

BSC WALES

GUIDANCE NOTES TO THE

ALL WALES PROTOCOL FOR

POST PAYMENT VERIFICATION

OF

NHS OPHTHALMIC SERVICE

CLAIMS

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GUIDANCE NOTES TO THE ALL WALES
PROTOCOL FOR
POST PAYMENT VERIFICATION OF
NHS OPHTHALMIC SERVICE CLAIMS

1. PURPOSE

1.1 This document sets out detailed guidance to accompany the All Wales protocol agreed by the BSC on behalf of the Local Health Boards in consultation with Optometry Wales and the Regional Optometric Committees. It details the arrangements for access by the BSC staff to records held at the practices, including patient record cards where necessary, in order to confirm that the claims made by the practice are correct and in accordance at the time of claiming with the relevant NHS General Ophthalmic Services Regulations, with any specific LHB procedures, including Welsh Eye Care Initiatives, and to ensure the service claimed has been delivered.

1.2 The verification process currently involves checking sample claims from all categories of services provided. These are as follows: -

- GOS 1: Application for an NHS funded sight test
- GOS 2: Patient's optical prescription or statement*
- GOS 3: NHS optical voucher and patient's statement
- GOS 4: NHS optical repair/replacement voucher application form
- GOS 5: Help with the cost of a private sight test*
- GOS 6: Application for a mobile NHS funded sight test
- Welsh Eye Care Initiative and any other national or local optometric initiative
- Forms relating to payment of grants for pre registration trainees and, if appropriate
- Forms relating to Diabetic Retinopathy

*Checks with patients as deemed necessary

1.3 The aim of the PPV process is to ensure propriety of payments of public monies by the LHB, this requires the BSC to undertake probity checks on a continuous basis. This will give the necessary assurance to the Local Health Boards that public monies have been expended appropriately, and also assurance to the contractors regarding their arrangements.

1.4 It is important to note that Ophthalmic PPV is a financial exercise and should not be confused with the role of clinical governance. During the PPV process checks are made to monitor claims of all persons or bodies

corporate, as the case may be, who/which claim NHS fees for the provision of ophthalmic services. The process is not a tool for clinical governance; however there will be instances where clinical variances outside the parameters of normal practice will be apparent.

- 1.5 In instances where there is an issue of apparent clinical variances, as in 1.4 above, the PPV team should notify and enlist the assistance of an independent optometric advisor from the NPHS, or other appropriately qualified and experienced person, approved by the LHB, in consultation with the relevant regional/local Optometric Committee, in respect of their professional advice and judgement. There may be occasions when it would be advisable for the advisor to be selected from another region to ensure there is objectivity and avoid the possibility of a conflict of interest.
- 1.6 It is expected that claims reviewed will have been submitted within the agreed policy on claims in the guidelines agreed in the Memorandum of Understanding (e.g. frequency, annotation) to be found with WHC(2002) 13 – Appendix 1 attached

2 MONITORING OF CLAIMS BY LHBs

- 2.1 In order to monitor patterns of claims from optical practices effectively, a Management Information System will be utilised. The Management System provides a range of information to assist the LHB to monitor claims and match patients to claims.
- 2.2 Staff with the relevant skills to interpret the output from the Management Information system will review the data and carry out monthly monitoring. Due to the many differences between practices and practice populations within an LHB area, local factors will need to be taken into consideration when interpreting the output.
- 2.3 The management information system will be capable of producing statistics to highlight outliers in respect of claims submitted by all practitioners in the LHB area. It will be used to establish the average number of GOS claims in the LHB area and break them down into individual services.
- 2.4 This data will also be examined alongside the National average in Wales for each service.

3 PRACTICE VISIT ARRANGEMENTS

- 3.1 A schedule of visits will be agreed between the LHB and BSC and visits to practices will be made by agreed prior appointment and in agreement with the practice, usually within normal BSC and practice staff working hours. Before the visit, BSC staff will consult with the LHB and select a

sample of claims made by the practice during the preceding 12 months covering each type of claim, normally in respect of the provision of services to patients. The details of patients selected will normally be notified to the practice 48 hours in advance of the visit.

- 3.2 For all PPV visits to local branches of a multiple or national company, the PPV team will need to ensure that the Contractor has been informed of the visit as well as the practice staff. The PPV team will inspect any guidance issued by the multiple or company's head office so that local variations can be identified. Where appropriate, the PPV team will issue advice.
- 3.3 All details of planned visits will be notified to the Local Counter Fraud Services in advance as in some cases it may be detrimental for a PPV visit to be conducted at a practice which is the subject of an investigation.
- 3.4 Where PPV staff receive a reliable piece of information they will give consideration to a targeted PPV visit. In these instances the PPV staff will immediately contact the relevant LHB, which will consult with the local counter fraud specialist as deemed necessary as to further action.
- 3.5 Overall sample sizes and numbers between types of claim, may be influenced by the findings of the previous Post Payment Verification reports, the claims pattern shown on the BSC's monitoring records and responses from the practice and/or patients to enquiries by the BSC seeking confirmation of the services provided. The BSC will make and record a reasonable judgement on the reliance that can be placed on patient responses, as this may vary substantially between areas and may have an impact on the sample sizes of claims to be checked at practices.
- 3.6 The sample size, in terms of services to patients, and the number of verification visits to practice premises in a 3-year cycle, will normally be based on the average number in the preceding 12 months of forms GOS 3 submitted by the practice. The following table will be used:

