoveries are effected by Practitioner Services through the Practitioner Services Payment processes. This will ensure that all such adjustments are recorded in the payment systems and that any consequential adjustments for other payments (such as pension deductions) take account of the adjustment.

Annex I – Dental Payments

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Introduction

The following sections detail the payment verification requirements for General Dental Services (GDS).

Practitioner Services (Dental) operates under the aegis of the Scottish Dental Practice Board (SDPB) whose powers are set out in statutory legislation. The role of Practitioner Services Dental, as agents of the Scottish Dental Practice Board, is to attest that care and treatment proposed or provided under GDS is appropriate having undertaken a risk versus benefit analysis. In addition this clinical governance process will inform the verification of payments.

Practitioner Services (Dental) operates a computerised payments system (MIDAS) as well as an optical character recognition system (iDent), both of which undertake extensive pre-payment validation on dental payment claims. Electronic Data Interchange (EDI) is accepted by MIDAS and the checks noted below apply equally to scanned paper claim input and data fed through EDI.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GDS)(Scotland) Regulations 2010, the Statement of Dental Remuneration (SDR) and the Scottish Dental Practice Board Regulations 1997, para 10(2). The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to dental practitioners.

Capitation & Continuing Care

Capitation and continuing care payments are based on the numbers and ages of the patients registered with the dentist. These details are gathered when dental claim forms are submitted and payment will continue unless the patient registers with another dentist, dies, embarks (has left the United Kingdom) or is de-registered by the dentist.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present;
- patient existence/status by matching to CHI;
- validation against the SDR; and
- duplication on MIDAS.

Level 2 will comprise trend analysis of claims, including, but not limited to:

- number of registrations by contractor;
- registrations by contractor that are unmatched to CHI; and
- registrations by contractor with no IOS claims.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters;
- sampling of patient records and associated documentation; and
- liaison with private capitation scheme providers to establish registration status.

Level 4 will comprise of a percentage of unmatched registrations (where an IOS claim has been made) being included in the random examinations of patients by the Scottish Dental Reference Service (SDRS) as per Appendix A.

Outputs:

Quarterly PV report detailing:

- Ø Results and status of checking process
- Ø Any necessary recommendations, actions and recoveries.

Items of Service

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by MIDAS/iDENT – to ensure all mandatory information is present;
- patient existence/status by matching to CHI;
- validation against the SDR and any provisos or time limits that apply;
- duplication on MIDAS;
- the patient's date of birth for age exemption; and
- checking the total value of the claim and applying prior approval as appropriate.

Prior Approval – claims with values in excess of the prior approval limit require to be submitted for checking before treatment is carried out. These are assessed for both clinical and financial appropriateness.

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- individual and combinations of item of service claims;
- items claimed where the patient does not pay the statutory charge;
- level of earnings; and
- cost per case and throughput.

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters;
- sampling of patient records and associated documentation;
- applying the "special prior approval" process or the "prior approval by targeting" regulation; and
- referral of patients to the SDRS to confirm that treatment proposed or claimed was in accordance with the SDR in compliance with the NHS (GDS)(Scotland) Regulations 2010.

Level 4 will involve the SDRS examining a sample of patients, chosen at random, from every NHS dentist to confirm that treatment claimed was in accordance with the Statement of Dental Remuneration in compliance with the NHS (GDS) (Scotland) Regulations 2010.

Any practitioner who receives an unsatisfactory report from the SDRS in relation to the validity or standard of treatment provided to the patient is automatically referred to the NHS Board for consideration.

Outputs:

Quarterly PV report detailing:

- Ø results and status of checking process;
- Ø details of information used to verify service provision; and
- Ø any necessary recommendations, actions and recoveries.

SDRS reports

Allowances

Allowances are based on existing data held within MIDAS (e.g. General Dental Practice Allowance and Commitment Payment) or they are the subject of separate claims submitted by the dentist or practice.

Level 1 will comprise 100% checking of:

- mandatory information and supporting documentation is present;
- validation against the SDR and any provisos or time limits that apply; and
- duplication on MIDAS.

Outputs

Quarterly PV report detailing:

- Ø results and status of checking process; and
- Ø any necessary recommendations, actions and recoveries.

Appendix A – Inspection of Patients – Scottish Dental Reference Service (SDRS)

1 Background

1.1 One of the methods of verifying payments made under General Dental Services (GDS) arrangements is to examine patients. This service is carried out by a Dental Reference Officer (DRO) employed by the SDRS. The DRO inspects patients' mouths before extensive work is carried out, or after they have received treatment.

1.2 All patients receiving treatment under GDS sign to say that they agree to be examined by a dental reference officer if necessary

2 Selection of Patients

2.1 Every year a number of patients, chosen at random, from every NHS dentist are invited to attend the SDRS. Patients may also be invited to attend where the application of risk assessment or trend analysis in relation to claims received from practitioners suggests that this would be appropriate.

2.2 Practitioners are advised about appointment timings for their patients and are permitted to attend the examination.

3 SDRS Reports

3.1 Once a practitioners patients have been examined, a report is produced which details DRO's opinion of the clinical care and treatment/clinical treatment proposals, and any concerns relating to possible clerical errors, mis-claims or regulatory concerns.

3.2 Clerical errors, mis-claims or regulatory concerns are classified in a SDRS report as follows:

Administrative (i) m: possible mis-claim e.g. claiming the wrong code.

Administrative (i) c: possible clerical error e.g. mixing an upper and lower or left and right on the charting of a restoration.

Administrative (i) r: possible regulatory error e.g. claiming an amalgam on the occlusal surface of a premolar when a composite was provided.

3.3 The (i) code assigned to the examination by the DRO will determine the course of action to be taken. This may include no further action, further patient examinations, discussion with or referral to the Health Board, or in some cases a tri-partite meeting between Practitioner Services, the NHS Boards and CFS.

Payment Verification Protocol – Medical

Payment Verification Programme for 2013-2014 Financial year

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Introduction

The following sections detail the payment verification requirements for Primary Medical Services, including the relevant elements contained within the GMS Contract Agreement in Scotland 2013-2014.

The verification arrangements outlined will require local negotiation between NHS Boards and Practitioner Services on implementation. This should ensure that a consistent approach is taken to payment verification irrespective of who performs it (reference Appendix A – GMS PV Checklist).

Each of the three Practitioner Services Regional Offices supports a dedicated Medical PV team to undertake the required payment verification work. These teams work in close co-operation with their respective NHS Boards and colleagues in the other Medical departments to ensure co-ordination in payment verification and related activities.

Enhanced Services

This document includes direction on payment verification for all enhanced services, i.e. Directed, National and Local/Scottish Enhanced Services Programme. The payment verification outlined in this paper provides basic principles that should be adhered to when agreeing the payment verification required for an enhanced service.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments relating to the GMS Contract. The requirement for this evidence will be in line with that detailed in the Contract, in the Statement of Financial Entitlements or in locally negotiated contract documentation. It is particularly important to retain evidence that is generated by the running of a computer generated search, as this provides the most reliable means of supplying data, should practices be required to do so, that fully reconciles with the claim submitted. Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support a payment to the GP Practice.

Data Protection

PCA (M)(2005) 10, Confidentiality & Disclosure of Information Code of Practice, illustrates the circumstances under which disclosure of patient identifiable data may be made in relation to checking entitlement to payments and management of health services. The guidance contained in this document is consistent with this code of practice.

The practice visit protocol, contained as Appendix B in this document, pays particular attention to minimising the use of identifiable personal data in the payment verification process. The use of clinical input is recommended to streamline the process, provide professional consistency, and limit the amount of investigation necessary in validating service provision.

Premises and IT Costs

Expenditure on premises and IT will be met through each Board's internal payment systems and as such will be subject to probity checks through the Board's normal control processes. There is therefore no payment verification required. Where Practitioner Services are required to make payments on behalf of NHS Boards these will be checked for correct authorisation.

Payment Verification for Global Sum

METHOD

The Global Sum is the payment to GP Contractors for delivering essential and additional services and from 2013-2014 the Core Standards transferred from QOF as part of the GMS Contract Agreement in Scotland 2013-2014.

Arrangements for the Payment Verification of the Global Sum will now include Organisational Core Standard Payment as outlined in the Statement of Financial Entitlements.

A GP Practice's allocation is dependent on their share of the Scottish workload, based on a number of weighting factors (reference Annexe B, Scottish Allocation Formula, GMS Statement of Financial Entitlements).

The most significant risk to the Health Board share of the Global Sum is the accuracy of data held on the Community Health Index (CHI).

The verification of the data held on the CHI is achieved in a number of ways. Although the intent of these control and verification processes is primarily focussed on the accuracy of patient data for health administration purposes, assurance can be taken from the existence and application of many of these controls for payment verification purposes. The following controls and processes are used to verify GP Practice Population List Size and weighting factors:

System/Process Generated Controls

- All new patient registrations transferred electronically via PARTNERS to the Community Health Index (CHI) are subject to an auto-matching process against existing CHI records. If a patient cannot be auto-matched further information is requested from the GP Practice so that positive patient identification can be ensured.
- All patient addresses transferred by PARTNERS to CHI are subject to an auto-post coding process to ensure validity of address within the Health Board Area.
- All deceased patients are automatically deducted from the GP Practice on CHI using an interface file from NHS Central Register (information being derived from General Register of Scotland). Patients registering elsewhere in the UK are deducted from the GP Practice on CHI following matching by NHS Central Register.
- Patients are automatically deducted from GP Practice on registration with another GP Practice in Scotland.
- All patients confirmed as no longer residing at an address are removed on CHI and automatically deducted from GP Practice lists via PARTNERS.
- Quarterly archiving of GP Practice systems and generation of PARTNERS reports ensures that all patient transactions (acceptances and deductions) have been completed by the GP Practice.

- All patients whose address is an exact match with a Care Home address will automatically have a Care Home indicator inserted on CHI.
- Where new patient registrations are not transferred by PARTNERS manual scrutiny of registration forms is undertaken.
- Registration Teams check unmatched patients (without CHI number) to NHS Central Register database to ensure positive patient identification.

Random Checking

- Validation on patient data for a minimum of 10% of GP Practices annually via Patient Information Comparison Test (PICT) to ensure that patient data on CHI and on GP systems match. The following fields can be validated:

  1. Date of Birth and Sex differences
  2. Name differences
  3. Unmatched patients
  4. Patients on CHI but not on practice system
  5. Patients who have left the practice
  6. GP Reference differences
  7. Address differences
  8. Possible duplicates
  9. Missing CHI Postcodes
  10. Mileage differences

Targeted Checking

- Manual scrutiny of registration forms where there is concern regarding the quality of registration data submitted via PARTNERS.

- Data Quality work which contributes to the removal of patients from CHI:

  1. UK and Scottish Duplicate Patient matching exercises to ensure that patients are only registered with one GP Practice.
  2. Bi-annual short term residency checks on patients such as, Students, c/o Addresses, Holiday Parks, or Immigrant status.
  3. Annual checks on patients aged over 100.
  4. Quarterly checks on Care Home Residents.
  5. All mail to patients (medical card or enquiry circular) that is returned in post is followed up with the GP Practice and where appropriate patients are removed from CHI and from the GP Practice list.

- Validation on patient data via PiCT for capitation dispute, data quality concerns or system migration (fields as above).

