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Chief Executives
Directors of Finance
NHS Health Boards

Dear Colleague

REVISED PAYMENT VERIFICATION PROTOCOLS – GENERAL DENTAL SERVICES, PRIMARY MEDICAL SERVICES, GENERAL OPHTHALMIC SERVICES, PHARMACEUTICAL SERVICES

The attached document updates and supersedes the guidance on payment verification procedures contained in DL (2025)17 and outlines the arrangements for payment verification for 2025-26 and beyond.

BACKGROUND
This revision includes the following main changes:

Dental

The revision for 2025-26 has no significant changes to the PV Protocol, but there will be an update to the risk assessment that determines the priority of PV work to be carried out and consideration for any future changes.

Medical

The revision for 2025-26 has no significant changes to the PV Protocol, but there will be an update to the risk assessment that determines the priority of PV work to be carried out and consideration for any future changes.

DL (2025)17

16 July 2025

Addresses

For action
Chief Executives and Directors of Finance, NHS Boards

Chief Executive, NHS National Services Scotland

For information
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Ophthalmic

The revision for 2025-26 to the PV Protocol reflects the inclusion of the Optometry Enhanced Services for Community Glaucoma Services including registration, primary and secondary assessment payments.

Pharmacy
The revision for 2025-26 has no significant changes to the PV Protocol, but Appendices have been added to explain the services types covered within payment verification.

ACTION
Chief Executives are asked to:

- note the revised protocol and ensure that relevant staff within their Boards are familiar with this;
- note that the revised protocol will remain in force for future financial years unless updated
- share the protocol with FHS contractors;
- ensure that their Audit Committee have sight of the protocol;
- work with NSS Contractor Finance and Practitioner Services in ensuring the implementation of the protocol;
- note that contractors must retain evidence to substantiate the validity of payments and, where this cannot be found, any fees paid may be recovered; and
- note that tri-partite discussion should take place between NSS, NHSScotland Counter Fraud Services and the relevant NHS Board where a concern relating to potential fraud arises in the course of payment verification, and that, where a tri-partite meeting is deemed necessary, this should take place within 2 weeks of the simultaneous notification of the concern to the Board and NHSScotland Counter Fraud Services by NSS Contractor Finance.

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

FURTHER INFORMATION
Further information is available from Lorraine Bagen, Head of Contractor Finance, Finance Operations,NHS National Services Scotland: email: Lorraine.bagen@nhs.scot

Yours faithfully

Fiona Bennett
Chief Finance Officer

Payment Verification Protocols

Payment Verification Programme for 2025-26 Onwards

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Introduction

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

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

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

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

1.5 The verification process across all contractor streams relies, amongst other things, on the accuracy of CHI. Further details in relation to the verification of CHI data is detailed within Annex II, Medical Payments.

1.6 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.

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

Ophthalmic, Pharmaceutical and Dental Payments

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

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

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

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

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

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

GMS Payments

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

- validation of data quality;
- checking of source documentation and activity monitoring. The purpose of this is to reduce the requirement to access patient medical records if on a practice visit.

Inspection of Clinical Records

2.7 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 a local NHS Board level. The methodology of actual practice visits is detailed further in Appendix A of the Medical and Ophthalmic Annexes.

Risk Assessment

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

3.2 In order to ensure that these risk matrices continue to reflect both the materiality of, and the risks relating to, all contractor payment types, it is intended that the application of the risk assessment methodology will be subject to annual review. This review will be undertaken by the appropriate PV Contractor Group, and shall be subject to approval by the PV Governance Group.

Reporting to NHS Boards

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

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

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

Countering Fraud

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

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

Adjustment to Payments

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

Annex I – Dental Payments

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Introduction

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

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

Dental, unlike the other contractor streams within Practitioner Services, have a responsibility regarding Clinical Governance. And if we are aware of any significant clinical issues during the course of an investigation, notification will be discussed with the relevant NHS Board at the earliest opportunity for agreement to be reached whether a referral to the GDC is appropriate.

Practitioner Services (Dental) operates a computerised payment system (MIDAS) as well as a number of electronic systems for claims transmission (eDental, eOrtho and Web forms). All claims have consistent prepayment validation as detailed in the following sections applied by MIDAS in addition to their own specific rules which relate to the system of capture.

Retention of Evidence

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

Where evidence to substantiate the validity of payments cannot be found, any fees paid will be recovered by Practitioner Services/NSS Contractor Finance where possible.

Capitation & Continuing Care

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

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Claim forms by MIDAS – to ensure all mandatory information is present
- Patient existence/status by matching to CHI
- Validation against the SDR
- Duplication on MIDAS

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

- Number of registrations by contractor
- Registrations by contractor that are unmatched to CHI
- Registrations by contractor with no IOS claims

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

- Patient letters
- Sampling of patient records and associated documentation
- Liaison with private capitation scheme providers to establish registration status

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

Outputs:

Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries (as per Appendix B)

Items of Service

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Claim forms by MIDAS – to ensure all mandatory information is present
- Patient existence/status by matching to CHI
- Validation against the SDR and any provisos or time limits that apply, including tooth specific validation where appropriate for specific IOS
- Duplication on MIDAS
- The patient's date of birth for age exemption
- Checking the total value of the claim and applying prior approval as appropriate

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

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

- Individual and combinations of item of service claims
- Items claimed where the patient does not pay the statutory charge
- Level of earnings
- Cost per case and throughput

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

- Patient letters/questionnaires
- Sampling of patient records and associated documentation
- Applying the "special prior approval" process or the "prior approval by targeting" regulation
- Referral of patients to the SDRS to confirm that treatment proposed or claimed was in accordance with the SDR in compliance with the NHS (GDS)(Scotland) Regulations 2010
- Further investigation as a result of adverse outcome of SDRS examination.

