

Factsheet 10

Paying for permanent residential care

April 2019

About this factsheet

This factsheet has information about the financial help that may be available from the local authority if you need care in a care home. It also covers arranging and paying for care yourself.

You may find it helpful to read other Age UK factsheets on residential care funding and social care service provision, and on free NHS continuing healthcare, which may involve residential care provision.

The information in this factsheet is correct for the period April 2019 – March 2020. Benefit rates are reviewed annually and take effect in April but rules and figures can sometimes change during the year.

The information in this factsheet is applicable in England. If you are in Scotland, Wales or Northern Ireland, please contact Age Scotland, Age Cymru or Age NI for their version of this factsheet. Contact details can be found at the back of this factsheet.

Contact details for any organisations mentioned in this factsheet can be found in the *Useful organisations* section.

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1 Recent developments

Local Authority Circular (DHSC) (2019)1, published in January 2019, kept all the figures and financial thresholds for charging for care and support at the same levels as the previous financial year.

2 Sources and terms used in this factsheet

Care Act 2014, regulations and statutory guidance

This factsheet is based on the *Care Act 2014 ('the Act')*, introduced in April 2015. There are references to the charging regulations and statutory guidance that support the Act, which set out how a local authority must administer adult social care.

These include the *Care and Support (Charging and Assessment of Resources) Regulations 2014 ('the charging regulations')* and the *Care and Support Statutory Guidance ('the statutory guidance')*. Section 8 of the guidance covers '*Charging and financial assessment*' and the Annexes include:

- Annex B: Treatment of capital
- Annex C: Treatment of income
- Annex E: Deprivation of assets

Care homes and nursing homes

This factsheet provides information about '*care homes*' and '*nursing homes*'. These are standard terms used by the Care Quality Commission, the industry standards regulator. Nursing homes are care homes where a nurse must be present to provide or supervise medical-type care alongside basic personal care. We use '*care home*' in this factsheet unless discussing something to do with a nursing home.

Local authority

In this factsheet, references to a '*local authority*' refer to the adult social services department of the local authority or council. It is also used to describe similar departments within: a county council, a district council for an area in which there is no county council, a London borough council, or the Common Council of the City of London.

Capital

Capital takes many forms, but it generally refers to money or assets you own that may be available to fund part, or all, of meeting your assessed needs. It can be buildings or land, savings or stocks and shares or trusts. It is not regular payments of income, such as pensions or benefits.

3 How to obtain help from your local authority

If you need residential care, the local authority may have a duty to arrange it once it has assessed your needs. You are likely to have to pay something towards fees from your income and capital. If the local authority is involved in arranging your placement, the amount you pay is worked out via a financial assessment, also called a 'means test'.

See section 14.1 for your potential right to free residential care provision via NHS Continuing Healthcare.

Note

If you have more than £23,250 in capital, the local authority do not contribute towards your fees.

3.1 Assessment of needs

Your local authority must carry out a needs assessment to establish your eligible needs and whether residential care is an appropriate way to meet these needs before deciding if they will help with the cost. If you may have care and support needs, they must assess you, regardless of your financial situation. Eligible needs are needs that are assessed as having a significant impact on your wellbeing. One way to meet eligible needs is by the provision of accommodation in a care home or in premises of some other type.

Before recommending a care home, all other options allowing you to stay at home should be considered or tried, if this is what you want. Other accommodation may be suitable such as warden controlled or extra-care sheltered housing and you should be told about possible options.

If the local authority is required to meet your needs, the needs assessment results in a care and support plan setting out how your needs will be met. It should include your personal budget. This is the amount the local authority calculates it will cost to meet your eligible needs after a financial assessment.

If the local authority decides they are not required to meet your needs, it must give you a written record of the decision and the reasons for it. This may be because you do not have eligible needs, or the financial assessment means you have to pay full fees (you are a 'self-funder') and you can arrange to meet your own needs or have support to do this in a safe and appropriate manner.

The local authority has a duty to provide any necessary information and advice, regardless of whether they help pay for a care home. See section 15 if you are a self-funder of your care home place.

See factsheet 41, *How to get care and support*, for more information about needs assessments.

4 The financial assessment

The financial assessment is how a local authority calculates your contribution to care home fees, when it is arranged by them. Your income and capital are taken into account. The care home fee amount depends on the needs assessment and the recommendation made to meet them.

A 'sufficient' personal budget and choice

Your care and support plan must include a personal budget if you are going to receive financial support from the local authority. This sets out the cost of meeting your needs, how much you have to contribute and how much the local authority is going to pay, usually on a weekly basis.

Your personal budget must be sufficient to meet your eligible needs. The local authority must show there is at least one suitable care home available at your personal budget level and should offer a choice. Additional payments, known as '*top-ups*', must not be requested unless the local authority has shown your personal budget is sufficient to pay for at least one suitable option.

The local authority does not pay the total personal budget figure towards the cost of your care. Instead, it pays the difference between the personal budget figure and the amount you are assessed as being able to contribute through the financial assessment. See section 10 for examples of how this works in practice.

