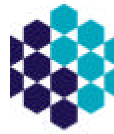


Subject:

**Circular Reference: HSS (F) 6/2006**

**Probity Checks of Payments made under the New General Medical Services Contract**

**26 January 2006**

For Action by:

- **HSS Board Chief Executives**
- **HSS Board Directors of Finance**
- **Chief Executive Central Services Agency**
- **Director of Finance Central Services Agency**
- **Chief Medical Officer DHSSPS**
- **Medical Practitioners**

For Information to:

- **Director of Primary Care DHSSPS**

Summary of Contents:

**The purpose of this circular is to implement agreed arrangements for securing assurance on overall HSS Board expenditure on General Medical Services.**

Enquiries:

**Any enquiries about the contents of this Circular should be addressed to:**

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**Related documents:**
HSS (F) 38/2005
HSS (F) 62/2005

**Status of Contents:**
**Action**

**Implementation:**
**Immediate**

Additional Copies:
**Tel: 028 90 523389**
**www.dhsspsni.gov.uk**

**GUIDANCE TO BOARDS ON PROBITY CHECKS OF PAYMENTS MADE UNDER THE NEW GENERAL MEDICAL SERVICES CONTRACT**

## 1. Introduction

1.1 Post payment checks in respect of general medical services have been normal practice for many years. The original guidance was issued in Departmental Circular HSS (F) 35/98. This guidance has been updated to take account of the new General Medical Services (nGMS) Contract which came into force in the UK on 1 April 2004 and replaces Circular HSS (F) 35/98.

1.2 The system of non-cash limited fees and allowances has been replaced by an overall level of investment in primary care. Each Health and Social Services Board receives a cash-limited sum for nGMS as part of its total allocation and commissions primary care from practices or other providers rather than with individual GPs.

1.3 Under the nGMS Contract Boards allocate resources to practices in three main ways:

1.3.1 The Global Sum - to cover running costs. This is a weighted capitation allocation to practices to cover "essential and additional services" for their registered patients. It covers basic running costs, practice staff, though not premises or I.T. The Global Sum is based on list size and calculated quarterly and paid monthly.

1.3.2 Enhanced Services - payments for practices for an extended range and level of services, for example, influenza immunisations and minor surgery services.

1.3.3 Quality Payments - earned by practices for achieving high quality clinical and organisational standards within the terms of the Quality and Outcomes Framework (QOF).

1.4 There are separate funding streams for:

- premises
- information management and technology (Boards rather than practices are responsible for funding purchase and maintenance of IM&T and these will remain Board assets)
- seniority, maternity, paternity, sick pay, etc

1.5 The procedures that require to be implemented in order to determine the level of payment that each practice receives have been set out in the GMS Statement of Financial Entitlements (SFE) issued by the Department of Health and Social Services and Public Safety. Any payments made by Boards to a contractor under an nGMS Contract may be subjected to verification and probity checks.

## 2. Background

2.1 All public bodies have a responsibility to ensure that there are effective systems of internal control in place in order that assets are safeguarded, transactions authorised and properly recorded and material errors or irregularities are either prevented or detected.

2.2 Following developments in the private sector regarding the proper governance of organisations, Accounting Officers of Central Government Departments (and Accountable Officers of their associated bodies) are obliged to make positive assurance statements regarding the operation of their organisation's internal control systems. These statements, which are personally signed off by Accounting/Accountable Officers, are subject to audit and must therefore be supported by evidence, capable of independent substantiation.

2.3 The payment of independent contractors for the provision of Family Health Services (general medical, dental, pharmaceutical and ophthalmic services) poses particular problems for the Department, Health and Social Services Boards and the Central Services Agency in complying with the accepted standards of control expected of public organisations in the procurement of goods and services. These are essentially associated with the volume of services provided which are subject to individual claims by large numbers of contractors. In such circumstances it is simply not possible to confirm, prior to payment, that services for which claims have been submitted have actually been provided and claims have been submitted correctly.

