AISMA Doctor Newsline

A helpful resource for the practice business

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Fraud

Watch out – there's a lot of fraud about!

Fraudsters are finding new methods to target GP practices. **Ian Crompton** warns about what you and your staff need to be on the lookout for

GP practices, as with many other businesses, need to maintain a high level of vigilance in order to spot fraudsters who continue to develop new, increasingly sophisticated tactics to steal their funds.

This is particularly the case with cyber fraud attacks where criminals can easily hide their identity from unsuspecting victims.

Ransomware and cyber extortion are both relatively recent types of fraud seen targeting medical practices.

Ransomware

This is a type of malicious software, known as malware, which blocks or restricts access to the infected computer system.

Fraudsters usually infect a victim's PC by encrypting files on the system's hard drive and then threatening that the user will not be able to access their data again unless a ransom is paid.

The files will be almost impossible to decrypt without paying the ransom for the encryption key and this forces many victims into paying the ransom to

the fraudster, usually in bitcoins which are difficult to trace.

Cyber extortion

This is a crime which occurs when a fraudster issues a threat and demand via online methods to a potential victim.

As with ransomware, the demand is usually aimed at forcing a payment to the fraudster in bitcoins or they will carry out their threat.

Threats can vary but may include fraudsters leaking confidential data obtained from the victim's PC out on to the Internet, or they could threaten to post thousands of negative comments about the victim's business using online review sites, causing reputational damage.

GP practices should protect themselves against these types of fraud by:

- Ensuring they have a good quality anti-virus software suite, which is scanned and updated regularly
- Carrying out operating system updates as soon as they become available
- Promoting awareness amongst practice staff to ensure they think before they click on unknown links
- Considering where their data resides. Ransomware is usually restricted to local hard drives or locally available shared drives. Information assets should therefore be held in at least two totally separated locations, such as a portable hard disk for daily backups of important data, and an additional network-attached storage for larger backups
- Retaining the original cyber extortion emails, with headers. Maintain a timeline of the attack, recording all times, type and content of the contact and report it to Action Fraud (see opposite).

Of course, it is still important to be alert to the other common fraud scams known to target the healthcare sector, including:

Invoice fraud

This is where a fraudster sends an email or letter which appears to have been sent by a known supplier to the practice, asking them to make future payments into a new account number. If the request is not verified to make sure it is genuine, the next payment could go to the fraudster.

CEO fraud

This is the name given to the scam where fraudsters hack into or imitate the email account of a senior person within the practice and send an email to a member of the practice staff asking for an urgent and often highly confidential payment to be made.

If the member of staff does not independently verify that the email is genuine, funds will be sent to the account details supplied in the fraudulent email.

All fraud targeting your medical practice, even if it has been prevented, should be reported to www.actionfraud.police.uk

For more information visit the Lloyds Bank website to review our online fraud guidance brochure. **http://bit.ly/295p6Lw**

Ian Crompton is UK head of healthcare banking services, SME Banking, Lloyds Bank

ESSENTIAL TIPS
for you and your staff

- Never divulge online banking passwords or online banking secure codes to anyone on the telephone, even if you think you are talking to the bank
- Do not rely on your phone's caller display to identify a caller. Fraudsters can make your phone's incoming display show a genuine number
- Be aware that a bank will never call you and tell you to transfer your money to a 'safe' account
- If you see unusual screens or pop-up boxes when using your online banking or unusual requests to enter bank passwords, log out immediately and call your bank
- If possible, set up your online banking so that two separate people are required to make any payments

OPINION

Be prepared to make the most of meeting your accountant

Chris Howe*, AISMA committee member

If you have a March accounting year end, as many GP practices do, a meeting with your specialist accountant may be scheduled for some time in the next few weeks.

This is your opportunity to gain useful insights into practice finances and your personal financial position, so you should be well prepared to make the most from the consultation.

Your own interest in the meeting may include some or all of the following:

- practice performance
- estimates of your tax bill
- cash-flow and bonus pay-outs
- discussion of pension tax implications
- published earnings statements
- retirement
- recruitment, or
- even your own lifetime cash-flow forecast.

From a practice performance perspective, you may compare your partner profits with the previous year and ascertain reasons for changes.

Or you could study your own statistics against national profiles such as those derived from the AISMA client survey.

From a tax viewpoint, if your profit share has held up under the current financial pressures, then your July tax bill may be no surprise because it is in line with estimates given to you many months ago.

But if partner profits have dipped then there may be time to reduce your July tax bill to a more appropriate level.