Only your own resources should be considered

Local authorities cannot generally assess joint resources of couples. They can only look at your own capital and income. This includes income and savings in your sole name. Jointly held savings are divided equally in the financial assessment, unless evidence shows your share is unequal. The exception is jointly owned property, where your actual share or beneficial interest must be taken into account.

'Light touch' means test

A local authority can carry out a '*light touch*' financial assessment, if satisfied your financial resources do, or do not, exceed financial limits. For example, because you receive certain benefits, or own a property with no mortgage. You must be asked to consent to a '*light touch*' assessment and it should be appropriately processed and recorded.

A written record of the charging decision

You must be given a written record of your charging decision by the local authority. It should explain how the assessment was carried out, what the charges will be, how often they are made and the likelihood of fluctuations in charges. It should be provided in a way you can easily understand, as early as possible.

5 Your savings and other types of capital

Most forms of capital are included in the financial assessment, including savings, bank or building society accounts, National Savings accounts, Premium Bonds, stocks and shares, and property (buildings or land). For more about how the property is valued and deferred payment agreements, see factsheet 38, *Property and paying for residential care*.

5.1 General points about treatment of capital

Valuation of capital

If your capital is valued at more than £23,250, no precise valuation is needed because you are expected to pay full fees yourself. Capital either has a market value – the amount a willing buyer would pay (e.g. for stocks and shares), or a surrender value (e.g. Premium Bonds).

Any outstanding debt secured against an asset, such as a mortgage, is deducted from the value. If in order to realise an asset, you would incur expenses by selling it, 10 per cent is deducted from the capital value for the purposes of the financial assessment.

If you have more than £23,250

You must pay full care home fees (self-fund) until your capital reduces to the upper capital limit, £23,250, at which point a local authority may have to start to assist you with funding.

If you have between £14,250 and £23,250

Capital between £14,250 and £23,250 is assessed as if you have an assumed (or 'tariff') income. For every £250 or part of £250 above £14,250, you are treated as if you have an extra £1 a week income.

Example

If you have capital of £14,750 you are treated as having £2 a week income (two lots of £250). Ask for a review when your capital drops down to the next £250 band.

If you have below £14,250

Capital less than £14,250 is fully disregarded for charging purposes.

Other disregarded capital

Certain capital can be partly or fully disregarded. This includes the potential surrender value of life insurance policies or annuities. Certain types of investment bond with life assurance elements are disregarded.

If you are unsure whether a bond has a life assurance element, ask the company that issued the bond or your financial adviser. Age UK cannot advise on particular financial products.

Funds held in trust or administered by a court that can only be disposed of by a court order or direction and which derive from personal injury payments, including compensation for vaccine damage and criminal injuries can be disregarded permanently. Personal injury payments not in a trust are disregarded for 52 weeks.

£10,000 compensation payments made to Far East Prisoners of War on or after 1 February 2001 are disregarded. Payments made to people who caught hepatitis C as a result of contaminated blood products are disregarded, and payments related to Creutzfeldt-Jakob disease.

Treatment of money held in trust depends on your rights to demand the trust money be paid to you. The rules are complicated so seek advice from the trust provider.

12-week property disregard

If your home is included in the financial assessment, it is disregarded for the first 12 weeks of a permanent care home placement. This allows you time to sell the property or arrange deferred payments with the local authority.

Note

Personal possessions are disregarded as long as they were not bought with the intention of avoiding residential care charges.

Jointly held capital

If you jointly hold capital (e.g. savings) with other people, you and other owners are treated as having equal interests in it, unless evidence shows your share is unequal

An exception is for jointly owned property. The value must be calculated in terms of the present sale value of your beneficial interest. This is the part you own that could be sold to a willing buyer with the proceeds of sale going to you. See factsheet 38, *Property and paying for residential care*, for more information.

Note

If you have a joint bank or building society account, you are usually assessed as having half of the balance. It is worth dividing joint accounts so that each person holds their money separately, to ensure it is accurately taken into account when paying fees.

Notional capital

This is capital that is included even though you do not have it. For example, it could be funds available on request, such as an unclaimed Premium Bond win or capital disposed of to avoid using it to pay for care home fees. If you are assessed as having notional capital, its value must be reduced on a weekly basis by the difference between the weekly rate you pay for residential care and the weekly rate you would have paid if notional capital did not apply.

5.2 Business asset short-term disregards

If you are a permanent resident, the local authority should disregard the capital value of any eligible business assets for a reasonable period of time, providing steps are being taken to realise the capital value and specified information is provided.

If no immediate intention to realise the capital value in the business assets is demonstrated, the local authority can take the asset value into account in the means test immediately.

The local authority should obtain information about:

- the nature of the business asset
- the estimated length of time necessary to realise the asset
- your share of the assets
- a statement of what, if any, steps have been taken to realise the assets, what these steps were and what is intended in the near future, and
- any other relevant evidence, for example your health, receivership, liquidation or an estate agent's confirmation of placing any property on the market.