## 3. Reasons for Probity Checks

3.1 The Board has a responsibility to gain assurance that payments received by a practice are fully justified and in accordance with the SFE. Undertaking probity checks does not imply lack of trust in general medical practices, but is a normal requirement to make available evidence of service provision to support financial reimbursement.

3.2 **The reasons for probity checks are:**

3.2.1 to gain assurance that claims being submitted are proper and in accordance with the SFE.

3.2.2 to help decide whether fraudulent claims are being submitted.

3.2.3 the latter reason will apply normally only when there is evidence of unexpected or abnormal trends in claims by a general medical practice or where specific information warrants a detailed investigation.

3.4 Boards still have a duty to make sure that the payments made are valid and it would clearly be inappropriate for payments to be made when there are doubts about the validity of claims. These doubts might arise out of the claims themselves or where Boards remain dissatisfied with the outcome of enquiries into previous claims.

## 4. Access to Practice-Held Records

4.1 There are several probity checks open to Boards that do not require access to records held at the practice. However, it will be necessary for Board staff to access such records as part of the post payment verification of claims and on occasion they will wish to check claims against information that is only available in patients medical records (which may be held on paper or on computer and should record details of all illnesses / treatment provided). In doing so, proper safeguards must be observed about confidentiality and Boards should ensure that procedures are consistent with the guidance *"The Protection and use of Patient and Client Information"*, issued in June 1999 by the Department's Information Policy Branch.

## 5. Roles of Boards, Auditors, the Central Services Agency and the Counter Fraud Unit

5.1 It is important that the respective roles of the main parties involved are understood clearly:

i **Boards** have the prime responsibility for the commissioning of services from practices and for ensuring that they have sufficient information to demonstrate their accountability for the use of public funds;

ii **Internal Audit** is an independent appraisal service established by the Board for the review of the internal controls within the organisation. They should be consulted about the implementation of the probity checks and be asked to make recommendations on the standards of internal control to be applied. However, they should not normally have an operational responsibility for the inspections themselves;

iii **External Audit** is responsible for providing an opinion on whether the accounts present a true and fair view of the financial affairs and whether there are arrangements in place for the proper use of resources and safeguards against fraud and corruption;

iv **The Central Services Agency** acts as paymaster on behalf of the four Boards in relation to General Medical contractors and maintains the Central Register of all patients on practice lists, and Doctors accredited to work in Primary Care (Primary Care Performing List) for each Board.

v **The Counter Fraud Unit** will undertake investigations into cases of potential or actual fraud involving contractors, either jointly with the Boards or on their behalf. The Unit will also be responsible for the detection and pursuit of fraudulent claims to exemption from/remission of FHS charges.

## 6. Pre-requisites for Implementing Probity Checks under the new General Medical Services Contract

6.1 **As a minimum these include:**

i commitment from Boards to implement the probity checks of the nGMS Contract as soon as appropriate information and guidance is available, although it should be noted that post payment verification processes had been established under the previous arrangements (Departmental Circular HSS(F)35/98);

ii an information system which will enable the Boards to manage the probity checking process;

iii a written local protocol to be shared with the Local Medical Committee as to the overall inspection process to be carried out. A model protocol is appended to this guidance at Annex A. Boards may wish to use this as a guide in determining their own local arrangements.

## 7. Probity Checks

7.1 Accumulated management information from within the Board / CSA should be used to help Boards decide on the areas or practices which require greater scrutiny.

7.2 Boards will have a range of actions from which to select in deciding how to conduct probity checks.

**These include:**

i taking account of information already held within the Board/CSA;

ii writing to patients seeking their confirmation of facts claimed by the practice. This needs to be handled sensitively and letters to patients should make it clear that the enquiry is a routine one and is not to be taken as implying concerns about the honesty of the practice. It may not be appropriate to make direct approaches to patients in the case of certain services e.g. contraceptive services. Sample letters are appended at Annex C. The format of the letters is for guidance only and may be adapted by Boards in consultation with the Local Medical Committee to suit particular circumstances;

iii making a direct approach to the practice to ask for its comments on information generated from the management information system or on apparent discrepancies or anomalies arising from monitoring processes;

iv carrying out a visit to the practice to discuss its claims and payments, including inspection of practice held records and examination of the supporting systems and procedures within the practice.