New partners may be given guidance on how their tax bills will pan out over the next 18 months, taking account of the odd rules that apply under self-assessment. Retiring partners may require a forecast of the timing of their final tax bills.

The accounts should summarise partner current accounts, showing partners' 'paper' profits, and the balance remaining after deductions for superannuation, tax (if paid by the practice) and drawings.

If a drawings forecast was prepared, hopefully partners' balances are roughly equivalent and in proportion to profit shares. If the drawings forecast was prudent, and performance has been as expected, then a bonus drawing may be available when the practice cash-flow allows.

Pension taxes are an increasing problem for many GPs, with the reduction of the Annual Allowance to £40,000, the fall in the Lifetime Allowance to £1 million, and for high earners, the tapering of the Annual Allowance down to a paltry £10,000.

Your tax advisor may give guidance about the impact of these recent levies, albeit with rough estimates owing to the complexity of the calculations.

These additional taxes are so onerous for some high earning GPs that calculations have demonstrated that a reduction in time commitment from 100% to 75% might only see a drawings reduction of 5-10%.

If you have spent additional time on personal finance over the years with your accountant and financial advisor then you may benefit from an individual meeting to review your lifetime cash-flow forecast.

For those worried about retirement, or funding offspring through education and later life, this may well allay any fears and even demonstrate that you are unlikely to ever be able to spend all your funds. Of course, then inheritance tax may appear as a topic of discussion.

Your accountant will be well prepared – as Tom Stoppard said: 'My whole life is waiting for the questions to which I have prepared answers' - but time may run out before the next surgery session commences. So do come well prepared and you will leave more knowledgeable.

Seize your chance to get one step ahead

GPs and practice managers need to act on an important NHS policy document so they can turn it to advantage for their practices. **Deborah Wood**** casts an accountant's financial eye over the *General Practice Forward View*

Over the last decade investment in secondary care specialists has grown three times faster than investment in GPs in primary care. Now, at last, the NHS seems to have recognised that this imbalance needs redressing.

NHS England's *General Practice Forward View* document, published in April 2016, sets out practical ways for this to be dealt with over the next five years and includes information on additional funding for investment in staff, technology, premises, indemnity, bureaucracy and care redesign.

The aim of the support package is to reinvent the clinical model, the career model and the business model to reinvigorate general practice.

Keeping general practice at the core of patient-centred, co-ordinated, high-quality community care that encompasses the complexity of acute, long-term, mental and social care is the goal.

The GP's role will be to lead multi-disciplinary teams linking hospital, community and social care professionals to provide co-ordinated care for their patient list. This is likely to be in a networked, collaborative environment in which specialisms can thrive.

Greater use of technology will also be a key component for making these ideas work.

GPs and practice managers need to be abreast

of what is in the document so that they can consider what is available to their own practices at a local level.

Investment

£2.4 billion a year to 2020-21 is on the table, which represents a 14% real terms increase. For 2016-17 this means that an additional £322m is allocated into primary care.

In addition there will be a Sustainability and Transformation package of £508m over five years to support struggling practices, develop the workforce and stimulate care redesign.

Each area in England had to produce a plan to secure and support general practice by July 2016. This funding includes £56m for a practice resilience programme starting in 2016-17, £206m to grow the workforce, and £246m for service redesign.

The practice funding formula will be recalculated in the summer of 2016 to reflect workload, deprivation and rurality issues. PMS reviews are being phased in over a minimum of four years requiring a published reinvestment plan for local savings before full implementation.

Proposals to find ways to tackle the high cost of indemnity for GPs are being developed from July 2016.

From April 2016 CCGs, local authorities and NHS England are able to pool their Better Care Fund budgets to jointly commission services including nurses in GP settings to provide a co-ordination role for patients with long term conditions; GPs providing services in care/nursing homes; providing mental health care professionals in a GP setting and hosting social workers in GP surgeries.

Workforce

Ambitious targets have been set by NHS England together with Health Education England to double the rate of additional doctors coming into general practice over the next five years. This means an increase in GP training recruitment to 3,250 a year to support 5,000 new GPs by 2020. As I write, there has been a 70% take up of places for 2016-17.

There are bursaries of up to £20,000 available to attract 109 GP trainees into under-doctored areas and a national induction and refresher scheme offers a £2,300 a month bursary during the supervised period for returners.