Average monthly numbers forms GOS3	Sample size patients per visit	Normal number of visits within 3-year cycle
Up to 200	100	1
201 – 400	100	2
401 – 600	100	3
And so on and so forth		

- 3.7 Routine verification visits to practice premises, are likely to be normally no more than half a day in duration, with additional time required where BSC staff experience difficulty in verifying claims. If the practice has

more than one set of premises the verification process may include visits to all sites.

- 3.8 Additional visits from the BSC may be needed where a higher level of claims is evident. Normally there will be one further visit within the 3 year period above for each 200 average claims per month per practice where the number of claim forms submitted is in excess of 200 average per month. Additional visits may also be needed if there is a substantial change in the trend of claims evident from the BSC's management information system, or where routine inquiries made by the BSC do not provide satisfactory evidence of service provision.
- 3.9 Normally two suitably trained staff from the BSC will undertake these visits. The BSC has discretion to decide the composition of the visiting team, and will ensure that staff involved in post-payment checks and visits to practices will in all circumstances respect patient confidentiality (refer Section 5). Procedures will comply with Welsh Health Department guidelines "The Protection and Use of Patient Information", issued on 7th March 1996 (DGM (96) 43). Whenever possible, the BSC will inform the practice before the visit of the names of the BSC staff attending. All BSC staff visiting practices must carry accepted identification so that their status can be verified by the practices on request.
- 3.10 In the event the PPV visiting team includes any qualified Local Counter Fraud Officers, then other than being required to participate as any other officer in attendance, they will not lead or otherwise take part in any required subsequent enquiry where fraud is suspected or found.
- 3.11 At the beginning of the visit the contractor will provide the evidence from their records for the claims previously notified to them by the PPV team. This evidence will be drawn from the following possible sources;
- Patients attendance confirmed from reception records
 - Patient records for sight testing and dispensing of spectacles or contact lenses
 - Order books and/or invoices
 - Workshop records where appropriate
 - Day books and ledgers
 - Copies of documents provided by the patient where available
 - Computerised records
 - Orders specifying
 - Strength of lenses
 - Any additions e.g. tints, prisms, small frames
 - Receipts/receipt books

NB Where not required to be kept longer under a term of service requirement (see section 3.12), practices will be expected to retain

all documentation relating to a transaction for a minimum period of 18 months

- 3.12 The regulations in the terms of service require that a contractor shall either personally keep, or have made legally enforceable arrangements to keep, a proper record in respect of each patient to whom he provides general ophthalmic services, giving appropriate details of sight testing. All such records are to be kept for a period of seven years and during that period, to be produced when required to do so under the terms of service.
- 3.13 Members of the practice staff need to be available to help the BSC team and should normally include the Practice Manager. Optometrist presence during the verification process is at the practice's own discretion and the practice may also invite another person, such as a ROC/LOC representative, to be present if it wishes.

4 AUDIT PROCESS

- 4.1 Routine visits will involve minimum sampling targets which will be agreed between the LHB and the BSC with the BSC staff looking at: -
- Procedures in place for testing, recall and visiting;
 - Systems and procedures including explanation of internal controls within the practice for submitting each type of claim and for ensuring claims conform with the Regulatory or LHB/WAG procedure and the requirement of any service specification;
 - How the practice prepares the claims for submission to the LHB/BSC as the case may be and who is involved;
 - Whether arrangements to undertake point of service checks are satisfactory;
 - Information sources used to deal with claims for payment;
 - Existence of adequate computer security.
 - Records maintained by the practice to provide evidence of services provided to patients;
 - Day books and/or appointment diaries;
 - Orders to suppliers of optical appliances etc, eg wholesalers and optical laboratories.
- 4.2 Where appropriate, percentages etc. will be compared against the average for the LHB/BSC and/or All Wales averages. The BSC will have regard to the overall number of claims when analysing such indicators, since small sample sizes may be less reliable. Performance indicators may be used to select claims for examination. These may include:
- Frequency of sight tests (GOS 1);
 - Sight tests to voucher time periods (GOS 3);
 - Voucher to collection time period (GOS 3);

