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Dear Colleague

## **FAMILY HEALTH SERVICES – PAYMENT VERIFICATION PROCEDURES**

### **Purpose**

1. This letter outlines guidance on payment verification arrangements for family health services (FHS) which supersedes the guidance contained in HDL (2005)49.

### **Background**

2. There are 4 payment verification protocols attached covering primary medical services, general dental services, general ophthalmic services and pharmaceutical services. The major revisions on this occasion are to the protocol for general ophthalmic services in view of the introduction of the new NHS eye examination from 1 April 2006 which is available free of charge to all of those who are legally and ordinarily resident in the UK. The shift from NHS sight tests, which were available only to specific categories of patients, to the new NHS eye examinations, which are available to a wider spectrum of people, has caused some difficulties with respect to identifying those who are legally and ordinarily resident. It should be noted that a shortened version of the guidance on overseas visitors and exemption from NHS charges will be issued shortly by the Health Directorates' Patient Focus and International Issues Team which will assist generally with identification of people falling within this category for free NHS eye examinations, free NHS dental examinations, which were also introduced on 1 April 2006, and other NHS services.

4 October 2007

### **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  
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3. There are some minor revisions to the protocols covering primary medical services and pharmaceutical services. The protocol relating to general dental services is currently being revised by the Dental Payment Verification Group, in line with the other 3. This will be completed within the 2007-2008 financial year and a further CEL will be issued in due course.

4. The procedures have been accepted by the Scottish Government and by Audit Scotland as providing an adequate framework to provide assurance to Boards on the accuracy and validity of payments to family health service contractors made on their behalf by Practitioner Services. It is for Boards to ensure that they are content with the operation of the procedures. A hard copy of the PV protocols is attached. Please note that electronic copies of this CEL and Annex can also be downloaded from the SHOW website at

[www.sehd.scot.nhs.uk](http://www.sehd.scot.nhs.uk)

### Action

5. **NHS Boards** are asked to:

- note the procedures document attached in the Annex;
- ensure that their Audit Committees are fully informed of these arrangements;
- work with Practitioner Services in ensuring implementation of the procedures;
- note that, in accordance with HDL (2005)5, teams undertaking payment verification visits to practices will alert NHSScotland Counter Fraud Services ("CFS") and the relevant Board simultaneously where a concern arises in the course of their visit relating to a potential fraud and also that a tri-partite meeting between Practitioner Services, the NHS Board and the CFS will take place before a visit report is issued;
- note that a further CEL will be issued once the general dental services protocol has been revised; and
- note that a shortened version of the guidance on overseas visitors and NHS dental charges will be issued by the Executive in due course.

6. Copies of the protocols have also been sent to the relevant professional representative bodies.

Yours sincerely



Jane Davidson  
Deputy Director of Health Finance

# Family Health Services Payment Verification Protocols



## TABLE OF CONTENTS

|   |                                       |   |
|---|---------------------------------------|---|
| 1 | Introduction.....                     | 5 |
| 2 | Contractor Checking .....             | 6 |
| 3 | Risk Assessment.....                  | 7 |
| 4 | Reporting to NHS Boards .....         | 7 |
| 5 | Countering Fraud.....                 | 8 |
| 6 | Adjustment to Payments.....           | 8 |
|   | Annex I - Dental Payments.....        | 1 |
|   | Annex II – Medical Payments.....      | 1 |
|   | Annex III - Ophthalmic Payments ..... | 1 |
|   | Annex IV – Pharmacy Payments .....    | 1 |

## 1 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 made by Practitioner Services Division (PSD), 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 Whilst accountability for carrying out payment verification ultimately rests with the NHS Boards, there is an onus on Practitioner Services, as paying agents, to implement appropriate arrangements for a programme of overall payment verification (PV) at both the pre- and post payment stages. This forms a central part of the Partnership Agreement between Practitioner Services and the NHS Boards.
- 1.4 It is vital that a consistent approach is taken to PV across the contractor streams and Regional Offices of Practitioner Services, 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 now dealt with within a Partnership Agreement between Counter Fraud Services (CFS) and the NHS Boards.

## 2 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** For all claims, as part of the routine pre-payment checking procedures undertaken by the Payments and Registration Teams, with endorsements to show check completed.

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
- 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 A of the Medical and Ophthalmic Annexes.

## 3 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.

## 4 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.

## **5 Countering Fraud**

NHSScotland Counter Fraud Services (CFS) has the responsibility of working with others to prevent, detect and investigate fraud against any part of the NHS in Scotland. Under SEHD's NHS Counter Fraud Strategy, 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.

Practitioner Services through the application of its internal control systems, either pre- or post-payment, may identify irregularities which could potentially be fraud. Whenever that happens Practitioner Services will make its concerns known to both CFS and the Board concerned. Thereafter 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.

## **6 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**

**TABLE OF CONTENTS**

|                           |          |
|---------------------------|----------|
| <b>Introduction .....</b> | <b>2</b> |
| <b>1. Level 1.....</b>    | <b>2</b> |
| <b>2. Level 2.....</b>    | <b>3</b> |
| <b>3. Level 3.....</b>    | <b>3</b> |
| <b>4. Level 4.....</b>    | <b>4</b> |

*The guidance for the payment verification of Dental payments below is currently being revised by the Dental Payment Verification Group, in line with the revisions completed for Medical, Ophthalmic and Pharmacy. This revision will be completed within the 2007-08 financial year and will provide the next update to the Payment Verification Protocol.*

## Introduction

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

Practitioner Services (Dental) operates under the aegis of the Scottish Dental Practice Board (SDPB) whose powers are set out in statutory regulations. These powers are summarised in 'Guide to the Functions of the SDPB'.

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

The PV team in Dental is known as the monitoring team and includes five professionally qualified dental advisers. The team works in close co-operation with Healthcare Information Group (within the Information Services Division) as the source of statistical advice.

### 1. Level 1

The payments system.

**This will automatically carry out Level 1 checks for 100% of claims including:**

- each item of service claimed is code validated and scrutinised against the Statement of Dental Remuneration in respect of the fee, and any provisos or time-limits that apply to it;
- checking that the total value is below the prior approval limit;
- the completion of mandatory fields;
- duplication of claims;
- existence of dentist signatures and authorised identification stamp;
- existence of patient signature;
- matching the patient details with the national database;
- checking the patients registration with the dentist;
- checking the patients date of birth for age exemption

#### **Prior Approval.**

All claims above the Prior Approval limit require to be submitted for checking before treatment is carried out. These are assessed for both clinical and financial appropriateness.

This Level 1 check is equivalent to over 1% of all claims made for the GDS in Scotland, annually.

It should be noted that Dental are currently working on a link between MIDAS and CHI which will further improve checking in respect of capitation payments. It is planned to introduce these at Level 1.

## 2. Level 2

The Dental monitoring team will carry out a Level 2 check on a minimum 1% sample of contractors, in respect of:

- items of service (risk assessed);
- patient registration and list size;
- level of earnings;
- cost per claim and throughput.

These checks will be based on the findings of trend analysis provided by the MIDAS system and Business Objects.

## 3. Level 3

Where the outcome of the above checking proves unsatisfactory or inconclusive the monitoring team will undertake Level 3 checking as appropriate including:

- trapping all claims from an identified practitioner, prior to payment, for further assessment;
- applying the 'prior approval by targeting' regulation;
- applying the 'special prior approval' process;
- sampling patient record cards;
- detailed assessment of the dentists prescribing pattern in conjunction with patient histories and record cards;
- referral of the patient for clinical examination by the Scottish Dental Reference Service to confirm that the treatment was provided.

#### **4. Level 4**

Practitioner Services (Dental) does not carry out practice visits and currently has no powers to do so. However, it does, through the Scottish Dental Reference Service (SDRS), undertake random and targeted examinations of patients. There are approximately 10,000 referrals made to the SDRS annually which equates to 0.3% of all claims for treatment for the GDS in Scotland.

The checks undertaken by the SDRS include:

- existence of patient;
- confirmation of registration with dentist;
- confirmation of signature and exemption status check;
- requirement for items of service (as applicable);
- provision of items of service;
- standard of treatment.

Any practitioner who receives an unsatisfactory report from the SDRS, in relation to the validity or standard of treatment provided to his/her patient, is automatically referred back for assessment at Level 3 and will have further cases selected and referred to the SDRS.

## Annex II – Medical Payments

### TABLE OF CONTENTS

|   |           |
|---|-----------|
| <b>Introduction</b> .....   | <b>2</b>  |
| <b>1. Payment Verification For Global Sum</b> .....                                 | <b>3</b>  |
| <b>2. Payment Verification For Temporary Patient Adjustment (TPA)</b> .....         | <b>6</b>  |
| <b>3. Payment Verification For Additional Services</b> .....                        | <b>7</b>  |
| <b>4. Payment Verification For Payments For A Specific Purpose</b> .....            | <b>8</b>  |
| <b>5. Payment Verification for Section 17c Contract</b> .....                       | <b>10</b> |
| <b>6. Payment Verification For Seniority</b> .....                                  | <b>11</b> |
| <b>7. Enhanced Services</b> .....   | <b>12</b> |
| 7.1 Payment Verification For Directed, National and Local Enhanced Services.....    | 12        |
| 7.2 Payment Verification For Cardiovascular Disease Risk Registers.....             | 13        |
| 7.3 Payment Verification For Access to Contractor Based Primary Care Services ..... | 14        |
| <b>8. Quality and Outcomes Framework</b> .....                                      | <b>15</b> |
| 8.1 QOF Points Value .....  | 16        |
| 8.2 QOF Data Gathering & Reporting .....  | 16        |
| 8.3 QOF Review.....   | 17        |
| 8.4 QOF Payment Verification - Clinical Domain .....                                | 18        |
| 8.5 QOF Payment Verification - Non-‘Clinical’ Domains .....                         | 25        |
| 8.6 QOF Payment Verification Visits.....  | 28        |
| 8.7 Assurance Levels (2004/5 & 2005/6) .....  | 28        |
| <b>9. GP Practice System Security</b> .....   | <b>30</b> |
| <b>Appendix A – Clinical Inspection of Medical Records/Practice Visits</b> .....    | <b>31</b> |
| <b>Appendix B – GMS Payment Verification Checklist</b> .....                        | <b>35</b> |
| <b>Appendix C – GP Practice System Security Checklist</b> .....                     | <b>42</b> |

## **Introduction**

The following sections detail the payment verification requirements for Primary Medical Services.