In addition to trying to attract new and returning doctors into general practice there will be:

- investment in 3,000 additional mental health therapists
- existing investment in clinical pharmacist positions to be increased to expand the programme by a further 1,500 pharmacists in general practice by 2020,
- £15m investment in training capacity in general practice for nurses
- £45m to support training for reception/clerical staff
- 1,000 physician associates to be trained
- pilots for medical assistant roles
- £6m for practice manager development and
- £3.5m for multi-disciplinary training hubs.

And there is also £16m on top of the £3.5m previously announced to be invested in specialist mental health services to support GPs themselves who are suffering from stress and burnout.

Workload

Research suggests that workload in general practice has increased by 2.5% a year since 2007-08, with 27% of GP appointments potentially avoidable.

A £30m development programme 'Releasing time for patients' will facilitate patients to self-manage their illness and practices to support people with long-term conditions to self-care and influence the involvement of community pharmacy.

There will be some tightening up of legal matters in NHS Standard Contracts to help prevent workload shifting inappropriately from secondary to primary care with CCGs responsible for monitoring this.

Pilot sites are operating better communication methods between GPs and consultants to access advice and minimise referrals. Use of IT systems that simplify the process for new care plans are to be actioned for 2017-18.

In addition, £40m of additional funding over four years is available for practice resilience plans.

BMA roadshows have provided advice on 10 actions to create capacity.

On the back of CQC inspections to date, 87% of practices have been found to be good or outstanding so five yearly reviews are to be instigated. Along with professional indemnity fees, CQC registration fee increases are reflected in the annual Review Body pay award.

QOF is to be reviewed and it is likely that the unplanned admissions enhanced service will cease at 31 March 2017.

GP practice data collection and payment systems are to be simplified. CQRS data can be entered manually to avoid cash flow problems. The payment systems providers will be expected to improve their accuracy and to develop a payment

claim/reconciliation tool.

Computerised paperless systems and integration across NHS organisations is also moving forward.

Various initiatives are in place to create best practice guidelines for practice workload/appointment management. Interaction with social prescribing and the Fit for Work campaign is intended to reduce the burden on GP practices.

Practice infrastructure

£900m is included within the overall investment funds for capital investment over the next five years. New rules are being created to enable NHS England to fund up to 100% of premises development from September 2016 (currently 66%).

Practices that are tenants of NHS Property Services will be encouraged to sign new leases from May 2016 to October 2017 and their stamp duty land tax costs will be funded.

Transitional funding for practices seeing significant increases in facilities management costs within leases held by NHS Property Services or Community Health Partnerships will be available from 1 May 2016 to 31 October 2017.

CCGs will be allocated an 18% increase in funding for IT services and technology for general practice.

Online access for patients, online consultations, an approved medical apps library, Wi-Fi in practices, and communication improvements are all being funded via a £45m national programme.

Care redesign

This will include integration of extended access with out of hours and urgent care services involving reformation of the 111 service to ensure there is sufficient access at evenings and weekends and working at scale through access hubs.

The new Multispeciality Community Provider Contract is being developed for April 2017 to create a new clinical and business model based on the patient list. Funding will be for the whole population budget and for the full service range.

Working at scale is encouraged to develop economies of scale, quality improvements, assist with workforce development and redesign delivery of care services.

Federation systems are envisaged to provide resilience by sharing back-office functions and pools of staff.

Overview

The *General Practice Forward View* certainly contains a lot of useful ideas about how to improve the current situation for general practice. There is a mixture of new funding and redeployment of existing funding together with best practice guidelines which should all help.

Practices need to get close to their CCGs and check out the plans for how the various investment funds will be allocated to ensure they are getting access to their fair share.

There is a clear need to do something different in general practice but is the five year turnaround time achievable or too ambitious? Is there enough fighting spirit left amongst the GP leaders to roll their sleeves up and make it work? Will all the parties collaborate together sufficiently quickly to make change happen?

It is incumbent upon the GPC and RCGP together with CCGs and member practices to steer the implementation process effectively to ensure that general practice continues to be fully sustained, not just for the next five years, but also for the next generation.

AISMA Doctor Newsline is published by the Association of Independent Specialist Medical Accountants, a national network of specialist accountancy firms providing expert advice to medical practices throughout the UK. www.aisma.org.uk

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Take another look at your recruitment policy

We all know it is tough out there if you are trying to recruit a new GP to your practice. So try and think outside the box. **Fiona Dalziel** gives her tips

The publication in April of NHS England's *General Practice Forward View*, with its promise of an extra £2.4 billion for the country's general practice will - at the very least - make practices feel someone out there is listening.