Payment Verification Practice Visit

- Where patient registration data is submitted via PARTNERS the Payment Verification visiting team will check a sample of recent patient registrations to ensure that General Practice Registration Form (GPR) has been completed and

retained by the practice electronically as verification that a contract between the GP Practice and the patient exists.

Trend Analysis

- Monitoring of levels of the following using the Quarterly Summary Totals report by Health Board Area:

  1. Capitation Totals by age/sex bands
  2. Patients in Care Homes registered with the practice in the last 12 months
  3. Patients in Care Homes registered with the practice more than 12 months ago
  4. All other patients registered with the practice in the last 12 months
  5. All other patients registered with the practice more than 12 months ago
  6. Number of Dispensing Patients
  7. Number of Mileage patients

- Monitoring of levels of the following through Key Performance Indicators using the Quarterly Summary Run:

  1. Number of new registrations in CHI in quarter
  2. Number of patients removed from CHI as deceased

- Number of patients removed from CHI as moved out of Health Board Area.
- Pre-Payment checking of quarterly payments being authorised by GP Practice on the value of the Global Sum Payment to ensure that variances no more than +/- 5% of the value of the previous quarter.

OUTPUTS

Ø A Global Sum Verification Report will be generated on a quarterly basis.

The report will detail the results of the checking and any actions taken as a result of the checks and provide recommendations to the Health Board.

Payment Verification of Organisational Core Standard Payment

METHOD

To verify practice compliance with these standards one or more of the following techniques will be used:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. (See Appendix B). Verification may also include the inspection of written evidence retained outwith the patient record and a review of the underlying systems and processes that a practice has in place. e.g. training logs, Significant Event reports, Board correspondence and practice minutes.
- Discussion and verification of GP Practice policies and procedures either during the practice visit or as part of office based verification work.
- Review of complaint logs.

OUTPUTS

- Results and status of checking process.
- Details of information used to verify compliance with Organisation Core Standard Payment.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Temporary Patient Adjustment (TPA)

METHOD

To verify that the payment of the TPA is appropriate the following checks will be undertaken:

- Random sampling of GP Practice records for evidence of service provision at practice visit.
- Complaint logs will be reviewed annually to identify complaints, or a pattern of complaints, that could indicate a lack of service provision. If an absence of service is found, this should be subject to further investigation, and if necessary further action taken.
- Where concerns exist over an absence of provision of service, a practice may be asked to demonstrate their process of recording instances where treatment of a temporary patient(s) has been refused.

The incorrect registration of temporary patients as permanent patients will be checked as part of the payment verification for Global Sum.

OUTPUTS

- Number of records checked at practice visit and results.
- Record of check made to Complaint logs.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Additional Services

METHOD

To verify that these services are being provided, one or more of the following verification techniques will be undertaken as applicable:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix B.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS

- Ø Number of records checked at practice visit and results.
- Ø Details of information used to verify service provision.
- Ø Any necessary recommendations, actions and recoveries.

Payment Verification for Payments for a Specific Purpose

METHOD
To verify that these payments are valid, source documentation will be reviewed as follows:

Maternity/Paternity/Adoption –

- Agree entitlement under appropriate employment legislation (length of absence, employment status, etc) under Statement of Financial Entitlements (SFE) 9.3.
- Agree conditions of payment are met. (Cert. of confinement, letter stating paternity details, letter from adoption agency, confirmation of cost of locum cover) under SFE 9.7.

Sick Leave –

- Agree entitlement under the SFE 10.3. (Length of absence, payment of SSP, absence of accident compensation).
- Agree necessity of locum cover under SFE 10.4.
- Confirm prior approval from NHS Board under SFE 10.9.
- Check to Med. Certs and confirm cost of locum cover under SFE 10.9.

Suspensions –

- Agree entitlement under SFE 11.3 (Suspended GP on full income).
- Agree necessity of locum cover under SFE 11.4.
- Confirm cost of locum cover under SFE 11.7.

Study Leave –

- Agree entitlement under the SFE 12.2 (Study leave>= 10wks <= 12 months, approved by local Dir. of Postgraduate GP Education, determined by NHS Board as affordable, not paid elsewhere).
- Agree necessity of locum cover under SFE 12.6.
- Confirm prior approval from NHS Board under SFE 12.9.
- Confirm cost of locum cover under SFE 12.9.

Golden Hello –

- Standard - Agree entitlement under the SFE 14.2. (e.g. Minimum 1/5th of part-time posts, fixed term of >2 yrs, not previously employed as specified).
- Remote - Confirm practice meets definition of remote & rural under SFE 14.4.1.
- Deprived - Confirm practice meets definition of deprived under SFE 14.4.2.
- Confirm that either remote or deprived payment made (not both) under SFE 14.4.3.
- Non Principal Doctors - Agree entitlement under the SFE 14.2 (e.g. Min 1/5th of part-time posts, fixed term of >2 yrs, not previously employed as specified).

Recruitment –

- Confirm appropriate receipts.
- Ensure application is within 12 months of the doctor taking up post.

Relocation –

- Confirm submission of 3 competitive tenders.

Retainer Scheme –

- Confirm the contractor is a suitable employer of members of the Retainer Scheme.
- Confirm the service sessions have been arranged by the Dir. of Postgraduate GP Education.

Adults with Incapacity –

- Analysis of outlier data.
- Where outlier analysis suggests further investigation is required, seek confirmation with the independent health professional.

OUTPUTS

Ø Numbers and value of payments made by payment type and practice.

Ø Any specific matters arising in the processing of payments.

Payment Verification for Section 17c Contract

METHOD

Payments to practices holding section 17c contracts are split into two streams:

- Payments that map to those received by section 17j practices.
- Payments that are specific to their section 17c contract.

Payments that map to those received by section 17j practices are subject to the payment verification processes outlined elsewhere in this document.

To verify that payments specific to a section 17c contract are appropriate, these practices will be subject to NHS Boards contract monitoring processes which may involve:

- NHS Board quarterly review.
- Analysis of practice produced statistics which demonstrate contract compliance.
- Reviewing as appropriate section 17c contracts against other/new funding streams to identify and adjust any duplication of payment.

OUTPUTS

- Ø Number of records checked at practice visit and results.
- Ø Details of information used to verify service provision.
- Ø Any necessary recommendations, actions and recoveries.
- Ø As per agreed local monitoring process.

Payment Verification for Seniority

METHOD

When all existing GPs transferred to the new GMS contract in 2004 their Seniority claims were subject to a programme of payment verification checking which was completed in 2007. To verify that new claims for Seniority payments are valid, checks will be undertaken, prior to payment, as follows:

- Reasonableness of claim – to check appropriateness of dates against information on form seems appropriate - General Medical Council (GMC) registration date, NHS service start date.
- check for length of service.
- check eligibility of breaks in service.
- where applicable check with Scottish Government (SG) for eligibility of non-NHS Service.

OUTPUTS

- details of new claimants received in quarter and level of seniority.
- results and status of checking process.

Payment Verification for Enhanced Services

INTRODUCTION

The method and output sections below provide generic guidance for the payment verification of all Enhanced Services. This includes Directed, National and Local services and those defined within the Scottish Enhanced Services Programme.

METHOD

To verify that these services are being provided the relevant specification for the service must be obtained. The practice's compliance against this specification will be verified by one or more of the following techniques:

- Practice Visit – the purpose of which is to examine a percentage of patient records. Records to be reviewed will be selected at random. (See Appendix B). Verification may also include the inspection of written evidence retained outwith the patient record and a review of the underlying systems and processes that a practice has in place.
- Analysis of anonymised practice prescribing information.
- Analysis of GP Practice activity information.
- Discussion of GP Practice policies and procedures.
- Confirmation letters/surveys to patients.
- Review of Complaints log.
- Discussion of how Extended Hours service was planned and organised. Checks to provide evidence that the service is being provided, (e.g. check against availability in the appointment system, notification of service availability to patients - practice leaflet, posters, etc.)

OUTPUTS

- Results and status of checking process.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for the Quality and Outcomes Framework – 2012/13

INTRODUCTION

The Quality & Outcomes Framework (QOF), as specified in the Statement of Financial Entitlements (SFE), rewards practices on the basis of the quality of care delivered to patients. Participation in the QOF is on a voluntary basis.

The framework contains four domains, one clinical and three non-clinical domains. Each domain contains a range of areas described by key indicators and each indicator describes different aspects of performance that a practice is required to undertake.

The four domains are:

- **Clinical** – comprising 22 clinical areas.
- **Organisational** – comprising 6 areas; Records & Information, Information for Patients, Education & Training, Practice Management, Medicines Management and Quality & Productivity.
- **Patient Experience**
- **Additional Services** – comprising 4 areas; Cervical Screening, Child Health Surveillance, Maternity Services and Contraception.

QOF Points Value

The overall number of points that a GP Practice can achieve (in 2012-13) is as follows:

Domain	Points
Clinical	638
Organisational	185.5
Quality & Productivity	99.5
Patient Experience	33
Additional Services	44
TOTAL	**1000**

QOF Data Gathering & Reporting

A single national system (QOF Calculator) collects national achievement data, computes national disease prevalence rates and applies computations to calculate points and payments.

Data held within practice clinical systems forms the basis for a practice's achievement declaration in respect of each indicator within the clinical domain and a number of the indicators within the non-clinical domains. Clinical data recording is based on Read codes and only data that is useful and relevant to patient care should be collected i.e. it is not collected purely for audit purposes.

In relation to a number of other indicators within the non-clinical domains, practices declare their achievement via a “Yes/No” answer process and are required to retain written evidence as proof that they have met the requirements of the indicator.

The data one indicator comes from a source other than the practice:

- Payment for the CS1 indicator is actioned by Practitioner Services via the manual input of achievement data from the screening systems utilised by NHS Boards.

QOF Review

The review of a Practice’s achievement under the QOF involves four distinct processes:

- **Pre-Payment Checking –**

1. The monitoring of practices on an ongoing basis to ascertain how their reported disease register sizes within QOF Calculator change and how they compare to the size of the disease register at the end of the preceding financial year.
2. Following the submission of a practice’s QOF achievement declaration, NHS Boards and practices have a set period during which pre-payment verification must be carried out. It is only when this process is complete to the satisfaction of the NHS Board that the achievement declaration of each practice can be approved and payment made in respect of QOF. Practices and NHS Boards will sign off their achievement in accordance with the timetable set out in the SFE. Guidance to NHS Boards about how pre-payment verification may be undertaken as part of their annual assurance processes is provided in Appendix C.

- **Post Payment Checking –**

3. All NHS Boards will have a practice review programme in place. Where this incorporates an element of QOF review then any significant issues arising from this process should be made available to be considered as part of payment verification.
4. A payment verification visit to provide assurance in respect of the validity of a practice’s QOF achievements, and hence payment, for the preceding financial year. These visits will be on a random sample basis (five percent of all practices/minimum of one, per year, per NHS Board). In addition, at the request of the NHS Board, visits may be carried out where, for example, the application of risk assessment or trend analysis suggests that this may be appropriate.

QOF Payment Verification Methodology

While the QOF contains four domains, for payment verification purposes it is more practical to group the indicators within these domains under the following three headings according to the type of evidence that a practice holds and where it is recorded. The indicators which comprise each of the headings are detailed in Appendix D.