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 B – 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 Directed and National Enhanced Services (DES & NES) in the GMS contract. Many NHS Boards will implement a Local Enhanced Service (LES), perhaps with local variations to an original NES. The payment verification for the essential services outlined in this paper provides basic principles that should be adhered to when agreeing the payment verification required for a LES.

## **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 Entitlement 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.

## **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 an appendix to 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 normal payment systems and as such will be subject to probity checks through the Board's normal internal 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.

## 1. Payment Verification For Global Sum

### METHOD

The most significant area of risk for global sum payments is inaccurate data being held on the Community Health Index (CHI).

Verification of the data held on the CHI will be achieved in the following ways:

### New Registrations

- The Payments Automation and Registration Transfer Network by Electronic Reciprocal Software (PARTNERS) interface provides an auto matching process for new registrations and patient amendments transmitted from GP Practices (this requires operator approval). This process includes 100% auto postcode checking against the Royal Mail electronic Postcode Address File (PAF) and produces daily exception reports for missing or incorrect postcodes. These are manually corrected. This process also auto checks addresses and postcodes for Nursing Home or Residential Home indicator status. Where there is an exact match this will be automatically inserted.
- There is a manual scrutiny of registration forms from practices not linked via PARTNERS (less than 3% of practices only register patients via paper submission to Practitioner Services) prior to registration. Where concerns exist as to the completeness of electronic data submission by practices, registration forms will be scrutinised manually to ensure correct matches are achieved.
- Correspondence is sent to all patients (either medical card or questionnaire) on registration. Where this correspondence is returned 'undelivered' by the Royal Mail, an exercise will be undertaken to investigate and, if appropriate, deduct the relevant patients from the GP Practice list.
- Levels of new registrations are monitored, with outliers being identified, investigated and followed up where appropriate.
- Where registrations and patient detail amendments are submitted by practices on an electronic only basis (via PARTNERS), a check will be carried out on the registration process in operation, utilising a sample of recent registrations. In particular the paperwork retained by the practice will be scrutinised. This check will be carried out as part of the random payment verification visit. Where these checks give rise to concern an increased sample will be tested. Where appropriate, follow up action will be taken, and patients may be removed from the practice list.
- A pilot project is currently being run in one NHS Board Area in relation to the registration of overseas visitors. Dependent on the results of this, and on a review of the current guidance, it may be possible to include additional, specific, verification action to identify and address inappropriate NHS registration. Until this is complete, and a view taken, the guidance contained in this document will outline the verification required.

## Existing Registrations

- Random Rolling Practice Information Comparison Test (PiCT) Programme - 30% of practices per annum will have the registration data they hold on their clinical system matched to that held by Practitioner Services on CHI. Amendments and deductions will be made to each system as required as part of the exercise and other action followed up as appropriate.
- Targeted PiCT Exercises – these will be conducted in specific instances, e.g. where there is a capitation dispute, where there is a temporary loss of the PARTNERS link, which could result in the loss of data transmission between GP System and CHI. PiCT exercises may also be targeted as a result of previous exercises or where there are concerns around data quality. As with random PiCT exercises, amendments and deductions are made to each system as required as part of the exercise and other action followed up as appropriate.
- 100+ Age Checks – a quarterly reconciliation between CHI and NHS Central register of all registered patients who are aged 100 and above. Patients will be deducted from the GP Practice list as appropriate.
- Routine NHS Mailing – A significant volume of routine NHS mailing is undertaken using the data held on CHI (e.g. annual 65+ Influenza Vaccination Advice letters, Screening Programme letters, Childhood Immunisation letters), covering approximately 50% of the population. Where this correspondence is returned 'undelivered' by the Royal Mail and Practitioner Services is advised, an exercise will be undertaken to investigate and, if appropriate, amend or deduct the relevant patients from the GP Practice list.
- Targeted Investigation/Mailing – Sections of the population are not covered by other routine NHS mailing or data quality exercises (e.g. young adult males not in higher education) and specific investigation and/or targeted mailing will be undertaken. Where appropriate the relevant patients data will be updated or deducted from the GP Practice list.
- Mobile Populations – Patient registration may be potentially limited in duration (e.g. students, immigrants, multiple occupancy or C/O addresses). Specific action will be taken to identify and investigate these for follow up action, e.g. targeted mailing or checking exercises with GP Practices. Where appropriate the relevant patient details will be updated or deducted from the GP Practice list. The volume of checks may be varied across the three Practitioner Services regional offices due to inherent differences in populations. This work will continue on a targeted basis across all NHS Boards as areas of high patient turnover are identified.
- Nursing/Residential Home Confirmation – all institutions defined on the CHI as a Nursing/Residential Home will be written to annually to check that the residents registered on CHI with the institution are correct. Amendments and removals are made to CHI where appropriate.
- Both Scottish and UK wide duplication exercises are run periodically to reconcile data held between NHS organisations
- CHI data quality work is carried out by Practitioner Services Registration as part of routine processing and through specific exercises, though these are not always directly payment related. Where specific new developments in this area provide assurance on payments, these will also be reflected in payment verification reporting.

## OUTPUTS

Review PV work through Quarterly PV return to NHS Boards

Quarterly report to NHS Boards to include the following:

- Total Population Statistics –
  - number of new Registrations
  - number of Nursing/Residential Home residents
  - number of missing postcodes
  - number of practices at quarter end
- Results of new registration level monitoring
- Number and % of PiCT jobs run at quarter end and numbers of patients involved and % of patients removed
- Number of 100+ Age Checks and number of patients removed at quarter end
- Number and % of nursing home patients checked and numbers and % removed and added at relevant quarter end.
- Results of returned undelivered mail exercises, both Practitioner Services and routine NHS Mailing
- Results of Mobile Population checks
- Additional narrative as required on results of checking and indication of further action as appropriate.
- On ongoing checks for duplications in CHI.

Practice Visit Report –

- Numbers and % of registrations checked at practice visits.

## 2. Payment Verification For Temporary Patient Adjustment (TPA)

### METHOD

To verify that these services are being provided the following checks will be undertaken:

- Random checks to GP Practice records for evidence of service provision at practice visit
- NHS Board complaint logs should be reviewed annually to identify complaints, or a pattern of complaints, that could indicate a lack of service provision. If instances of potential lack of service are found, these should be subject to further investigation, and if necessary further action.
- Where concerns exist over a lack 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 NHS Board Complaints log
- Any necessary recommendations, actions and recoveries

### **3. 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:

- 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

## 4. Payment Verification For Payments For A Specific Purpose

### METHOD

Checking of source documentation to ensure validity:

#### 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.
- Check to Med. Certs and confirm cost of locum cover.

#### 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

#### 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. Confirm cost of locum cover.

**Golden Hello –**

- Standard - Agree entitlement under the SFE 14.2. (e.g. Minimum 1/5<sup>th</sup> 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 1/5<sup>th</sup> 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 Education.

**Adults with Incapacity -**

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

**OUTPUTS**

- Numbers and value of payments made by payment type and practice
- Any specific matters arising in the processing of payments

## 5. 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. These are subject to the payment verification processes outlined in this document.
- Payments that are specific to their section 17c contract. These will be subject to NHS Boards contract monitoring processes which will involve:
  - NHS Board quarterly review
  - Analysis of practice produced statistics which demonstrate contract compliance
  - Review as appropriate section 17c contracts against other/new funding streams to identify and adjust any duplication of payment

### OUTPUTS

- As per agreed local monitoring process

## 6. Payment Verification For Seniority

### METHOD

Checks required on eligibility of reckonable service for all claims from new entrants to NHS Scotland.

#### Pre-payment checking -

- Reasonableness of claim – to check dates against information on form seems appropriate - General Medical Council (GMC) registration date, NHS service start date.

#### Post Payment Checking -

- check for length of service
- check for undeclared breaks in service against NHS records including superannuation records.
- check eligibility of breaks in service
- where applicable check with Scottish Executive (SE) for eligibility of non-NHS Service.

### OUTPUTS

#### Pre Payment -

- name and practice of new claimants received in quarter

#### Post Payment -

- results and status of checking process

## **7. Enhanced Services**

### **7.1 *Payment Verification For Directed, National and Local Enhanced Services***

#### **INTRODUCTION**

The method and output sections below provide generic guidance for the payment verification of all Directed and National Enhanced Services. Where specific guidance for new or existing enhanced services is required, this is provided in the following sections. The payment verification guidance in these sections provides some basic principles that should be adhered to when agreeing the payment verification required for a Local Enhanced Service.