6 Your income

Your income can be included in your financial assessment. It is usually looked at on a weekly basis and taken into account in full, unless identified as being fully or partly disregarded.

The local authority calculate income on the basis that benefits such as Pension Credit are being claimed, so it is important to ensure you have applied for any possible benefits. If your weekly eligible income exceeds the weekly care home fee, you are deemed a self-funder via income.

Income disregarded from the financial assessment

Common income disregards include:

- Disability Living Allowance or Personal Independence Payment mobility components (not care or daily living components)
- War Widows' and Widowers' special payments

- Christmas Bonus
- charitable and voluntary payments (which could be made by a relative)
- Child Tax Credit or Guardian's Allowance
- personal injury trust payments
- awards of certain damages
- discretionary payments made to people infected with hepatitis C by contaminated blood products
- any earnings
- War Pension Scheme payments paid to injured veterans with the exception of any allowance for constant attendance allowance which is awarded in cases of significant disability.

Income that is partly disregarded

Common types of income partly disregarded include:

- £10 a week of War Widow's, War Widower's, War Disablement Pension paid to non-veterans
- 50 per cent of a private/occupational pension where the pension is received by a married person or a civil partner in a home, provided this is paid to a spouse or civil partner and they do not live in the same home
- qualifying income for Pension Credit Savings Credit equivalent to the amount of Savings Credit received is disregarded up to a maximum of £5.75 a week (£8.60 for a couple)
- if your income is too high to claim Pension Credit Savings Credit, a flat-rate disregard of £5.75/£8.60 a week is applied.

Capital treated as income

Some capital assets are treated as income. This includes payments under an annuity, earnings not paid as income and pre-arranged third party payments to pay for residential care, but not voluntary payments, for example to remove arrears.

Where an agreement or court order provides that periodic payments are to be made to a care home resident as a result of any personal injury, any non-income periodical payments are treated as income.

Notional income

Notional income is income you are treated as having even though you do not actually receive it. This might include, for example, income that would be available on application but you have not yet applied for it or you have only applied for some of it, income that is due but has not been received or income that the you have deliberately deprived yourself of for the purpose of reducing the amount you are liable to pay for your care.

7 Deprivation of assets

If you give away assets or dispose of them to put yourself into a better position to obtain local authority help with care home fees, you may be assessed as if you still have the assets. Deliberate deprivation can be found for both capital and income.

A local authority must use its discretion when assessing the timing and motives for the transfer of eligible assets prior to a financial assessment. You must have known you may need care and support and have reduced your assets in order to reduce your potential financial contribution. If this has been done to remove a debt that would otherwise remain, even if not immediately due, this must not be considered as deprivation.

It is important to be aware eligible assets can be disposed of, or used, for justifiable reasons. The local authority must genuinely consider all the circumstances in question and be able to explain their decision. If they decide you did deliberately deprive yourself of capital or income, you are treated as having notional capital or income. For more information see factsheet 40, *Deprivation of assets in social care*.

8 Social security and disability benefits

Whether you are single or one of a couple, the local authority expects you to claim all social security benefits you are entitled to when you move to live permanently in a care home. They can include them in the calculation of your financial assessment, whether you claim them or not.

If you already claim a social security benefit, the local authority may ask to see details. It may ask you for permission to request information from your local social security office.

Social security benefits include: State Pension, Attendance Allowance (AA), Disabled Living Allowance (DLA), Personal Independence Payments (PIP) and Pension Credit (PC).

8.1 Pension Credit

Pension Credit has two parts:

- Guarantee Credit and
- Savings Credit.

It is means tested and entitlement is based on income and capital. Capital up to £10,000 is disregarded. You are treated as having 'tariff' income of £1 a week for every £500 above £10,000. There is no upper capital limit. You must have reached State Pension age to claim.

Eligibility for Pension Credit is worked out by adding up your income, including any tariff income. Most forms of income are taken into account as 'qualifying income'.

If you are a member of a couple and one of you moves permanently into a care home, each of you are treated as single people for Pension Credit. If you are a member of a couple and you enter a care home on a temporary basis for respite or a trial period, you remain treated as a couple.

For more information, see factsheet 39, *Paying for care in a care home if you have a partner*, and factsheet 48, *Pension Credit*.

8.1.1 Guarantee Credit

Guarantee Credit tops up your income if it is below a level known as your '*appropriate minimum guarantee*'. The appropriate minimum guarantee is £167.25 a week for a single person and £255.25 a week for a couple.

You may be entitled to extra amounts if you receive AA, DLA (middle or high rate care component) or PIP (daily living component). You can also receive extra if you are a carer and towards some housing costs.

The amount of Guarantee Credit paid is the difference between your assessed income (less any disregarded amounts) and the appropriate minimum guarantee.