A - Data Held Within a Patient Record

Each indicator within the clinical domain requires the recording of key data within a patient record, and in addition there are a number of indicators in the non-clinical domains that also require this type of recording. Given the large numbers of indicators of this nature, five groupings have been developed to take cognisance of the effect the indicator has on payment, the indicator type, and the method of verification to be used.

1. Disease Register Integrity –

   A patient's inclusion within a register should be verified via the review of other supporting clinical evidence held within the patient record. For example, a patient's inclusion within the Heart Failure register may be confirmed by an Echocardiogram or by specialist assessment.

2. Trend Analysis of Blood Pressure Readings –

   A sample of patients who have met these indicators should be identified and analysis of the historical blood pressure readings contained within their record should take place. This analysis should look at the trends within a patient's blood pressure readings over time, and increases/decreases in prescribing of anti-hypertensive therapy. Assurance should also be gained, where appropriate, by cross matching blood pressure readings to other evidence of face-to-face contact with the patient e.g. entries within the appointment book, records of house calls and information collected by other members of the Community Health Team.

3. Lab Tests –

   A sample of patients who have met these indicators should be identified and the system recorded value cross-referenced to lab results. If lab results are automatically downloaded into the practice's system, then further verification is not required in respect of these indicators.

4. Data Recording –

   Verification of these indicators is achieved via reference to the records of a sample of patients who have met the indicator in question. In addition, for indicators that involve a face-to-face contact, cross-matching to entries in the appointment book should take place. For indicators that relate to the carrying out of annual reviews, the record should be examined to ensure that all required aspects of the review are documented. The PC2 indicator may be verified by reference to the system for initiating and recording meetings.

5. Repeat Prescribing –

   A sample of patients who have met these indicators should be identified and a check made to their medical record that they were prescribed the drug in question

during the contract year for which the payment was made. Consideration should be given to cross-referencing prescribing entries with data contained within the appointment book, however it should be noted that the primary source of repeat prescribing is not the GP/patient consultation, and this may be of limited value. Therefore, a "systems & processes" discussion should take place in order to assess the controls in place surrounding repeat prescribing within the practice. In particular, this discussion should identify how repeat prescribing records are established, updated, and who within the practice has authority to prepare and issue scripts.

Within each of these five groupings, the principle of "cross verification" has been utilised where possible. For example, CHD 8, STROKE 7, PAD 4 and DM 17 are indicators within different disease areas that relate to the measuring of total cholesterol levels. It is not necessary to test all 4 indicators; if a satisfactory level of verification is achieved via the testing of Stroke patients who have met this indicator, it is reasonable to assume that an equally satisfactory level of verification will be achieved for Chronic Heart Disease, Peripheral Arterial Disease and Diabetic patients who have met this indicator.

Exception Coding

In addition to the recording of key data for each indicator, practices may also record "Exception Codes" within a patient record. These codes exclude patients from the performance target for each indicator in order that practices are not penalised financially for patient characteristics which were beyond their reasonable control. In practical terms, this means that an accepted Read Code has been entered into the patient's record to reflect a valid reason for exclusion.

A practice's use of exception coding will be assessed against 'New Guidance on Exception Reporting – October 2006' PCA (M)(2006) 15 and CEL 14 (2012) 'Supplementary Guidance on Exception Reporting – April 2012'. This will include the review of supporting clinical evidence held within the patient record e.g. a patient who has been exception coded as Refused/Declined should have evidence within their patient record that they were invited on at least 3 separate occasions within the preceding 12 months.

During the verification of the Trend Analysis, Lab Tests, Data Validation, and Repeat Prescribing indicators, consideration will be given to instances where Exception Coding has assisted the practice in meeting the payment threshold.

B – Data Held Outwith a Patient Record

Within the non-clinical domains there are a number of indicators which require practices to retain written evidence outwith the patient record as proof that they have met the requirements of the indicator.

Wherever possible, in order to minimise the volume of verification work undertaken, cognisance will be taken of the assurance gained from any review of evidence carried out by the NHS Board in relation to QOF pre-payment verification work.

Verification of non-clinical organisational indicators will be undertaken broadly in line with Quality and Outcomes Framework Section 4 in the Statement of Financial Entitlements. This will include verification of a sample of Grade A, B and C evidence, by the inspection of written evidence and a review of the underlying systems and processes that a practice has in place.

C - Indicators Where External Verification is Relied Upon
There is 1 indicator where external verification is relied upon:

- Additional Services – (CS1).

The achievement data held on screening systems is the subject of routine review by NHS Boards, with further independent verification being provided via the laboratory assessment of samples. No further specific verification is therefore required in respect of this indicator.

Following the application of the annual Payment Verification risk assessment, the selection of the indicators, in line with the methodology above, will result in the testing of at least 70% of the points achieved by a practice. In determining the sample spread across the groupings detailed above, cognisance will be taken of any locally known areas of risk or concern.

QOF Payment Verification Visits

The QOF payment verification visit may be carried out on its own, or at the same time as the Additional/Enhanced Services payment verification visit. It is for Practitioner Services and Boards to agree this locally; however it is recommended that the visit be made as close to the payment date as is possible. The visit will conform to the principles detailed in Appendix B – Clinical Inspection of Medical Records/Practice Visits.

Outputs

Ø Pre -payment Checking.

An analysis of how reported disease register sizes within QOF Calculator change, and how this compares to the size of a disease register at the end of the preceding financial year.

Ø Post Payment Checking.

Further to the completion of a practice visit, a report will be produced which details the following:

- information used to verify service provision;
- number of records checked and results;
- any necessary recommendations, actions and recoveries; and
- level of assurance gained.

GP Practice System Security

Payment verification practice visits comprehensively utilise data held within GP clinical systems, and it is therefore necessary to seek assurance that there are no issues regarding the reliability or the integrity of the systems that hold this data.

NHS Boards are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for GP practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained that appropriate measures are in place to ensure the integrity of the data held within each GP Practice's clinical system.

In obtaining this level of assurance, consideration will be given to the following areas:

- an established policy on System Security should exist that all practices have access to and have agreed to abide by;
- administrator access to the system should only be used when performing relevant duties;
- a comprehensive backup routine should exist, backup logs should be examined on a regular basis with issues being resolved where appropriate, and appropriate storage of backup media should occur; and
- up to date anti-virus software should be installed, and be working satisfactorily.

In addition, confirmation will be sought during a practice visit that users have a unique login to the GP clinical system, that they keep their password confidential, and that they will log off when they are no longer using the system.

OUTPUTS

Ø Any necessary recommendations and actions.

Appendix A – GMS Payment Verification Checklist

The table below is an illustrative example only. It will require expansion or amendment for local NHS Board agreement and implementation.

Payment	Data Source	Check / Process	Who	Reporting	Where
Global Sum					
System/Process Generated Controls	-	Auto matching via PARTNERS/Auto postcoding of transactions/NH/RH indicator		No of patients registered in quarter	Global Sum Verification Report
	-	Manual scrutiny of GPR for non PARTNERS linked practices		No of patients registered in quarter	Global Sum Verification Report
	-	Deduction of decease patients		No of deceased patients	Global Sum Verification Report
	-	Deduction of patients as no longer resident		No of patients removed	Global Sum Verification Report
	-	Checks with NHSCR		No of patients registered in quarter	Global Sum Verification Report
Random Checking					
	-	Validation on patient data from PICT comparison of 10% of GP Practices		No of jobs and outcome	Global Sum Verification Report
Targeted Checking					
	-	Manual Scrutiny of registration forms where there is a concern regarding the quality of registration data submitted via PARTNERS		Issues as appropriate	Global Sum Verification Report
	-	Data Quality Work that contributes to the removal of patients from CHI		No of patients removed	Global Sum Verification Report

Payment	Data Source	Check / Process	Who	Reporting	Where
Global Sum					
	-	Validation on patient data from PICT comparison for capitation dispute, data quality concerns		No of jobs and outcome	Global Sum Verification Report
Practice Visit					
	-	Signature/process check when only electronic claims during Practice Visit		No of checks & results	tba
Trend Analysis					
	-	Monitoring of levels of: Capitation by age/sex Patients in Care Homes < 12 months Patients in Care Homes > 12 Months Other patients < 12 months Other patients > 12 months Dispensing patients Mileage patients		Previous Quarter comparison	Global Sum Verification Report
	-	Monitoring of the levels through KPI of: New registrations in quarter Removals as deceased Removals as moved outwith HB area		Previous Quarter comparison	Global Sum Verification Report
	-	Pre-payment checking of quarterly Global Sum payments being authorised by GP Practice of variance +/- 5%		Variance report	Global Sum Verification Report

Payment	Data Source	Check / Process	Who	Reporting	Where
Core Standards					
	-	Service provision to patient record		No of checks and results	tba
	-	Review of complaint logs		Date of review and or follow up action taken	tba

Payment	Data Source	Check / Process	Who	Reporting	Where
TPA					
Temporary Patients	**-**	Service provision to patient record		No of checks and results	tba
	-	Review of complaints log		Date of review and or follow up action taken	tba

Payment	Data Source	Check / Process	Who	Reporting	Where
Additional Services					
Contraceptive		Service provision to patient record		No of checks & results	tba
Minor Surgery		Service provision to patient record		No of checks & results	tba
Imm/Vacc		Service provision to patient record		No of checks & results	tba
CHS		Service provision to patient record		No of checks & results	tba
Two Year Old Immunisation Payment		Review of call / recall system		-	-
Five Year Old Immunisation Payment		Review of call / recall system		-	-
Cervical Screening		Review of call / recall system		-	-

Payment	Data Source	Check / Process	Who	Reporting	Where
PSP					
Locums - Mat/Pat/Adoption	-	Entitlement		-	tba
Locums -Sick Leave	-	Entitlement		-	tba
	-	Necessity		-	tba
	-	Prior Approval		-	tba
	-	Check to Medical Cert. & Confirm Cost		-	tba
Locums - Suspension	-	Entitlement		-	tba
	-	Necessity		-	tba
	-	Confirm cost		-	tba
Study Leave	-	Entitlement		-	tba
	-	Necessity		-	tba
	-	Prior Approval		-	tba
	-	Cost		-	tba
GH - Standard	-	Entitlement		-	tba
GH - Remote	-	Entitlement		-	tba
GH - Deprived	-	Entitlement		-	tba
GH - Non Principle	-	Entitlement		-	tba
GH - Recruitment	-	Entitlement		-	tba
	-	Check appropriate receipts		-	tba
GH - Relocation	-	Tenders Received		-	tba
Retainer	-	Contractor Suitable		-	tba
	-	Arranged by Dir of PGE		-	tba
Adults with Incapacity	-	No of Certificates Issued		No of Fees Paid	tba
	-	Outlier Analysis of Data		Analysis of Outliers	tba

Payment	Data Source	Check / Process	Who	Reporting	Where
17c					
Global Sum	-	As per 17j		As per 17j	As per 17j
TPA	-	As per 17j		As per 17j	As per 17j
Additional Services	-	As per 17j		As per 17j	As per 17j
PSP	-	As per 17j		As per 17j	As per 17j
Seniority	-	As per 17j		As per 17j	As per 17j
17c Element	-	Review in line with each practices 17c agreement		-	-
Enhanced Services	-	As per 17j		As per 17j	As per 17j
QOF	-	As per 17j		As per 17j	as per 17j