#### **METHOD**

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

- 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

#### **OUTPUTS**

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

## **7.2 Payment Verification For Cardiovascular Disease Risk Registers**

### **DESCRIPTION**

As defined by Scottish Executive (SE) NHS Circular PCA (M)(2006)7, engagement payments will be paid to Contractors at the end of April 2006 who compile a CVD risk data set on all patients between 45 and 64 years of age on whom there is no entry in the electronic record since 1 April 2001 of blood pressure and /or smoking status and submit this information to PS by 17 April 2006. The data required to be collected to qualify for payment for this service will comprise of –

- age
- gender
- BMI
- past medical history
- family history
- tobacco use
- blood pressure.

Achievement payment will only be paid in April 2007 once all data required has been entered in the patient record of each patient with missing data.

Aspiration payments will be paid monthly to participating practices based on the share of people in the target population that are on the practice list.

### **METHOD**

- To verify that these services are being provided, a review of detailed practice activity information will be undertaken. From this information a sample will be selected which will be reviewed against patients' records during a practice visit.
- Practices will be asked to demonstrate the initiatives they have undertaken to reach those patients with missing data.

### **OUTPUTS**

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

### **7.3 Payment Verification For Access to Contractor Based Primary Care Services**

#### **DESCRIPTION**

As defined by SE NHS Circulars PCA (M)(2006)7 and HDL (2005)61, to ensure that anyone contacting their GP surgery has guaranteed access to a GP, nurse or other Health care professional within 48 hours in accordance with their clinical need.

Definitions –

- 48 hours – 2 working days
- Access – face to face, telephone, email
- Professional – doctor, nurse, health visitor or other health care professional in the practice with which the person is registered who is competent to deal with patient's clinical needs.
- Exclusions –
  - patient does not want contact within 48 hours,
  - patient specifies particular professional,
  - patient offered within 48 hours, but states a preference for an alternative outwith 48 hours.

#### **METHOD**

Will be dependent on practice's monitoring system and so may include:

- A check of practice accreditation
- A review of the practice appointment system
- A review of "telephone surgery" policy
- A review of triage procedures
- Availability of open access sessions
- A review of practice's 48 hour consultation surveys
- Confirmation letters/surveys to patients
- Review of Board's complaints log

Some of these may be reviewed during a PV visit to a practice

#### **OUTPUTS**

- Details of information used to verify service provision and results
- Any necessary recommendations, actions and recoveries

## 8. Quality and Outcomes Framework

### INTRODUCTION

The Quality & Outcomes Framework (QOF) rewards practices on the basis of the quality of care delivered to patients.

The framework contains 4 domains, and each domain contains a range of areas described by key indicators. Each indicator describes different aspects of performance that a practice is required to undertake.

The four domains are:

- **Clinical** – in 2004/5 and 2005/6, this domain covered 10 clinical areas, rising to 19 in 2006/7 onwards:

| 2004/5 & 2005/6                       | 2006/7 Onwards                        |
|---------------------------------------|---------------------------------------|
| Chronic Heart Disease (incl. LVD)     | Chronic Heart Disease                 |
| Stroke                                | Heart Failure                         |
| Hypertension                          | Stroke                                |
| Diabetes                              | Hypertension                          |
| Chronic Obstructive Pulmonary Disease | Diabetes                              |
| Epilepsy                              | Chronic Obstructive Pulmonary Disease |
| Hypothyroidism                        | Epilepsy                              |
| Cancer                                | Hypothyroidism                        |
| Mental Health                         | Cancer                                |
| Asthma                                | Palliative Care                       |
|                                       | Mental Health                         |
|                                       | Asthma                                |
|                                       | Dementia                              |
|                                       | Depression                            |
|                                       | Chronic Kidney Disease                |
|                                       | Atrial Fibrillation                   |
|                                       | Obesity                               |
|                                       | Learning Disabilities                 |
|                                       | Smoking                               |

In addition, payments are made in respect of Holistic Care, which is based on the breadth of achievement a practice displays across the various clinical areas.

- **Organisational** - this domain covers 4 areas; Records & Information About Patients, Information for Patients, Education & Training, Practice Management, Medicines Management.
- **Patient Experience** – this domain covers 2 areas; Length of Consultation and Patient Survey
- **Additional Services** – this domain covers 4 areas; Cervical Screening, Child Health Surveillance, Maternity Services, Contraceptive Services

In addition, in financial years 2004/5 and 2005/6 only, payments were made to practices in respect of Quality Practice, which is based on the breadth of the achievement a practice displays over the non-clinical domains.

Payments were also made to practices who could demonstrate that they met the requirements of the 48-hour Access target. For 2006/7 this payment is made via an enhanced service.

### 8.1 QOF Points Value

The overall value of quality points in the QOF was initially set in financial year 2004/5, and changed for financial year 2006/7 as follows:

| Domain              | 2004/5 & 2005/6 | 2006/7 Onwards |
|---------------------|-----------------|----------------|
| Clinical            | 650             | 675            |
| Organisational      | 184             | 181            |
| Patient Experience  | 100             | 108            |
| Additional Services | 36              | 36             |
| Quality Practice    | 30              | -              |
| Access              | 50              | -              |
| <b>TOTAL</b>        | <b>1050</b>     | <b>1000</b>    |

### 8.2 QOF Data Gathering & Reporting

Data held within practice clinical systems forms the basis for a practice's achievement declaration in respect of each clinical indicator. Clinical data recording is based entirely 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 non-clinical indicators, 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 only one indicator within the QOF comes from a source other than the practice. Payment for the CS1 indicator, contained within the Additional Services domain, is actioned by Practitioner Services via the manual input of achievement data from the screening systems utilised by NHS Boards.

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

### **8.3 QOF Review**

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

#### **Pre-Payment Checking –**

- On an ongoing basis, practices should be monitored to ascertain how their reported disease register sizes within QMAS change month on month, and how they compare to the size of the disease register at the end of the preceding financial year.
- Following the submission of a practice's year-end QOF achievement declaration, NHS Boards have a 10-day "window" in early April during which pre-payment verification should 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 within QMAS and payment made.

#### **Post Payment Checking –**

- A qualitative/supportive QOF review visit intended to review the practice's achievement of QOF in the previous year, and promote progression towards achievement of quality within practices for the current financial year. As detailed in the Winter Guidance ([www.paymodernisation.scot.nhs.uk/gms/quality/docs/WinterII-Final.doc](http://www.paymodernisation.scot.nhs.uk/gms/quality/docs/WinterII-Final.doc)), all practices received a qualitative/supportive visit in financial year 2005/6, which reflected on that year's progression, and also their achievement in 2004/5. In financial year 2006/7, the frequency of visits changed to that determined by experience and local knowledge, and as a minimum will be carried out on a two yearly basis. This visit reflected on that year's progression, and also the practice's achievement in 2005/6.
- 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 sample basis, which can be either random (five percent of practices/minimum of two, per year, per NHS Board), or targeted.

#### **8.4 QOF Payment Verification - Clinical Domain**

Each clinical area contains indicators that relate to the compiling of a disease register, the diagnosis and initial management of the disease, and how it is to be treated in the long term.

The sample size for the verification of the clinical domain of the QOF would not normally exceed that which it is practical to review in a 2-3 hour session. In order to facilitate this, given the large numbers of indicators within the clinical domain, individual indicators have been grouped. These groupings take cognisance of the affect the indicator has on payment, the indicator type, and the method of verification to be used.

Within each grouping, the principle of “cross verification” has been utilised where possible. For example, CHD7, STROKE7 and DM16 are indicators within different disease areas that relate to the measuring of total cholesterol levels. It is not necessary to test all 3 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 and Diabetic patients who have met this indicator.

Indicators have been grouped as follows:

- Disease Register Integrity,
- Exception Coding,
- Trend Analysis,
- Lab Tests,
- Data Validation,
- Repeat Prescribing,
- Referrals.

Verification of each of these groups may be achieved as follows:

### Disease Register Integrity

Practices are awarded points for establishing and updating disease registers, however the integrity of the disease registers a practice holds is crucial to other aspects of their QOF payment. The size of a practice's disease registers are used to calculate national disease prevalence levels, and hence to weight practice's QOF payments for each disease area. In addition, the points attributed to each indicator within the category are based on a "% achieved" from the register's total pool of patients.

A patient's inclusion within a register can be verified via the review of other supporting clinical evidence held within the patient record. For example, a patient's inclusion within the Asthma register may be confirmed by the existence of disease-specific drugs and peak flow measurements within their patient record.

The indicators relating to this grouping are as follows:

| 2004/5 & 2005/6 | Points    | 2006/7 Onwards | Points    |
|-----------------|-----------|----------------|-----------|
| CHD1            | 6         | CHD1           | 4         |
| LVD1            | 4         | HF1            | 4         |
| STROKE1         | 4         | STROKE1        | 2         |
| BP1             | 9         | BP1            | 6         |
| DM1             | 6         | DM19           | 6         |
| COPD1           | 5         | COPD1          | 3         |
| EPILEPSY1       | 2         | EPILEPSY5      | 1         |
| THYROID1        | 2         | THYROID1       | 1         |
| CANCER1         | 6         | CANCER1        | 5         |
| MH1             | 7         | PC1            | 3         |
| ASTHMA1         | 7         | MH8            | 4         |
|                 |           | ASTHMA1        | 4         |
|                 |           | DEM1           | 5         |
|                 |           | CKD1           | 6         |
|                 |           | AF1            | 5         |
|                 |           | OB1            | 8         |
|                 |           | LD1            | 4         |
| <b>TOTAL</b>    | <b>58</b> | <b>TOTAL</b>   | <b>71</b> |

## Exception Coding

Practices can exclude patients from the performance target within each disease category by “exception coding” them in order that they 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.