8.1.2 Savings Credit

If you are a couple, you can get Savings Credit if both of you reached State Pension age before 6 April 2016. If only one of you did, you cannot claim unless you or your partner had an existing award from before 6 April 2016 and have remained entitled since. Savings Credit is abolished for people reaching State Pension age on or after 6 April 2016.

You may be entitled to Savings Credit if your qualifying income is above a threshold. The current weekly threshold amounts are £144.38 for a single person and £229.67 for a couple.

8.1.3 Pension Credit and property

While you try to sell a property, the value can be disregarded when calculating your Pension Credit for up to for 26 weeks (or longer '*if reasonable*'), provided the Pension Service is satisfied you are taking '*reasonable steps*' to sell it. For more information see factsheet 38, *Property and paying for residential care*.

Note

The local authority expects you to claim any Pension Credit you are entitled to. If you do not claim, they can treat you as though you are in receipt of the unclaimed award as '*notional income*'.

8.2 Disability benefits

Attendance Allowance (AA), Disability Living Allowance (DLA) and Personal Independence Payment (PIP) are benefits paid if you have certain care or mobility needs. AA can only be claimed if you have reached State Pension age and it does not have a mobility component. If you claim DLA or PIP before reaching State Pension age, you can continue to receive it after you reach State Pension age, even if your payment includes a mobility element.

You are treated as resident in a care home for these benefits when any of the costs of any qualifying service (accommodation, board and personal care) provided to you are paid for by the NHS or a local authority.

DLA and PIP mobility components are fully disregarded in the residential care means test as they do not relate to the provision of personal care and support. They should continue to be paid to you in all circumstances.

If you pay the full cost of your fees (self-funders or retrospective self-funders), you can continue to receive AA, DLA, or PIP. If the local authority arranges your care and made a contract with the care home but you pay the full fees, you can continue to receive AA, DLA care component or PIP daily living component.

NHS funded nursing care payments made to a nursing home do not affect entitlement to AA, DLA care component or PIP daily living component.

If you receive AA, DLA care component or PIP daily living component and move into a care home arranged by the local authority, they are included in the financial assessment as part of your income. However, the payments normally stop after four weeks (sooner if linked to a stay in hospital or earlier period of state-funded care) if you receive financial support from your local authority.

If you have a property included in the means test for permanent residential care, you may be entitled to funding support during the initial 12-week property disregard period. If so, these rules for AA, DLA or PIP apply. If you become a self-funder after 12 weeks, ask for the benefit to be reinstated as you are not receiving funding assistance.

AA, DLA care component or PIP daily living component can be paid while you receive interim or temporary funding from a local authority (e.g. while you sell your property) provided any funding assistance from the local authority will be repaid in full.

AA, DLA and PIP can be paid again if a local authority no longer give you help with the cost of fees, for example you inherit a large sum of money. It is important to inform the appropriate authority of any changes, so you can receive all the benefits you are entitled to.

AA, DLA care component or PIP daily living component may be payable if you are temporarily away from a care home. You should always inform DWP if you want your AA, DLA or PIP to be paid again.

If you go into a care home from the community, the days you enter and leave the care home are counted as days in the community. The day of transfer between a care home and a hospital or similar institution is treated as a day in a care home.

If AA, DLA care component or PIP daily living component stops because you get local authority funding and you subsequently return home, or move elsewhere, for example sheltered housing, ask for it to be paid again.

Disability benefits and Pension Credit for self-funders

If you receive AA, DLA middle or high rate care component or PIP daily living component, you normally receive an extra amount (severe disability addition) with PC Guarantee Credit. PC can be paid while you receive interim funding providing your property is up for sale. It is important to make sure you receive the extra amount while you are paid AA, DLA or PIP as this may reduce the amount that is ultimately repaid to the local authority from your capital.

If you enter into a deferred payment agreement, AA, DLA care component or PIP daily living component can be paid as long as you will refund the local authority in full. Eligibility for PC may be affected if your property is not up for sale. If you are a self-funder, you can keep a severe disability addition paid with your PC. For more information see factsheet 34, *Attendance Allowance* and factsheet 87, *Personal Independence Payment and Disability Living Allowance*.

Introduction of Personal Independence Payment

DLA is being replaced by PIP. New adult claimants must apply for PIP. If you currently receive DLA, this continues but if your circumstances change, you may be invited to claim PIP. All working age DLA recipients are being assessed for PIP over the next few years. If you currently receive DLA and were over 65 on 8 April 2013, you will not move to PIP.

9 Personal Expenses Allowance

The local authority must let you to keep a Personal Expenses Allowance (PEA) of £24.90 a week. You should not be asked to put your PEA towards the cost of any of your basic care if you are a permanent or temporary care home resident. It is for your own personal use.

Local authorities have a discretionary power to increase your PEA. The statutory guidance has illustrative examples to assist local authorities in the use of this discretion. One relates to where one of a couple goes into a care home, their property is disregarded in the financial assessment and they have ongoing housing costs.