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

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

Outputs:
Quarterly PV report detailing:

- Results and status of checking process
- Details of information used to verify service provision
- Any necessary recommendations, actions and recoveries (as per Appendix B)
- SDRS reports

Allowances

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

Level 1 will comprise 100% checking of:

- Mandatory information and supporting documentation are present
- Validation against the SDR and any provisos or time limits that apply
- Duplication on MIDAS

Outputs:
Quarterly PV report detailing:

- Results and status of checking process
- Any necessary recommendations, actions and recoveries (as per Appendix B)

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

1 Background

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

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

2 Selection of Patients

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

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

3 SDRS Reports

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

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

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

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

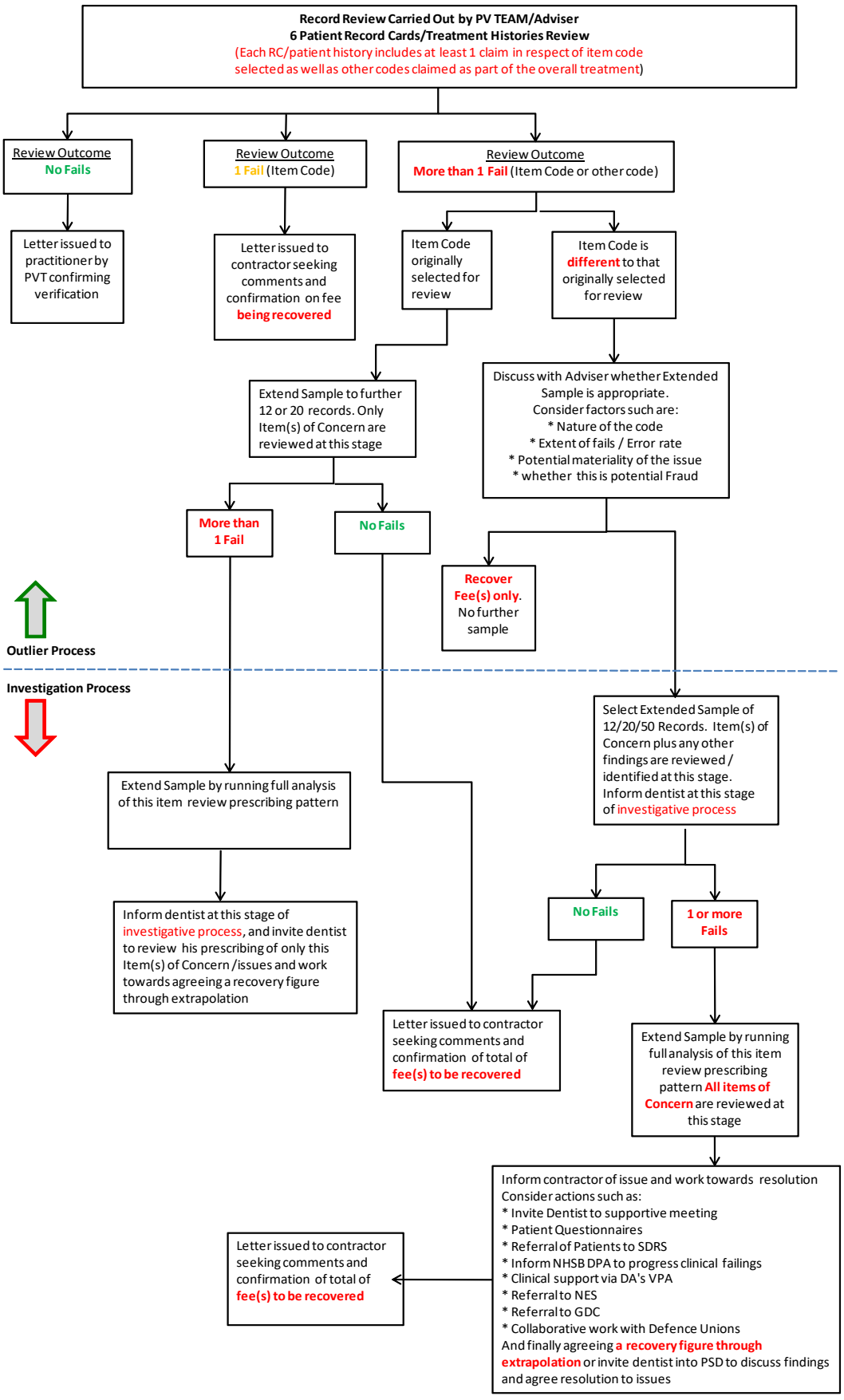
Administrative (i) r: possible regulatory error e.g. claiming an amalgam on the occlusal surface of a premolar when a composite was provided

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

3.3 The code assigned to the examination will determine the course of action to be taken. This may include no further action, further patient examinations, discussion with or referral to the NHS Board, or in some cases a tri-partite meeting between Practitioner Services/NSS Contractor Finance, the NHS Boards and Counter Fraud Services

3.4 Appendix B

FLOWCHART DEMOSTRATING GUIDELINES FOR PAYMENT VERIFICATION REVIEWS



Recovery of overpayments
Under Regulation 25(1) of the National Health Service (General Dental Services (Scotland) Regulations 2010, Practitioner Services (as the Agency) will draw to the attention of the dentist payments which they consider have been made in circumstances in which they are not due and therefore proceed to recover the overpayment.

