HSJ LOCAL briefing

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THE CONTINUING CARE CLAIMS DELUGE

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

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In brief

Issue The Department of Health set a deadline of 30 September 2012 for anyone wanting to claim backdated NHS continuing healthcare funding for care received between 2004 and 2011. As a result, England's 151 primary care trusts have been "deluged" with around 60,000 claims.

Context The deluge creates a significant cost pressure for PCTs in a financial year in which they are scrambling to get their finances in order, ahead of the April 2013 handover to clinical commissioning groups under the government's NHS reforms. Commissioning groups are anxious that if PCTs are not able to make full provision for their continuing care liabilities then CCGs could be forced to pick up the tab.

OutcomeSome PCTs will need loans or bailouts from their neighbours to meet continuing care liabilities and avoid deficit in 2012-13. CCGs will continue to press for assurances that national funds will be set aside to cover retrospective continuing care liabilities for which PCTs have not been able to make provision. The NHS Commissioning Board says the DH is currently "working to find a solution" to such cases, but the department says no decisions have yet been taken.

Background

Last March, the Department of Health set a deadline for anyone who wanted to make a retrospective claim for NHS continuing healthcare funding. Continuing healthcare packages cover the full cost of a person's ongoing out-of-hospital care – for example, services from a care home, community nurse or specialist therapist – provided their primary need for that care is deemed to be a "health need". Retrospective claims can be made by people who have in the past paid for care that was eligible for NHS funding.

The department announced that anyone who wanted to claim for care received between 2004-05 and 2010-11 would have to do so by 30 September 2012. It also set a second cut-off date – of 31 March this year – for anyone wanting to make a retrospective claim dating from after 1 April 2011.

Deluged with claims

The effect of the first deadline was, in the words of one primary care trust finance director, that PCTs were "deluged with claims".

According to a DH spokeswoman, England's 151 PCTs have received approximately 60,000 requests to date, although she adds that the department does "not know yet how many of these requests will go forward to full assessment".

For PCTs, scrambling to get their finances in order ahead of their abolition at the end of the financial year, this has created two problems. The first is the huge task of attempting to go through enough of these claims to get a reasonable assessment of their liability by the end of the financial year.

The second is finding the money to pay for them – a cost that, for some PCTs, is expected to run to eight-figure sums. There is little doubt that some will be feeling this pressure particularly acutely in a financial year when there is a strong expectation that no PCT should record a deficit: under the government's health reforms, deficits incurred by PCTs in 2012-13 will be passed to the new clinical commissioning groups which succeed them.

However, HSJ understands that the situation has also created widespread anxiety among CCGs. This is ironic, because the commissioning sources HSJ spoke to for this article all believed the DH's purpose in setting deadlines for backdated claims was to ensure a clean financial slate for the new commissioners when they took over in April. (When NHS chief executive Sir David Nicholson announced the cut-off dates, he wrote that it was "considered timely to introduce these changes in order that at the point of handover to CCGs, we have set clear deadlines for historical cases requiring assessment of eligibility".)

The anxiety arises because if PCTs cannot get a full picture of their liability by the end of the financial year, they may not be able to make adequate provision for it in their accounts. The CCGs' fear is that this will leave them having to pick up the tab.

The cost

HSJ surveyed the latest finance reports of around half the country's PCTs, finding 28 that provided estimates of the likely cost of the continuing care restitution claims they had received. These estimates ranged from £500,000 for NHS Heywood, Middleton and Rochdale, in Greater Manchester, to £14m for NHS Lincolnshire, which covers a population roughly three times as large. The total estimated costs for the 28 PCTs were £119m. Using these estimates to derive an average cost per weighted head of population would suggest a total cost across England in excess of £600m.

This is at best a very rough guess. Partly because the sample HSJ found had disproportionately large numbers of PCTs from certain areas, notably the North West and London, and also because many of the reports stated that their estimates were based on detailed analysis of only a small proportion of the claims received. PCT finance sources told HSJ that commissioners were basing their estimates on a range of assumptions.

However, it is already clear that the cost pressure will have a significant impact in some areas, particularly those where commissioners are already under financial strain.HSJ found a number of areas where commissioners had concluded they would only be able to make the necessary provisions continuing care claims with the help of loans or bailouts from neighbouring PCTs.

For example, the north west London cluster of PCTs' latest finance report shows that eight months into the financial year Hillingdon was £7.5m in deficit, due to higher than planned activity at its local acute hospital and failure to meet the PCT's quality, innovation productivity and prevention (QIPP) savings targets.

But the report adds that without external support, Hillingdon's deficit for the full year would be £22m, after the commissioner had made "provision for continuing care retrospective claims" and met "other non-recurrent costs, including transition costs due to the PCT closedown".

To cover this £22m gap, Hillingdon plans to take a £15m loan from nearby Brent, which it is expected that Hillingdon CCG will have to pay back over three years. The remaining £6.2m will be covered "on a non-repayable basis" from the 2 per cent of NHS North West London's allocation that was "topsliced" by strategic health authority NHS London in 2012-13 to be used for non-recurrent expenditure.