10 The means test calculation

Once a local authority has all the information about your income and capital, it calculates how much you should contribute towards the costs, ensuring you are left with a PEA of £24.90 a week. The local authority should give you written information setting out how it calculated the amount you should pay, including the level of your personal budget.

The following examples show what your contribution might be.

Example 1

You are 83, single and live in a rented flat. You have capital of £5,000 and your weekly income is State Pension of £125.95 and PC Guarantee Credit of £41.30, to give an assessable amount of £167.25 a week.

The local authority arranges for you to move permanently into a care home. Your personal budget is set at £700 a week to meet your assessed eligible care and support needs. The home costs £700 a week.

Your capital is ignored by the local authority because it is less than £14,250.

The local authority calculation	£
Your total weekly income (£125.95 plus £41.30)	167.25
Less PEA	24.90
Your weekly contribution to personal budget	142.35
Local authority's contribution to personal budget	557.65
Cost of the home	700.00

Example 2

You are married, aged 82, with a weekly private pension of £200. Your wife will remain living in the flat you jointly own. Your State Pension is £125.95 a week. You have a savings account in your name of £10,400 and a joint account of £8,000.

The local authority agrees to arrange a permanent place for you in a care home costing £650 a week. Your personal budget is set at £650 a week to meet your assessed eligible care and support needs. The value of your flat is ignored because your wife continues to live there. Half your private pension is ignored as you pay half to your wife.

Your savings of £10,400, together with half of the balance of the joint account, £4,000, are included in the calculation. Your total capital is assessed as £14,400, so you have a tariff income of £1 a week. Your State Pension and the other half of your private pension are included.

Your weekly income means you do not qualify for Pension Credit Guarantee Credit or Savings Credit. The local authority must disregard £5.75 a week of income as well as allowing you to retain a PEA of £24.90.

The local authority calculation	£
State Pension	125.95
50% private pension	100.00
Tariff income from capital	1.00
Your total weekly income	226.95
Less Personal Expenses Allowance (PEA)	24.90
Less Pension Credit disregard of qualifying income	5.75
Your weekly contribution to personal budget	196.30
Local authority's contribution to personal budget	453.70
Cost of the home	650.00

11 Choice of accommodation and top-up

Your local authority assessment and care planning process determines the type of accommodation best suited to meet your needs. Your local authority has a duty to provide suitable local residential care at your personal budget level, with at least one available choice.

You have a right to choose your particular provider or location, subject to certain conditions. That choice must not be limited to settings or care home providers your local authority already contracts with or operates and does not have to be within the local area.

As well as any area in England, arrangements can be made for placements in Scotland, Wales and Northern Ireland (*Schedule 1 of the Act, Chapter 21 of the statutory guidance*).

In this situation, you have the right to choose between different providers of that type of accommodation provided that:

- the accommodation is suitable to meet your assessed needs
- to do so would not cost the local authority more than the amount specified in your personal budget for accommodation of that type
- the accommodation is available, and
- the provider will enter into a contract with the local authority at the fee rate in your personal budget on the local authority terms and conditions.

For more information, see factsheet 29, *Finding, choosing and funding a care home*.

11.1 Third party contributions

If your preferred accommodation costs more than the local authority specifies in your personal budget, it must still make arrangements for you in that home as long as someone else (and sometimes yourself) can make up the difference between that figure and the home's fee. This is a third party contribution or an '*additional payment*' or '*top-up*'.

The local authority cannot set an arbitrary ceiling on the amount they pay such that you are required to have a top-up in order to meet the cost of the care home. It must demonstrate that care and support suitable to meet your assessed eligible needs can be arranged within the amount specified in your personal budget. It must show there is at least one suitable care home at your personal budget level.

Your personal budget must reflect the cost of meeting your individual eligible needs. For example, you may have specific religious or dietary needs, or a particular need to be near relatives or friends to maintain your wellbeing. Your assessment must consider all the needs you have and your local authority must be adequately flexible in the way it responds to ensure they are met.

If no care home can meet your assessed eligible needs within the amount set by the local authority, it must increase your personal budget to meet the extra cost.

If you choose a care home costing more than the amount in your personal budget because you prefer it and a third party agrees to pay the additional cost, the local authority must make a contract with your preferred home, subject to the conditions above. The third party must show they can reasonably expect to be able to contribute for as long as the arrangement lasts – i.e. for the length of time you are in the home.

The third party and the local authority must agree what will happen if the home's fees are subsequently increased. The local authority will not necessarily agree to pay for all, or even part of, an increase.

If the third party additional payments cannot be continued, you may have to move to another less expensive home. The local authority should carry out an assessment of the effect on your wellbeing and any risks involved before taking this course of action.

Additional payments and choice of accommodation also apply if you are placed for 'after care' under section 117 of the *Mental Health Act 1983*.

Note that any agreement to pay a 'top-up' is made with the local authority, not the care home. If the care home requests payment of a 'top-up', raise this with the local authority.