Extrapolation to the entire population is used to make recoveries where a high number of systematic errors are identified from either the original or extended sample of record cards and item of service claims tested. This aims to keep the administrative burden to a reasonable level for both the practitioner and practitioner services.

Annex II – Medical Payments

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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.

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments relating to the GMS Contract. The requirement for this evidence will be in line with that detailed in the Contract, in the Statement of Financial Entitlements or in locally negotiated contract documentation. It is particularly important to retain evidence that is generated by the running of a computer-generated search, as this provides the most reliable means of supplying data, that fully reconciles with the claim submitted should practices be required to do so.

Scottish Government Records Management: NHS Code of Practice (Scotland) Version 2.1 provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support a payment to the GP Practice.

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

Data Protection

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

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

Premises and IT Costs

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

GP Minimum Earnings Expectation

PCA(M)(2019)05, GP Minimum Earnings Expectation (MEE) was introduced from 1st April 2019.

Generally, payment verification will be undertaken at the pre-payment stage and will include a review of the:

- MEE claim form
- GP Annual Certificate of pensionable profits
- Practice's certified Annual Accounts

- HMRC Partnership Tax Return

Post payment verification may be undertaken should any concerns arise following the payment of a MEE claim

Payment Verification for Global Sum

METHOD

The Global Sum is the payment to GP Contractors for the delivery of essential services as expert medical generalists.

A GP Practice's global sum allocation is dependent on their share of the Scottish workload, as determined by the GP Workload Formula. The formula is based on the best available evidence and reflects the workload of GPs. The formula estimates the number of consultations per patient dependent, in the main, on their age, sex, and deprivation status of the neighbourhood in which they live.

The data held on the Community Health Index (CHI) provides age, sex and postcode information to the workload formula, and hence the accuracy of this data is essential in ensuring that the global sum payment is correct.

This is achieved in a number of ways, as detailed below. Although the intent of these control and processes are primarily focussed on health administration, assurance can be taken from the existence and application of many of these controls for payment verification purposes.

System/Process Generated Controls

- All new patient registrations transferred electronically via PARTNERS to the Community Health Index (CHI) are subject to an auto-matching process against existing CHI records. If a patient cannot be auto-matched further information is requested from the GP Practice so that positive patient identification can be ensured.
- All patient addresses transferred by PARTNERS to CHI are subject to an auto-post coding process to ensure validity of address within the Health Board Area.
- All deceased patients are automatically deducted from the GP Practice on CHI using an interface file from NHS Central Register (information being derived from General Register of Scotland). Patients registering elsewhere in the UK are deducted from the GP Practice on CHI following matching by NHS Central Register.
- Patients are automatically deducted from GP Practice on registration with another GP Practice in Scotland.
- All patients confirmed as no longer residing at an address are removed on CHI and automatically deducted from GP Practice lists via PARTNERS.
- All patients whose address is an exact match with a Care Home address will automatically have a Care Home indicator inserted on CHI.
- Registration Teams check unmatched patients (without CHI number) to NHS Central Register database to ensure positive patient identification.

Targeted Checking

Validation on patient data via Patient Information Comparison Test (PICT), as and when required, for example, Practice mergers, capitation disputes and IT server upgrades to ensure that patient data on CHI and on GP systems match. The following fields can be validated:

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

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

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

Pre-Payment checking of quarterly payments being authorised by PG Practice on the value of the Global Sum Payment to ensure that variances no more than +/- 5% of the value of the previous quarter.

Reporting of CHI Data Quality Work

The CHI checks undertaken by the Practitioner Services Registration Teams are reported to NHS Boards as follows:

1. Quarterly KPIs by Board, which includes:
   - Number of incorrect CHI patient identifications
   - GP Practice registrations
   - GP Practice new registrations
   - GP Practice Patient amendments and transfers
   - Number of Patient assignments

2. Quarterly “Additions & Deductions” printout by Practice, which includes:
   - Capitation
   - Number of additions
   - % of additions to capitation
   - Number of deductions
   - % of deductions to capitation

Payment Verification for Payments for a Specific Purpose

METHOD

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

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

OUTPUTS:

- Numbers and values of payments made by practice type and practice.
- Any specific matters arising in the processing of payments.
- Where a practice visit has been deemed appropriate – the purpose of this visit is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.
- Details of information used to verify service provision.
- Any necessary recommendations, actions and recoveries.

Payment Verification for Non Section 17j Contract

METHOD

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

To verify that payments specific to Non Section 17j contracts are appropriate, these practices will be subject to NHS Boards' contract monitoring processes which may involve:

- NHS Board quarterly review.
- Analysis of practice produced statistics which demonstrate contract compliance.
- Reviewing as appropriate Non Section 17j contracts against other/new funding streams to identify and adjust any duplication of payment.
- Where a practice visit has been deemed appropriate – the purpose of this visit is to examine a percentage of patient records. Records to be reviewed will be selected at random. See Appendix A.