But although general practice in Wales is also to receive more, the same cannot yet be said for Scotland or Northern Ireland and the impact will take time to work through.

Our difficulties will not be solved overnight. So what strategies can practices put in place to try to weather the recruitment storm?

It is often said that, in a crisis, planning is a waste of time; all we can do is firefight.

Indeed for many GPs and, increasingly now for whole practices, last ditch attempts to hold the burning edifice together have resulted in GP partners retiring early or taking salaried posts or

practices closing.

As someone said, we cannot knit GPs. Many practices are already working with fewer GPs and introducing new colleagues into the team. How can having a plan help with this?

Plan A, Plan B, Plan C

Take some time out as far ahead as possible to agree what your ideal would be, then agree what you could live with, and finally agree what might fill at least some of the gap if neither of these happens.

Under time pressure, these decisions are harder to make and disagreements can arise about direction of travel.

Looking at value for money

When considering your options for replacing a GP, especially a partner, think about the relative value to the practice of different professionals.

It may be helpful to draw up a table so that you can compare the following elements:

- How many appointments will we lose when we have the vacancy?
- What other work will need to be covered, either by the replacement or by being shared out among those remaining? This will include house calls, triage, referrals, signing prescriptions and other responsibilities such as looking after a QOF area. Not all professionals being recruited as an alternative to a GP will be able to do all of these. Identify which professionals could do which tasks.
- What are the competencies of different professionals, at what grade? For instance, who might be able to do some house calls, who might be able to prescribe? What must they be able to do as a minimum?
- What clinics or clinical areas such as hypertension or family planning might they be able to take over, perhaps to free up nurse practitioner or GP time?
- How many appointments might different professionals be able to offer? Not all will be able to consult at 10 minutes and certainly none will cover the ground that a GP does in the time.
- What would be the annual cost, including employer's national insurance and pension scheme contributions, of each option?
- What about professional regulation and indemnity?

Prioritising your options

Working through the above comparisons will help clarify Plan A, Plan B and Plan C. It may be that you feel that the range of services provided by a physician associate will work best in your practice and that you would not feel the loss of an ability to prescribe.

Alternatively, a pharmacist might feel like a more useful option and, indeed, many areas now offer salary subsidy schemes for pharmacists making them good value for money as long as the subsidy continues.

Have an awareness of the relative availability of your chosen options as well. In some areas, they are all in short supply, including trained nurse practitioners.

This will also influence your decision about what pay to offer; employing a nurse practitioner with no actual general practice experience will mean a period of training but a lower starting salary.

Competing with several local practices for the only experienced nurse practitioner available may make you consider increasing your offer.

At this stage, it will also be useful to recalculate partners' shares, if relevant. If you are losing a partner and unable to replace them then although salary costs will increase, drawings could rise as well. And so it may help to see how many non-GP professionals you can employ for the cost of a partner.

Putting it in place

If you have managed to employ a GP - congratulations! Little reorganisation may be needed. The employment for the first time of one or more of the alternative professions may mean you will need to reorganise workload and consider signposting patients to your new team member.

Fiona Dalziel runs DL Practice Management Consultancy

Maximise your income for personally administered items

Many practices are losing thousands of pounds a year by not getting the full income they are due for Personally Administered Items. **Tracy Hole** demystifies this complex process and provides hints and tips to help surgeries maximise their income

Complex processes involved in purchasing and managing Personally Administered Items (PAIs), and then claiming for them from Prescription Services (formally the PPA) means it is extremely difficult for GP practices to know if they are maximising their income.

Practices submit their FP34D returns each month based on the prescriptions raised, but it is very difficult to know what is claimable and whether all the eligible items used have been given a prescription.

Often claimable items are not included because it is thought that it is not worth raising the paperwork, or the items are not bought at all because of concerns over their high cost - for example cancer drugs.

And not filling in the forms correctly can cost the surgery money through reduced dispensing fees.

All of these issues can compound together to create a significant shortfall in income for many GPs.

So here are our simple tips that can help make a big difference:

1 Make sure you know what is claimable

You can claim for:

- Vaccines, anaesthetics, injections
- Pessaries
- IUCDs (including diaphragms)
- Diagnostic Reagents
- Sutures, but not all are claimable – check carefully

You can find the list of claimable items at www.dmd.medicines.org.uk

2 Conduct an end-to-end review

Once you know what to look for, go through your historic invoices to quantify all the PAIs you buy and compare this with the prescriptions raised and income received. This will tell you how much income you have under-claimed.