Residents' contributions to more expensive accommodation

You cannot usually top-up your own fees to meet additional costs of more expensive accommodation, for example using your Personal Expenses Allowance or disregarded capital or income. However, if your property is subject to the 12-week disregard, or you have a 'deferred payment agreement' or receive accommodation under section 117 for mental health aftercare, you can make additional payments yourself.

This is possible if you will have enough resources to pay for more expensive accommodation once the value of your home is realised. You can meet the top-up from disregarded income or capital or you may be able to add the top-up to your deferred payment agreement.

The basic contract price should cover all essential care but may not cover things like clothing or hairdressing. You can use your PEA to cover these costs. The statutory guidance states '*This money is for the person to spend as they wish and any pressure from a local authority or provider to do otherwise is not permitted*'.

Your PEA should not be spent on board, lodgings and care contracted by the local authority. This does not stop you buying services from the care home if they are genuinely additional to local authority contracted services or assessed as necessary by the NHS. Find out exactly what care has been arranged in the contract.

12 Arrangements for paying the care home fees

Where a local authority arranges a care home placement, it is responsible for contracting with the provider. They guarantee payment of the full fee, including any 'top-up', as part of their legal duty to ensure your eligible needs are met under the Act.

The local authority generally pays the full fee and then collects from you the amount you have been assessed to pay towards your personal budget. If a 'top-up' is required for your accommodation and all parties agree (you or the 'third party' paying the top-up, the local authority and the home), you and the local authority can each pay your respective share directly to the provider. Statutory guidance states this is not recommended.

13 NHS and other care services in care homes

The NHS is responsible for providing community health services to you in your care home on the same basis as if you are in your own home. These services include district nursing and other specialist nursing. You can receive physiotherapy, speech and language therapy, occupational therapy and chiropody. Your GP should visit you if needed.

The NHS is responsible for providing continence services to you in a home providing nursing care and for meeting the cost of any continence supplies (such as continence pads) that you are assessed as requiring, including any specialist equipment related to needs.

Community health services such as continence supplies and district nursing should be provided if you are in a care home that does not provide nursing care, using the same criteria as for people living in their own homes.

Where services are provided by the NHS, they are free of charge. The NHS covers the cost of health-related equipment provided to you that is not standard provision within the home, if you are assessed as needing it. Your Clinical Commissioning Group should have its own criteria for the type of help it provides, based on statutory guidance. These criteria should be published and available locally.

Your local authority can provide other personal social care services to you in a care home based on your assessed eligible needs. This includes short-term rehabilitation (called '*bed-based intermediate care*') or the provision of bespoke disability equipment such as specialist seating - beyond what a care home has a duty to provide as a registered service provider. This is based on your right to social care in the area where you permanently live. Local authority-provided equipment is free.

Action

If you have difficulty obtaining information or feel that you have been incorrectly charged for products and services in your care home, consider making a complaint.

Local authorities and NHS services are required to operate formal complaints procedures and should provide you with details.

For more information see factsheet 44, *NHS services*, and factsheet 42, *Disability equipment and home adaptations*.

14 Non-means tested assistance with care costs

This section sets out exceptions to the means tested funding requirement for residential care and other related services.

14.1 Fully funded NHS continuing healthcare

In certain circumstances, the NHS is responsible for meeting the full cost of your care in a care home. This is called NHS continuing healthcare or '*fully funded care*'. To be eligible, you must have a high level of health-related needs in a number of areas (known as '*domains*') resulting in your '*primary need*' being health-based, thus entitling you to free health care rather than means tested social care.

If you might be eligible, the professionals involved in your care, for example GP, nursing staff or social worker, must actively consider this possibility. They should tell you or your representatives of your rights and carry out an appropriate assessment based on the *National Framework* for NHS continuing healthcare guidelines and its assessment tools. To move to a social care means test without addressing your potential right to free NHS service provision may constitute poor professional practice and can be challenged.

Note

If you think your need for NHS continuing healthcare has not been addressed but should have been, you should ask to be assessed.

For more information see factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

14.2 Short-term rehabilitation in a care home

You may be eligible for short-term rehabilitation in a care home provided by your local authority ('*bed-based intermediate care*'). It must be provided free of charge for at least the first six weeks. After this, you can be charged in a similar way to other local authority services.

It is often provided to prevent hospital admission or after discharge from hospital if a rehabilitation potential is identified. The purpose of this service is to enable you to maintain or regain the ability to live independently in your own home. There should be an initial agreed rehabilitation plan and reviews throughout to gauge progress, and an agreed future action plan at the end.

It does not normally last longer than six weeks, but can be extended if there is evidence that further progress can be made. At the end of the period, you may qualify for fully funded NHS continuing healthcare, or require other social care services which may be charged for. For more information, see factsheet 76, *Intermediate care and reablement*.

14.3 NHS-funded nursing care payments

The NHS is responsible for meeting registered nursing costs for residents in care homes that also provide nursing care, known as nursing homes.

Nursing care is care given by a registered nurse in providing, planning or supervising your care. It does not include time spent by other staff involved in your general personal care.