OUTPUTS:

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

Payment Verification for Seniority

METHOD
To verify that new claims for Seniority payments are valid, checks will be undertaken, prior to payment, as follows:

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

OUTPUTS:

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

Payment Verification for Enhanced Services

INTRODUCTION

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

METHOD

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

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

OUTPUTS:

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

GP Practice System Security

Where a practice visit has been deemed appropriate the Payment verification visit will comprehensively utilise data held within GP clinical systems, and it is therefore necessary to seek assurance that there are no issues regarding the reliability or the integrity of the systems that hold this data.

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

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

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

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

OUTPUTS:

- Any necessary recommendations and actions.

Appendix A – Clinical Inspection of Medical Records/Practice Visits

1 Background

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

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

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

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

2 Practice visit

2.1 Where it has been deemed appropriate to undertake a practice visit Practitioner Services staff will conduct these visits in conjunction with the NHS Board medical advisor and this may have been a result of a risk assessment or trend analysis. Where possible these visits will be made virtually by Teams but where necessary these visits will take place physically in person to the practice.

2.2 Practitioner Services will collaborate with the NHS Board and jointly agree that this is necessary to gain a level of payment assurance.

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

2.4 The contractor will be given at least four weeks' notice of the intention to carry out a visit. Every effort will be made to carry out the visit at a mutually convenient time.

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

3. Selection of Records

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

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

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

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

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

3.6 The areas selected for review will be determined by the risk assessment methodology. The numbers selected for review in each area will be determined by the agreed statistical

sampling methodology where appropriate. The visiting team will ascertain the identity of only the patients selected for audit during the visit.

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

4 Visiting Team

4.1 The team visiting the practice may comprise representatives from Practitioner Services the NHS Board, and a GP who is independent to the practice, who may be from another NHS Board area,

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

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

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

5. Examining the Clinical Records

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

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

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

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

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

6. Concluding the Visit

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

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

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

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

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

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

7. Practice Visit Report

7.1 The report should be drafted as soon as possible following the visit and every attempt should be made to minimise the use of patient identifiable data contained within it. If significant Clinical Governance issues were identified at the visit, the NHS Board would be notified immediately. It should be noted that practice visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

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

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

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

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

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

Annex III – Ophthalmic Payments

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Introduction

The following sections detail the payment verification requirements for:

- General Ophthalmic Services (GOS), the legislation for which is set out in The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006 ("2006 Regulations"), SSI 2006/135, as amended, and the GOS Statement of Remuneration ("Statement");
- NHS optical vouchers, the legislation for which is set out in The National Health Service (Optical Charges and Payments) (Scotland) Regulations 1998 ("1998 Regulations"), SI 1998/642, as amended;
- Community Glaucoma Service (CGS), the legislation for which is set out in The Optometry Enhanced Services (Glaucoma) (Scotland) Directions 2022 ("2022 Directions").

Practitioner Services (Ophthalmic) operate a computerised payment system (OPTIX) and eOphthalmic allows electronic GOS and NHS optical voucher claims to be transmitted to the system for payment purposes both of which undertake extensive pre-payment validation on ophthalmic payment claims. CGS claims will also be paid through the Optix payment system and subject to pre and post payment verification checks

Retention of Evidence

Practices are required to retain evidence to substantiate the validity of payments. The requirement for this evidence will be in accordance with the relevant legislation. The Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020 also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as the minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to community optometry practices and optometrists / ophthalmic medical practitioners.

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

GOS 1 Primary Eye Examination Claim

Primary Eye Examination (PEE) payments are based on claims made by optometrist / ophthalmic medical practitioners for undertaking examinations to test sight and identify signs of eye disease. Claims are submitted on the GOS 1 form electronically via a webform or a Practice Management System (PMS).

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- claim forms by OPTIX – to ensure all mandatory information is present
- Patient existence/status by matching to CHI
- validation against the 2006 Regulations and Statement and any provisos or time limits that apply
- duplication on OPTIX
- the patient's date of birth, to assist in ensuring the frequency with which a patient is entitled to a PEE (set out in Appendix B of the Statement) is adhered to
- checking the total value of the claim

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

- Individual and combinations of item of service claims

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

- sampling of record cards and associated documentation
- patient letters
- should it be necessary carry out a practice visit as per Appendix A

Level 4 will comprise random sampling of claims including, but not limited to:

- a random assessment of claims, which will require examining a sample of patients records from NHS optometrists / ophthalmic medical practitioners to confirm that treatment claimed was in accordance with relevant legislation.

Outputs:

Quarterly PV report detailing:

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

If a practice visit has been undertaken, a report will be produced which details the following:

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

GOS 1 Supplementary Eye Examinations

Supplementary Eye Examination (SEE) payments are based on claims made by optometrist/ ophthalmic medical practitioners for eye examinations which support the on-going care of patients, allowing referrals to the Hospital Eye Service to be refined and patients to be monitored. SEEs also allow emergency ocular conditions to be seen in a community setting and patients treated, or appropriately directed. Claims are submitted on the GOS 1 form submitted electronically via a webform or Practice Management System (PMS).