- Average cost of vouchers reimbursed;
 - Percentage of tints prescribed per voucher;
 - Percentage of second pairs per voucher;
 - Percentage of small frame supplements per voucher;
 - Percentage of complex lenses per voucher;
 - Sight tests per optician;
 - Percentage of domiciliary visits;
 - Relationship between repairs and replacements;
 - Practice protocols relating to NHS funded services provided to patients, taking into account the profile of the practice patient group; and
- 4.3 With the agreement of the relevant NHS Trust, and to avoid possible duplicate claims, a check may also be carried out on NHS Trust creditor payments in respect of Hospital Eye Services.
- 4.4 The purpose of seeking an explanation of the practice's internal control system is to confirm that:
- There are adequate procedures for recording services provided;
 - There is a satisfactory understanding and application of the provisions set out in the Ophthalmic Regulations, LHB and WAG required arrangements;
 - Systems exist to prevent errors and omissions, as far as possible, in the claims and any returns submitted to the LHB.
- 4.5 The BSC team will expect to obtain 100% verification of service provision on their sample check of practice records.
- 4.6 Where the practice records are computerised, practice staff should produce relevant information on the computer screen. There will not normally be a need to print such records.
- 4.7 The BSC team may wish to discuss with the practice their recent claims record as well as any recent changes and, if appropriate, identify reasons for the level of service being above or below the local average eg. practice demographics and specialisms.

5 CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

- 5.1 In cases involving forms GOS 1; GOS 3; GOS 4; GOS 5; and GOS 6, the patient will have already given explicit consent to the disclosure of relevant information from these forms.
- 5.2 In other cases, where it is necessary for BSC staff to access patient records in order to verify claims, access will be requested on the clear understanding that proper confidentiality safeguards are observed. All staff involved in accessing patient records will take account of the Code

of Practice on Confidentiality and Disclosure of Information introduced under WHC(2006) 16 in March 2006. Paragraphs 5.3 -5.7 below are based on the Code.

Anonymised or aggregated patient information

General

- 5.3 Wherever practicable, patient data disclosed for purposes other than the patient's care should be anonymised. Anonymised or statistical information is not confidential and may be used with relatively few constraints. *Anonymised information* is information that does not identify an individual. Anonymisation requires the removal of name, address, full postcode, date of birth, NHS number and local patient identifiable codes, and any other detail or combination of details that might support identification. *Aggregated information* is statistical information, which, if care is taken with respect to rare conditions etc, will also provide anonymity for patients.
- 5.4 In certain circumstances, contractors may need to anonymise patient records prior to disclosure. It will usually be for the person passing on the data to ensure that it is passed on in a non-identifiable form, wherever that is practical. LHBs and contractors should aim to work together to develop the capacity to generate anonymised and aggregated information. In particular, the upgrading of practice IT equipment will provide opportunities to improve this capacity.
- 5.5 There are circumstances where it will not be practicable for anonymised information to be generated in order to satisfy the purposes of third parties. This may be because there is limited capacity to anonymise information by a contractor, or where the contractor is unable to anonymise data with a reasonable degree of ease (for example because it would involve substantial additional work, or because the purpose to be satisfied requires examination of original records. Where any of these apply, care must be taken to ensure that disclosure of information is lawful.

LHBs

- 5.6 The circumstances in which the LHB, or persons authorised by the LHB, may need to access and obtain information that identifies individual patients should be limited. A decision to disclose such information to the LHB will be a matter for the contractor. However, a contractor may risk being in breach of its contract if it refuses to produce information which the LHB reasonably requires and which it has requested in accordance with the relevant requirements of the Code. The circumstances in which, in the view of the Welsh Assembly Government, patient identifiable

information would generally be reasonably required by the LHB and could lawfully be disclosed by the practice would include: -

- (i) where the practice is unable to anonymise data that is needed to support the wider functioning of the NHS, including the management of healthcare services. For example, this may be where the practice does not possess an IT system which can ensure complete anonymisation, or where it is not practicable to anonymise paper records - such as where this would require substantial additional work on the part of the practice, or where the practice cannot guarantee to erase all identifying information. The practice should make a judgement in the context of each request for information as to whether or not anonymisation is practicable. Where anonymisation is not practicable, data may be released to the LHB in patient identifiable form (but see paragraph 5.8);
- (ii) where the LHB is investigating and assuring the quality and provision of clinical care - for example, in relation to a written complaint made by, or on behalf of, a patient (whether living or dead);
- (iii) where it is needed in relation to the management of the contract or agreement – for example, where remedial action, or termination of the contract/agreement is being considered (eg. because of poor record keeping);
- (iv) where the LHB considers there is a serious risk to patient health or safety;
- (v) investigation of suspected fraud or any other potential criminal activity.

5.7 In cases where patient identifiable information is required, it will, in some circumstances, be necessary to obtain the consent of the individual concerned to disclosure (see sub section 5.1 and 5.2 above). This will depend upon the circumstances of the case. For example, consent will not be necessary to comply with the Data Protection Act or common law duties of confidentiality where the practice is unable to anonymise data and the LHB requires access to data for:

- checking legal entitlement to payments; or
- the management of healthcare services – provided that those accessing that data are bound by a duty of confidentiality not to disclose information.