Responsibility for meeting nursing care costs lies with your Clinical Commissioning Group (CCG). If you move to a different CCG area, you become the responsibility of that CCG when you register with a GP.

The NHS makes payments directly to your nursing home. The weekly rate for 2018/2019 was £158.16. Before you move into a care home, the service provider must clearly set out the fees they intend to charge and what services they cover. This should be stated in the statement of terms and conditions they provide. You should ask if the fee quoted includes or excludes payments made by the NHS for NHS-funded nursing care.

14.4 Mental health 'after-care' services – section 117

If you have been detained in hospital for treatment under certain sections of the *Mental Health Act 1983*, your residential care may be provided as an 'after-care' service under Section 117. Local authorities cannot charge for after-care provided under Section 117.

This places a joint duty on health and local authorities to provide after-care services. Section 75(5) of the *Care Act 2014* confirms its purpose is to meet ongoing mental health-related needs and to reduce 'the risk of a deterioration of the person's mental condition...requiring admission to a hospital again for treatment for mental disorder.'

Choice of accommodation

The *Mental Health Act 1983* was amended by the *Care Act 2014* to make it clear that local authorities are required to provide or arrange the provision of preferred accommodation if specified conditions are met.

People who receive mental health after-care have broadly the same rights to choice of accommodation as someone receiving care and support under the *Care Act 2014* although there are no restrictions upon when the resident can top-up themselves.

After-care and dementia

In *R v Richmond LBC and others, ex parte Watson and others [1992] 2 CCLR 402*, it was held that after-care provision under Section 117 does not have to continue indefinitely but it must continue until the health body and the local authority are satisfied the individual no longer needs such services. The judge felt it was difficult to see how such a situation could arise where the illness is dementia.

In *Complaint number 06/B/16774 against Bath and NE Somerset Council, 2008*, the Local Government Ombudsman found maladministration when a local authority sought to discharge a person with dementia from a section 117 care home placement because they had 'settled'. It was stated that:

Whether or not a person is 'settled in a nursing or residential home' is an irrelevant consideration. The key question must be, would removal of this person (settled or not) from this nursing or residential home mean that she is at risk of readmission to hospital? If the answer is yes then the person cannot be discharged from aftercare.

15 Arranging and paying for your care yourself

You are free to find a place in a care home yourself if you can make your own arrangements and pay the fees.

After a local authority needs assessment, the financial assessment may find you must pay the whole amount of your care home fees. This is sometimes called 'self-funding'. If you have support and assistance or can manage alone, you are expected to arrange this yourself. Otherwise, the local authority must assist you to ensure your needs are met, as per section 3.1.

Each care home must adhere to standards set out by the Care Quality Commission CQC. Regulation 19 of the *Care Quality Commission (Registration) Regulations 2009* on fees requires the provision of a written copy of the terms and conditions to be provided prior to the placement commencing.

If your funds run down to the upper capital limit

If you self-fund in a care home but your capital falls towards the upper capital limit (£23,250), ask your local authority for an assessment of your care needs, to see if you are now eligible for funding assistance. This may take time to arrange so it is worth asking a few months before your capital reduces to £23,250.

Your local authority must undertake a requested needs assessment and related financial assessment as soon as reasonably possible, taking into account the urgency of your needs. Once aware of your situation, they should seek to ensure you are not inappropriately forced to use up your capital as a result of an assessment delay. If this happens, you can complain, which can include a request for financial compensation.

If the home in which you have been self-funding costs more than the local authority is prepared to pay, this can cause difficulties if you apply for local authority assistance. They may require a third party to make up the difference. If none is available, they may conclude you need to move to a cheaper care home.

If this is recommended, ask the local authority to carry out an assessment of all your needs including your physical or psychological wellbeing and your social and cultural needs. They should look at the risk to your wellbeing of moving you.

If your existing care home is found to be the only one that can meet your assessed eligible needs, the full cost should be met by the local authority. The statutory guidance states local authorities '*should not have arbitrary ceilings*' to their personal budget calculations.

If you have trouble selling your home, you may be able to negotiate a deferred payments agreement as an interim '*bridging loan*'. For more information, see factsheet 38, *Property and paying for residential care*.

If you move areas for care home accommodation

If you move into a care home in a different local authority area from where you lived before and have been self-funding, the local authority in the area you now live is usually responsible for assisting you if you may become entitled to funding support.

Benefits entitlement

You can claim AA, DLA care component or PIP daily living component if you do not receive funding for residential care from a local authority. NHS payments for registered nursing care do not affect your right to receive these benefits. Depending on capital and income, you may be able to claim Pension Credit.

16 The local authority information and advice duty

Your local authority has a duty to provide an information and advice service relating to care and support for you. As a minimum, this must include the following:

- the local care and support system and how it operates
- the choice of types of care and support
- the choice of providers available to you
- how to access the care and support that is available
- how to access independent financial advice relevant to meeting your needs for care and support, and
- how to raise concerns about your safety or wellbeing.