Level 1 will comprise 100% checking of:

- claim forms by OPTIX – to ensure all mandatory information is present
- Patient existence/status by matching to CHI
- validation against the GOS regulations and any provisos or time limits that apply
- duplication on OPTIX
- checking the total value of the claim

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

- Individual and combinations of different SEE code types
- The volume of SEE by contractor

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

- sampling of patient records and associated documentation
- patient letters
- should it be necessary carry out a practice visit as per Appendix A

Level 4 will comprise random sampling of claims including, but not limited to:

- a random assessment of claims, which will require examining a sample of patients records from NHS optometrists / ophthalmic medical practitioners to confirm that treatment claimed was in accordance with relevant legislation.

Outputs:

Quarterly PV report detailing:

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

If a practice visit has been undertaken, a report will be produced which details the following:

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

GOS 1 Domiciliary Visits

A patient is eligible to have a GOS eye examination in the place where they normally reside if they cannot leave that place unaccompanied (for reasons of physical or mental ill health or disability) to attend a practice. An optometrist / ophthalmic medical practitioner who provides such a GOS eye examination is entitled to claim for payment of a domiciliary visiting fee in addition to the relevant PEE or SEE fee, and this claim is made on the same GOS 1 form as the PEE or SEE claim.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

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

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

- examination of record cards and associated documentation

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

- sampling of patient records and associated documentation
- patient letters
- should it be necessary carry out a practice visit as per Appendix A

Level 4 will comprise random sampling of claims including, but not limited to:

- a random assessment of claims, which will require examining a sample of patients records from NHS optometrists / ophthalmic medical practitioners to confirm that treatment claimed was in accordance with relevant legislation.

Outputs:

Quarterly PV report detailing:

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

If a practice visit has been undertaken, a report will be produced which details the following:

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

GOS3 NHS Optical Vouchers

GOS3 NHS optical vouchers are issued by optometrist /ophthalmic medical practitioners to patients who are eligible for help with costs towards glasses or contact lenses. Claims are submitted on the electronic GOS3 form which is submitted via webform or Practice Management System (PMS). The GOS3 voucher may contain a number of payment elements including the voucher value (based on the prescription) and supplementary items such as Prisms, Tints, Small Glasses, and Complex Lenses.

Level 1 will comprise 100% checking of:

- claim forms by OPTIX – to ensure all mandatory information is present
- validation against the 1998 Regulations and any provisos or time limits that apply
- duplication on OPTIX (this is not relevant where it is a discretionary voucher claim)
- checking the total value of the claim

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

- ratio of GOS3 claims to total eye examination claims

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

- sampling of patient records and associated documentation
- patient letters
- should it be necessary carry out a practice visit as per Appendix A
- for glasses that have not yet been collected, verification (using relevant equipment or an agreed app) that the prescription corresponds to that which is being claimed for. This can only be done during a practice visit.

Level 4 will comprise random sampling of claims including, but not limited to:

- a random assessment of claims, which will require examining a sample of patients records from NHS optometrists / ophthalmic medical practitioners to confirm that treatment claimed was in accordance with relevant legislation.
- for glasses that have not yet been collected, verification (using relevant equipment or an agreed app) that the prescription corresponds to that which is being claimed for. This can only be done during a practice visit.

Outputs:

Quarterly PV report detailing:

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

If a practice visit has been undertaken, a report will be produced which details the following:

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

GOS 4 Repair/Replacement NHS Optical Vouchers

GOS4 repair and replacement NHS optical vouchers are issued by optometrist / ophthalmic medical practitioners primarily in respect of patients under 16 years of age, and those aged 16 or over with a physical or mental illness or disability, whose glasses or contact lenses have suffered damage or been lost (and, in the case of those with a physical or mental illness or disability, the damage or loss is a result of that illness/disability) and require either to be repaired or replaced. Claims are submitted on the GOS4 form via webform or PMS.

Level 1 will comprise 100% checking of:

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

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

- examination of record cards and associated documentation

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

- sampling of patient records and associated documentation
- patient letters
- should it be necessary carry out a practice visit as per Appendix A
- for glasses that have not yet been collected, verification (using relevant equipment or an agreed app) that the prescription corresponds to that which is being claimed for. This can only be done during a practice visit.

Level 4 will comprise random sampling of claims including, but not limited to:

- a random assessment of claims, which will require examining a sample of patients records from NHS optometrists / ophthalmic medical practitioners to confirm that treatment claimed was in accordance with relevant legislation.
- for glasses that have not yet been collected, verification (using relevant equipment or an agreed app) that the prescription corresponds to that which is being claimed for. This can only be done during a practice visit.