Likewise, the same report notes that Hounslow is showing a year-to-date deficit of £3.2m. The PCT continues to forecast breakeven for the year, but this forecast includes "£1.2m of assumed [external] support

HSJ LOCAL briefing

hsj.co.uk/briefing February 2013

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to address the continuing care risk". The report notes that if Hounslow's provision for continuing care claims is excluded, the PCT "is able to deliver financial balance in the likely case".

The south east London PCT cluster's latest finance report shows that eight months into the financial year the cluster estimated it would have to make a provision of £17.5m to cover the retrospective continuing care claims it had received. This has placed particular strain on Bexley Care Trust, which is forecast to be liable for £4.7m of those costs.

The report shows that by the end of November Bexley had only made provision for £2.5m of those costs, but that as a result it had cut its forecast surplus for the year from £3.5m to £1.8m. The report said that the full provision would be made in the following finance report, at which stage "conclusions will be reached" on how Bexley would fund this provision, and on the impact this would have on its bottom line for 2012-13.

The difficulty of making an accurate assessment of the impact is compounded by the fact that there is another deadline, for more recent retrospective claims, that falls on the last day of the financial year. NHS Greater Manchester's finance report states: "There is a second deadline of 31 March 2013 for submitting claims which relate to this financial year. It is not yet known what volume of additional claims will be received. There is a risk that significant claims at 31 March 2013 could affect achievement of target surpluses."

Even in areas where PCTs are confident they can meet the costs of continuing care claims internally, without any impact on their bottom line, there is clearly an opportunity cost to clearing the backlog at this point. This is because continuing care will eat up a significant chunk of the money available for one-off expenditure in 2012-13.

As one PCT cluster finance director put it to HSJ: "There's an opportunity cost, because had we not been drawing a line under continuing healthcare this year, this money would probably have pump-primed innovation and change elsewhere in the [health] system."

That is clearly significant at a point when the NHS is halfway through a four-year £20bn savings drive, in which savings are expected to come from introducing more efficient models of healthcare delivery.

However, the cluster finance director added: "It's probably a good thing for CCGs that the Department of Health has done this, because we're clearing out a backlog here. If they hadn't done this now, at some point those claims would have come forward in the future, and they would have come forward when CCGs were in place – and CCGs would have picked up the costs."

An inherited debt?

That view has been disputed by some CCG leaders. Their fear is that, far from clearing the decks for CCGs before they took control, the policy may have landed them with a major cost pressure.

The reason for this anxiety is essentially an accounting problem. As it was explained to HSJ by PCT finance directors, the issue hinges on how thoroughly PCTs are able to assess their liability for the thousands of claims they have received before their organisations are wound up at the end of the financial year.

If a PCT is able to persuade their auditors that they have made a robust assessment of how many claims will be successful and their likely cost, it can make a provision for them in its accounts: essentially, it can set aside money from this year to pay for them. Its successor CCGs would therefore inherit the liability, but also the funds to cover it.

If, however, the PCT's auditors are not persuaded that the commissioner has made a rigorous assessment of the likely costs, then they may insist that these costs are set down in the accounts as a "contingent liability".

Put simply, this is a note in the accounts saying the commissioner may be liable for a given sum from retrospective continuing care claims. If the costs are recorded as a contingent liability, the PCT cannot set aside a provision to pay for them.

"The problem is that the vast majority will not be estimated before the PCTs are wound up," one CCG chief officer, the equivalent of a chief executive, told HSJ.

"My concern is that they've essentially brought forward the liability by encouraging people to put in claims that would otherwise have come in dribs and drabs – they've concentrated the problem into a much more compacted timescale. The majority of those contingent liabilities will become payable in 2013-14 and 2014-15 as we work through the claims. In effect that's giving us an immediate cost pressure right at the beginning of our journey as CCGs."

If the intention of setting a deadline for backlog claims was to give CCGs a "clean slate", he added, the effect "has been exactly the opposite of what was intended".

There seems to be a consensus that at least a significant proportion of continuing care claims will be set down as contingent liabilities. One PCT finance director from the south of England told HSJ: "Even with their best efforts, there's still going to be a high level of claims counted as contingent liabilities rather than provisions. There just isn't enough time left to do the work before the end of the year."

Views are split, however, about what that will mean for CCGs. Some argue that the department or the NHS Commissioning Board will have to find a way to set aside money to cover contingent liabilities which would otherwise be problematic for CCGs.

"I'm confident that the centre will not allow CCGs to be landed with a massive problem with continuing care claims," the southern PCT finance director told HSJ. "If it becomes a problem they will have to resolve it because it would look so bad." CCGs have in the past been assured they will not be expected to pick up PCTs' historic debts.

However, the CCG chief officer told HSJ that his and other commissioning groups had raised the issue with the DH and the commissioning board and had not yet received any assurance about whether there would be a "national solution". He added: "Unless they're going to make a special provision in our budgets for this, it seems to me that the only way to deal with it is to set aside some money nationally to absorb these [additional] costs.

"I've spoken to dozens of CCG leaders about this, and the vast majority of them share these concerns."

A commissioning board spokesman told HSJ: "PCTs are in the process of providing contingency for all of the backdated continuing care claims. If they are unable to do this the Department of Health is currently working to find a solution."

The DH's spokeswoman told HSJ it was "working with PCTs and SHAs to handle the process". She added: "This includes looking at the financial management implications and what happens after the transition to CCGs. The work is ongoing and no decisions have been made yet."