Payment	Data Source	Check / Process	Who	Reporting	Where
Seniority					
Pre-Payment	-	Reasonableness (GMC registration data/NHS start date)		Details of new claims & results of checking	tba
	-	Length of Service		Details of new claims & results of checking	tba
	-	Eligibility of breaks in service		Details of new claims & results of checking	tba
	-	Eligibility of non NHS Service		Details of new claims & results of checking	tba

Payment	Data Source	Check / Process	Who	Reporting	Where
Enhanced Services					
DES					
List		Service provision to patient record/Activity Monitoring		No of checks & results, etc-	tba
all					
contracted					
DESs					
NES					
List					tba
all					
contracted					
NESs					
LES		Service provision to patient record/Activity Monitoring		No of checks & results, etc	
List					tba
all					
Contracted LESs					
Scottish		Service provision to patient record/Activity Monitoring		No of checks & results, etc	tba
Enhanced Services					
Programme					
List					
all					
contracted					
services					

Payment	Data Source	Check / Process	Who	Reporting	Where
QOF					
Disease Register Size		Monitor disease register size (within year) and identification of outliers		-	tba
Pre-Payment Verification		Scrutiny of practices achievement declaration		Results of scrutiny and action taken	tba
Clinical Indicators		Service provision to patient record		No of checks & results	tba
		Review of the application of Exception Coding		No of checks & results	tba
Organisational Indicators		Review of evidence and sample testing		No of checks & results	tba

General	Data Source	Check / Process	Who	Reporting	Where
GP Practice Systems					
Assurance on Integrity of Clinical System		System Security policy exists			tba
		Appropriate Administrator access use			tba
		Backup process			tba
		Anti-virus software protection		-	tba

Appendix B – Clinical Inspection of Medical Records/Practice Visits

1 Background

1.1 As detailed in the circular, one of the methods of verifying payments under the GMS contract is to carry out a practice visit. During such a visit, certain payments made to the practice will be verified to source details i.e. patient's clinical records. These clinical records may be paper based or electronically held.

1.2 At present, the verification process will require manual access to named patient data. However, it is hoped in future that electronic methods of interrogation, which may allow the anonymity of patients to be preserved, will be developed.

1.3 Particular attention has been paid to minimising the use of identifiable personal data in the payment verification process.

Practices should try to ensure that all patients receive fair processing information notices briefly explaining about these visits – this can be done when the patient registers or visits the surgery.

2 Selection of Practices

2.1 Practitioner Services and NHS Boards will jointly agree the selection of practices.

2.2 Visits may be carried out as a result of random selection, or where, for example, the application of risk assessment or trend analysis suggests that this may be appropriate. For random visits, 3% of practices are required to be visited in regard of a number of GMS payments (as indicated in this guidance) and 5% in regard of Quality and Outcomes payments, each financial year. GP Practices would not normally be selected for a random visit, for the same reason, over two consecutive years.

2.3 Practices will be advised of when the visit will take place, and the reason therefor.

3. Selection of Records

3.1 In advance of the inspection of patients' clinical records, a sample will be identified for examination.

3.2 For payments where data is held centrally, this will be possible via access to the Community Health Index, or on the various screening systems used throughout the country.

3.3 For payments where information is not held centrally, the practice will be asked to identify patients to whom they have provided the services selected for payment verification.

3.4 Where appropriate, this information should be submitted to Practitioner Services via secure e-mail or paper format through the normal delivery service used for medical records.

3.5 The information will require to cover a minimum time period, to give a reasonable reflection of activity, but also to minimise the number of patients involved. This information should be specific to the service concerned, and where possible should only detail the CHI number and date of service.

3.6 From the above sources, a sample will be identified for examination during the visit. The visiting team will require to ascertain the identity of only the patients selected for audit during the visit.

3.7 Once the practice visit is completed, the outcome agreed and no further audit is required, the entire list from which the sample was taken will be destroyed.

3.8 The total number of patient records identified for examination will not normally exceed that which it is practical to review in a 2-3 hour session. The numbers of records selected in each payment area will be determined by a risk methodology consistent with that applied to the payment tables in the protocol, thus ensuring that a minimum number of records are accessed for the purposes of verification.

4 Visiting Team

4.1 The team visiting the practice may comprise representatives from both Practitioner Services and the NHS Board. A GP who is independent to the practice should also attend. To enhance independence, it may be appropriate to utilise a GP from a neighbouring NHS Board area.

4.2 As all members of the visiting team are NHS staff/contractors, they are contractually obliged to respect patient confidentiality and are bound by the NHS code of practice.

4.3 Only the GP team member will be required to access the clinical records. They may also be required to provide guidance in discussions with the practice.

4.4 The team members conducting the visit will be appropriately familiar with the GMS contract.

5. Examining the Clinical Records

5.1 The visiting team should be afforded sufficient space and time to examine the clinical records to ascertain whether evidence exists to verify that the payment made to the practice was appropriate. Only the parts of the record relevant to the verification process will be inspected.

5.2 The audit should be carried out in a private, non-public area of the practice where patient confidentiality can be observed, and clinical details can be discussed where necessary out-with the earshot of patients.

5.3 A member of the practice staff should be available to assist with the location of evidence, if required.

5.4 The visiting team should provide the GP practice with an annotated list of all the records examined during the visit, signed by the visiting GP. The practice will be advised to securely retain this list for a period of not less than seven years, in order to maintain an audit trail of patient records accessed by medical practitioners from outwith the practice.

5.5 It is recommended good practice that where electronic records are being accessed by the GP from the visiting team, the GP practice grants access to the computer system via a 'read only' account.

6. Concluding the Visit

6.1 Where the visit has identified issues, these will be discussed with the practice with a view to resolving them.

6.2 In instances where resolution of these issues is achieved, the visit may then be concluded, and the practice advised of the following:

- which payments were verified, and which payments were not;
- whether an extended sample of clinical records require to be examined/further investigation carried out;
- what actions the practice is required to take as a result of the visit; and
- whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

6.3 These discussions, and the agreements reached, will form the basis of the draft practice visit report.

6.4 Where the discussions with the practice do not resolve the visiting team's concerns, no further dialogue will take place and the matter will be reported to the NHS Board and (if appropriate) to CFS simultaneously.

6.5 Practitioner Services do not have any responsibility regarding Clinical Governance within the GP Practice. However, if, in exceptional circumstances, they become aware of any clinical issues during the visit, these will be referred on to the relevant NHS Board at the earliest opportunity, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit and every attempt should be made to minimise the use of patient identifiable data contained within it. It should be noted that Practice Visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

7.2 In instances where the visit has highlighted no areas of significant concern a draft report will be sent to the practice for confirmation of factual accuracy.

7.3 Once the comments have been acknowledged by the practice, a copy of the final report will be sent to the practice and the NHS Board, with a copy being retained by Practitioner Services. In order to comply with the principles of Data Protection and patient confidentiality, patients should not be identifiable in the report sent to the NHS Board.

7.4 In order to facilitate the equitable assessment of contractors, the conclusions resulting from a visit, and any further action required, will be clearly and consistently shown in all final reports. In order to facilitate this, the report will contain one of the following four summary conclusions:

1. High level of assurance gained – no recommendations/actions necessary.
2. Adequate level of assurance gained – no significant recommendations/ actions necessary.
3. Limited level of assurance gained – key recommendations/actions made – re testing required following implementation of recommendations.
4. Inadequate level of assurance gained – issues escalated to appropriate authority for consideration of further action.

7.5 In instances where the visit has highlighted significant areas for concern, a report will not be sent to the practice until the tri-partite discussion between Practitioner Services, the NHS Board and CFS has taken place, and their agreement reached as to the appropriate course of action. This discussion will normally take place within two weeks of the notification of concern.

Appendix C - QOF Year End Pre-Payment Verification

Introduction

Following the submission of a practice's QOF achievement declaration, NHS Boards and practices have a set period during which pre-payment verification must be carried out. It is only when this process is complete to the satisfaction of the NHS Board that the achievement declaration of each practice can be approved and payment made in respect of QOF. Practices and NHS Boards are required to sign off their achievement in accordance with the timetable set out in the SFE.

This appendix provides guidance to NHS Boards about how pre-payment verification may be undertaken as part of NHS Boards' annual assurance processes. While it is for NHS Boards to determine the extent to which the guidance in this appendix is applied, any significant variances from the guidance should be reported to the relevant governance committee within the NHS Board.

QOF Achievement Review

In order to facilitate the pre-payment verification process, NHS Boards will establish a group to review QOF achievement within the Board area. Whilst most of this work will be undertaken during the pre-payment verification period, there is also a requirement for a degree of pre-payment verification throughout the year. NHS Boards should develop and agree a timetable to facilitate this process.

The membership of this group must comprise appropriately experienced NHS Board staff who will report their conclusions via the relevant governance committee within the NHS Board. The conclusions of the review group should be documented and retained in accordance with the requirements of Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1. Auditors may also want to use the outputs from this process to obtain assurance on the QOF payments included within the annual accounts.

This group will consider the outputs of several processes as part of pre-payment verification. Good practice suggests consideration of the following areas:

1. Practice Review Programme

All NHS Boards will have a practice review programme in place. Where this incorporates an element of QOF review then any significant issues arising from this process should be made available to be considered as part of pre-payment verification. If this is not possible due to timing issues, any issues should be considered as part of post payment verification.

2. PV Visit Programme

In accordance with the current payment verification arrangements for QOF, 5% of practices (minimum 1) will be randomly selected and visited to have their achievement in respect of QOF for the previous financial year verified. During these visits, an agreed minimum percentage of the achieved points will be verified via direct access to patient and practice records.

The outcomes of the PV visit programme should be fed back into the group reviewing QOF achievement.

3. In-Year Monitoring of Disease Registers

The integrity of disease registers is fundamental to the validity of all payments for the clinical indicators in QOF. It is therefore vital that practices are monitored on an ongoing basis to ascertain how their reported disease register sizes change.

As part of this process it is recommended that NHS Boards:

- Determine locally appropriate variance levels for each disease register size (e.g. +/- 10%) and identify any GP practices that fall outwith this. Towards the end of the financial year this should be monitored against the previous year end figure on a monthly basis.
- Where the technology permits, disease register searches should be run on a regular basis to determine that all relevant patients are included in the appropriate disease register (e.g. the prescribing of disease specific drugs to a patient not included on the relevant disease register).

It is recommended that practices print out/store their disease registers when the year end submission is made for their current achievement. This will provide more accurate, accessible information should a review or PV visit be required.

4. Year End Data Analysis

Building on the outputs from the practice review programme and the in-year monitoring of disease registers, NHS Boards must carry out specific analysis of points achievement and prevalence data submitted at year end.

As part of this process it is recommended that NHS Boards consider:

Points Achievement –

- Identifying a locally appropriate percentage of achievement to ensure outlier practices can be followed up, to the satisfaction of the Board, prior to final sign off.
- Investigating significant variances in achievement for the current year, as compared to previous years.
- Satisfying themselves as to the validity of achievement for those indicators not attained in previous years. To assist this process, reference may be made to any organisational evidence that a Board has opted to request prior to payment.
- Identifying practices within the NHS Board area that have a similar demographic profile, but report a significant difference in achievement.