Outputs:

Quarterly PV report detailing:

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

If a practice visit has been undertaken, a report will be produced which details the following:

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

Enhanced Services: Community Glaucoma Services (CGS) Registration

CGS registration payments are based on the numbers of patients registered with the accredited provider at the end of the month. These details are gathered when registration claim forms are submitted and payment will continue unless the patient registers with another provider, dies, embarks (no longer ordinarily resident in Scotland), is de-registered by the accredited provider or a period of 21 months have passed since the previous primary community glaucoma assessment.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Claim forms by Optix (CGS database) – to ensure all mandatory information is present
- Patient existence/status by matching to CHI
- Validation against the 2022 Directions
- Duplication on Optix (CGS database)
- CGS AP are registered with NHS Board

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

- Number of registrations by accredited provider
- Registrations by accredited provider that are unmatched to CHI
- Registrations by accredited provider with no assessment claims

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

- Sampling of patient records and associated documentation
- Patient letters
- Liaison with health board or HES to establish registration eligibility

Level 4 will comprise random sampling of claims including, but not limited to:

- examination of the patient record on the OpenEyes Electronic Patient Record system and associated documentation to establish that the patient was identified by the HES as being eligible to be discharged from the HES and registered under the CGS.

Outputs:

Quarterly PV report detailing:

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

Enhanced Services: Community Glaucoma Services (CGS)
Primary Assessments

Primary community glaucoma assessment (PCGA) payments are based on valid assessment claims submitted by the accredited clinician / assisting accredited clinician. These details are gathered when valid assessment claim forms are submitted, and payment will be calculated and paid where appropriate.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Claim forms by Optix (CGS database) – to ensure all mandatory information is present
- Patient existence/status by matching to CHI/valid registration status
- Validation against the 2022 Directions
- Duplication of PCGA claims
- That the claimant is registered with the relevant NHS Board as an accredited clinician / assisting accredited clinician for CGS purposes
- That the accredited clinician / assisting accredited clinician who submitted the claim is associated with the Payment Location Code of the accredited provider with whom the patient is registered

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

- Number of PCGAs by accredited clinician / assisting accredited clinician
- PCGAs by accredited clinician / assisting accredited clinician that are unmatched to CHI

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

- Sampling of patient records and associated documentation (EPR)
- Patient letters
- Liaison with health board or HES to establish status

Level 4 will comprise random sampling of claims including, but not limited to:

- examination of the patient record on the OpenEyes Electronic Patient Record system and associated documentation to establish that the patient has been managed in accordance with the relevant clinical guidelines as set out in the 2022 Directions

Outputs:

Quarterly PV report detailing:

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

Enhanced Services: Community Glaucoma Services (CGS)

Supplementary Assessments

Supplementary community glaucoma assessment (SCGA) payments are based on the valid assessment claims submitted by the accredited clinician / assisting accredited clinician. These details are gathered when valid assessment claim forms are submitted, and payment will be calculated and paid where appropriate.

Payment verification checking takes place on 4 levels as follows:

Level 1 will comprise 100% checking of:

- Claim forms by Optix (CGS database) – to ensure all mandatory information is present
- Patient existence/status by matching to CHI/valid registration status
- Validation against the 2022 Directions
- Duplication of SCGA claims (where not clinically appropriate)
- That the claimant is registered with the relevant NHS Board as an accredited clinician / assisting accredited clinician for CGS purposes
- That the accredited clinician who submitted the claim is associated with the Payment Location Code of the accredited provider with whom the patient is registered

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

- Number of SCGAs by accredited clinician / assisting accredited clinician
- SCGAs by accredited clinician / assisting accredited clinician that are unmatched to CHI
- Accredited clinicians and assisting accredited clinicians with no primary assessment claims

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

- Sampling of patient records and associated documentation (EPR)
- Patient letters

Level 4 will comprise random sampling of claims including, but not limited to:

- examination of the patient record on the OpenEyes Electronic Patient Record system and associated documentation to establish that the patient has been managed in accordance with the relevant guidelines as set out in the 2022 Directions

Outputs:

Quarterly PV report detailing:

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

IT System Security

For payment verification for Enhanced Services: Community Glaucoma Services (CGS) P&CFS will use the Electronic Patient Record (EPR) system hosted by NHS Education for Scotland and the health boards.

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

Optometrist / ophthalmic medical practitioners are responsible for the purchase, maintenance, upgrade and running costs of integrated IM&T systems for their practices, as well as for telecommunications links within the NHS. Within each NHS Board area, assurances will be obtained as part of the premises inspection programme that appropriate measures are in place to ensure the integrity of the data held within each ophthalmic practice's clinical system.

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

- That the practice has current registration with the Information Commissioner's Office regarding Data Protection
- an established policy on System Security should exist that all employees have access to and have agreed to abide by.
- administrator access to the system should only be used when performing relevant duties.
- a comprehensive backup routine should exist, and appropriate storage of backup media should occur; and
- all staff utilising the VPN connection comply with of the Acceptable User Policy in place in their Health Board

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

OUTPUTS:

- Any necessary recommendations and actions.

Appendix A – Inspection of Ophthalmic Records and Practice Visits

1. Background

1.1. One of the methods of verifying payments made under General Ophthalmic Services (GOS) and NHS optical vouchers is to examine patient records. This may be a request for records cards provided to NSS Contractor Finance or access to a clinical system or these checks may be carried out during practice visits. A selection of records will be examined looking at a range of items of service.

1.2. All records will either be paper based or electronic and cross-checking may be required with any relevant electronically held information, as well as with order books and appointment diaries if necessary.

2. Practice visit

2.1. Where it has been deemed appropriate to undertake a practice visit, NSS Contractor Finance staff will conduct these visits in conjunction with the NHS Board's nominated optometric advisor. This may have been a result of a risk assessment or trend analysis.