Where a LHB requires access to a particular patient record for the purposes of the PPV and the practice can demonstrate that disclosure of that particular record would:

- (a) be unlawful for a reason not relating to data protection or the common law duty of confidentiality – e.g. because of a court order or another statutory requirement;
- (b) involve the disclosure of personal data relating to third parties without their consent and which cannot be removed with a reasonable degree of ease; or
- (c) a patient has explicitly requested non-disclosure of particularly sensitive aspects of their records which cannot be removed from the material to be disclosed with a reasonable degree of ease.

the practice should explain its reasons for non-disclosure to the LHB and ask the LHB to select a different record. LHBs should normally accede to such requests, unless the purpose for which the information is required would thereby be defeated. If this is the case, the issue of consent to disclosure should be further considered.

- 5.8 Where the patient's consent is not sought to identifiable information under subsection 5.7 above, the reasons why must be documented, and there must be a clear audit trail.

DATA PROTECTION ACT 1998

- 5.9 Access to data held by Practices will be carried out in accordance with the requirements of the Data Protection Act 1998, related Statutory requirements and good practice guidance from the National Assembly for Wales. Details of the Data Protection Act can be obtained at:
<http://www.hmsa.gov.uk/acts/acts1998/19980029.htm>

The main aspects of the Act considered to be relevant are that Section 29 (4) (a) (ii) and 29 (5) and also that data collection and record keeping is in order under the Second Principle of the DPA and the Post Payment Verification is possible under Section 31(1) and Section 31(2)(a)(i) having regard to Section 31(3)(a) and (c). The requirements of Paragraph 5(b) and 5(d) of Schedule 2 to the DPA and Paragraph 7(1)(b) of Schedule 3 to the DPA will also be met.

NOTICES TO PATIENTS

- 5.10 It would be good practice to display in waiting rooms or on reception desks, the Notice to Patients as given at Appendix 2.(A optional but recommended bilingual version appears as Appendix 3)

6 VISIT OUTCOMES

- 6.1 An owner or another nominated person as the case may require, will be informed of the visit outcome. BSC staff will inform the practice of any observations and where appropriate advise about the practice's systems/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. Following each visit, and normally within 28 days, the BSC will give the practice a written report. With the letter will be a letter advising that there is an opportunity, again normally within 28 days, for the contractor to comment on the BSC's findings before they are formally considered by the LHB's management. Practices are reminded that Regional/Local Optometric Committees are able to provide support and advise.

- 6.2 Follow up visits normally within six months but no later than twelve months after, may be required to confirm changes have been implemented as recommended by the LHB/BSC and accepted by the practice. Where the BSC team find discrepancies or claims that cannot be verified/validated owing to lack of evidence, additional records will normally be examined in order to establish the extent of the problem and the underlying reasons.
- 6.3 Where it is established that some claims have been submitted incorrectly or there are doubts about their validity, BSC will inform the appropriate LHB and recommend one or more of the following actions:

Action 1 Extending the sample of claims in the area of concern

Action 2 If a practice has submitted erroneous claims to the LHB, the LHB and the practice will agree, in writing, on whether there should be any repayment or other financial adjustment, including consideration of past claiming patterns and whether there is a need for extrapolation based on current findings.

In the event of an inability to agree the value of any repayment, the LHB may use either the regulatory provision for recovery of overpayments or, alternatively, pursue the matter through the civil courts.

In addition, the practice will undertake to improve systems in order to prevent repetition of the errors in future.

Where there is evidence of underclaiming the LHB will consider whether or not it is appropriate for the practice to submit amended claims for consideration of payment.

Action 3 Where the BSC staff are dissatisfied with the evidence or the explanations given in respect of errors found, the matter will be referred to the LHB, normally within 28 days, for its comments and instructions, including the need for any further enquiries. The BSC may also extend its enquiries with/to patients if it is appropriate to the type of claim under review.

If appropriate, the BSC will report its findings, along with any recommendations, normally within 28 days, back to the practice and to the LHB.

In the event that the LHB is of a view that there is a need for a recovery to take place, and without prejudice to any other action it may take, if there is an inability to agree the value of any repayment, the LHB may use either the regulatory provision for recovery of overpayments or, alternatively, pursue the matter through the civil courts.

Action 4 If there is a possibility of fraud the BSC will contact, in the first instance, the LHB's Director of Finance who will consult with the Local Counter Fraud Specialist (LCFS) to determine the most appropriate action which, depending on the circumstances may include involving the Police; External Auditors; and/or the NHS Counter Fraud Service (Wales) Team.

In the event that the LHB is of a view that there is a need for a recovery to take place, and without prejudice to any other action it may take, if there is an inability to agree the value of any repayment, the LHB may use either the regulatory provision for recovery of overpayments or, alternatively, pursue the matter through the civil courts.

7 CO-OPERATION OF PRACTICES and REPRESENTATIONS TO LHBs

- 7.1 This protocol is designed to create understanding and trust between the LHB, BSC and Optometrists and to allow the visits to be informative for all parties.
- 7.2 If a practice refuses to co-operate with the BSC by, for example, not allowing reasonable access to practice-held records within the terms of this protocol, the BSC will contact the LHB and seek its help to resolve any problems as quickly and amicably as possible. The LHB will contact the Regional/Local Optometric Committee for advice and/or assistance.
- 7.3 Where a practice is concerned about the conduct or outcome of the PPV activity which cannot be resolved with the BSC, then it may make representations etc. to the LHB's Chief Executive. Such representations should normally be in writing.