Prevalence –

- Identifying a locally appropriate level of prevalence to ensure outlier practices can be followed up, to the satisfaction of the Board, prior to final sign off.
- Investigating significant variances in prevalence for the current year, as compared to previous years.
- Identifying practices within the NHS Board area that have a similar demographic profile, but report a significant difference in prevalence.

Exception Coding –

- Identifying instances where practice (as opposed to system) generated exception coding has resulted in achievement of a payment threshold. In so doing it may also be useful, where possible, to consider this in the context of the number of practices that achieved the payment threshold without the use of exception coding.

Specific Indicator Analysis –

- Defining a rationale to select a number of indicators to review in detail. This may focus on new or changed indicators and those with a high number of points. Consideration should also be given to the linkages or relationships between indicators.

Review of "Non-Clinical" Evidence –

- Defining a rationale to select a number of "non-clinical" indicators for which evidence will be requested and reviewed.

5. Assurance from Existing NHS Board Processes

Evidence obtained from existing NHS Board processes may provide assurance in relation to achievement of specific indicators (e.g. confirmation provided to the group reviewing QOF achievement from prescribing advisors that the requirements of MED6/10 have been met). Details of the assurance obtained from existing Board processes should form part of the report to the governance committee.

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Remedial Action

Should the group reviewing QOF achievement discover any issues of concern during the pre-payment verification process, they must consider what remedial action is required.

A common course of action would be to enter into dialogue with the practice in an attempt to clarify any issues of concern. In the case of more serious issues, consideration should be given to the making of an interim payment, with any balance due being paid to the practice once a more in-depth investigation has been carried out.

NHS Boards may also wish to consider the referral of issues of concern to PSD in order that a Payment Verification visit is carried out. Where issues are of a serious nature NHS Boards should consider invoking a tri-partite discussion with PSD and CFS.

Where adjustments to practice achievement are made, by either NHS Boards or practices, appropriate supporting documentation should be retained and reported to the relevant governance committee. This evidence may also inform the annual PV visit programme.

Conclusion

While this appendix aims to provide pre-payment verification guidance, it is for individual NHS Boards to satisfy themselves that an appropriate level of assurance exists about the reasonableness of each individual practice's QOF claims. This guidance provides a framework around which NHS Boards can plan and undertake QOF pre-payment verification. Boards may wish to discuss these arrangements with their auditors, especially where they diverge from this guidance.

Appendix D – QOF Tables

Data Source	Grouping	Sub Grouping	Indicator	Description	Evidence Category	Points	Total
Patient Record	Data Recording	Clinical Intervention	BP 4	The percentage of patients with hypertension in whom there is a record of the blood pressure in the preceding 9 months		8	
Patient Record	Data Recording	Clinical Intervention	CHD 12	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 September to 31 March		7	
Patient Record	Data Recording	Clinical Intervention	CKD 2	The percentage of patients on the CKD register whose notes have a record of blood pressure in the preceding 15 months		4	
Patient Record	Data Recording	Clinical Intervention	COPD 10	The percentage of patients with COPD with a record of FEV1 in the preceding 15 months		7	
Patient Record	Data Recording	Clinical Intervention	COPD 8	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 September to 31 March		6	
Patient Record	Data Recording	Clinical Intervention	DM 10	The percentage of patients with diabetes with a record of neuropathy testing in the preceding 15 months		3	
Patient Record	Data Recording	Clinical Intervention	DM 18	The percentage of patients with diabetes who have had influenza immunisation in the preceding 1 September to 31 March		3	
Patient Record	Data Recording	Clinical Intervention	DM 2	The percentage of patients with diabetes whose notes record BMI in the preceding 15 months		1	
Patient Record	Data Recording	Clinical Intervention	DM 21	The percentage of patients with diabetes who have a record of retinal screening in the preceding 15 months		5	
Patient Record	Data Recording	Clinical Intervention	DM 29	The percentage of patients with diabetes with a record of a foot examination & risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes or		4	

				previous ulcer) or 4) ulcerated foot within the preceding 15 months			
Patient Record	Data Recording	Clinical Intervention	MH 12	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months		4	
Patient Record	Data Recording	Clinical Intervention	MH 13	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months		4	
Patient Record	Data Recording	Clinical Intervention	STROKE 10	The percentage of patients with TIA or stroke who have had influenza immunisation in the preceding 1 September to 31 March		2	58
Patient Record	Data Recording	Clinical Review	ASTHMA 9	The percentage of patients with asthma who have had an asthma review in the preceding 15 months that includes an assessment of asthma control using the 3 RCP questions		20	
Patient Record	Data Recording	Clinical Review	ASTHMA 10	The percentage of patients with asthma between the ages of 14 and 19 years in whom there is a record of smoking status in the preceding 15 months		6	
Patient Record	Data Recording	Clinical Review	CANCER 3	The percentage of patients with cancer, diagnosed within the preceding 18 months who have a patient review recorded as occurring within 6 months of the practice receiving confirmation of the diagnosis		6	
Patient Record	Data Recording	Clinical Review	COPD 13	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the MRC dyspnoea score in the preceding 15 months		9	
Patient Record	Data Recording	Clinical Review	DEM 2	The percentage of patients diagnosed with dementia whose care has been reviewed in the preceding 15 months		15	
Patient Record	Data Recording	Clinical Review	DEP 1	The percentage of patients on the diabetes register and/or the CHD register for whom case finding for depression has been undertaken on one occasion during the preceding 15 months using two standard screening questions		6	

Patient Record	Data Recording	Clinical Review	DEP 6	In those patients with a new diagnosis of depression, recorded between the preceding 1 April to 31 March, the percentage of patients who have had an assessment of severity at the time of diagnosis using an assessment tool validated for use in primary care		17	
Patient Record	Data Recording	Clinical Review	DEP 7	In those patients with a new diagnosis of depression and assessment of severity recorded between the preceding 1 April to 31 March, the percentage of patients who have had a further assessment of severity 2 - 12 weeks (inclusive) after the initial recording of the assessment of severity. Both assessments should be completed using an assessment tool validated for use in primary care		8	
Patient Record	Data Recording	Clinical Review	EPILEPSY 6	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have a record of seizure frequency in the preceding 15 months		6	
Patient Record	Data Recording	Clinical Review	EPILEPSY 8	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 15 months		4	
Patient Record	Data Recording	Clinical Review	EPILEPSY 9	The percentage of women under the age of 55 years who are taking antiepileptic drugs who have a record of information and counselling about contraception, conception and pregnancy in the preceding 15 months		3	
Patient Record	Data Recording	Clinical Review	MH 10	The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate		6	
Patient Record	Data Recording	Clinical Review	MH 11	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months		4	
Patient Record	Data Recording	Clinical Review	MH 16	The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) with		5	

				schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years			
Patient Record	Data Recording	Clinical Review	PC 2	The practice has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed		3	
Patient Record	Data Recording	Clinical Review	PP 1	In those patients with a new diagnosis of hypertension (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) recorded between the preceding 1 April to 31 March: the percentage of patients aged 30 to 74 years who have had a face to face cardiovascular risk assessment at the outset of diagnosis (within 3 months of the initial diagnosis) using an agreed risk assessment tool		8	
Patient Record	Data Recording	Clinical Review	PP 2	The percentage of people diagnosed with hypertension (diagnosed after 1 April 2009) who are given lifestyle advice in the preceding 15 months for: increasing physical activity, smoking cessation, safe alcohol consumption and healthy diet		5	
Patient Record	Data Recording	Clinical Review	SH 2	The percentage of women prescribed an oral or patch contraceptive method who have also received information from the practice about long acting reversible methods of contraception in the preceding 15 months (Payment stages 40–90%)		3	
Patient Record	Data Recording	Clinical Review	SH 3	The percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within 1 month of, the prescription (Payment stages 40–90%)		3	
Patient Record	Data Recording	Clinical Review	SMOKING 5	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 15 months		25	

Patient Record	Data Recording	Clinical Review	SMOKING 6	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months		25	
Patient Record	Data Recording	Clinical Review	SMOKING 7	The percentage of patients aged 15 years and over whose notes record smoking status in the preceding 27 months		11	
Patient Record	Data Recording	Clinical Review	SMOKING 8	The percentage of patients aged 15 years and over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 27 months		12	
Patient Record	Data Recording	Clinical Review	AF 5	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHADS2 risk stratification scoring system in the preceding 15 months (excluding those whose previous CHADS2 score is greater than 1)		10	220
Patient Record	Data Recording	Other	MEDICINES 11	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines Standard 80%		7	
Patient Record	Data Recording	Other	MEDICINES 12	A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed repeat medicines (Standard 80%)		8	
Patient Record	Data Recording	Other	RECORDS 11	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 65% of patients		10	
Patient Record	Data Recording	Other	RECORDS 15	The practice has up to date clinical summaries in at least 60% of patient records		25	
Patient Record	Data Recording	Other	RECORDS 17	The blood pressure of patients aged 45 years and over is recorded in the preceding 5 years for at least 80% of patients		5	
Patient Record	Data Recording	Other	RECORDS 18	The practice has up to date clinical summaries in at least 80% of patient records		8	

Patient Record	Data Recording	Other	RECORDS 19	80% of newly registered patients have had their notes summarised within 8 weeks of receipt by the practice		7	
Patient Record	Data Recording	Other	RECORDS 20	The practice has up to date clinical summaries in at least 70% of patient records		12	
Patient Record	Data Recording	Other	RECORDS 9	For repeat medicines, an indication for the drug can be identified in the records (for drugs added to the repeat prescription with effect from 1 April 2004) Minimum Standard 80%		4	86
Patient Record	Disease Register Integrity		BP 1	The practice can produce a register of patients with established hypertension		6	
Patient Record	Disease Register Integrity		AF 1	The practice can produce a register of patients with atrial fibrillation		5	
Patient Record	Disease Register Integrity		ASTHMA 1	The practice can produce a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months		4	
Patient Record	Disease Register Integrity		ASTHMA 8	The percentage of patients aged 8 years and over diagnosed as having asthma from 1 April 2006 with measures of variability or reversibility		15	
Patient Record	Disease Register Integrity		CANCER 1	The practice can produce a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers from 1 April 2003'		5	
Patient record	Disease Register Integrity		CHD 1	The practice can produce a register of patients with coronary heart disease		4	
Patient	Disease		CKD 1	The practice can produce a register of patients aged 18		6	

Record	Register Integrity			years and over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)			
Patient Record	Disease Register Integrity		COPD 14	The practice can produce a register of patients with COPD		3	
Patient Record	Disease Register Integrity		COPD 15	The percentage of all patients with COPD diagnosed after 1 April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry		5	
Patient Record	Disease Register Integrity		DEM 1	The practice can produce a register of patients diagnosed with dementia		5	
Patient Record	Disease Register Integrity		DM 32	The practice can produce a register of all patients aged 17 years and over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed		6	
Patient Record	Disease Register Integrity		EPILEPSY 5	The practice can produce a register of patients aged 18 years and over receiving drug treatment for epilepsy		1	
Patient Record	Disease Register integrity		HF 1	The practice can produce a register of patients with heart failure		4	
Patient Record	Disease Register Integrity		HF 2	The percentage of patients with a diagnosis of heart failure (diagnosed after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment		6	
Patient Record	Disease Register Integrity		LD 1	The practice can produce a register of patients aged 18 years and over with learning disabilities		4	
Patient Record	Disease Register Integrity		MH 8	The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses		4	
Patient Record	Disease Register Integrity		OB 1	The practice can produce a register of patients aged 16 years and over with a BMI greater than or equal to 30 in the preceding 15 months		8	