2.2. Practitioner Services will collaborate with the NHS Board and jointly agree that this is necessary to gain a level of payment assurance. This could be on the basis of an outcome of a recent Practice Inspection or routine record card check.

2.3. Optometrists / ophthalmic medical practitioners will be advised of when the visit will take place and the reason therefor.

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

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

3. Selection of Records

3.1. In advance of the visit, a number of claims will be identified for examination. NSS Contractor Finance will extract this information from the OPTIX system and cross reference this to the Community Health Index (CHI).

3.2. NSS Contractor Finance will examine record cards from recent visits by patients, though this will be dependent on the 'items of service' being checked and the throughput of the practice.

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

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

3.5. During the visit, NSS Contractor Finance staff may take copies of a sample of the patient records they have checked, either by photocopying, photographing or by electronic scanning. This will support

instances where there is a need for clarification on any matter that cannot be resolved during the practice visit.

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

4. Visiting Team

4.1. The team visiting the practice may comprise representatives from both Practitioner Services and the NHS Board. An Optometrist, who is independent to the practice, may also attend. In these cases, all of the purposes of the visit will be made clear to the contractor before the visit is made.

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

5. Examining the Patient Record Cards

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

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

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

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

6. Concluding the Visit

6.1. Where the visit has identified issues, these will be discussed with the practice with a view to resolving them. The independent optometrist may assist these discussions by providing advice and guidance in relation to clinical matters.

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

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

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

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

6.5. Practitioner Services do not have any remit regarding Clinical Governance. If, however, they become aware of any significant clinical issues during the course of the visit, this will be taken forward by the relevant NHS Board Optometric advisor/Lead who will be present at the visit, for them to take forward through the appropriate channels.

7. Practice Visit Report

7.1. The report should be drafted as soon as possible following the visit. It should be noted that practice visit reports may be made available under Freedom of Information requests, subject to individual request consideration and report content.

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

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

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

- High level of assurance gained – no recommendations/actions necessary
- Adequate level of assurance gained – no significant recommendations/actions necessary
- Limited level of assurance gained – key recommendations/actions made – retesting required following implementation of recommendations
- Inadequate level of assurance gained - issues escalated to appropriate authority for consideration of further action

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

Appendix B - Community Glaucoma Service (CGS)

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PCA(O)2022(06)

CGS Registrations

The CGS is a national NHS service in Scotland that provides a means by which patients who have lower risk glaucoma or treated ocular hypertension, and who have been under the care of the Hospital Eye Service (HES), may be discharged to receive care from CGS accredited providers in the community – as supported by SIGN 144 Guidelines. Accredited providers are optometrists included on Part 1 of the Health Board's Ophthalmic List for GOS purposes, and who have been registered with the Health Board to provide the CGS from specified practice premises.

CGS registration payments are based on the numbers of patients registered with the accredited provider at the end of the month, and are paid to the Payment Location Code of the accredited provider to support the ongoing care and recall of patients – further information on what registration payments support is set out under paragraph 6 of PCA(O)2022(06). These details are gathered when registration claim forms are submitted and payment will continue unless the patient registers with another provider, dies, embarks (no longer ordinarily resident in Scotland), is de-registered by the accredited provider or a period of 21 months have passed since the previous primary community glaucoma assessment.

CGS Primary Assessments

Primary community glaucoma assessment (PCGA) payments are based on the valid assessment claims submitted by the accredited clinician / assisting accredited clinician, and are paid to the Payment Location Code of the accredited provider for the provision of PCGAs undertaken in accordance with Schedule 5 of the 2024 Directions. These details are gathered when valid assessment claim forms are submitted, and payment will be calculated and paid where appropriate. The Ophthalmology Electronic Patient Record system is the source of all clinical data for the CGS.

CGS Supplementary Assessments

Supplementary community glaucoma assessment (SCGA) payments are based on the valid assessment claims submitted by the accredited clinician / assisting accredited clinician and are paid to the Payment Location Code of the accredited provider for the provision of SCGAs undertaken in accordance with Schedule 5 of the 2024 Directions. These details are gathered when valid assessment claim forms are submitted, and payment will be calculated and paid where appropriate. The Ophthalmology Electronic Patient Record system is the source of all clinical data for the CGS.

Annex IV – Pharmaceutical Payments

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Introduction

The following sections detail the payment verification requirements for General Pharmaceutical Services (GPS).

Practitioner Services operates a scanning and optical character recognition system and a payment system (DCVP) both of which undertake extensive pre- payment validation on pharmaceutical payment claims from community pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

Retention of Evidence

Pharmaceutical Contractors are required to retain evidence to substantiate the validity of claims made and payment received. The requirement for this evidence will be in accordance with the General Pharmaceutical regulations and the Scottish Government Records Management: Health and Social Care Code of Practice (Scotland) 2020 which also provides a schedule listing the retention period for financial records in NHS Scotland. This specifies six years plus the current year as minimum retention period for most financial records. For the avoidance of doubt this would relate to any information used to support NHS payments to pharmacies, dispensing doctors, stoma suppliers and appliance suppliers.

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

Not Collected / Not Dispensed

Practitioner Services commenced from December 2019 an additional post-payment exercise to address any claims not collected or not dispensed.