7.3 Whilst visits to practices will not, therefore, be the sole means for Boards to satisfy themselves about the probity of claims, such visits are an important aspect of the post-payment verification procedure. A cyclical programme of visits should be devised by each Board to include every practice within its area. This will normally take place within a three year period, but should not exceed five years. Review of available information held within the Board, including apparent discrepancies from other monitoring processes, may well prompt a visit to the practice sooner than would otherwise be the case.

7.4 For a routine visit, the aim is to gain assurance that the payments received by a practice are fully justified and in accordance with the SFE. The most cost-effective way of doing this will be to look at a sample of individual patient records and/or carrying out checks of patient level data (e.g. blood pressures). The sample size will be a matter for each Board to determine locally after discussions with their internal and external auditors. The records inspected will depend upon the information kept at the practice. A written protocol updated to take account of the new Contract should be shared with

the Local Medical Committee before any inspections begin. The use of standard programmes and documentation for the work to be done by visiting staff will help in making the process as efficient as possible and assist in assessing the quality of the work done.

7.5 The composition of the visiting team is at the discretion of the Board, but only a Medical Officer of the Board will have the right to inspect the actual patient medical records. The Board will ensure that all those who are involved in the probity checks, including those who visit practices, are aware of the need to respect patient confidentiality and it will take appropriate steps to see that such confidentiality is not breached. Procedures will be consistent with guidelines issued by the Department's Information Policy Branch: *'The Protection and Use of Patient and Client Information'* issued in June 1999. Whenever possible, advance notice will be given to the practice of the names of those who will be visiting.

7.6 Checks and visits to investigate a suspicion of fraud can take place at any time and are completely separate to the routine probity checks. These should be carried out in accordance with the Departmental Circular HSS (F) 38/05, '*Revised Fraud Reporting Arrangements*' and the Board's own Internal Fraud Response Plan (see Section 10).

7.7 Any aspect of the nGMS Contract may be covered by probity checks following review by the Board of emerging areas of risk in the light of experience.

## 8. QOF Probity Checks

8.1 The QOF is a major component of the nGMS Contract and a substantial proportion of an individual practice income can be derived through high achievement of the QOF.

8.2 Although QOF is intended to be a "high trust" system there a number of methods Boards should use to ensure payments are accurate and public money is safeguarded.

These include:-

### *8.3 Annual QOF Review*

An annual review visit to each practice to look at achievement against QOF indicators and provide Boards with an assessment of likely achievement by 31 March, to confirm data collection and quality are accurate and to discuss aspirations for the following year.

8.4 It is recommended that a random QOF probity check to 5% of practices takes place annually and ideally early in the financial year to avoid clashing with the annual QOF review visit during the second half of the year. National guidance states that the random QOF probity check must not be combined with the annual QOF review visit.

### *8.5 Pre-payment Verification*

At the end of the financial year PCAS provides data to Boards on their practices' achievements against the QOF. Boards then have a short period of time in which to carry out pre-payment verification checks on the data.

### 8.6 *5% Random Probity Check*

This should be a random check and does not imply any suspicion of a practice. If Boards have suspicions of fraud these should be pursued through the normal procedures. The random probity checks should not be combined with the QOF visits and should be timed to avoid the period when they take place.

8.6.1 **The visit could include:**

An in-depth review of various aspects of the QOF including; very high or low prevalence rates compared to Board or Northern Ireland average, very high or low levels of exception reporting, very high or low levels of achievement compared to the practice aspiration or Board or Northern Ireland average, any sudden large changes in the figures, any substantial discrepancies between the annual QOF review report and the achievement claim disproportionate amounts of data entry at certain times of the year.