Patient Record	Disease Register Integrity		OST 1	The practice can produce a register of patients: 1. Aged 50-74 years with a record of a fragility fracture after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 years and over with a record of a fragility fracture after 1 April 2012		3	
Patient Record	Disease Register Integrity		PAD 1	The practice can produce a register of patients with peripheral arterial disease		2	
Patient Record	Disease Register Integrity		PC 3	The practice has a complete register available of all patients in need of palliative care/support irrespective of age		3	
Patient Record	Disease Register Integrity		SH 1	The practice can produce a register of women who have been prescribed any method of contraception at least once in the last year, or other appropriate interval e.g. last 5 years for an IUS		4	
Patient Record	Disease Register Integrity		STROKE 1	The practice can produce a register of patients with stroke or TIA		2	
Patient Record	Disease Register Integrity		STROKE 13	The percentage of new patients with a stroke or TIA who have been referred for further investigation		2	
Patient Record	Disease Register Integrity		THYROID 1	The practice can produce a register of patients with hypothyroidism		1	108
Patient Record	Lab Tests		CHD 8	The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less		17	
Patient Record	Lab Tests		CKD 6	The percentage of patients on the CKD register whose notes have a record of a urine albumin:creatinine ratio (or protein:creatinine ratio) test in the preceding 15 months		6	
Patient Record	Lab Tests		DEM 4	The percentage of patients with a new diagnosis of dementia recorded between the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin		6	

				B12 and folate levels recorded 6 months before or after entering on to the register			
Patient Record	Lab Tests		DM 17	The percentage of patients with diabetes whose last measured total cholesterol within the preceding 15 months is 5mmol/l or less		6	
Patient Record	Lab Tests		DM 13	The percentage of patients with diabetes who have a record of micro-albuminuria testing in the preceding 15 months (exception reporting for patients with proteinuria)		3	
Patient Record	Lab Tests		DM 22	The percentage of patients with diabetes who have a record of estimated glomerular filtration rate (eGFR) or serum creatinine testing in the preceding 15 months		1	
Patient Record	Lab Tests		DM 26	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol (equivalent to HbA1c of 7.5% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months		17	
Patient Record	Lab Tests		DM 27	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months		8	
Patient Record	Lab Tests		DM 28	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 75 mmol/mol (equivalent to HbA1c of 9% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months		10	
Patient Record	Lab Tests		LD 2	The percentage of patients on the learning disability register with Down's Syndrome aged 18 years and over who have a record of blood TSH in the preceding 15 months (excluding those who are on the thyroid disease register)		3	
Patient Record	Lab Tests		MH 17	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months		1	

Patient Record	Lab Tests		MH 18	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months		2	
Patient Record	Lab Tests		MH 19	The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol:hdl ratio in the preceding 15 months		5	
Patient Record	Lab Tests		MH 20	The percentage of patients aged 40 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding15 months		5	
Patient Record	Lab Tests		PAD 4	The percentage of patients with peripheral arterial disease in whom the last measured total cholesterol (measured in the preceding 15 months) is 5.0mmol/l or less		3	
Patient Record	Lab Tests		STROKE 7	The percentage of patients with TIA or stroke who have a record of total cholesterol in the preceding 15 months		2	
Patient Record	Lab Tests		STROKE 8	The percentage of patients with TIA or stroke whose last measured total cholesterol (measured in the preceding 15 months) is 5mmol/l or less		5	
Patient Record	Lab Tests		THYROID 2	The percentage of patients with hypothyroidism with thyroid function tests recorded in the preceding 15 months		6	106
Patient Record	Repeat Prescribing		AF 6	In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1(latest in the preceding 15 months), the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy		6	
Patient Record	Repeat Prescribing		AF 7	In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy		6	
Patient	Repeat		CHD 10	The percentage of patients with coronary heart disease		7	

Record	Prescribing			who are currently treated with a beta-blocker (unless a contraindication or side effects are recorded)			
Patient Record	Repeat Prescribing		CHD 9	The percentage of patients with coronary heart disease with a record in the preceding 15 months that aspirin, an alternative anti-platelet therapy, or an anticoagulant is being taken (unless a contraindication or side effects are recorded)		7	
Patient Record	Repeat Prescribing		CHD14	The percentage of patients with a history of myocardial infarction (from 1 April 2011) currently treated with an ACE inhibitor (or ARB if ACE intolerant), aspirin or an alternative anti-platelet therapy, beta blocker and statin (unless a contraindication or side effects are recorded)		10	
Patient Record	Repeat Prescribing		CKD 5	The percentage of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded)		9	
Patient Record	Repeat Prescribing		DM 15	The percentage of patients with diabetes with a diagnosis of proteinuria or micro-albuminuria who are treated with ACE inhibitors (or A2 antagonists)		3	
Patient Record	Repeat Prescribing		HF 3	The percentage of patients with a current diagnosis of heart failure due to Left Ventricular Dysfunction (LVD) who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who can tolerate therapy and for whom there is no contraindication		10	
Patient Record	Repeat Prescribing		HF 4	The percentage of patients with a current diagnosis of heart failure due to LVD who are currently treated with an ACE inhibitor or Angiotensin Receptor Blocker (ARB), who are additionally treated with a beta-blocker licensed for heart failure, or recorded as intolerant to or having a contraindication to beta-blockers		9	
Patient Record	Repeat Prescribing		OST 2	The percentage of patients aged between 50 and 74 years, with a fragility fracture, in whom osteoporosis is confirmed on DXA scan, who are currently treated with		3	

				an appropriate bone-sparing agent			
Patient Record	Repeat Prescribing		OST 3	The percentage of patients aged 75 years and over with a fragility fracture, who are currently treated with an appropriate bone-sparing agent		3	
Patient Record	Repeat Prescribing		PAD 2	The percentage of patients with peripheral arterial disease with a record in the preceding 15 months that aspirin or an alternative anti-platelet is being taken		2	
Patient Record	Repeat Prescribing		STROKE 12	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record that an anti-platelet agent (aspirin, clopidogrel, dipyridamole or a combination), or an anticoagulant is being taken (unless a contraindication or side effects are recorded)		4	79
Patient Record	Trend Analysis		BP 5	The percentage of patients with hypertension in whom the last blood pressure (measured in the preceding 9 months) is 150/90 or less		55	
Patient Record	Trend Analysis		CHD 6	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less		17	
Patient Record	Trend Analysis		CKD 3	The percentage of patients on the CKD register in whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less		11	
Patient Record	Trend Analysis		DM 30	The percentage of patients with diabetes in whom the last blood pressure is 150/90 or less in the preceding 15 months		8	
Patient Record	Trend Analysis		DM 31	The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less in the preceding 15 months		10	
Patient Record	Trend Analysis		PAD 3	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less		2	

Patient Record	Trend Analysis		STROKE 6	The percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less		5	108
Outwith Patient Record	-		CHS 1	Child development checks are offered at intervals that are consistent with national guidelines and policy		6	
Outwith Patient Record	-		CS 5	The practice has a system for informing all women of the results of cervical smears		2	
Outwith Patient Record	-		CS 6	The practice has a policy for auditing its cervical screening service, and performs an audit of inadequate cervical smears in relation to individual smear-takers at least every 2 years		2	
Outwith Patient Record	-		CS 7	The practice has a protocol that is in line with national guidance and practice for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate smear rates		7	
Outwith Patient Record	-		EDUCATION 9	All practice-employed non-clinical team members have an annual appraisal		3	
Outwith Patient Record	-		EDUCATION 10	The practice has undertaken a minimum of 3 significant event reviews within the preceding year		6	
Outwith Patient Record	-		EDUCATION 5	There is a record of all practice-employed staff having attended training/updating in basic life support skills in the preceding 36 months		3	
Outwith Patient Record	-		EDUCATION 6	The practice conducts an annual review of patient complaints and suggestions to ascertain general learning points which are shared with the team		3	
Outwith Patient	-		EDUCATION 7	The practice has undertaken a minimum of 12 significant event reviews in the preceding 3 years which		4	

Record				could include: · Any death occurring in the practice premises · New cancer diagnoses · Deaths where terminal care has taken place at home · Any suicides · Admissions under the Mental Health Act · Child protection cases · Medication errors · A significant event occurring when a patient may have been subjected to harm, had the circumstances / outcome been different (near miss)			
Outwith Patient Record	-		EDUCATION 8	All practice-employed nurses have personal learning plans which have been reviewed at annual appraisal		5	
Outwith Patient Record	-		EDUCATION 11	There is a record of all practice-employed clinical staff and clinical partners having attended training/updating in basic life support skills in the preceding 18 months		4	
Outwith Patient Record	-		INFORMATION 5	The practice supports smokers in stopping smoking by a strategy which includes providing literature and offering appropriate therapy		2	
Outwith Patient Record	-		MANAGEMENT 1	Individual healthcare professionals have access to information on local procedures relating to Child Protection		1	
Outwith Patient Record	-		MANAGEMENT 10	There is a written procedures manual that includes staff employment policies including equal opportunities, bullying and harassment and sickness absence (including illegal drugs, alcohol and stress), to which staff have access		2	
Outwith Patient Record	-		MANAGEMENT 2	There are clearly defined arrangements for backing up computer data, back-up verification, safe storage of back-up tapes and authorisation for loading programmes where a computer is used		1	
Outwith	-		MANAGEMENT	The Hepatitis B status of all doctors and relevant		0.5	

Patient Record			3	practice-employed staff is recorded and immunisation recommended if required in accordance with national guidance			
Outwith Patient Record	-		MANAGEMENT 5	The practice offers a range of appointment times to patients, which as a minimum should include morning and afternoon appointments 5 mornings and 4 afternoons per week, except where agreed with the PCO		3	
Outwith Patient Record	-		MANAGEMENT 7	The practice has systems in place to ensure regular and appropriate inspection, calibration, maintenance and replacement of equipment including: · A defined responsible person · Clear recording · Systematic pre-planned schedules · Reporting of faults		3	
Outwith Patient Record	-		MANAGEMENT 9	The practice has a protocol for the identification of carers and a mechanism for the referral of carers for social services assessment		3	
Outwith Patient Record	-		MAT 1	Antenatal care and screening are offered according to current local guidelines		6	
Outwith Patient Record	-		MEDICINES 10	The practice meets the PCO prescribing adviser at least annually, has agreed up to three actions related to prescribing and subsequently provided evidence of change		4	
Outwith Patient Record	-		MEDICINES 2	The practice possesses the equipment and in-date emergency drugs to treat anaphylaxis		2	
Outwith Patient Record	-		MEDICINES 3	There is a system for checking the expiry dates of emergency drugs on at least an annual basis		2	
Outwith Patient	-		MEDICINES 4	The number of hours from requesting a prescription to availability for collection by the patient is 72 hours or		3	

