The Scottish Government
Directorate for Finance, eHealth and Analytics

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 11 (2014) and outlines the arrangements for payment verification for 2015-16.

BACKGROUND

2. This revision includes the following main changes:

Dental

The revision for 2015-16 has resulted in a change to the protocol to reflect the implementation of tooth specific validation at level 1 for items of service.

Medical

The changes reflect the continuing development of the GP contract, in particular the structure of QOF for 2014-15, the creation of the Clinical Core Standard payment, and the continued requirement on GP practices to maintain the integrity of QOF disease registers.

Ophthalmic

The revision for 2014-15 has resulted in only minor changes to the protocol.

Pharmaceutical

The changes to the protocol relate to the categories of payments included in core payment verification reporting.

DL (2015) 18

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

Enquiries to:

Tel: 0131 244 1816
E-mail:
david.bishop@scotland.gsi.gov.uk

ACTION

3. Chief Executives are asked to:

- note the revised protocol and ensure that relevant staff within their Boards are familiar with this;
- share the protocol with FHS contractors;
- ensure that their Audit Committee have sight of the protocol;
- work with Practitioner Services in ensuring implementation of the protocol;
- note that contractors must retain evidence to substantiate the validity of payments, and where this cannot be found, any fees paid may be recovered; and
- note that tri-partite discussions should take place between Practitioner Services, NHSScotland Counter Fraud Services 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 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, NHS National Services Scotland:

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

Yours faithfully

John Matheson CBE
Director of Finance, eHealth and Analytics

Payment Verification Protocols

Payment Verification Programme for 2015-16

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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, GPs, 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 Counter Fraud Services and the NHS Boards.

Contractor Checking

Ophthalmic, Pharmaceutical and Dental Payments

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

2.2 **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.

2.3 **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; and

- the formal assessment of the level of risk associated with a particular payment category indicates a need for more detailed testing.

2.4 **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.

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

GMS Payments

2.6 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.

Inspection of Clinical Records

2.9 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 A of the Medical and Ophthalmic Annexes.

Risk Assessment

3.1 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.

3.2 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

4.1 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.

4.2 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.

4.3 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

5.1 NHSScotland Counter Fraud Services has the responsibility of working with others to prevent, detect and investigate fraud against any part of the NHS in Scotland. Under the Scottish Government's 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.

5.2 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

6.1 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 affected 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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1. Introduction

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

It should be noted that 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. Where appropriate, the outputs from 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.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

2. 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
- 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
- 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
- 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:

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

3. 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, including tooth specific validation where appropriate for specific items of service.
- duplication on MIDAS
- the patient's date of birth for age exemption
- 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
- 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
- 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
- Further investigation as a result of adverse outcome of SDRS examination.

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:

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

4. 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
- duplication on MIDAS

Outputs:

Quarterly PV report detailing:

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

5. Appendix A – Examination 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

2.2 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

Administrative P: possible violation or avoidance of Prior Approval Regulations/requirements

3.3 The 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 NHS Board, or in some cases a tri-partite meeting between Practitioner Services, the NHS Boards and Counter Fraud Services.

Annex II – Medical Payments

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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.

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.

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, that fully reconciles with the claim submitted should practices be required to do so,. 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.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

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 A 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. Arrangements for the Payment Verification of the Global Sum include Organisational and Clinical Core Standard Payments as outlined in the Statement of Financial Entitlements.

A GP Practice's global sum allocation, excluding Core Standard Payments, 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 accuracy of the Global Sum is dependent upon the 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

- 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, the following technique will be used:

- Discussion and verification of GP Practice policies and procedures either during a practice visit or as part of office based verification work.

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 of Clinical Core Standard Payment

As part of the 2014-2015 GMS Contract Agreement, 264 QOF points were transferred to Global Sum. The decision on whether or not it is appropriate to provide a particular service to a patient in these areas is taken by the GP, usually in conjunction with the patient, and is based on clinical judgement rather than simply whether the action was previously required to achieve a QOF indicator.

The expectation is that for the clinical areas transferred via the Clinical Core Standard Payment in 2014-2015, these services will continue to be provided, where it is considered clinically appropriate, and suitably recorded in the patient's clinical record.

In accordance with PCA(M)09, there will be no specific payment verification arrangements aligned to the Clinical Core Standard Payment.