## 9. Output from the Probity Checking Process

### 9.1 There will be several possible products:

i it is expected that the vast majority of checks will provide assurance with regard to payments made;

ii information identifying over-claims or over-payments which should lead to recovery of funds from the practice, or under-claims or under-payments which should lead to amended claims by and/or reimbursement to the practice;

iii information for the internal and external auditors to assist in their work;

iv aggregated information in anonymised form that can be regularly shared with practices to enable them to assess where they stand in relation to the Board/Northern Ireland average and to other practices.

v in the case of a visit, a report setting out the results of the visit which should be shared in draft form with the practice and finalised in light of any comments received;

vi a periodic summary report of findings for the Chief Executive or the Director of Finance of the Board.

## 10. Fraudulent Claims

10.1 Any indication of possible fraudulent claims must be investigated fully until the suspicions are either confirmed, or allayed. Each case will be different but experience has shown that the key to a successful investigation is a carefully thought out fraud response plan which covers arrangements for:

i liaison with internal and external auditors, the Counter Fraud Unit, the Police and the Department;

ii training for staff, in particular ensuring that investigating staff, where it is not the police, have adequate knowledge of the procedures for collecting evidence under the Police and Criminal Evidence (Northern Ireland) Order 1989;

iii investigating the suspected fraud which will involve:

- collaboration with the Counter Fraud Unit
- contacting the internal/external auditor and Police
- assigning responsibility for investigation to a specific person
- preparing a background and objectives statement
- considering likely outcome with the Police
- agreeing terms of reference, scope and key dates
- identifying staff resources and responsibilities
- estimating and monitoring costs of investigations
- maintaining regular contact with Senior Managers and the Police
- identifying lessons learned and action required;

iv reporting fraud;

v recovery of losses;

vi procedures for preparing and preserving evidence and managing public relations; and

vii prosecution and disciplinary action against the perpetrators.

It is important that these issues are discussed with all the interested parties in a calm and collected manner so that a general consensus is reached on the Board's approach to fraud investigation. Making these arrangements should not be left until the Board is faced with investigating an actual case of fraud.

## 11. Conclusion

11.1 A summary of the key steps which Boards need to take to have in place for probity checks is included as Annex B.

## 12. Action

12.1 Health and Social Services Boards are asked to implement as soon as possible the updated arrangements for probity checks for all GMS practices. Boards, in implementing this guidance, should share the approach to be adopted with the Local Medical Committee.

**ANNEX A**

# MODEL LOCAL PROTOCOL COVERING PROBITY CHECKS OF PAYMENTS MADE UNDER THE NEW GENERAL MEDICAL SERVICES (nGMS) CONTRACT

## PURPOSE

**1** The Guidance to Boards issued on 26 January 2006 sets out the principles governing probity checks of claims and payments under the new General Medical Services (nGMS) Contract which came into force in the UK on 1 April 2004. The guidance provides for the inspection of patient medical records at practices as part of the verification process and that each Board should update local arrangements in the form of a protocol which should be shared with the Local Medical Committee (LMC).

**2** This document sets out the local protocol agreed by the [name] Board and shared with the [name] Local Medical Committee. It details the arrangements for access by Board staff to records held at practices, including patient medical records where necessary, in order to verify that the claims made by the practice are correct and in accordance with the Statement of Financial Entitlements (SFE). It should be read in conjunction with the main guidance referred to above.

## PRACTICE VISITS ARRANGEMENTS

**3** The routine probity check will cover a range of areas within the nGMS Contract, looking in detail at particular issues, which will necessitate a visit to the practice.

**4** Routine visits to practices will be made by prior appointment, and timed so as to minimise the inconvenience to doctors and their staff. The practice will be given at least one month's notice of the intention to visit.