- 7.4 It is recognised that where a practice is dissatisfied with the outcome of its representations to the LHB's Chief Executive, it may consider referring the matter to the Public Services Ombudsman for Wales.

8 OPERATION OF THIS PROTOCOL

- 8.1 Enquiries concerning the interpretation or application of this protocol should be directed as indicated below:

LHB area

Bridgend	Carmarthen	Ceredigion
Neath Port Talbot	Pembrokeshire	Powys
Swansea		

Regional Head of Finance/PPV Manager
BSC Mid and West Wales Region
01792 458066

LHB area

Anglesey	Conwy	Denbighshire
Flintshire	Gwynedd	Wrexham

Regional Head of Finance/PPV Manager
BSC North Wales Region
01352 700227

LHB area

Blaenau Gwent	Caerphilly	Cardiff
Merthyr Tydfil	Monmouthshire	Newport
Rhondda Cynon Taff	Torfaen	Vale of Glamorgan

Regional Head of Finance/PPV Manager
BSC South East Wales Region
01495 332000

- 8.2 Other potentially useful contact names are shown in Appendix 4.
- 8.3 This protocol comes into use from 1 November 2006 and supersedes all previous versions.

WELSH HEALTH CIRCULAR

**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

Parc Cathays
Caerdydd CF10 3NQ

Cathays Park
Cardiff CF10 3NQ

Issue Date: 1 February 2002

Status: Action

Title: GENERAL OPHTHALMIC SERVICES: FREQUENCY OF SIGHT TESTS

For Action by:

Chief Executives - Health Authorities

Action required *See paragraph(s) : 2 and 3*

For Information to: See attached list

Sender: Mr Gerry Lynch

Primary and Community Health Division

National Assembly contact(s) : Mr Stephen Chamberlain (02920 825518)

Enclosure(s): GOS Note February 2002 and Memorandum of Understanding

Tel: 029 20825111 GTN: 1208

Linell union/Direct line: 029 20825518

Facs/Fax: 029 20

Minicom: 029 20823280

<http://cymruweb.wales.nhs.uk>

Distribution List

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Welsh Secretary	British Medical Association
Secretary	Wales TUC
Secretary to the Welsh Board	Royal College of Midwives
Secretary to the Welsh Board	Royal College of Nursing
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Secretary	British College of Optometrists
	British Orthoptic Society
Senior Industrial Relations Officer	Chartered Society of Physiotherapists
Regional Officer	Electrical & Engineering Staff Association
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Industrial Relations Officer	Society of Chiropodists & Podiatrists
Officer for Wales	Society of Radiographers
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Secretary	Union of Construction Allied Trades & Technicians
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Information Officer	Wales Council for Voluntary Action
Dean of Faculty	University of Wales Bangor
Chief Executive	Commission for Racial Equality
	Clinical Effectiveness Support Unit, Llandough
Chief Pharmaceutical Advisor	Guild of Health Care Pharmacists
Welsh Central Pharmaceutical Committee	PSNC
Welsh Executive	Royal Pharmaceutical Society
Chief Officers	Community Health Councils
Chairman	Welsh Optometric Committee
Chairman	Welsh Medical Committee
Miss R Clapperton	NAO

Dear Colleague

SUMMARY

1. **This circular gives advice on frequency of sight testing and how the box in Part 3 of the GOS1 should be brought into use from 1 January 2002. It encloses a copy of a GOS Note to optometrists and OMPs and a copy of the Memorandum of Understanding on the Frequency of NHS sight tests agreed with the profession.**

ACTION

2. Health Authorities should bring this circular to the attention of all staff dealing with general ophthalmic services; to Directors of Finance and to Local Counter Fraud Specialists.
3. Health Authorities should also distribute copies of the attached GOS Note to all optometrists and ophthalmic medical practitioners in their areas. A bulk supply for this purpose is being sent to contractor services departments.

BACKGROUND

4. Annex A to WHC(2001)18 advised at paragraph 11 that the box titled "*In the case of a retest at less than the standard interval*" on the reverse of the new version of the GOS 1 form should not be used until further notice. A Memorandum of Understanding on Frequency of sight tests has now been agreed with the profession which contains numerical codes to be entered into this box when sight tests are carried out at intervals shorter than those listed in the Memorandum.

CLINICAL JUDGEMENT

5. It is for optometrists and ophthalmic medical practitioners to decide, in the light of their assessment of the patient's eye care needs, whether a patient's sight needs to be tested. The interval at which the patient should be advised to have a subsequent sight test/eye examination is also a matter of clinical judgement. However, unnecessary NHS sight tests and NHS optical vouchers result in the misallocation of NHS funds from other areas of patient care. The coding system will inform Health Authorities of the reasons for sight tests undertaken at shorter than expected intervals whilst protecting the clinical judgement of practitioners.