If it appears that there is a systematic failure to provide any of the transferred services, this may require recourse to a formal review of the clinical decision making recorded within the patient file. This process is not part of payment verification.

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 A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS

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

Payment Verification for Payments for a Specific Purpose

METHOD

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

- Confirmation of adherence to entitlement criteria as per the relevant section of the Statement of Financial Entitlements (SFE) are met
- Confirmation that all relevant conditions of payment as per the relevant section of the SFE are met
- Analysis of outlier detail

Immunisations

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 A.
- Analysis of anonymised practice prescribing information.
- Review of practice activity information including national call/recall systems.

OUTPUTS

- Numbers and values of payments made by practice type and practice.
- Any specific matters arising in the processing of payments.
- Number of records checked at practice visits and results.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

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

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

Payment Verification for Seniority

METHOD

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

The method and output sections below provide generic guidance for the payment verification of all Enhanced Services.

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 A). 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 that the correct additional consultation time is being provided via 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 – 2014/15

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 17 areas
- Public Health – comprising 5 areas
- Quality & Safety – comprising 5 areas
- Medicines Management

QOF Points Value

The overall number of points that a GP Practice can achieve (in 2014-2015) is as follows:

Domain	Points
Clinical	515
Public Health	20
Quality & Safety	111
Medicines Management	13
TOTAL	**659**

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 for one indicator comes from a source other than the practice:

Payment for the CS001(S) 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 a national timetable. 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. Where an NHS Board has a practice review programme incorporating 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 (5% of practices/minimum of 1 practice, 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

Verification of QOF indicators will be undertaken broadly in line with the Scottish Quality & Outcomes Framework – Guidance for NHS Boards and GP Practices.

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.

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. 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.

2. Lab Test Results

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

3. Clinical Review and Clinical Intervention
   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.

4. 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 or hospital correspondence.,

Within each of these four groupings, the principle of "cross verification" has been utilised where possible.

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, CEL 14 (2012) 'Supplementary Guidance on Exception Reporting – April 2012' and Quality & Outcomes Framework (QOF) Guidance for NHS Boards and GP Practices 2014/15. This will include the review of supporting clinical evidence held within the patient record.

During the verification of the Trend Analysis, Lab Test Results, Clinical Intervention, Clinical Review and Repeat Prescribing indicators, consideration will be given to instances where Exception Coding has assisted the practice in meeting the payment threshold.

Disease Prevalence

The integrity of disease registers is fundamental to the accuracy of a number of QOF indicator payments. It is therefore vital that practices maintain accurate and up to date disease registers.

- A patient's inclusion within a register will be verified via the review of other supporting clinical evidence held within the patient record.
- Registers will be reviewed to ensure that newly diagnosed patients have been added.
- Practices are required to demonstrate how they have maintained accurate and up to date disease registers.

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.

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.

OUTPUTS

- **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.

- **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

- Any necessary recommendations and actions.

Appendix A – 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 (5% of practices/minimum of 1 practice per year, per NHS Board) or where, for example, the application of risk assessment or trend analysis suggests that this may be appropriate

2.3 The contractor will be given at least four weeks notice of the intention to carry out a visit and the reason for it.

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 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 The areas selected for review will be determined by the risk assessment methodology The numbers selected for review in each area will be determined by the statistical sampling methodology, thus ensuring that a minimum number of records are accessed for the purposes of verification The visiting team will 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.

4 Visiting Team

4.1 The team visiting the practice may comprise representatives from Practitioner Services the NHS Board, and a GP who is independent to the practice, who may be from a another 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 they become aware of any significant 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 Counter fraud services 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 B - 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, 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.
- Request practices to run regular (at least annually) clinical searches 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 indicator. 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.

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.

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered.

GOS 1 Primary Eye Examination Claim

Primary Eye Examination payments are based on claims made by contractors for undertaking examinations to test sight and identify signs of eye disease. Claims are submitted on the GOS 1 form.