Record				less (excluding weekends and bank/local holidays)			
Outwith Patient Record	-		MEDICINES 6	The practice meets the PCO prescribing adviser at least annually and agrees up to three actions related to prescribing		4	
Outwith Patient Record	-		MEDICINES 8	The number of hours from requesting a prescription to availability for collection by the patient is 48 hours or less (excluding weekends and bank/local holidays)		6	
Outwith Patient Record	-		PE 1	The length of routine booked appointments with the doctors in the practice is not less than 10 minutes (If the practice routinely sees extras during booked surgeries, then the average booked consultation length should allow for the average number of extras seen in a surgery session. If the extras are seen at the end, then it is not necessary to make this adjustment). For practices with only an open surgery system, the average face to face time spent by the GP with the patient is at least 8 minutes. Practices that routinely operate a mixed economy of booked and open surgeries should report on both criteria		33	
Outwith Patient Record	-		QP 6	The practice meets internally to review the data on secondary care outpatient referrals provided by the PCO		5	
Outwith Patient Record	-		QP 7	The practice participates in an external peer review with a group of practices to compare its secondary care outpatient referral data either with practices in the group of practices or with practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO		5	
Outwith Patient Record	-		QP 8	The practice engages with the development of and follows 3 agreed care pathways for improving the management of patients in the primary care setting (unless in individual cases they justify clinical reasons		11	

				for not doing this) to avoid inappropriate outpatient referrals and produces a report of the action taken to the PCO no later than 31 March 2012			
Outwith Patient Record	-		QP 9	The practice meets internally to review the data on emergency admissions provided by the PCO		5	
Outwith Patient Record	-		QP 10	The practice participates in an external peer review with a group of practices to compare its data on emergency admissions either with practices in the group of practices or practices in the PCO area and proposes areas for commissioning or service design improvements to the PCO		15	
Outwith Patient Record	-		QP 11	The practice engages with the development of and follows 3 agreed care pathways (unless in individual cases they justify clinical reasons for not doing this) in the management and treatment of patients in aiming to avoid emergency admissions and produces a report of the action taken to the PCO no later than 31 March 2012		27.5	
Outwith Patient Record	-		QP 12	The practice meets internally to review the data on accident and emergency attendances provided by the PCO no later than 31 July 2012. The review will include consideration of whether access to clinicians in the practices is appropriate, in light of the patterns on accident and emergency attendance		7	
Outwith Patient Record	-		QP 13	The practice participates in an external peer review with a group of practices to compare its data on accident and emergency attendances, either with practices in the group of practices or practices in the PCO area and agrees an improvement plan firstly with the group and then with the PCO no later than 30 September 2012. The review should include, if appropriate, proposals for improvement to access arrangements in the practice in order to reduce avoidable accident and emergency attendances and may also include proposals for commissioning or		9	

				service design improvements to the PCO			
Outwith Patient Record	-		QP 14	The practice implements the improvement plan that aims to reduce avoidable accident and emergency attendances and produces a report of the action taken to the PCO no later than 31 March 2013		15	
Outwith Patient Record	-		RECORDS 13	There is a system to alert the out of hours service or duty doctor to patients dying at home		2	
Outwith Patient Record	-		RECORDS 3	The practice has a system for transferring and acting on information about patients seen by other doctors out of hours		1	
Outwith Patient Record	-		RECORDS 8	There is a designated place for the recording of drug allergies and adverse reactions in the notes and these are clearly recorded		1	
No further verification required	-		CS 1	The percentage of patients (aged from 25 to 64 in England and Northern Ireland, from 20 to 60 in Scotland and from 20 to 64 in Wales) whose notes record that a cervical screening test has been performed in the preceding 5 years (Payment stages 40–80%)		11	235
			TOTAL			**1000**	**1000**

Annex III – Ophthalmic Payments

TABLE OF CONTENTS

Introduction

The following sections detail the payment verification requirements for General Ophthalmic Services (GOS).

Practitioner Services (Ophthalmic) operate a scanning and optical character recognition system (iDENT) and a computerised payment system (OPTIX) both of which undertake extensive pre-payment validation on ophthalmic payment claims.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the NHS (GOS)(Scotland) Regulations 2010. The Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to ophthalmic practitioners.

Payment verification checking takes place on 4 levels as follows:

Level 1

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present;
- validation against the GOS regulations and any provisos or time limits that apply;
- duplication on OPTIX;
- the patient's date of birth for age exemption; and
- checking the total value of the claim.

Level 2

Level 2 will comprise risk driven trend analysis of claims, including, but not limited to:

- number of primary eye examinations;
- number of supplementary eye examinations;
- number of supplementary examinations compared with primary examinations;
- reasons for supplementary examinations;
- number of primary and supplementary examinations conducted in a day;
- domiciliary visits and the number of eye examinations conducted in a day;
- tints;
- prisms;
- supply of 2 pairs rather than bifocals;
- complex lenses;
- small frame supplements;
- small frame replacements; and
- repairs and replacements.

Level 3

Level 3 checking will be undertaken as appropriate where the outcome of the above analysis proves unsatisfactory or inconclusive. This may include:

- patient letters;
- sampling of patient records and associated documentation;
- the carrying out of practice visits as per Appendix A; and
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for.

Level 4

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A; and
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for.

Where patient records are checked during a visit to a practice or called in for examination, a sample will be checked to establish that they comply with the minimum data set as laid down in Schedule 5 of the NHS (General Ophthalmic Services) (Scotland) Regulations 2006.

Outputs:
Quarterly PV report detailing:

- Ø results and status of checking process;
- Ø details of information used to verify service provision; and
- Ø any necessary recommendations, actions and recoveries.

Further to the completion of a practice visit, a report will be produced which details the following:

- Ø information used to verify service provision;
- Ø number of records checked and results;
- Ø any necessary recommendations, actions and recoveries; and
- Ø level of assurance gained.

Appendix A – Inspection of Ophthalmic Records and Practice Visits

1. Background

1.1 One of the methods of verifying payments made under General Ophthalmic Services (GOS) arrangements is to examine patient records. It has been agreed to carry out these checks during practice visits. During these visits a selection of records will be examined looking at particular items of service.

1.2 These records will usually be paper based though cross-checking may be required with any relevant electronically held information, as well as with order books and appointment diaries.

1.3 All patients receiving treatment under GOS sign to say that their information can be looked at for checking purposes – in this instance as part of the payment verification process.

2. Selection of Practices

2.1 Practitioner Services staff will conduct these visits on either a random basis with regard to the risk matrix and the quota of record card checks to be carried out for that particular NHS Board, or where the application of risk assessment or trend analysis suggests that this would be appropriate.

2.2 Practitioner Services and NHS Boards will jointly agree the selection of practices. In the case of those visits carried out as part of random sampling, consideration will be given to avoiding the selection of any practices that have recently been in receipt of a Practice Inspection or routine record card check.

2.3 Contractors will be advised of when the visit will take place.

2.4 The contractor will be given at least two weeks' notice of the intention to carry out a visit. Every effort will be made to carry out the visit at a mutually convenient time, including giving consideration to visits 'out of hours' where that is feasible.

2.5 In the event that a contractor fails to give access to patient records then the NHS Board will be alerted so that the contractor may be warned that he or she may be subject to a referral for NHS disciplinary procedures.

3. Selection of Records

3.1 In advance of the visit, a number of patients' record cards will be identified for examination. Practitioner Services will extract this information from the OPTIX system. Details of these claims will be prepared for use by the visiting team during their visit, with the physical records being obtained during the visit. Other records may be selected during the visit.

3.2 The practice will be consulted on how they store their records and, where possible, the sample of records will be chosen in such a manner as to facilitate extraction of the records by the practice.

3.3 Practitioner Services will examine record cards from recent visits by patients, though this will be dependent on the 'items of service' being checked and the throughput of the practice.

3.4 The total number of patient records identified for examination would not normally exceed that which it is practical to review in a two-hour session. However, this may vary for larger practices and where records are held centrally for a number of practices in different NHS Boards.

3.5 The numbers of records selected for each 'item of service' as part of the random practice visit will be determined by a risk methodology, thus ensuring that a minimum threshold is achieved for the number of records that are accessed for the purposes of verification. For visits concentrating on specific areas, the volume of checks will be determined by the specific circumstances and in consultation with the relevant NHS Board.

3.6 During the visit, Practitioner Services staff will be required to take copies of a sample of the patient records they have checked, either by photocopying, photographing or by electronic scanning. This is for audit purposes to show evidence that records have been checked and will also be necessary in the event of any issues arising or where there is a need for clarification on any matter that cannot be resolved during the practice visit.

3.7 Once the practice visit is completed, the outcome agreed and no further audit is required, the copies of the patient records will be destroyed.

4. Visiting Team

4.1 The team visiting the practice will comprise a group drawn from Practitioner Services staff with appropriate knowledge and skills in:

- monitoring and the technicalities of the updated GOS arrangements;
- checking spectacles;
- customer service skills; and
- the ability to demonstrate procedures to practice staff.

4.2 As all members of the visiting team are NHS staff/contractors, they are contractually obliged to respect patient and business confidentiality and are bound by the NHS code of practice.

4.3 Should they so desire, the relevant NHS Board may undertake a visit at the same time as the visiting team. This may be of particular assistance if locally run schemes are to be verified by the NHS Board during the visit. In these cases, all of the purposes of the visit will be made clear to the contractor before the visit is made.

5. Examining the Patient Record Cards

5.1 The visiting team should be afforded sufficient space and time to examine the patient record cards to ascertain whether evidence exists to verify that payments made to the contractor were appropriate.

5.2 The audit should be carried out in a private, non-public area of the practice where patient confidentiality can be observed, and issues can be discussed where necessary out-with the earshot of patients.

5.3 A member of the practice staff should be available to assist with the location of evidence, if required.

5.4 It is recommended good practice that, where the visiting team is accessing electronic records, the contractor grants access to the computer system via a 'read only' account.

6. Concluding the Visit

6.1 Where the visit has identified issues, these will be discussed with the practice with a view to resolving them.

6.2 In instances where resolution of these issues is achieved, the visit may then be concluded, and the practice advised of the following:

- which payments were verified, and which payments were not;
- whether an extended sample of clinical records require to be examined/further investigation carried out;
- what actions the practice is required to take as a result of the visit; and
- whether recoveries require to be made as a result of the visit, and the terms according to which they will be made.

6.3 These discussions, and the agreements reached will form the basis of the draft practice visit report.

6.4 Where the discussions with the practice do not resolve the visiting team's concerns, no further dialogue will take place and the matter will be reported to the NHS Board and (if appropriate) to CFS simultaneously.

6.5 Practitioner Services do not have any remit regarding Clinical Governance. However, if, in exceptional circumstances, they become aware of any clinical issues during the course of the visit, these will be referred on to the relevant NHS Board at the earliest opportunity, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit.

7.2 In instances where the visit highlighted no areas of significant concern, a draft report will be sent to the contractor for confirmation of factual accuracy.

7.3 Once the contents have been agreed by the contractor, a copy of the final report will be sent to the contractor and the NHS Board, with a copy being retained by Practitioner Services.