The application of exception coding can be verified via the review of other supporting clinical evidence held within the patient record. For example, 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. In particular, a practice’s use of exception coding will be assessed against PCA (M)(2006) 15.

The sample selected for audit should focus on indicators where exception coding has assisted the practice in meeting the indicator threshold. This sample should comprise, where possible, the following types of exception coding:

- Refused/Declined,
- Unsuitable,
- Maximum Tolerated Medication,
- Prescribing Not Appropriate/Not Tolerated
- Informed Dissent.

## Trend Analysis

Verification of indicators that relate to the control of blood pressure within disease-appropriate ranges is achieved in two ways:

A sample of patients who have met the indicator should be selected for audit during a visit and analysis of the historical blood pressure values 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.

The indicators relating to this grouping are as follows:

| <b>2004/5 &amp; 2005/6</b> | <b>Points</b> | <b>2006/7 Onwards</b> | <b>Points</b> |
|----------------------------|---------------|-----------------------|---------------|
| CHD6                       | 19            | CHD6                  | 19            |
| STROKE6                    | 5             | STROKE6               | 5             |
| BP5                        | 56            | BP5                   | 57            |
| DM12                       | 17            | DM12                  | 18            |
|                            |               | CKD3                  | 11            |
| <b>TOTAL</b>               | <b>97</b>     | <b>TOTAL</b>          | <b>110</b>    |

**Lab Tests**

Verification of indicators that relate to the carrying out and recording of results of lab tests is achieved as follows:

A sample of patients who have met the indicator should be selected for audit during a visit, and the system recorded value cross-referenced to paper lab results. In paper-light practices, reference will be made to scanned images of the test results. If lab results are automatically downloaded into the practice's system, then further verification is not required in respect of these indicators.

The indicators relating to this grouping are as follows:

| <b>2004/5 &amp; 2005/6</b> | <b>Points</b> | <b>2006/7 Onwards</b> | <b>Points</b> |
|----------------------------|---------------|-----------------------|---------------|
| CHD7/STROKE7/DM16          | 12            | CHD7/STROKE7/DM16     | 12            |
| CHD8/STROKE8/DM17          | 27            | CHD8/STROKE8/DM17     | 28            |
| DM5                        | 3             | DM5                   | 3             |
| DM6                        | 16            | DM20                  | 17            |
| DM7                        | 11            | DM7                   | 11            |
| DM13                       | 3             | DM13                  | 3             |
| DM14                       | 3             | DM22                  | 3             |
| THYROID2                   | 6             | THYROID2              | 6             |
| MH3                        | 3             | MH4                   | 1             |
| MH4                        | 3             | MH5                   | 2             |
| MH5                        | 5             |                       |               |
| <b>TOTAL</b>               | <b>92</b>     | <b>TOTAL</b>          | <b>86</b>     |

**Data Validation**

Data validation covers a group of indicators that relate to a variety of actions such as the taking of measurements, the provision of vaccinations and the carrying out of annual reviews.

Verification of these indicators is achieved via reference to the records of a sample of patients who have met the indicator. 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. PC2 (2006/7 QOF) may be verified by reference to the system utilised by the practice for initiating and recording meetings.

The indicators relating to this grouping are as follows:

| <b>2004/5 &amp; 2005/6</b>               | <b>Points</b> | <b>2006/7 Onwards</b>         | <b>Points</b> |
|--|---------------|-------------------------------|---------------|
| CHD3/STROKE3/BP2/DM3/COPD4/ASTHM<br>A3/4 | 41            | CHD5/STROKE5/DM11/CKD2        | 18            |
| CHD4/STROKE4/BP3/DM4/COPD5/ASTHM<br>A5   | 33            | CHD12/STROKE10/DM18/COPD<br>8 | 18            |
| CHD5/BP4//STROKE5/DM11                   | 32            | BP4                           | 20            |
| CHD12/STROKE10/DM18/COPD8/ASTHM<br>A7    | 30            | DM2                           | 3             |
| DM2                                      | 3             | COPD9                         | 10            |
| COPD2                                    | 5             | COPD10                        | 7             |
| COPD3                                    | 5             | COPD11                        | 7             |
| COPD6                                    | 6             | EPILEPSY6                     | 4             |
| COPD7                                    | 6             | EPILEPSY8                     | 6             |
| EPILEPSY2                                | 4             | CANCER3                       | 6             |
| EPILEPSY4                                | 6             | PC2                           | 3             |
| CANCER2                                  | 6             | MH9                           | 23            |
| MH2                                      | 23            | MH6                           | 6             |
| ASTHMA2                                  | 15            | MH7                           | 3             |
| ASTHMA6                                  | 20            | ASTHMA8                       | 15            |
|  |               | ASTHMA3                       | 6             |
|  |               | ASTHMA6                       | 20            |
|  |               | DEM2                          | 15            |
|  |               | DEP1                          | 8             |
|  |               | DEP2                          | 25            |
|  |               | SMOKING1                      | 33            |
|  |               | SMOKING2                      | 35            |
| <b>TOTAL</b>                             | <b>235</b>    | <b>TOTAL</b>                  | <b>291</b>    |

### Repeat Prescribing

Verification of indicators that relate to the repeat prescribing of various drugs, or the review of existing medication, is achieved as follows:

A sample of patients who have met the indicator should be selected for audit during a visit, and a check made to their medical record that they were in receipt of the drug in question at the end of the contract year.

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 issue scripts.

The indicators relating to this grouping are as follows:

| <b>2004/5 &amp; 2005/6</b> | <b>Points</b> | <b>2006/7 Onwards</b> | <b>Points</b> |
|----------------------------|---------------|-----------------------|---------------|
| CHD9                       | 7             | CHD9                  | 7             |
| CHD10                      | 7             | CHD10                 | 7             |
| CHD11                      | 7             | CHD11                 | 7             |
| LVD3                       | 10            | HF3                   | 10            |
| STROKE9                    | 4             | STROKE12              | 4             |
| DM15                       | 3             | DM15                  | 3             |
| EPILEPSY3                  | 4             | EPILEPSY7             | 4             |
|                            |               | CKD4                  | 4             |
|                            |               | AF3                   | 15            |
| <b>TOTAL</b>               | <b>42</b>     | <b>TOTAL</b>          | <b>61</b>     |

## Referrals

Verification of indicators that relate to the referral of a patient for a specific procedure to be carried out is achieved as follows:

A sample of patients who have met the indicator should be selected for audit during a visit, and cross-referenced to paper referral letters and results. In paper-light practices, reference will be made to scanned images.

The indicators relating to this grouping are as follows:

| <b>2004/5 &amp; 2005/6</b> | <b>Points</b> | <b>2006/7 Onwards</b> | <b>Points</b> |
|----------------------------|---------------|-----------------------|---------------|
| CHD2                       | 7             | CHD2                  | 7             |
| LVD2                       | 6             | HF2                   | 6             |
| STROKE2                    | 2             | STROKE11              | 2             |
| DM8                        | 5             | DM21                  | 5             |
| DM9                        | 3             | DM9                   | 3             |
| DM10                       | 3             | DM10                  | 3             |
|                            |               | AF2                   | 10            |
| <b>TOTAL</b>               | <b>26</b>     | <b>TOTAL</b>          | <b>36</b>     |

## Holistic Care

No specific verification is required as this payment is derived from a calculation based on the clinical domain achievement (via QMAS).

## Sample Size/Spread

In selecting the indicators to test during the visit, at least 80% of the points achieved by a practice should be tested. In determining the sample spread across the seven groupings detailed above, cognisance should be taken of any locally known areas of risk or concern.

## 8.5 QOF Payment Verification - Non-'Clinical' Domains

The non-'clinical' domains comprise the following areas:

- Organisational
- Patient Experience
- Additional Services

As previously stated, practices are required to retain written evidence as proof that they have met the requirements of the non-clinical indicators which comprise each of these domains. The reviewing of this evidence is a key feature of the qualitative/supportive visit.

In order to reduce the number of visits that practices receive annually, wherever possible reliance is placed on the assurance gained from the qualitative/supportive visits undertaken in line with the Winter Guidance.

The evidence that practices are required to provide in respect of each non-clinical indicator is categorised as follows;

- Grade A – data to be made available in advance of a visit
- Grade B - data to be made available during a visit
- Grade C – data which may be requested

### Financial Year 2005/6

As detailed in the Winter Guidance for QOF Review, all practices received a qualitative/supportive visit in financial year 2005/6, which reflected on that year's progression, and also their achievement in 2004/5. Hence all Grade A and B evidence held by practices to substantiate their organisational indicator claims for 2004/5 was assessed as part of this process. Practices which held Practice Accreditation v1A or Quality Practice Award v7 "in date", were excluded from the assessment of organisational evidence, as they had already been assessed against a similar quality standard prior to the inception of the QOF.

