factsheet

Age UK
The new force combining
Age Concern and Help the Aged

Factsheet 10 ● April 2015

Paying for permanent residential care

About this factsheet

This factsheet provides information on the financial help that may be available from the local authority for older people (aged 60 and over) needing care in a care home. It should be read in conjunction with Age UK's other factsheets on care home funding, social care service provision and NHS continuing healthcare.

The information in this factsheet is correct for the period April 2015 – March 2016.

This factsheet describes the situation in England. There are differences in the rules for funding care in a care home in Northern Ireland, Scotland and Wales. Readers in these nations should contact their respective national offices for information specific to where they live – see section 22 for details.

For details of how to order other factsheets and information materials mentioned inside go to section 22.

Inside this factsheet

1 Recent developments

The ***Care Act 2014*** came into force on 1st April 2015 along with a range of new supporting regulations and a single set of new statutory guidance, which, taken together, describe how the Act should be applied in practice. The aim of the change is to simplify and modernise the system, which had become untenably complex.

The most significant new regulation in relation to this factsheet is the *Care and Support (Charging and Assessment of Resources) Regulations 2014*, which will be called **the charging regulations** in this text. The other main source for this factsheet is the *Care and Support Statutory Guidance 2014*, which will be referred to as **the statutory guidance** in the text; it has a number of sections on charging for care. These support sections 14-17 in the *Care Act 2014*, which covers charging for services. Sections 34-36 covers deferred payments agreements and sections 69-70 covers debt recovery and deprivation of assets.

This means that the existing system of adult social care of laws, regulations and guidance, developed over a period of 65 years, has generally been superseded and is now **no longer applicable**; except in a few cases, for example the complaints regulations. An example of this general revocation is the statutory guidance entitled the *Charging for residential accommodation guide, known as* **CRAG**. This is the guidance on which this factsheet was previously based. It will now be based on the documents mentioned above, which are listed with web links in the **Appendix** at section 20.

The *Care Act 2014* is actually coming into force in **two stages,** in April 2015 and April 2016. Some of the key changes introduced for local authorities in April 2015 are:

- The promotion of individual **wellbeing** as an overarching principle within all activities including: assessment, eligibility, prevention, means testing and care and support planning.

- New national eligibility criterion for the adult requesting services and their carer(s) leading to rights to services for both; the previous four, locally set, eligibility levels have now become one, set at roughly the previous 'substantial' level. Carers now have an absolute right to have their eligible support needs met for the first time. Further information about this can be found in Factsheet 41, *Social care assessment, eligibility and care planning.*
- The whole system is now administered via personal budgets.
- A 'universal' information and advice provision duty.
- New 'market shaping' duties to ensure appropriate local service provision.
- There are many other changes from April 2015, which are described within our range of updated factsheets on adult social care.

The **April 2016 changes** under various sections of the *Care Act 2014* relate to the introduction of new rules on paying for care based on the **Dilnot** care funding recommendations made in 2013 and the subsequent government response. These include:

- A **lifetime care cost cap** (£72,000 in 2016) above which the State meets the cost of eligible social care needs. Those under 25 in April 2016 will not be charged for social care. This will be excluding a new **daily living cost charge** (£230 per week in in 2016).
- An increased upper capital limit from £23,250 to £27,000 in non-residential care or where the value of the resident's home is disregarded, or £118,000 where the value of the resident's home is not disregarded.
- The introduction of **care accounts** which will track personal expenditure towards meeting eligible care needs, towards the new care cost cap. Each account will be adjusted annually in line with the rise in average earning. Some local authorities may start to assess for care accounts ahead of April 2016.
- The introduction of **independent personal budgets**, where contribution to the care account is monitored without the need for a means test.
- An **increased tariff income/lower capital** limit figure from £14,250 to £17,000. Tariff income is further explained in section 4.

- A new **appeals system** under which social care funding decisions made by a local authority can be challenged and independently reviewed.
- Some amendments to the charging and the choice of accommodation regulations.

Draft regulations have been created to support the planned funding-related changes in April 2016 following a government consultation, which ended on 30th March 2015.

The transitional system and eligibility

In this factsheet we will describe the transitional system that will be in existence between April 2015 and April 2016; we will amend it again next year in-light of the new charging rules cited above. Government advice on how local authorities should manage the transition over the next couple of years is set down in section 23 of the statutory guidance.

Here, it states that the new national eligibility criteria is intended to allow for **the same level of access** to care and support to be maintained in adult social care in the vast majority of circumstances and cases.

Note: We will focus on the adult entering residential care in this factsheet as it is on the residential care means test.

Definitions of terms used in the text

In this factsheet references to the '**local authority**' or '**council**' will refer to the adult social services department of the local authority or council. The relevant social services department may be called the 'adult social services' or 'older persons' department or team.

We will use the term 'local authority' in this factsheet to describe this type of service. However, generally, the term 'local authority' can also describe: a county council in England, a district council for an area in England for which there is no county council, a London borough council, or the Common Council of the City of London.

The term '**care home**' is used to mean any home that is registered with the Care Quality Commission (CQC) to provide accommodation together with personal care and also possibly nursing care. This includes local authority homes and independent homes, which are run by private or voluntary sector providers. These are all regularly inspected and monitored by the CQC based on national standards. The CQC's terms for them are **nursing home** (requiring a registered nurse to be on site) and **care home**. A specialist service such as 'dementia care' may also be added to the descriptions found on the CQC's website. See section 21 for the CQC's contact details.