THE MEMORANDUM

6. A working party comprising the College of Optometrists, the Association of Optometrists, the Federation of Ophthalmic and Dispensing Opticians and the Department of Health reviewed and reported on good practice on sight test intervals. The College has included a full version of the working party's findings in its *Code of Ethics and Guidance for Professional Conduct*. For use within the general ophthalmic services FODO, AOP and the Department have summarised the findings in the attached Memorandum.

USE OF THE MEMORANDUM

7. As the introduction indicates, where optometrists and ophthalmic medical practitioners carry out NHS sight tests at intervals equivalent to or greater than those given in paragraph 2.2 of the guidance, no entries are required at Part 3 of the form GOS 1. Where a test is undertaken at a shorter interval the practitioner should enter the appropriate code given at paragraph 3.1 of the memorandum. **Only the**

code number is required. When the forms are revised the title of the box will be amended to show that a coding system is in use.

MONITORING SCHEMES

8. There may be shared care or co-management schemes undertaken in accordance with a protocol agreed with hospital ophthalmologists and general practitioners. Since they provide for patients for whom a confirmatory diagnosis has been made in the secondary care sector, these schemes are outwith the GOS. Where such schemes are in operation, payments to practitioners should be made from hospital and community health services funds, but where refraction is required as part of the agreed protocol, a NHS sight test fee may be claimed for eligible patients

BROKEN OR LOST SPECTACLES

9. Paragraph 22 of the Annex to WHC(97) 42/FPN713 indicated how patients who had lost or broken their spectacles (and did not meet the criteria for replacement/ repair) might exert pressure on practitioners for early re-tests. In these circumstances practitioners should still determine the need for testing on the basis of clinical judgement informed by the attached guidance. Patients experiencing major hardship as a result of not having serviceable spectacles should be advised to consult the Health Authority.

MEASUREMENT OF INTERVALS BETWEEN SIGHT TESTS

10. Practitioners have to make appointments to accommodate their patients' commitments and this may result in tests conducted slightly earlier than the intervals in the annex. To give some flexibility, Health Authorities should not challenge claims for tests made within one month of these intervals.

ENQUIRIES

11. Any enquiries about the contents of this circular should be addressed to Mr Stephen Chamberlain at the above address (Tel. No 02920 825518).

WELSH LANGUAGE VERSION

12. In view of the urgency, this circular is being distributed in English only. A Welsh language version will follow as soon as it is available.

Yours sincerely

GERRY LYNCH
Primary and Community Health Division



**Cynulliad Cenedlaethol Cymru
The National Assembly for Wales**

Parc Cathays / Cathays Park
Caerdydd / Cardiff
CF10 3NQ

**To: Optometrists
Ophthalmic Medical Practitioners**

GENERAL OPHTHALMIC SERVICES

FREQUENCY OF SIGHT TESTS – MEMORANDUM OF UNDERSTANDING

SUMMARY

- 1. This circular gives advice on frequency of sight testing and how the box in Part 3 of the GOS1 should be brought into use from 1 February 2002. It encloses a copy of the Memorandum of Understanding on the Frequency of NHS Sight Tests agreed with the profession.**

ACTION

2. From 1 February 2002, optometrists and OMPs should enter the appropriate codes for any sight tests undertaken at shorter intervals than those given at paragraph 2.2 of the Memorandum.

BACKGROUND

3. Annex A to GOS Note – March 2001(2) advised at paragraph 11 that the box titled “*In the case of a retest at less than the standard interval*” on the reverse of the new version of the GOS 1 form should not be used until further notice. A Memorandum of Understanding on Frequency of sight tests has now been agreed with the profession which contains numerical codes to be entered into this box when sight tests are carried out at intervals shorter than those listed in the Memorandum.

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4. It is for optometrists and ophthalmic medical practitioner to decide, in the light of their assessment of the patient’s eye care needs, whether a patient’s sight needs to be tested. The interval at which the patient should be advised to have a subsequent sight test/eye examination is also a matter of clinical judgement. However, unnecessary NHS sight tests and NHS optical vouchers result in the misallocation of NHS funds from other areas of patient care. The coding system will inform health authorities of the reasons for sight tests undertaken at shorter than expected intervals whilst protecting the clinical judgement of practitioners.

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5. A working party comprising the College of Optometrists, the Association of Optometrists, the Federation of Ophthalmic and Dispensing Opticians and the Department of Health reviewed and reported on good practice on sight test intervals. The College has included a full version of the working party's findings in its *Code of Ethics and Guidance for Professional Conduct*. For use within the general ophthalmic services FODO, AOP and the Department have summarised the findings in the attached Memorandum.