For achievement in 2004/5 (reviewed in 2005/6) the points associated with each evidence category is as follows:

| <b>Category</b> | <b>Points</b> |
|-----------------|---------------|
| Grade A         | 293           |
| Grade B         | 21.5          |
| Grade C         | 42.5          |
| No Evidence     | 2             |
| <b>TOTAL</b>    | <b>359</b>    |

Provided that NHS Boards conducted their qualitative/supportive visit in line with the Winter Guidance, and that issues of concern were brought to the attention of the NHS Board for action, this process was deemed to provide an appropriate level of payment verification assurance for non-clinical domains for 2004/5 payments. No further action in respect of non-clinical domains was therefore required as part of any payment verification visit.

### Financial Year 2006/7

For financial year 2006/7 onwards, the qualitative/supportive visits should be undertaken at a frequency determined by experience and local knowledge (and in the context of the Board's overall visits regime) and as minimum be carried out on a two yearly basis in all but exceptional circumstances.

- **“Core”** Grade A evidence – evidence that relates to indicators which require action to be taken within the financial year in question. This evidence must be reviewed annually.
- **“Non-core”** Grade A evidence – evidence that relates to indicators which require the existence of policies and other supportive documentation. This evidence will have been reviewed during the 2005/6 qualitative/supportive visit.

Hence, if a practice is in receipt of a qualitative/supportive visit within financial year 2006/7, only their “Core” Grade A evidence will be assessed, as “Non-core” Grade A evidence will have been assessed during the previous year's visit. As in 2005/6, practices which held Practice Accreditation v1A or Quality Practice Award v7 “in date”, were excluded from the assessment of organisational evidence, as they had already been assessed against a similar quality standard prior to the inception of the QOF.

For achievement in 2005/6 (reviewed in 2006/7) the points associated with each evidence category is as follows:

| Category           | Points     |
|--------------------|------------|
| “Core” Grade A     | 244.5      |
| “Non-core” Grade A | 48.5       |
| Grade B            | 21.5       |
| Grade C            | 42.5       |
| No Evidence        | 2          |
| <b>TOTAL</b>       | <b>359</b> |

Once again, provided that NHS Boards conduct their qualitative/supportive visit in line with the Winter Guidance, and that issues of concern are brought to the attention of the NHS Board for action, this process is deemed to provide an appropriate level of payment verification assurance for non-clinical domains for 2005/6 payments. Consequently, for those practices receiving a payment verification visit **and** a qualitative/supportive visit within the same financial year no further action in respect of non-clinical domains is required.

However, practices receiving a payment verification visit, which **are not** scheduled to receive a qualitative/supportive visit in the same financial year, must have their “Core” Grade A evidence assessed as part of the payment verification process.

Where the Winter Guidance has not been complied with, the NHS Board will initiate action to address any consequent concerns regarding the level of assurance gained.

“Core” Grade A evidence is as follows:

| <b>Evidence</b>            | <b>Indicator</b> | <b>Points</b> |
|----------------------------|------------------|---------------|
| Patient Note Surveys       | R9               | 4             |
|                            | R15              | 25            |
|                            | R18              | 8             |
|                            | R19              | 7             |
|                            | Med5             | 7             |
|                            | Med9             | 8             |
| Practice Leaflet           | Inf3             | 1             |
|                            | Inf7             | 1.5           |
|                            | M5               | 3             |
|                            | Med4             | 3             |
|                            | Med8             | 6             |
| Significant Event Analyses | E2               | 4             |
|                            | E7               | 4             |
| Review of Complaints       | E6               | 3             |
| Prescribing Actions        | Med6             | 4             |
|                            | Med10            | 4             |
| Audit of Cervical Smears   | CS6              | 2             |
| Consultation Length Survey | PE1              | 30            |
| Patient Survey             | PE2              | 40            |
|                            | PE3              | 15            |
|                            | PE4              | 15            |
| Access Declaration         | Access Bonus     | 50            |
| <b>TOTAL</b>               |                  | <b>250.5</b>  |

### **Financial Year 2007/8**

Until the Winter Group has met and reviewed their guidance for that year it will not be possible to ascertain the extent to which the qualitative/supportive visit provides assurance as to the validity of a practice’s QOF achievements in respect of the non-clinical domain, for visits carried out in financial year 2007/8.

**Additional Services – (CS1 11 Points)**

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 verification is therefore required in respect of this indicator.

**Quality Practice (2004/5 & 2005/6 Only)**

No specific verification is required as this payment is derived from a calculation based on the non-‘clinical’ domains achievement (via QMAS).

**8.6 QOF Payment Verification Visits**

The QOF payment verification visit may be carried out on its own, or at the same time as either the qualitative/supportive QOF review visit or 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 principles detailed in Appendix A – Clinical Inspection of Medical Records/Practice Visits are applicable to this

**8.7 Assurance Levels (2004/5 & 2005/6)**

Implementation of the QOF payment verification guidelines described within this document will provide the following levels of assurance as to the validity of a practice’s achievement:

- **Clinical indicators** – assurance will be provided for a minimum of 80% of points achieved
- **Non-Clinical indicators** – assurance will be provided for a minimum of 88.1% of points achieved

In addition, the verification of the clinical and non-clinical indicators will, as a by-product, provide assurance as to the validity of the Holistic Care and Quality Practice payments.

In totality therefore, the minimum level of assurance that can be gained from the payment verification process, is 83.1% of points achieved.

This can be summarised as follows:

| Domain       | Total Points | Assurance Provided Via   | Points Assessed |
|--------------|--------------|--|-----------------|
| Clinical     | 650          | Assessment of a minimum of 80% of clinical indicator points achieved | 440             |
|              |              | Holistic Care  | 80              |
| Non-clinical | 400          | Assessment of Grade A/B evidence                                     | 314.5           |
|              |              | Quality Practice   | 27              |
|              |              | CS1 Indicator  | 11              |
|              | <b>1050</b>  |  | <b>872.5</b>    |

**Outputs**

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

## 9. GP Practice System Security

To gain assurance that the proper procedures are in place, the GP Practice System Security Checklist included as Appendix C should be completed. Once completed, and the level of compliance ascertained, the significance of any areas of non-compliance can be assessed, in order to determine whether there is any impact on the reliability or the integrity of the data produced by the Practice's IT system.

It is noted that not all parts of the checklist will be under the control of practice staff, and consequently the checklist should be completed through a combination of:

- reference to appropriate documentation maintained by the practice,
- visual check of the premises
- questions to appropriate Practice Staff (or, if appropriate, Health Board IT staff outwith the practice visit)
- for those practices taking advantage of hosting arrangements, assurances from the Health Board IT staff that the adequacy of security standards has been independently confirmed.

## **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 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 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.
- 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 on disc 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 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. This is necessary to facilitate the retrieval of records by the practice and an efficient audit of notes by the visiting team.
- 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.
- 3.9 On arrival, the practice will be advised which clinical records will be examined and will require to make these available to the visiting team.

#### **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. In order to ensure 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 practices 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;
  - 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. 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.
- 7.2 In instances where the visit has been 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 agreed 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.
- 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 meeting between Practitioner Services, the NHS Board and Counter Fraud Services has taken place, and their agreement reached as to the appropriate course of action.

## Appendix B – 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                  | Contract Type | Data Source | Check / Process  | Who | Reporting                    | Where            |
|--------------------------|---------------|-------------|--|-----|------------------------------|------------------|
| <b>Global Sum</b>        |               |             |  |     |                              |                  |
| <b>New Registrations</b> |               |             |  |     |                              |                  |
| <b>Pre-registration</b>  | -             | -           | PARTNERS Interface for linked practices (auto matching process plus operator approval, auto post coding and NH/RH indicator) |     | No of new registrations      | Quarterly Report |
|                          | -             | -           | Manual GPR check for non linked practices/concerns over incomplete submission  |     | No of new registrations      | Quarterly Report |
|                          | ---           | ---         | Correspondence to patients through Medical Card/Questionnaire on registration  |     | No of removals re PO returns | Quarterly Report |
|                          | ---           | ---         | Monitor levels of new registrations and identification and follow up of outliers   |     | Quarterly outlier analysis   | Quarterly Report |
| <b>Post-registration</b> | -             | -           | Signature/process check when only electronic claims during Practice Visit  |     | No of checks & results       | Visit Report     |

Annex II – Medical Payments

| Payment                       | Contract Type | Data Source | Check / Process   | Who | Reporting                     | Where            |
|-------------------------------|---------------|-------------|---|-----|-------------------------------|------------------|
| <b>Global Sum</b>             |               |             |   |     |                               |                  |
| <b>Existing Registrations</b> |               |             |   |     |                               |                  |
|                               | -             | -           | PICT random rolling programme                                 |     | No of Jobs run & removals     | Quarterly Report |
|                               | -             | -           | PICT re capitation dispute                                    |     | No of Jobs run & removals     | Quarterly Report |
|                               | -             | -           | PICT re loss of PARTNERS                                      |     | No of Jobs run & removals     | Quarterly Report |
|                               | -             | -           | PICT re DQ concerns   |     | No of Jobs run & removals     | Quarterly Report |
|                               | -             | -           | Over 100 years old confirmation                               |     | No of checks & removals       | Quarterly Report |
|                               | -             | -           | Over 65 years old Flu Invite - letters returned to PSD        |     | No of letters sent & removals | Quarterly Report |
|                               |               |             | Other NHS mailing/screening letter returns where PSD notified |     | No of returns & removals      | Quarterly Report |
|                               | -             | -           | Targeted Investigation/Mailing                                |     | No of checks & removals       | Quarterly Report |
|                               | -             | -           | Mobile Population Checks                                      |     | No of checks & removals       | Quarterly Report |
|                               | -             | -           | Nursing / Residential Home Confirmation from Homes            |     | No of checks & removals       | Quarterly Report |
|                               | -             | -           | National Duplication Exercises                                |     | No of checks & removals       | Quarterly Report |