7.4 In order to facilitate the equitable assessment of contractors, the conclusions resulting from a visit, and any further action required, will be clearly and consistently shown in all

final reports. In order to facilitate this, the report will contain one of the following four summary conclusions:

1. High level of assurance gained – no recommendations/actions necessary.
2. Adequate level of assurance gained – no significant recommendations/actions necessary.
3. Limited level of assurance gained – key recommendations/actions made – re testing required following implementation of recommendations.
4. Inadequate level of assurance gained - issues escalated to appropriate authority for consideration of further action.

7.5 In instances where the visit has highlighted significant areas of concern, a report will not be sent to the contractor until the tri-partite meeting between Practitioner Services, the NHS Boards and CFS has taken place, and their agreement reached as to the appropriate course of action.

Annex IV – Pharmaceutical Payments

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1 Introduction

The Scottish Government published NHS Circular CEL(2007)12, which outlines the Payment Verification (PV) program for Family Health Services. The requirements of NHS Boards have subsequently evolved and this revised protocol is designed to outline the new Payment Verification Program and to encompass the commencement of the new Community Pharmacy contract.

1.1 Level 1

The payments system (DCVP) will automatically carry out 100% Level 1 checks including:

- Ø Foreign Forms
- Ø Urgent Forms
- Ø Unknown Items
- Ø Minimum Gross Ingredient Cost
- Ø Out of Pocket Expenses
- Ø High Value Gross Ingredient Cost
- Ø Rejected Items
- Ø Unusual Fees
- Ø Pay and Report Items
- Ø Ambiguity Check
- Ø Invalid Form Serial Number
- Ø Invalid Community Health Index (CHI)
- Ø Invalid Date Check
- Ø Maximum Number of Instalments Exceeded
- Ø Invalid Formulary
- Ø Quantity Limited Exceeded
- Ø SLS Endorsement Exceeded
- Ø DTA Quantity Error

The following items are audited by NSS Service Audit and reported to each NHS Board in Scotland:

- Ø Gross Ingredient Cost (GIC) of the areas subject to PV procedures outlined in the following pages of this document.

- Ø Dispensing Fees, this excludes Dispensing Fees of the areas subject to PV procedures outlined in the following pages of this document.
- Ø Transitional Fees.
- Ø Regional Office Payments.

1.2 Level 2

Level 2 consists of the compilation and analysis of statistical information, which will be reported to NHS Boards on a quarterly basis. The PV Program will analyse the payment category areas selected by PV Pharmacy. The selected payment categories are:

Payment Categories Selected

- Ø Out Of Pocket Expenses (OOPE)
- Ø Stoma
- Ø Methadone
- Ø Minor Ailments Service (MAS)
- Ø Chronic Medication Service (CMS)
- Ø Influenza Vaccination Programme (seasonal)
- Ø Random Sampling
- Ø Public Health Service – Nicotine Replacement Therapy (NRT)
- Ø Public Health Service – Emergency Hormonal Contraception (EHC)

At the request of the NHS Boards, the 'Form Types' analysis will also continue to be included within the PV report.

- Ø Form Types

1.2.1 Out Of Pocket Expenses (OOPE) – the following data will be presented in tabular form by NHS Board area:

- Ø <u>View 1</u> – A summary report of the number of OOPE endorsements and the associated cost.
- Ø <u>View 2</u> – A detailed report of View 1 at Community Pharmacy Contractor Code level.
- Ø <u>View 3</u> – A detailed report of the prescription line items that have a OOPE claim greater than £50.

1.2.2 **Stoma** – the following data will be presented in tabular form by NHS Board area:

- Ø View 1 – A summary report of the number of items and the associated GIC paid for Stoma products.
- Ø View 2 – A detailed report of the number of prescription items, the associated GIC and the Appendix 2 submissions.

1.2.3 **Methadone** - the following data will be presented in tabular form by NHS Board area:

- Ø View 1 – A summary report of the number of items, GIC, instalments and supervisions for Methadone.
- Ø View 2 – A detailed report of the number of items, instalments and supervisions for Methadone.
- Ø View 3 – A detailed report of the number of items, number of prescriptions with no endorsements, number of prescriptions with only instalment endorsements and the number of prescriptions with instalment and supervision endorsements for Methadone.

1.2.4 **Minor Ailment Service (MAS)** - the following data will be presented in tabular form by NHS Board area:

- Ø View 1 – A summary report of the number of items and the associated GIC paid for MAS.
- Ø View 2 – A detailed report of the number of Patients registered for MAS that have received a treatment.
- Ø View 3 – A detailed report of the Contractors with a paper form submission rate of less than 90% for MAS.
- Ø View 4 – A detailed report of the Contractors that have registered more than 50 Patients in one day for MAS.

1.2.5 **Chronic Medication Service (CMS)** - the following data will be presented in Tabular form by NHS Board area:

- Ø View 1 – A summary report of the paper form submission rate for CMS.
- Ø View 2 – A detailed report of View 1 at Community Pharmacy Contractor Code level.
- Ø View 3 – A detailed report of the Contractors that have registered more than 50 Patients in one day for CMS.
- Ø View 4 – A detailed report of the number of CMS registrations that have an

assessment date.

1.2.6 **Influenza Vaccination Programme (seasonal)** - the following data will be presented in tabular form by NHS Board area:

- Ø PV will carry out a seasonal review of Influenza Vaccinations at NHS Board level. The review will compare the volume and associated GIC of Flu Vaccines claimed by the CP or Dispensing Doctor on the Stock Order (GP10A) or Prescriptions (GP10).

1.2.7 **Random Sampling** – the following data will be presented in tabular form by NHS Board area by NHS Board area:

- Ø PV will conduct random sampling across the prescriptions dispensed over the quarter of the report being issued, excluding dispensings made on a CPUS form. The sample size will be defined using statistical strata. The individual NHS Boards proportion (based on the number of items dispensed) of the prescriptions to be sampled will be defined as per the Table 1 shown below and the statistical strata referred to earlier.

Table 1

NHS Board (Dispenser)	Percentage of Total Random Sample
NHS Ayrshire & Arran	8%
NHS Borders	2%
NHS Dumfries & Galloway	4%
NHS Fife	7%
NHS Forth Valley	6%
NHS Grampian	9%
NHS Greater Glasgow & Clyde	23%
NHS Highland	6%
NHS Lanarkshire	12%
NHS Lothian	12%
NHS Orkney	1%
NHS Shetland	1%
NHS Tayside	8%
NHS Western Isles	1%
Scottish Total	100%

1.2.8 **Public Health Service, Nicotine Replacement Therapy (NRT)** – the following data will be presented in tabular form by NHS Board area:

- Ø View 1 – A detailed report comparing the number of CPUS forms submitted against the number of patients treated.

1.2.9 **Public Health Service, Emergency Hormonal Contraception (EHC)** – the following data will be presented in tabular form by NHS Board area:

- View 1 – A detailed report comparing the number of CPUS forms submitted against the number of patients treated.

1.3 Level 3

Further investigations undertaken at Level 3 may include any of the following:

- Ø Verification of the payment information from the centralised pharmaceutical data warehouse with the individual claims.
- Ø Extended samples providing further analysis of claims and/or prescribing patterns.
- Ø Requesting Pharmacy Contractors to provide Patient medication records.
- Ø Requesting Pharmacy Contractors to provide explanations to PV.
- Ø Requesting Pharmacy Contractors to provide supporting documentation as required.
- Ø Contacting Patients to confirm the services provided.
- Ø Advising Pharmacy Contractors of Best Practice as required.
- Ø Adhoc assignments as required.
- Ø Targeted sampling across the identified Risk Categories using statistical strata to decide on the volumes to be sampled.
- Ø The Payment Verification Manager will advise NHS Boards of any Clinical Governance issues found during the payment verification process. Clinical Governance issues will be discussed with the NHS Board and the appropriate action identified.

The amount of Level 3 work undertaken and the number of contacts with Patients will be determined through discussions with the appropriate NHS Board.

Where the outcome of the above checking proves unsatisfactory or inconclusive, this will be reported to the NHS Board on a quarterly basis or sooner if the situation dictates that this is required. PV will undertake additional extended sampling on direction from the NHS Board, i.e:

- Ø Undertaking a clinical inspection of Patient medication records.
- Ø Requesting explanations.

1.4 Level 4

PV will undertake a Level 4 check on randomly selected CP's for each NHS Board. The number of CP's to be sampled per NHS Board is detailed in Table 2.

- Ø The size of the sample undertaken will be based on statistical strata using the number of claims submitted by the CP (see Table 3).

- Ø A random sample of claims will be selected & checked against the details contained within the respective Patient medication records from the CP.

The level of this check will result in a minimum of 1% of all pharmacies across Scotland having records inspected annually and will involve the confirmation of a sample of claims across selected payment categories.

Table 2

NHS Board	Number of Active CP's in Oct 08	% of Total	Number of CP's to be sampled per year based on sample size of 21 & minimum of 1 per Board per year
NHS Ayrshire & Arran	92	7.62%	2
NHS Borders	26	2.15%	1
NHS Dumfries & Galloway	33	2.73%	1
NHS Fife	78	6.46%	1
NHS Forth Valley	69	5.72%	1
NHS Grampian	128	10.60%	2
NHS Greater Glasgow & Clyde	312	25.85%	4
NHS Highland	73	6.06%	1
NHS Lanarkshire	117	9.69%	2
NHS Lothian	180	14.91%	3
NHS Orkney	3	0.25%	1
NHS Shetland	3	0.25%	1
NHS Tayside	90	7.46%	2
NHS Western Isles	3	0.25%	1
Scottish Total	1,207	100%	23

Table 3

Band	No. of items per month (excl SO)	No. of prescriptions to be sampled	No. of CP's in this band as at Oct 08
A	1 - 5,000	20	553
B	5,001 - 10,000	25	535
C	10,001 - 15,000	30	95
D	15,001 - 20,000	35	20
E	20,001 - 25,000	40	3
F	25,001 - 30,000	45	1
G	30,000+	50	0

1.5 Pharmaceutical Payments – Clinical Inspection of Patient Records

As detailed earlier, it is intended that PV will arrange for the inspection of Patient medication records in the following two circumstances:

Level 3 PV Checks:

- Ø in order to pursue the outcome of any claims identified at Level 2 as requiring further investigation; or

- Ø where the formal assessment of the level of risk associated with a particular payment category indicates that such inspection would be beneficial.

Level 4 PV Checks:

- Ø PV will undertake examination of records on a minimum of 1% sample of pharmacies across Scotland chosen at random.
  With respect to Level 4 examination of records, a minimum of 1% of all pharmacies across Scotland will have records inspected annually; the examination to involve the confirmation of a sample of claims across selected payment categories.

Again, the size of the sample of claims to be checked will require to be statistically valid. This will be influenced by the number of claims submitted by individual pharmacies, and the types and frequency of errors detected.

PV will always consult with NHS Boards when Patient records are to be examined with a view to working jointly whenever possible.

1.6 Pharmaceutical Payments – Liaison with NHS Boards and CFS

For all categories of pharmaceutical payments, it is important that any matters of concern arising from the work undertaken by PV are acted upon quickly and appropriately.

Payment Verification at PSD (Pharmacy) will therefore supply quarterly reports to NHS Boards, detailing the verification work that they have undertaken.

If this work highlights any areas for concern, this will immediately be notified to both NHS Boards and the CFS. Consultation will then take place between all three parties, and a decision made as to how the matter will be taken forward, in line with the CFS/NHS Board Partnership Agreement.