Payment verification checking takes place on 4 levels as follows:

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
- checking the total value of the claim

Level 2 will comprise random sampling of claims including, but not limited to:

- examination of record cards and associated documentation to establish that they comply with the minimum data set as laid down in " The Statement"
- Check on number of primary examinations conducted in a day

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

- patient letters
- further sampling of record cards and associated documentation
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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
- Level of assurance gained

GOS 1 Supplementary Eye Examinations

Supplementary Eye Examination (SEE) payments are based on claims made by contractors where the patient presents and requires an examination prior to the minimum Primary Eye Examination frequency. Claims are submitted on the GOS 1 form.

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
- checking the total value of the claim

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

- Individual and combinations of different SEE code types
- number of SEE
- The number of times a patient has had multiple SEE in one quarter

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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
- Level of assurance gained

GOS 1 Domiciliary Visits

Domiciliary visits are claimed in respect of a patient who is eligible for a GOS eye examination and who is unable to leave the place where they normally reside unaccompanied (for reasons of physical or mental ill health or disability) to attend a practice. Claims are made as an accompaniment to a GOS 1 PEE or SEE claim.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present

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

- the number of domiciliary visits

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

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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
- Level of assurance gained

GOS 3 Spectacle Vouchers

Spectacle Vouchers are issued by contractors to patients who are eligible for help with costs towards glasses or contact lenses. The GOS 3 voucher may contain a number of payment elements including the voucher value (based on the prescription) and supplementary items such as Prisms, Tints, Small Glasses and Complex Lenses.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

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

- ratio of GOS3 claims to total eye examination claims
- ratio of 2 pairs and bifocals to total GOS3 claims
- ratio of tints to total GOS3 claims
- ratio of prisms to total GOS3 claims
- ratio of complex lenses to total GOS3 claims
- ratio of small frame supplements to total GOS3 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
- the carrying out of practice visits as per Appendix A
- for glasses that have not yet been collected, verification that the prescription corresponds to that which is being claimed for

Level 4 checking will be undertaken as follows:

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

Outputs:

Quarterly PV report detailing:

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

On completion of a practice visit, a report will be produced detailing the following:

- Information used to verify service provision
- Number of records checked and results
- Any necessary recommendations, actions and recoveries
- Level of assurance gained

GOS 4 Repair/Replacement Voucher

Repair and replacement vouchers are issued by contractors, primarily in respect of patients under 16 year of age, whose spectacles have suffered damage or been lost and require either to be repaired or replaced.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX/iDENT – to ensure all mandatory information is present
- validation against the NHS (Optical Charges & Payments) (Scotland) Regulations 1998 and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth for age exemption
- checking the total value of the claim

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

- ratio of repairs to total GOS 4 claims
- ratio of replacements to total GOS 4 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
- the carrying out of practice visits as per Appendix A

Level 4 checking will be undertaken as follows:

- the carrying out of practice visits as per Appendix A

Outputs:

Quarterly PV report detailing:

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

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
- 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 that these checks may be carried out during practice visits. During these visits a selection of records will be examined looking at a range of 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.

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 and the reason therefor.

2.4 The contractor will be given at least four 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 claims will be identified for examination. Practitioner Services will extract this information from the OPTIX system and cross reference this to the Community Health Index (CHI).

3.2 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.

3.3 The total number of patient records identified for examination would not normally exceed that which it is practical to review in a two to three hour session. This timeframe may however vary, particularly where records are held centrally.

3.4 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.

3.5 During the visit, Practitioner Services staff may take copies of a sample of the patient records they have checked, either by photocopying, photographing or by electronic scanning. This will support instances where there is a need for clarification on any matter that cannot be resolved during the practice visit.

3.6 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 may comprise representatives from both Practitioner Services and the NHS Board. An Optometrist, who is independent to the practice, should also attend.

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. The independent optometrist may assist these discussions by providing advice and guidance in relation to clinical matters.

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;
- 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 Counter Fraud Services simultaneously.

6.5 Practitioner Services do not have any remit regarding Clinical Governance. If, however, they become aware of any significant 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. 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 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 Counter Fraud Services has taken place, and their agreement reached as to the appropriate course of action

Annex IV – Pharmaceutical Payments

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Introduction

The Scottish Government published NHS Circular CEL 11 (2014), 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.

Level 1

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

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

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

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

- Transitional Fees.
- Regional Office Payments.