Annex II – Medical Payments

| Payment                   | Contract Type | Data Source | Check / Process                     | Who | Reporting                             | Where            |
|---------------------------|---------------|-------------|-------------------------------------|-----|---------------------------------------|------------------|
| <b>TPA</b>                |               |             |                                     |     |                                       |                  |
| <b>Temporary Patients</b> | -             | -           | Service provision to patient record |     | No of checks and results              | Visit Report     |
|                           |               |             | Review of NHS Board complaints log  |     | Date of review/Follow up action taken | Quarterly Report |

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

Annex II – Medical Payments

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

Annex II – Medical Payments

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

| Payment             | Contract Type | Data Source | Check / Process             | Who | Reporting              | Where            |
|---------------------|---------------|-------------|-----------------------------|-----|------------------------|------------------|
| <b>Seniority</b>    |               |             |                             |     |                        |                  |
| <b>Pre-Payment</b>  | -             | -           | Reasonableness              |     | No of checks & results | Quarterly Report |
|                     | -             | -           | GMC Registration            |     | No of checks & results | Quarterly Report |
|                     | -             | -           | NHS Service Start           |     | No of checks & results | Quarterly Report |
| <b>Post-Payment</b> | -             | -           | Length of Service           |     | No of checks & results | Quarterly Report |
|                     | -             | -           | Non NHS service eligibility |     | No of checks & results | Quarterly Report |

Annex II – Medical Payments

| Payment   | Contract Type | Data Source | Check / Process  | Who | Reporting                | Where        |
|---|---------------|-------------|--|-----|--------------------------|--------------|
| <b>Enhanced Services</b>                                |               |             |  |     |                          |              |
| <i>DES</i>  |               |             |  |     |                          |              |
| <b>Two Year Old Immunisation Payment</b>                |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results - | Visit Report |
| <b>Five Year Old Immunisation Payment</b>               |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results   | Visit Report |
| <b>Influenza - 65+/At Risk</b>                          |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results   | Visit Report |
| <b>Pneumococcal - 65+</b>                               |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results   | Visit Report |
| <b>Minor Surgery</b>                                    |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results   | Visit Report |
| <b>CVD Risk Dataset</b>                                 |               |             | Service provision to patient record/Activity Monitoring    |     | No of checks & results   | Visit Report |
| <b>Cancer Referral</b>                                  |               |             | Service provision to patient record, summary review report |     | No of checks & results   | Visit Report |
| <b>Adults with Learning Disabilities</b>                |               |             | Service provision to patient record                        |     | No of checks & results   | Visit Report |
| <b>Carers</b>   |               |             | Service provision to patient record                        |     | No of checks & results   | Visit Report |
| <b>Access to Contractor Based Primary Care Services</b> |               |             | Confirmation of service provision                          |     | No of checks & results   | Visit Report |
| <i>NES</i>  |               |             | Service provision to patient record/Activity Monitoring    |     |                          |              |
| List  |               |             |  |     |                          |              |
| all   |               |             |  |     |                          |              |
| contracted  |               |             |  |     |                          |              |
| NESs  |               |             |  |     |                          |              |
| <i>LES</i>  |               |             | Service provision to patient record/Activity Monitoring    |     |                          |              |
| List  |               |             |  |     |                          |              |
| all   |               |             |  |     |                          |              |
| Contracted LESs   |               |             |  |     |                          |              |

Annex II – Medical Payments

| Payment                             | Contract Type | Data Source | Check / Process  | Who | Reporting              | Where        |
|-------------------------------------|---------------|-------------|--|-----|------------------------|--------------|
| <b>QOF</b>                          |               |             |  |     |                        |              |
| <b><i>Disease Register Size</i></b> |               |             | Monitor disease register size (within year) and identification of outliers         |     | -                      | -            |
| <b><i>Exception Coding</i></b>      |               |             | Monitor exception coding levels (at prior year end) and identification of outliers |     | -                      | -            |
| <b><i>Clinical Indicators</i></b>   |               |             | Service provision to patient record  |     | No of checks & results | Visit Report |
|                                     |               |             | Application of Exception Coding  |     | No of checks & results | Visit Report |

**Appendix C – GP Practice System Security Checklist**

| <b>Check</b>                                   |  | <b>Compliance</b> |
|--|--|-------------------|
| <b>Backup</b>                                  |  |                   |
|  | With the assistance of the System Administrator, the Server's backup log should be examined and if failures have been recorded, then confirmation that action has been taken to resolve the issues should be shown.  |                   |
|  | Once per week a full backup should be performed and the tape stored off-site. Is there a procedure to ensure that this happens and in the event that the person who takes the tape away each week is not available, can the Practice still retrieve the tape?                            |                   |
|  | Is there a fire safe containing the computer backup tapes?   |                   |
| <b>System Security Policy and Procedure(s)</b> |  |                   |
|  | Has the Practice established System Security Policies and Procedures?<br>And if so:<br>Are they available to all Staff who use any of the Practices computers.   |                   |
|  | User Agreements, confirming that the Security Policies and Procedures will be complied with, should be signed by all System Users. It is good practice for the agreements to include reference to all appropriate parts of the System Security Policy. Are there signed User Agreements? |                   |
|  | Does every System User have a unique userid?   |                   |
|  | Has it been made clear to all Staff that they should keep their password confidential?   |                   |
|  | Has it been made clear to all staff that they should log off of the PC that they are using when leaving it?  |                   |
| <b>Computer Security Tests</b>                 |  |                   |
|  | All servers and a sample of PCs should be examined to confirm that the process to provide up to date anti-virus protection for all computers is working satisfactorily and that the software cannot be switched off by the users.  |                   |
|  | Computer display screens containing personal or confidential patient data, should not be visible to members of the general public.   |                   |
|  | Are all printers installed in secure areas (printouts may contain information to help a hacker and the IP range may be visible on the printer)?  |                   |
|  | Is all network equipment installed in secure areas?  |                   |

| <b>Servers should be secured (physically and logically)</b>                                |   |
|--|---|
|  | Are all servers installed in locked rooms with limited access – the room should not allow the viewing of the computer(s) or it's (their) screen(s)?   |
|  | Do all servers have UPS support?  |
|  | Was the administrator account logged off when you arrived and did the System Administrator log off when you left the server? The only times that the Administrator should be logged onto the server is while performing administrative duties, such as checking that backups have completed successfully.     |
|  | At least two people should have administrator privileges on the servers and do they both have the skills to administer user accounts?   |
| <b>PCs</b>   |   |
|  | Are all machines physically secured from theft? The machines should not be readily visible. The rooms in which they are located should be secured when out of use. Locking machines to something immovable may be appropriate. It should not be possible for a thief to pass machines through an open window. |
| <b>Safety for users</b>  |   |
|  | Confirm that none of the machines are trip hazards.   |
|  | Confirm that all cables are clear of passageways and out of normal reach?   |
|  | Confirm that none of the PCs, including displays and printers, are in such a position that they may easily be knocked over, or knocked off of a work surface.   |
| <b>Physical damage (These tests apply to PCs, Printers, Servers and Network Equipment)</b> |   |
|  | Are all machines well away from liquids?  |
|  | Are the internal cooling fans for each machine free from obstructions?  |
|  | Are all machines away from heat sources such as radiators?  |
|  | Are all machines in locations such that they are unlikely to receive mechanical shock such as a door being opened and banging into it?  |
|  | Is the machine in a normal office environment with acceptable heating and humidity levels?  |

## Annex III - Ophthalmic Payments

### TABLE OF CONTENTS

|   |   |
|---|---|
| Introduction .....  | 2 |
| 1. Level 1.....   | 3 |
| 2. Level 2.....   | 4 |
| 3. Level 3.....   | 5 |
| 4. Level 4.....   | 5 |
| 5. Examination of Record Cards .....                                | 5 |
| 6. The Scottish Optometric Reference Service (SORS) .....           | 6 |
| 7. Issues Other Than Payment Verification .....                     | 6 |
| Appendix A – Inspection of Ophthalmic Records/Practice Visits ..... | 7 |

## **Introduction**

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

Since 1<sup>st</sup> July 2001, Practitioner Services (Ophthalmic) has been operating a computerised payment system (Optix) as well as an optical character recognition system (iDENT), which combine to undertake extensive pre-payment validation on 100% of ophthalmic claims. This is now a national system and since the move to a single payment date (from July 2002) the system has provided extensive comparable data for Payment Verification (PV).

Payment Verification is undertaken by a monitoring team based in Edinburgh working in co-operation with NHS Boards (NHSB), Counter Fraud Services (CFS), the Central Legal Office (CLO) and Information Services (ISD) as sources of specialist advice.

With the introduction of the updated Scottish General Ophthalmic Services (GOS) arrangements from 1<sup>st</sup> April 2006 it has been necessary to update both the iDENT and OPTIX systems to accommodate the extra information being gathered. The changed nature of the GOS system from a 'sight test' to a much more extensive 'eye examination' requires a fresh approach to PV with a range of new checks being undertaken.