**5** The areas covered may be influenced by the claims pattern shown on the Board's records and responses from the practice or from patients to enquiries by the Board seeking confirmation of services provided. The Board will make a judgement about the reliance that can be placed on responses from patients.

**6** A cyclical programme of routine probity visits will be devised by each Board to include every practice within its area. If the practice has more than one surgery, the verification process may include visits to all sites.

**7** Additional visits from the Board may be needed to investigate probity related issues including apparent discrepancies arising from other monitoring processes or where routine enquiries made by the Board do not provide satisfactory evidence of service provision.

**8** The composition of the team is at the discretion of the Board, but only a medical officer of the Board will have the right to inspect the actual patient medical records. The Board will ensure that those who are involved in the probity checks, including those who visit practices, are aware of the need to respect patient confidentiality and it will take appropriate steps to see that such confidentiality is not breached (see also paragraph 14 of this protocol). Procedures will be consistent with guidelines issued by the Department's Information Policy Branch: *"The Protection and Use of Patient and Client Information"* issued in June 1999. Whenever possible, advance notice will be given to the practice of the names of those who will be visiting.

**9** Members of the practice staff need to be available to help the Board team and should normally include the Practice Manager. The presence of a GP during the verification process is at the discretion of the practice and the practice may invite any other person, such as an LMC representative, it if wishes.

## AUDIT PROCESS

**10** Routine visits will involve Board staff looking at:

- **i** Systems and procedures within the practice for submitting each type of claim and for ensuring claims conform with the SFE.
- **ii** How the practice prepares the claims for submission to the Board and who is involved;
- **iii** Information sources;
- **iv** Records maintained by the practice to provide evidence of services provided to patients; and
- **v** Practice protocols aimed at "maximising" the occurrence of particular services provided to patients.

**11** The purpose of the review of the practice's internal control systems is to gain assurance that:

- **i** There are adequate procedures for recording services provided by the practice to patients:
- **ii** There is a satisfactory understanding and application of the provisions set out in the SFE; and
- **iii** Systems exist to prevent errors and omissions, as far as possible, in the claims submitted.

**12** At the start of the visit, Board staff will submit to the Practice Manager (or other practice representative) details of the sample claims/payments they wish to inspect. The Board team will seek evidence from practice records of the service having been provided. Acceptance evidence might include:

- **i** Patient's attendance confirmed from the reception records;
- **ii** Vaccination records;
- **iii** Prescribing records; and
- **iv** Entries in patients' medical records.

**13** The Board team will expect to obtain 100 per cent verification of service provision on their sample check of practice records.

**14** Where access by authorised Board staff to patient medical records for the purpose of verifying claims is considered necessary, it will be sought on the clear understanding that proper safeguards are observed about accessing confidential patient information. In particular, Board staff will only request sight of records and information directly relevant to the stated purpose of their enquiry. Practice staff may facilitate the verification process by extracting the relevant records from the patient's medical notes and showing them to the Board staff. The information supplied should be sufficiently comprehensive to identify the nature of the service provided and other basic information supporting the particular claim under examination.

**15** Where the medical records are computerised, the practice staff should produce relevant information on the computer screen. There will normally be no need to produce the records in a printed format.

**16** The Board team may wish to discuss with the practice their recent claims record, for example in relation to the provision of a range of enhanced services.

## VISIT OUTCOMES

**17** A person nominated by the practice will normally be informed of the early conclusions arising at the end of the visit. Board staff will inform the practice of any observations and advice about the practice's systems and procedures, and the level of services being provided, based on their knowledge and experience. In this way the practice has an opportunity to benefit directly from the visit. Subsequent to each visit, the Board will provide the practice with a written report and provide an opportunity for the Practice to comment on the findings before they are formally considered by the Board's management.

**18** Follow up visits may be required to verify changes to practice procedures where recommendations have been made by the Board and accepted. Where the Board team finds discrepancies or claims that cannot be verified owing to lack of evidence, then additional records will normally be examined in order to ascertain the extent of the problem and the underlying reasons.