USE OF THE MEMORANDUM

6. As the introduction indicates, where optometrists and ophthalmic medical practitioners carry out NHS sight tests at intervals equivalent to or greater than those given in paragraph 2.2 of the guidance, no entries are required at Part 3 of the form GOS 1. Where a test is undertaken at a shorter interval the practitioner should enter the appropriate code given at paragraph 3.1 of the memorandum. **Only the code number is required. When the forms are revised the title of the box will be amended to show that a coding system is in use.**

MONITORING SCHEMES

7. There may be shared care or co-management schemes undertaken in accordance with a protocol agreed with hospital ophthalmologists and general practitioners. Since they provide for patients for whom a confirmatory diagnosis has been made in the secondary care sector, these schemes are outside the GOS. Where such schemes are in operation, payments to practitioners should be made from hospital and community health services funds, but where refraction is required as part of the agreed protocol, a NHS sight test fee may be claimed for eligible patients

BROKEN OR LOST SPECTACLES

8. Paragraph 22 of the Annex to WHC(97)42/FPN713 indicated how patients who had lost or broken their spectacles (and did not meet the criteria for replacement/ repair) might exert pressure on practitioners for early re-tests. In these circumstances practitioners should still determine the need for testing on the basis of clinical judgement informed by the attached guidance. Patients experiencing major hardship as a result of not having serviceable spectacles should be advised to consult the Health Authority.

MEASUREMENT OF INTERVALS BETWEEN SIGHT TESTS

9. Practitioners may have to make appointments to accommodate their patients' commitments and this may result in tests conducted slightly earlier than the intervals in the Memorandum. To give some flexibility health authorities should not challenge claims for tests made within one month of these intervals.

ENQUIRIES

10. Any enquiries about the content of this note should be addressed to the Health Authority.

MEMORANDUM OF UNDERSTANDING

FREQUENCY OF GOS SIGHT TESTS

1. Introduction

- 1.1 This Memorandum of Understanding refers to sight tests for different categories of patients under the General Ophthalmic Services (GOS). A sight test means a test by an optometrist or an ophthalmic medical practitioner (OMP) as defined in regulations.
- 1.2 Health Authorities and payments agencies will automatically pay all *bona fide* claims for GOS fees for sight tests carried out at the intervals listed below, subject to normal post-payment verification.
- 1.3 Claims for GOS fees for sight tests carried out at an interval, which is shorter than those listed below, will be accompanied by a justification by the optometrist or OMP by means of one of the numerical codes, described below. Such a sight test may be initiated by an optometrist or OMP or by a patient who presents with a problem requiring immediate attention in the judgement of the optometrist or OMP.

2. Minimum Intervals Between Sight Tests

- 2.1 The GOS regulations require practitioners to satisfy themselves that a sight test is clinically necessary. Therefore, the intervals given below are not to be read as applying automatically to all patients in a category.
- 2.2 However, optometrists and OMPs will not normally test the sight of patients under the GOS more frequently than according to the following schedule of intervals.

Patient's Age at Time of Sight Test Minimum Interval Between Sight Tests or Clinical Condition

Under 16 years, in the absence of any binocular vision anomaly	1 year
Under 7 years with binocular vision anomaly or corrected refractive error	6 months
7 years and over and under 16 with binocular vision anomaly or rapidly progressing myopia	6 months
16 years and over and under 70 years	2 years
70 years and over	1 year
40 years and over with family history of glaucoma or with ocular hypertension and not in a monitoring scheme	1 year
Diabetic patients	1 year

3. Reasons for Earlier Sight Test

- 3.1. An optometrist or OMP may carry out a sight test at a shorter interval than those listed above, either at the practitioner's initiative for a clinical reason, or because the patient presents him/herself to the practitioner with symptoms or concerns which might be related to an eye condition.
- 3.2. If an optometrist or OMP carries out a GOS sight test at an interval shorter than one of those listed above, the practitioner must annotate the GOS 1 form with one of the following codes:
 1. Patient is at risk of frequent changes of prescription for reasons not requiring medical referral or for reasons already known to a medical practitioner.
 2. Patient has pathology likely to worsen, for example age-related macular degeneration, cataract, corneal dystrophy, or congenital anomalies.
 3. Patient has presented with symptoms or concerns requiring ophthalmic investigation
 - 3.1 resulting in referral to a medical practitioner; or
 - 3.2 resulting in issue of a changed prescription; or
 - 3.3 resulting in either no change or no referral (the patient's record should indicate any symptoms shown to support this category of claim, if necessary).
 4. Patient needing complex lenses; or
 - 4.1 with corrected vision of less than 6/60 in one eye.
 5. Patient has
 - 5.1 presented for a sight test at the request of a medical practitioner; or
 - 5.2 is being managed by an optometrist under the GOC referral rules, for example suspect visual fields on one occasion which is not confirmed on repeat, or abnormal IOP with no other significant signs of glaucoma; or
 - 5.3 identified in protocols as needing to be seen more frequently because of risk factors.
 6. Other unusual circumstances requiring clinical investigation

Appendix 2

IMPORTANT NOTICE TO PATIENTS

PLEASE NOTE THAT AS IN MANY OTHER AREAS OF ACTIVITY FUNDED FROM THE PUBLIC PURSE, THE NATIONAL HEALTH SERVICE IN WALES REQUIRES ALL PRACTICES TO ENABLE ACCESS TO RECORDS HELD HERE TO ENSURE THAT THE PAYMENTS IT MAKES ON BEHALF OF TAX PAYERS TO US ARE ACCURATE.