## 1. Level 1

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

- Validation of prescription details and change in prescription as defined by ISO8980 1 & 2;
- Validation of claim form, including fees claimed/allowed and time limits for form submission;
- Frequency of eye examination and re-examination codes;
- Duplication of claims;
- Practitioner details and identification stamp;
- Existence of practitioner signatures;
- Existence of patient's or patient's representative signatures;
- Patient details check and patient matching with patient history;
- Link of GOS(S) 3 to GOS(S) 1 and GOS(S) 4 to GOS(S) 3 where available;
- Patient exemption type – evidence produced (for GOS(S) 3 and GOS(S) 4);
- Age/entitlement.
- NHS Board prior approval received where required.
- Whether refraction was carried out as part of the eye examination and whether this resulted in a change of prescription or not.
- Check that a reason is given when a Supplementary Eye Examination has been conducted.
- Ensure that a Supplementary Examination follows on from a Primary Examination except where a child under the age of 16 is referred by an ophthalmic hospital to an optician or ophthalmic medical practitioner for a cycloplegic refraction.
- Whether the patient was referred from another part of the NHS/carer (social worker).
- Whether the patient was referred to another part of the NHS/carer (social worker).

Where claims fail the validation within the Optix system, they are returned to the practitioner unpaid and seeking clarification.

## 2. Level 2

Payment verification at Level 2 consists of the production and analysis of statistical information.

Patterns of Prescribing: Practices with high or unusual prescribing patterns are highlighted from the claims received within the relevant quarter. Each of the following are assessed for their level of patient management/prescribing in each NHS Board area:

- Number of Primary Eye Examinations
- Number of Supplementary Eye Examinations
- Number of Supplementary Examinations compared with Primary Examinations.
- Reasons for Supplementary Examinations
- Number of Eye Examinations compared to number of vouchers issued.
- Number of Primary and Supplementary Examinations conducted in a day.
- Domiciliary visits and the number of eye examinations undertaken in a single day
- Tints;
- Prisms;
- Supply of 2 pairs rather than bifocals
- Complex lenses;
- Small frame supplements;
- Small frame replacements;
- Repairs and replacements;
- Earnings
- Cost per case.

Figures will also be available for:

- Instances where patients were referred from another part of the NHS/carer (social worker).
- Instances where patients were referred to another part of the NHS/carer (social worker).
- Details on certain clinical conditions that the patient may have.

Other ad hoc reports will also be produced to provide NHS Boards with general prescribing information e.g. the use of early re-examination codes.

Where concerns are highlighted from the Level 2 checks, and following discussion with the NHS Boards (including input from them on local factors), further investigations will be undertaken at Level 3 or it may be decided to refer the matter on to Counter Fraud Services.

### 3. Level 3

Level 3 validation will be undertaken on high or unusual prescribing patterns (identified at Level 2) or where the level 4 sampling process proves unsatisfactory or inconclusive. Level 3 checking may include:

- Further analysis of claims and prescribing patterns;
- Asking the practitioner for their observations;
- Examination of patient record cards;
- Sending letters to specific patients;
- Checking of patients' glasses to establish that they match up with what is being claimed for.

Where the outcome of level 3 checking is inconclusive or raises concern, cases will be discussed with the NHS Board and CFS.

### 4. Level 4

Random Sampling. The ophthalmic monitoring team will carry out sampling of a statistically significant sample of claims. The sample size will be assessed annually and adjusted depending on the overall level of mis-claiming uncovered. Sampling uses the following methods:

- Examination of patient record cards
- Random letters to patients e.g. to confirm that glasses or contact lenses were supplied where a voucher was claimed.

A Risk Assessment matrix will be used to quantify what proportion of the overall sample will be drawn from each item of service. The sample will be made up from checks within each NHS Board proportionate to their share of the national volume of claiming.

Any concerns or issues raised at this level will be referred to Level 3 for further investigation.

### 5. Examination of Record Cards

Where record cards are checked during a visit to a practice or called in for examination at Levels 3 and/or 4, a sample will be checked to establish that they comply with the minimum data set as laid down in the Memorandum to NHS: 2006 PCA(O)4, Annex D .

Practice visits will be conducted in line with the Ophthalmic Practice visit protocol (see Appendix A).

## 6. The Scottish Optometric Reference Service (SORS)

The remit of the Scottish Optometric Reference Service to check that glasses match what is being claimed for will be undertaken during practice visits by checking a random sample of glasses from those awaiting collection by patients entitled to optical vouchers. When the GOS 3 voucher for that pair of glasses is subsequently submitted for payment a letter will be sent to the patient to confirm that they have received the glasses.

Checks may be conducted on a targeted basis based on concerns raised at Level 3 or may be part of random checking as part of level 4. Verification of prescriptions matching the glasses/contact lenses issued will be undertaken.

This will establish:

- Existence of patient;
- Confirmation of signature and exemption status check (evidence will not be requested);
- Confirmation that, where a voucher payment was claimed, glasses or contact lenses were supplied;
- Confirmation that, where 2 vouchers were claimed, 2 pairs of glasses or contact lenses were dispensed;
- Confirmation that, where tints or prisms were claimed, these were supplied;
- Confirmation that, where a small frame supplement was claimed, this was supplied;
- Confirmation that, where a small frames supplement was claimed, this was for a child aged under 7 years;
- Confirmation that the prescription matches the voucher and/or supplement issued and claimed;
- Confirmation that, where a repair/replacement voucher payment was claimed, a repair or replacement was supplied.

## 7. Issues Other Than Payment Verification

Unlike its dental equivalent, which has a role in Clinical Governance performed on behalf of the Scottish Dental Practice Board, the sole focus of the Scottish Optometric Reference Service is on payment verification/probity issues and reports to NHS Boards will be restricted to these.

## **Appendix A – Inspection of Ophthalmic Records/Practice Visits**

### **Background**

- 1.1 One of the methods of verifying payments made under the General Ophthalmic Services (GOS) contract is to examine patient records. It has been agreed to carry out the bulk of 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. However, all Practitioner Services staff carrying out these checks will have been required to sign a confidentiality agreement.

### **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.
- 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 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 should be alerted so that the contractor may be warned that he or she may be subject to a referral under NHS disciplinary arrangements and patients will be called in to a Scottish Optometric Reference Service (SORS) clinic away from the practice to have glasses checked.

### **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.
- 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 make every effort to 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 sample 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 in consultation with the relevant NHS Board/s.
- 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 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;
  - 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 must 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;
- 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. 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, and every attempt should be made to minimise the use of patient identifiable data contained within it.

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. In order to comply with 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.

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 – Pharmacy Payments**

**TABLE OF CONTENTS**

**Introduction ..... 2**  
**1. Level 1..... 2**  
**2. Level 2..... 3**  
    2.1 Unsigned Prescriptions ..... 4  
    2.2 Oxygen Mileage Claims ..... 4  
    2.3 High Volume..... 4  
    2.4 Cross Border Flow ..... 5  
    2.5 Minor Ailments Service (MAS) ..... 5  
**3. Level 3..... 6**  
**4. Level 4..... 6**  
**Appendix A – Inspection of Pharmaceutical Records..... 7**

## Introduction

The following sections detail the payment verification requirements for General Pharmaceutical Services

Since July 2000, Practitioner Services (Pharmacy) has been operating a new computerised payment system (DCVP) as well as an optical character recognition system, which combine to undertake an extensive pre-payment validation on a wide range of fees and allowances. Practitioner Services (Pharmacy) also undertakes an extensive post-payment validation process on a number of fees & allowances.

Payment Verification (Pharmacy) is undertaken by a dedicated team of analysts based within Gyle Square in Edinburgh, working as part of a multi-disciplinary team involving all NHS Boards, Counter Fraud Services, Central Legal Office and Information Statistics Division.

The introduction of the New Pharmacy Contract, which is to be phased in over a number of years, necessitates this revision of the Pharmacy payment verification guidance within the PV Protocol.

### 1. Level 1

The payments system 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 & Report Items

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

- Gross Ingredient Cost (DCVP), this excludes GIC of the areas subject to Payment Verification procedures outlined below.
- Dispensing Fees, this excludes Dispensing Fees of the areas subject to Payment Verification procedures outlined below.
- Transitional Fees.
- Regional Office Payments.

## 2. Level 2

Payment Verification at Level 2 consists of the compilation & analysis of statistical information, which will be reported to NHS Boards on a quarterly report basis. The new Payment Verification Program will analyse data from Risk Categories as identified by the Payment Verification Pharmacy Risk Assessment Model. The target is to examine 5 Risk Categories, as detailed below:

### 5 Risk Categories

- Unsigned Prescriptions
- Oxygen Mileage Claims
- High Volume
- Cross Border Flow
- Minor Ailment Service

In order to ensure that significant new services are subject to scrutiny, the above 5 Risk Categories targeted includes the Minor Ailment Service rather than the 5<sup>th</sup> claim type as indicated in the Payment Verification Pharmacy Risk Assessment Model.

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

- Form Types

The Payment Verification Report will present the data in various Level 2 Tabular formats for review and discussion with each respective NHS Board by ranking Contractors with high or unusual data patterns within the above areas in relation to each relevant quarter.

Where concerns are highlighted from Level 2 reports, and following discussions with NHS Boards, further investigations will be undertaken at Level 3.