3 Ensure everyone knows what is claimable

- Choose someone to maintain an end-to-end view
- Communicate the list of items to clinicians
- Identify claimable items when they are ordered and then track them through the surgery using visual cues and signs to remind everyone.

4 Raise prescriptions for every claimable item

Do this no matter how low the cost as the dispensing fees quickly add up – see table on the following page.

5 Purchase cancer drugs, rather than issuing a prescription to the patient

Drugs such as Zoladex, Prostap and Decapapyl will earn the practice a profit of around £170 per patient per year. For example, a 6,000 patient surgery will have around six patients, resulting in a profit of over £1,000.

6 Ensure nothing is missed on the FP34D

When raising the FP34D, check the list of prescriptions against the list of items purchased and used. If there is a big difference each month, then this means that prescriptions have not been raised so further communications and training may be required.

Items often not claimed

Item	Refund Price	Income /item	Income /pack
Minims tetracaine 20pk	£0.51	£2.79	£55.89
Revaxis each	£6.50	£9.76	£9.76
Sutures W320 12pk	£1.18	£3.58	£42.96
Steri-strips 6x75 12pk	£0.73	£3.05	£36.63
Emla cream 5g tube each	£2.25	£4.82	£4.82
Instillagel 11ml 10pk	£1.58	£4.04	£40.35

7 Ensure you get the full dispensing fee for every item

The dispensing fee is reduced when more than 455 items are allocated to one GP in any one month. Therefore during the flu season enter 'Influenza' separately for each responsible GP and ensure no one GP has more than 455 items.

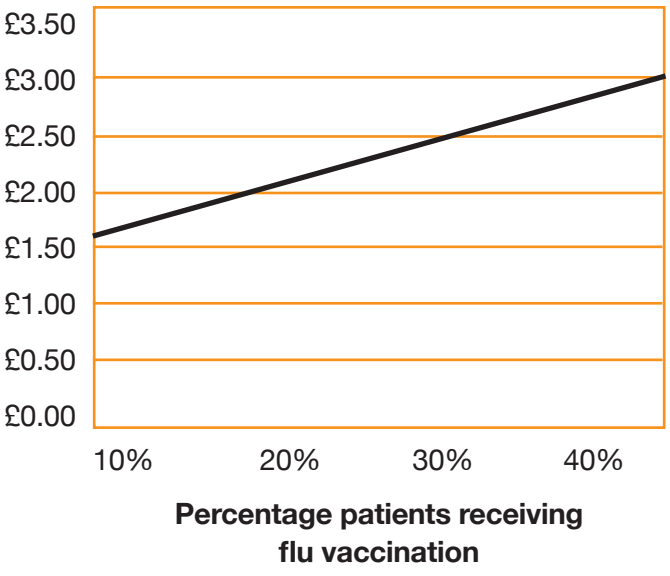
8 Check your Open Exeter payment

Keep a record of claims and the income you expect to receive. Check the payments for individual GPs. Log in to Open Exeter and go to 'Drug Payments'

9 Work with your accountant to understand your PAI profit

The Surgery Network has developed a 'PPA Health Check' (for non-dispensing practices). Using the graph below, look up your 'Target PAI profit per patient'. Then speak to your accountant to obtain the actual PAI profit from your accounts and compare the two. If there is a significant shortfall then you should investigate further.

Target PAI profit per patient (2015/16)



How The Surgery Network can help

We have developed a business platform to streamline purchasing, stock management and reclaiming processes. As well as providing the lowest prices available, our system identifies all the claimable items, and PAI reimbursement tools enable the quantity purchased and used to be tracked monthly.

We also offer a two hour workshop that will provide all the information you need to maximise reimbursement income.

Practices are successfully getting back their money. The manager of an 11,000 patient practice told us our PPA claims course proved to be extremely useful as a reconciliation we suggested enabled over £5,000 of claims that had been missed throughout the year to be tracked down.

Recently a detailed review of a 12,000 patient practice identified over £10,000 a year of unclaimed PAI income. Steps were taken to give an immediate improvement in income including:

- Simple visual cues introduced to make it easy for clinicians to know what is claimable
- Improved clinical system templates
- Implementation of our business platform to enable PAI orders to be reconciled with the monthly FP34D claim.

** Tracy Hole, a former GP practice manager, is a director of The Surgery Network who are dedicated to helping surgeries improve their business performance through cost savings, efficiency improvements and increased revenue. 01722 580085 info@surgerynetwork.org* **www.surgerynetwork.org**