THE NATIONAL HEALTH SERVICE CARRIES OUT PERIODIC CHECKS ON OCCASIONS AND ACCESSES DATA FROM RECORDS HELD HERE TO DISCHARGE ITS RESPONSIBILITIES. THE ACCESS IS CARRIED OUT IN ACCORDANCE WITH THE DATA PROTECTION ACT 1998, RELATED STATUTORY REQUIREMENTS AND GOOD PRACTICE GUIDANCE FROM THE WELSH ASSEMBLY GOVERNMENT. ALL MEMBERS OF NHS STAFF INVOLVED HAVE SIGNED A CONFIDENTIALITY AGREEMENT COVERING PATIENT AND PERSONAL INFORMATION.

ANY ENQUIRIES ON THE INFORMATION GIVEN IN THIS NOTICE SHOULD BE MADE TO YOUR LOCAL HEALTH BOARD. RECEPTION STAFF WILL BE ABLE TO GIVE YOU APPROPRIATE CONTACT DETAILS.



Appendix 3

Welsh Language Version of Appendix 2**HYSBYSIAD PWYSIG I GLEIFION**

NODWCH, FEL SY'N WIR AM NIFER O FEYSYDD GWEITHGAREDD ERAILL A ARIENNIR GAN ARIAN CYHOEDDUS, BOD Y GWASANAETH IECHYD GWLADOL YNG NGHYMURU YN EI GWNEUD YN OFYNNOL I'R HOLL BRACTISAU GANIATÁU MYNEDIAD I'R COFNODION A DDELIR YMA ER MWYN SICRHAU BOD Y TALIADAU A WNA AR RAN TRETHDALWYR YN GYWIR.

MAE'R GWASANAETH IECHYD GWLADOL YN CYNNAL GWIRIADAU CYFNODOL YN ACHLYSUROL AC YN EDRYCH AR DDATA O GOFNODION A DDELIR YMA ER MWYN CYFLAWNI EI GYFRIFOLDEBAU. GWNEIR HYN YN UNOL Â DEDDF DIOGELU DATA 1998, GOFYNION STATUDOL CYSYLLTIEDIG A CHANLLAW ARFER DA LLYWODRAETH CYNULLIAD CYMRU. MAE POB AELOD O STAFF Y GIG SYDD YNGHLWM Â HYN WEDI ARWYDDO CYTUNDEB CYFRINACHEDD SY'N CWMPASU GWYBODAETH AM GLEIFION A GWYBODAETH BERSONOL.

OS OES GENNYCH UNRHYW YMHOLIADAU AM Y WYBODAETH A RODDIR YN YR HYSBYSIAD HWN, DYLECH GYSYLLTU Â'CH BWRDD IECHYD LLEOL. GALL STAFF Y DDERBYNFA ROI'R MANYLION CYSWLLT PERTHNASOL I CHI.



Appendix 4

Useful Contact Details

<u>Organisation</u>	<u>Name and position</u>	<u>Contacts details</u>
South East Wales Regional Optometric Committee (SEWROC)	Helen Tilley Chairman	The Old Victoria Llandenny Nr Usk Tel e-mail helen@phtilley.freeseve.co.uk
South West Wales Regional Optometric Committee (SWWROC)	David Jenkins Chairman	17 Station Road Ystradgynlais Swansea SA9 1NT e-mail david_r_Jenkins@talk21.com
North Wales Regional Optometric Committee (NWWROC)	R H Gray Morris Chairman	6, William Street, Holyhead, Anglesey, North Wales. LL65 1RN Tel: 01407 762332
Federation of Opticians and Dispensing Opticians (FODO)	David Hewlett Chief Executive	199, Gloucester Terrace, London. W2 6LD e-mail admin@fodo.com
Association of Optometrists (AOP)	Fiona Mitchell Head of Legal Services	61, Southwark Street, London SE1 0HL e-mail fionamitchell@aop.org.uk

Association of Optometrists (AOP)	Richard Carswell Head of Public Affairs	61, Southwark Street, London SE1 0HL Tel 020 7207 2193 e-mail richardcarswell@aop.org.uk
Association of Dispensing Opticians (ABDO)	Sir Tony Garrett Chief Executive	199, Gloucester Terrace, London. W2 6LD e-mail general@abdolondon.org.uk
Welsh Optical Committee	Mervyn Hansford Chairman	Hill Grange, The Uplands, Newbridge, Gwent NP11 3RH 01495 243195 (eve) e-mail lynandmerv@enterprise.net
Optometry Wales	Michael Charlton Chairman	Gwelfor, Castle Morris, Haverfordwest Pembrokeshire 01348 873234 (day) 01348 891209 (eve) e-mail mncharlton@aol.com