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:-

- Minor Ailments Service (MAS)
- Chronic Medication Service (CMS)
- Influenza Vaccination Programme (seasonal)
- Random Sampling
- Public Health Service – Emergency Hormonal Contraception (EHC)
- Regional Office Payments
- Small Pack endorsing
- Gluten Free Foods
- Cross Boundary Flow (CBF)

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

- Form Types

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

- View 1 – A summary report of the number of items and the associated GIC paid for MAS.

- View 2 – A detailed report of the number of Patients registered for MAS that have received a treatment.

- View 3 – A detailed report of the Contractors that have registered more than 25 Patients in one day for MAS (CE Barcodes).

- View 4 – A detailed report of the Contractors that have registered more than 25 Patients in one day for MAS (RE Barcodes).

- View 5 – A detailed report at Contractor level highlighting the Contractors capitation band.

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

- View 1 – A detailed report at Contractor level of the Contractors CMS activity.

- View 2 – A detailed report of the Contractors that have registered more than 25 Patients in one day for CMS.

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

- 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).

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

- 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%**

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.

Regional Office Payments – the following data will be presented in tabular form by NHS Board area: -

- View 1 – A detailed report at Contractor level of the payments made to Contractors via the Kaizen spreadsheet.

Small Pack Endorsing – the following data will be presented in tabular & graphical form by NHS Board area: -

- View 1a – A graph at NHS Board level of the additional costs incurred due to small pack endorsing.

- View 1 – A detailed drug specific report of payments made where small pack endorsing/dispensing has taken place.

Gluten Free Foods (GFF) – the following data will be presented in tabular form by NHS Board area: -

- View 1 - A summary report of the number of items and the associated GIC paid for GFF.

- View 2 – A detailed report at Contractor level of the costs associated with GFF with and without a valid CHI.

- View 3 – A detailed report at Contractor level of the number of items associated with GFF with and without a valid CHI.

Cross Boundary Flow (CBF) – the following data will be presented in tabular form by NHS Board area: -

- View 1 - A report detailing the total number of paid items with associated Gross Ingredient Cost prescribed by GP practices in the reporting NHS Board area and dispensed by Community Pharmacies out with the NHS Board area.

- View 2 - A report detailing the total number of paid items with associated Gross Ingredient Cost prescribed by GP practices in the reporting NHS Board area and dispensed by Community Pharmacies out with the NHS Board area, broken down by NHS Board Prescriber Practice.

- View 3 - A report detailing the total number of paid items with associated Gross Ingredient Cost prescribed by GP practices in the reporting NHS Board area and dispensed by Community Pharmacies out with the NHS Board area, broken down by Community Pharmacy Contractor Code.

Level 3

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

- Verification of the payment information from the centralised pharmaceutical data warehouse with the individual claims.
- Extended samples providing further analysis of claims and/or prescribing patterns.
- Requesting Pharmacy Contractors to provide Patient medication records.
- Requesting Pharmacy Contractors to provide explanations to PV.
- Requesting Pharmacy Contractors to provide supporting documentation as required.
- Contacting Patients to confirm the services provided.
- Advising Pharmacy Contractors of Best Practice as required.
- Adhoc assignments as required.
- Targeted sampling across the identified Risk Categories using statistical strata to decide on the volumes to be sampled.
- 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.

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

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.

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

- 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 Feb 14	% 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	97	7.80%	2
NHS Borders	27	2.17%	1
NHS Dumfries & Galloway	35	2.81%	1
NHS Fife	85	6.83%	1
NHS Forth Valley	72	5.79%	1
NHS Grampian	131	10.53%	2
NHS Greater Glasgow & Clyde	312	25.08%	4
NHS Highland	78	6.27%	1
NHS Lanarkshire	121	9.73%	2
NHS Lothian	182	14.63%	3
NHS Orkney	4	0.32%	1
NHS Shetland	5	0.40%	1
NHS Tayside	92	7.40%	2
NHS Western Isles	3	0.24%	1
Scottish Total	**1,244**	**100.00%**	**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 Feb 14
A	1 - 5,000	20	530
B	5,001 - 10,000	25	594
C	10,001 - 15,000	30	102
D	15,001 - 20,000	35	14
E	20,001 - 25,000	40	4
F	25,001 - 30,000	45	0
G	30,000+	50	0

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:

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

- 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:

- 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.

Liaison with NHS Boards & 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.