## **2.1 Unsigned Prescriptions**

The following data will be presented in Tabular form by NHS Board area:

- View 1 – A summary report detailing the level of potential ‘unsigned prescriptions’ & the total associated GIC for each Prescribing Practice of the respective NHS Board and ranked by highest GIC. The data will provide the NHS Board total and a Scottish total for comparison.
- View 2 – A detailed report of View 1 in NHS Board Practice Code order. Each Practice will detail the number of potential ‘unsigned prescriptions’ written by each prescriber at the practice concerned, additionally the respective form types will also be stated. Practice subtotals will be provided which match the practice totals stated in View 1.
- View 3 – A summary report detailing the level of all potential ‘unsigned prescriptions’ written by any other NHS Board prescriber which have been dispensed by the reporting NHS Boards Pharmacy Contractors. The data will provide NHS Board totals.
- View 4 – A detailed report of View 3 detailing the total number of potential ‘unsigned prescriptions’ (written by any NHS Board prescriber) as dispensed by each reporting NHS Board Pharmacy Contractor Code, ranked by highest total GIC. The data will provide NHS Board totals.

## **2.2 Oxygen Mileage Claims**

The following data will be presented in Tabular form by NHS Board area:

- View 1 – A summary report detailing the total oxygen ‘service’ fees paid to each NHS Board Pharmacy Contractor ordered by Pharmacy Contractor code – detailing the total oxygen claims and the respective fees paid in relation to each fee category and a grand total paid to each Pharmacy Dispenser.
- View 2 – A detailed report listing the NHS Boards Pharmacy Contractors in order, detailing the level of claims in relation to each oxygen delivery mileage payment categories, which makes up the Total Delivery Mileage Paid. Additionally stating an NHS Board average, Scottish average and Scottish total for comparison.

## **2.3 High Volume**

The following data will be presented in Tabular form by NHS Board area:

- View 1 – A summary report detailing the total number of prescription items & the respective GIC paid in relation to each BNF chapter. Additionally indicating the number of ‘High volume items’ which breach predefined statistical limits for each BNF category – listing the total item breaches & the total GIC value of these breaches and a % breach of items for each BNF chapter.
- View 2 – A detailed report listing the NHS Boards Pharmacy Contractors in order, detailing the total number of prescription items paid for the quarter, and then indicating the number of the High volume items which breach predefined statistical limits for each BNF category & the total GIC value of these breaches. The data will provide NHS Board & Contractor totals.

## **2.4 Cross Border Flow**

The following data will be presented in Tabular form by NHS Board area:

- View 1 – A summary report detailing the total number of prescriptions written by the reporting NHS Boards Prescribers and the number dispensed in each NHS Board area & the respective associated Gross Ingredient Costs. The data will provide NHS Board totals.
- View 2 – A detailed report listing each NHS Board prescriber Practice - detailing the total number of prescriptions written by the Practice & the NHS Board area dispensed and the respective associated Gross Ingredient Costs.
- View 3 – A detailed report listing all NHS Boards Pharmacy dispenser codes which have dispensed the reporting NHS Board Prescribers prescriptions, indicating the total number of prescriptions dispensed by each dispenser and the respective GIC values.

## **2.5 Minor Ailments Service (MAS)**

The following data will be presented in Tabular form by NHS Board area: -

- View 1 – A summary report detailing the MAS activity of NHS Board Pharmacy Contractors, stating the total number of patients registered & the respective capitation fees paid in relation to each month being reported in the quarter. Quarterly averages will be stated for each Contractor.
- View 2 – A detailed report ranking the Pharmacy Contractors by highest capitation & the respective capitation fees paid for each individual month for the quarter.
- View 3 – A detailed report indicating the number of Treatment & Consultations, Consultation Only, GP Referral & associated GIC for each Pharmacy Contractor Code. The data will provide NHS Board totals.

### 3. Level 3

NHS Boards will review Payment Verification Reports on an ongoing quarterly basis in conjunction with Payment Verification Pharmacy to identify any Level 3 work to be undertaken.

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 &/or prescribing patterns.
- Requesting Pharmacy Contractors to provide Patient Medication Records.
- Requesting Pharmacy Contractors to provide explanations.
- Requesting Pharmacy Contractors to provide supporting documentation as required.
- Contacting patients to confirm the services provided.
- Checking mileages between Pharmacy premises and patients' addresses.
- Ensuring prescriber and dispenser codes are correct in respect of cross border flow.
- Verifying the presence of a prescriber signature in relation to unsigned prescriptions.
- Advising Pharmacy Contractors of Best Practice as required.
- Advising Pharmacy Contractors of the intention to reclaim fees.
- Adhoc assignments as required.

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. Payment Verification will undertake additional extended sampling on direction from the NHS Board i.e.

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

Where payment verification requires the examination of patient medication records, this will be undertaken in accordance with Appendix A.

### 4. Level 4

Payment Verification will undertake a Level 4 check on a randomly selected Pharmacy Contractor for each NHS Board.

- The size of the samples undertaken will be based on 'statistical strata' based on the number of claims submitted by the Pharmacy Contractors.
- A random sample of claims will be selected & checked against the details contained within the respective patient medication records from the pharmacy. (See Appendix A).

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

## Appendix A – Inspection of Pharmaceutical Records

### 1. Background

- 1.1 One of the methods of verifying payments made under the Community Pharmacy contract is to examine patient medication records. These records are typically held electronically, however, they may also be paper based.
- 1.2 At present, Payment Verification request that records are printed and sent to Practitioner Services by recorded delivery, for patient confidentiality and security reasons.
- 1.3 There is currently no requirement to visit any Contractors.

### 2. Selection of Contractors

- 2.1 It is intended that Practitioner Services will arrange for the inspection of patient medication records in the following two circumstances:

- Level 3 Payment Verification 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.

The quantity of Contractors selected to submit patient medication records for the above scenarios will be determined through discussions with the appropriate NHS Board.

- Level 4 Payment Verification Checks: Practitioner Services will undertake an examination of patient medication records. A minimum of 1% of all Contractors will have records inspected annually. Contractors are randomly selected for each NHS Board.

### 3. Selection of Records

- 3.1 In advance of the examination, a number of prescriptions will be identified. Practitioner Services will extract claim details from the Prescribing Information System (PIS) data warehouse via Business Objects, and verify this against the prescription images.
- 3.2 Practitioner Services will always consult with NHS Boards when patient medication records are to be examined, with a view to working jointly whenever possible.
- 3.3 Level 3 selection: the appropriate NHS Board may request that Practitioner Services inspect the patient medication records of specific Contractors - where random claims selected at level 2 require further investigation. The number of records requested is therefore determined by the number of claims selected in the sample and the errors highlighted.

- 3.4 NHS Boards may also request that Practitioner Services extend the sample for a number of Contractors, whose claims require further investigation. The results of the extended sample analysis may then warrant the inspection of patient medication records.
- 3.5 Level 4 selection: the size of the sample selected is required to be statistically valid. The number of records selected is therefore calculated by comparing the selected Contractor's number of prescription forms submitted for payment, against the 'Patient Medication Records Volume Request Matrix'. The minimum number is currently 25 prescriptions, which increases in intervals of 25 for each respective change in 'number of prescription forms' banding. The examination will involve the confirmation of a random sample of claims across selected payment categories.
- 3.6 NHS Boards may also request that Practitioner Services carry out a further Level 4 check - should the initial inspection prove unsatisfactory. The volume of records requested will be determined in consultation with the relevant NHS Board, however, these generally reflect the initial sample size.

#### **4. Examining the Patient Medication Records**

- 4.1 Practitioner Services request that Contractors submit all patient medication records by recorded delivery, for patient confidentiality and security reasons.
- 4.2 The audit is then carried out in the Payment Verification Department. Patient medication records will be examined to ascertain whether evidence exists to verify that payments made to the Contractor were appropriate. The necessary analysis sheet will then be completed, detailing the results of the investigation (for inclusion in the subsequent Payment Verification Quarterly Report – section 5 below).
- 4.3 All Practitioner Services staff carrying out these checks will have been required to sign a confidentiality agreement.
- 4.4 The records are then secured for future reference and evidence in accordance with the Policy for the Retention of Documents.

#### **5. Patient Medication Records Report**

- 5.1 The report should be drafted as soon as possible after the records have been analysed.
- 5.2 The conclusions will be clearly presented in each respective NHS Board's Payment Verification Quarterly Report. This report will indicate whether any further action is deemed necessary or whether sufficient evidence has been seen to give an adequate level of assurance to verify the accuracy of the claims. A copy of the report is retained by Practitioner Services.

- 5.3 Quarterly report meetings are arranged with each NHS Board at the earliest convenient time after the reports are issued. Practitioner Services endeavour to achieve this within a timescale of three weeks. At this meeting the NHS Board will determine whether any further action is required
- 5.4 Due to the large volume of patient medication records requested it is only feasible to provide feedback to Contractors when specifically requested by either the NHS Board or the Contractor. Feedback will take the form of a letter to the Contractor:
- Summarising the results of the inspection of records;
  - Requesting a further extended sample of records; or
  - Asking for an explanation of minor errors identified.
- 5.5 Where the inspection of an extended sample of records or the request for explanations of errors fails to provide a satisfactory outcome, then this will be reported to the NHS Board at the next Quarterly Report meeting.
- 5.6 If at any time the results of the inspection of records identifies issues of urgent concern, then Practitioner Services shall discuss the matter immediately with the NHS Board and Counter Fraud Services, and not wait for the quarterly meeting to take place.
- 5.7 Every attempt is made to minimise the use of patient identifiable data in the Payment Verification Quarterly Report. In particular, if it is deemed necessary to insert a scanned image of a prescription, any patient identifiable details will be edited (erased) from the image before insertion.