This does not fit into a specific category of payment, as listed below, but will be added on the basis of the risk matrix and general payment verification work at the post-payment stage will include a review of:

- Paper claims notified as NC/ND
- Electronic notification of NC/ND

Pharmacy Payment Verification Levels

Payment verification checking for each Service as detailed in Appendix C below takes place, as applicable, on 4 levels as follows:

Level 1 will comprise 100% checking, where applicable, of:

- Patients against CHI for existence and eligibility.
- Other checks as detailed in Appendix A
- Claims forms by the Patient Registration System – to ensure all mandatory information is present.

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

- Registration activity.
- Claim activity.
- Random letters to patients to confirm provision of service.

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

- Targeted letters to patients to confirm provision of service.
- Sampling of patient medication records and associated documentation.
- Review of the GP Letter of authority
- Targeted letters to contractors to request supporting documentation.

Level 4 checking will be undertaken as follows:

- Random sampling as outlined in Appendix B.

Outputs:

Quarterly PV report detailing:

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

Appendix A – Level 1 Checks

NSS Contractor Finance will automatically carry out 100% level 1 checking on the following:

a) All Foreign Forms & Items.
b) All Urgent Fees.
c) All High Value Items above a fixed amount.
d) All Low Value Items, below £0.02
e) All Dummy Items with Over-ride prices.
f) All Out of Pocket claims.
g) All Rejected Items.
h) All Pay & Report Items.
i) Any Unusual Fees above a fixed amount.
j) Any items set for Ambiguity Check.
k) Any Invalid CHI No.
l) All Instalments claimed above an agreed fixed amount.
m) All invalid formulary items, against form type, prescriber type and dispenser type.
n) Any Quantity Limit Exceeded as per limits set at item level on EVADIS.
o) Random Check of manually processed items.

The checks will be applied to the various service areas as follows:

- Pharmacy First Service. – b,c,d,e,g,h,i,j,k,l,m,n,o.
- Medicines Care:Review Service. - b,c,d,e,g,h,j,k,l,m,n,o.
- Gluten Free Food Service (GFF) - a,b,c,d,e,g,h,j,k,l,m,n,o.
- Acute Medication Service. - a,b,c,d,e,g,h,i,j,k,l,m,n,o.
- Out of Pocket Expenses. – f.
- Dispensing Doctors - b,c,d,e,g,h,j,l,m,n,o.
- Appliance/Stoma Suppliers - a,b,c,d,e,g,h,i,j,k,l,m,n,o.

Appendix B – Random Sampling

1. Background

1.1. One of the methods of verifying payments made under General Pharmaceutical Services (GPS) arrangements is to examine patient medication records as part of random sampling. During random sampling a selection of records will be examined looking at a range of claim/payment types.

2. Selection of Pharmacies

2.1. NSS will select the pharmacies to be included as part of the random sample. Pharmacies which have been selected within the previous five years random sampling will be excluded (with the exception of NHS Boards containing less than 5 contractors).

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

3. Selection of Records

3.1. The size of the sample undertaken will be based on statistical strata using the number of claims submitted by the pharmacy.

4. Examination of Patient Medication Records

4.1. The claims/payments included within the sample will be checked against the details contained within the respective patient medication records from the pharmacy.

Appendix C – Services Explained

Pharmacy First Service / Pharmacy First Plus Service

The Pharmacy First Services include the provision of consultation, prescribing (within a permitted range) dispensing and referral services to eligible patients. Eligibility for the Pharmacy First Scotland service is reserved for those who fit the following criteria:

- Everyone registered with a GP practice in Scotland or the Defence Medical Services on a permanent or temporary basis (including care home residents).
- People who live in Scotland (including gypsy or travellers / asylum seeker or dependant of an asylum seeker).

The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP2.

Medicines Care:Review Service

Medicines Care:Review Service payments relate to the provision of services to patients with ongoing long term medical conditions. This includes the assessment and planning of the patient's pharmaceutical care needs and the establishment of a shared care element, which allows the GP to produce a serial prescription to be dispensed at appropriate intervals.

Patients must be registered with a Scottish GP Practice and pharmacy to receive the service. The pharmacy receives payment for capitation and reimbursement for any drugs dispensed. Registrations and claims are made on form CP3.

Gluten Free Food Service (GFF)

Gluten Free Food Service payments are based on claims submitted for services to patients with a diagnosis of coeliac disease or dermatitis herpetiformis. The service allows patients to order and receive gluten free food from their pharmacy without the need to go through their GP. Claims are made via submission of a CPUS form.

Acute Medication Service

The Acute Medication Service (AMS) allows the Electronic Transfer of Prescriptions (ETP) and supports the provision of pharmaceutical care services for acute episodes of care and any associated counselling and advice.

Locally Negotiated Payments

Locally Negotiated Payments will be covered by the NHS Boards' internal and external audit processes and the NSS service audit process.

Out of Pocket Expenses

Community Pharmacies can claim reasonable Reimbursements for Out of Pocket Expenses for certain items, excluding any items in parts 2 – 7 and 9 of the Scottish Drug Tariff.

Other Contractor Types

Dispensing Doctors

Dispensing GP practices exist in those areas of Scotland where the population density is considered too low to support a pharmacy.

Appliance/Stoma Suppliers

Appliance/Stoma Suppliers are reimbursed for the provision of specialist products to Scottish patients.