This general local authority duty links with other broad local authority duties, for example to do with prevention and cooperation with local health and housing services. '*Independent financial advice*' is financial advice provided by a qualified person who is independent of the local authority in question, for example they are regulated by the Financial Conduct Authority. Financial advice is a paid for service.

17 People who can act on your behalf

Independent advocacy

If you have substantial difficulty being involved with the care and support process and have no appropriate person to such as a family member to assist you, the local authority must provide an independent advocate to support and represent you. A person should not be considered appropriate if you do not want them to be your advocate. The duty is triggered where you experience substantial difficulty:

- understanding relevant information
- retaining that information
- using or weighing that information as part of the process of being involved
- communicating your views, wishes or feelings.

Mental capacity – advocates and attorneys

While you are able to make decisions and express your views, you might think how you would want your affairs dealt with if you lose mental capacity in future. This can be done by creating a Lasting Power of Attorney (LPA), which can be for finance and property as well as health and welfare. If you lose mental capacity without an LPA in place, an application can be made for a Deputyship with the Court of Protection.

Local authorities must appoint an Independent Mental Capacity Advocate (IMCA) if you lack the mental capacity to make a decision, for example about moving into a care home and you have no friends or relatives to support you.

All actions taken on your behalf must be made in your *'best interests'* as defined by the *Mental Capacity Act 2005* and supporting Code of Practice and be in line with the highest possible ethical standards. You can contact the Office of the Public Guardian if you have any concerns about the behaviour and actions of an LPA or Deputy.

For more information see factsheet 22, *Arranging for someone to make decisions on your behalf*.

Appointees for benefits

If you receive social security benefits but are unable to manage your affairs, the DWP can appoint someone else to make claims and receive benefits on your behalf. An appointee is usually a close friend or relative who visits you regularly. Your local authority may also be able to act as your appointee. As a last resort, your care home owner can act as appointee, but in such cases, they must keep a record of the money collected on your behalf. You and a prospective appointee are interviewed before any appointment is made. An appointee's powers only extend to the management of social security benefits.

18 Complaints

If you are not satisfied with any aspect of the service you receive from your local authority, you can complain. Some issues might be dealt with informally, but you can make a formal complaint to the authority. Beyond this you have a right to complain to the Local Government and Social Care Ombudsman (LGO).

Once you are in a care home, you should be assisted to discuss issues and concerns via internal complaints and feedback procedures. If you have been placed by your local authority, you can use their complaints procedure.

If you have arranged and funded your placement independently, you can complain to the LGO if you have not been able to resolve the issue through the care home's complaints procedure.

You can inform the Care Quality Commission about any concerns you have. They do not have duties to respond to you individually. However, they have extensive powers and must respond appropriately.

If you have concerns about abuse or neglect, you can raise a safeguarding alert with the local authority. Its duty to investigate concerns applies to local authority and self-funding residents.

See factsheet 59, *How to resolve problems and complain about social care* and factsheet 78, *Safeguarding older people from abuse and neglect*.

Useful organisations

Care Quality Commission

www.cqc.org.uk

Telephone 03000 616 161 (free call)

Independent regulator of adult health and social care services in England, covering NHS, local authorities, private companies or voluntary organisations and people detained under the *Mental Health Act*.

Carers UK

www.carersuk.org

Telephone 0808 808 7777

Provides information and support for carers, including information about benefits.

Citizens Advice

www.citizensadvice.org.uk

Telephone 0344 411 1444 (England)

National network of advice centres offering free, confidential, independent advice, face to face or by telephone.

Equality Advisory Support Service

www.equalityadvisoryservice.com

Telephone helpline 0808 800 0082 Mon-Fri 9am-7pm, Sat 10am-2pm

Helpline provides information and advice about the *Equality Act 2010* and human rights.

Local Government and Social Care Ombudsman

www.lgo.org.uk/

Telephone 0300 061 0614

Provides free, independent, service for complaints about local authorities; also about social care service providers for self-funders.

Office of the Public Guardian

www.gov.uk/government/organisations/office-of-the-public-guardian

Telephone 0300 456 0300

Monitors and registers attorneys and deputies for people lacking mental capacity.

Relatives & Residents Association (The)

www.relres.org/

Telephone 020 7359 8136

Advice and support to older people in care homes, relatives and friends.

Age UK

Age UK provides advice and information for people in later life through our Age UK Advice line, publications and online. Call Age UK Advice to find out whether there is a local Age UK near you, and to order free copies of our information guides and factsheets.

Age UK Advice

www.ageuk.org.uk

0800 169 65 65

Lines are open seven days a week from 8.00am to 7.00pm

In Wales contact

Age Cymru Advice

www.agecymru.org.uk

0800 022 3444

In Northern Ireland contact

Age NI

www.ageni.org

0808 808 7575

In Scotland contact

Age Scotland

www.agescotland.org.uk

0800 124 4222

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