**19** Where it is ascertained that some claims have been submitted incorrectly or there are doubts about their validity, then certain actions will be taken by the Board staff which may include:

Action 1 Extending the sample of records checked;

Action 2 Information identifying over-claims or over-payments should lead to recovery of funds from the practice, or under-claims or under-payments should lead to amended claims by and/or reimbursement to the practice. The practice should undertake to prevent any repetition of the errors in future and, where applicable, implement any recommendations made by the Board.

Action 3 Where Board staff are dissatisfied with the evidence or the explanations given in respect of errors found, the matter will then be referred to other parties, for example the Medical Adviser or internal auditors, for comments and further enquiries. The Board should also extend its enquiries with patients if it is appropriate to the type of claim under review.

The Board will report its findings, along with any recommendations, back to the practice.

Action 4 If the Board becomes aware of the possibility of fraud, then it should consult the Counter Fraud Unit and, if necessary, the police and the external auditor. By agreement with the police, the Board may then collect additional evidence from the practice by invoking the rules under the Police and Criminal Evidence (Northern Ireland) Order 1989.

## CO-OPERATION OF PRACTICES

**20** Routine visits are to be seen as fact-finding and should not in any way be threatening to the practice or undertaken in an atmosphere of mistrust. It is in the interests of practices to co-operate fully with this protocol which is designed to create understanding and trust between the Boards and General Medical Practices and to allow the visits to be informative for both parties.

**21** If a practice refuses to co-operate with the Board by, for example, not allowing reasonable access to practice-held records within the terms of this protocol, the Board should contact the Local Medical Committee and seek its assistance in resolving the problem as quickly and amicably as possible. The Board reserves the right to take such further action as it deems necessary, including in extreme cases the suspension of further payments to the practice concerned until the matter is resolved.

## OPERATION OF THIS PROTOCOL

**22** Questions about the interpretation or application of this protocol should be directed in the first instance to [name and job title].

[name] Health and Social Services Board Date

**ANNEX B**

## CHECKLIST OF ACTIONS FOR BOARDS ON PROBITY CHECKS OF PAYMENTS MADE UNDER THE NEW GENERAL MEDICAL SERVICES CONTRACT

| | KEY ISSUE | RESPONSIBLE PERSON/TARGET DATE |
|---|---|---|
| 1 | Commitment from the Board to commence immediately procedures to implement guidance. | |
| 2 | Management information system to monitor claims and payments to General Medical Practices. | |
| 3 | Development and implementation of staff training | |
| 4 | Written local protocol updated and shared with the LMC | |
| 5 | Draw up programme of visits to practices. | |
| 6 | Draw up standard work programmes and documentation for visits. | |
| 7 | Determine staff resources to carry out process. | |
| 8 | Determine format of reports. | |

ANNEX C

***SPECIMEN LETTER TO PATIENT***

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

**Dear Sir/Madam**

The ____________ Health and Social Services Board is responsible for the payments made to General Medical Practices. We must also ensure that claims and payments are being made appropriately and that the best value for money is achieved for the services being provided to patients.

As part of our routine verification procedures, we write to a sample of patients to request confirmation that services claimed for by the General Medical Practices (GPs) have been provided in accordance with the current regulations.

I would be grateful if you would kindly complete the attached questionnaire and return it to me in the pre-paid envelope provided. A parent, guardian or other responsible person should complete and sign the form on behalf of a child under the age of 16 and for other persons unable to do so for themselves.

**I should stress that this is a routine enquiry** and your General Medical Practice is aware that this approach may be made to you. Thank you for your co-operation.

Yours faithfully

***Enc***

**To ______________________ Health and Social Services Board**

I confirm that I have received the following within the last 6 months (please tick whichever boxes apply. If one of the categories applies more than once, please enter the number of times in the box.

I cannot confirm that I have received any of the above services.

**Comments**

**Signed:** _______________ **Name:** _______________

**Date:** ________________ **Address:** ________________

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