2 How to obtain help from your local authority

Note: Section 8.2 of the new statutory guidance states that local authority charging procedures should promote "wellbeing, social inclusion, and support the [Government's] vision of personalisation, independence, choice and control".

Most people needing residential care will be expected to pay something towards the costs of their accommodation and personal care from their **income and/or capital**. If the local authority is involved in arranging your placement, the amount you may have to pay will be worked out via a means test, which is based on nationally set regulations and statutory guidance under the new *Care Act 2014.* The procedure for paying for residential care is explained in this factsheet.

However, there are **exceptions** to the requirement to pay for some or all of the care in a care home when it is arranged by the NHS or social services. For example, if you are found to be eligible for **NHS continuing healthcare** then all of the fee will be met by the NHS. The NHS **nursing care component** (also called Funded Nursing Care or FNC) of the service provided to you in a nursing home is also funded directly by the NHS. These exceptions are further discussed in section 15.

The new *Care Act 2014,* sections 14 to 17, provides a new, single, framework for charging for all adult care and support. It enables a local authority to **decide** whether or not to charge a person when it is arranging to meet their care and support needs. This could be where it has a **duty** to meet needs under section 18 of the Act or where it decides to assist with meeting this need (a **power/discretion**) under section 19 of the Act. Where it decides to charge, it must follow the charging regulations and have regard to the statutory guidance on charging. In the residential care context, where the financial assessment identifies that a person's resources exceed the upper capital limit (£23,250), a local authority is prohibited from paying towards the costs of care.

2.1 Assessment and service provision

Whether your stay in a care home will be temporary or permanent, your local authority must carry out an assessment of your needs to establish that you require this type of social care provision before it can assist you with the cost of the placement. Section 8 of the *Care Act 2014*, entitled 'How to meet needs', lists as one of its examples of what may be provided to meet assessed needs under sections 18 to 20 of the Act 'accommodation in a care home or in premises of some other type'.

Note: If you have already been assessed as needing a place in a care home, you may wish to move on to section 3, which explains how your contribution towards the cost of residential care will be calculated.

Sections 9 to 12 of the *Care Act 2014* set out the basic approach to assessment in the new system and confirm that a local authority has a **duty to assess your needs** if it appears that you may have needs for care and support, regardless of your financial situation. The new Act requires that your needs are assessed in terms of the outcomes you wish to achieve in your day-to-day life and the effect of any problems you are having on yourself and you support networks.

Your needs assessment will usually be carried out by a social worker (often called a care manager) or an occupational therapist, and must result in an agreed **care and support plan**. This should contain various elements including your **personal budget** amount, as defined in section 26 of the *Care Act 2014*. This is the amount the local authority calculates it should pay to meet your needs following the means test. It must be based on an accurate assessment of the cost of, in this situation, appropriate local care home provision. From April 2016, if you don't wish to be means tested following your needs assessment, you will be able to opt for an **independent personal budget**. This is described in section 28 of the *Care Act 2014*.

You should also be offered the option of **supported self-assessment** if this is possible and you should have access to an **independent advocate** if you are unable to engage effectively with the assessment process. This is further discussed in section 17.2. It has similarities with advocacy rights under the *Mental Capacity Act 2005*. Anyone who provides informal care can also be involved in your assessment to achieve a holistic picture of your ongoing circumstances.

Note: Prior to a care home recommendation, all other options allowing you to remain at home should be considered or trialled, if this is what you want to do. Also, other accommodation types may be suitable such as shared lives schemes, supported living or extra care housing. These are mentioned throughout the new statutory guidance, so your assessor should be aware of them as possible ways to meet your needs in the locality or elsewhere.

The *Care Act 2014* introduces a wide-ranging local authority duty to provide **information and advice** to all who need it. This is particularly important if you are found to be ineligible for care and support provision. The local authority must provide **written information** and also advice aimed at helping you understand the local care system, funding choices (including how to access independent financial advice) and possible preventive options. This will be further discussed in section 16. It links with new *Care Act 2014* duties to **prevent, reduce and delay** the need for future State support where possible, which are set out in section 2 of the Act.

The statutory guidance confirms that **assessment and care planning are free services**. If a person has eligible needs for care and support but the means test finds that they are required to pay the full amount, the *Care Act 2014*, at section 18(3), provides a 'right to request' that the local authority to meet these needs for an arrangement fee. However, section 8 of the statutory guidance confirms that this right does not extend to residential care. Therefore, if a local authority uses its **power (choice)** to meet a person's needs under the *Care Act 2014* in this context it **must not charge** an arrangement fee. This is because it is supporting that person under a power rather than a duty to meet needs, and the ability to charge the arrangement fee applies only to circumstances when the authority has a duty to meet needs on request (see chapter 8 of the statutory guidance).

There was a previous longstanding local authority duty to assist an eligible person with capital above the financial threshold who could not independently arrange their care home placement and who had no one to assist them when assistance was 'not otherwise available'. The *Care Act 2014*, at 18(4), confirms this ongoing duty to assist with the arrangements if an eligible individual:

> (a) lacks capacity to arrange for the provision of care and support; but
>
> (b) there is no person authorised to do so under the *Mental Capacity Act 2005* or otherwise in a position to do so on the adult's behalf.

As mental capacity is assessed as decision specific, a person may have capacity to decide where to live but not to arrange the contract and other complex arrangement requirements. In this type of case the local authority has a clear duty to meet eligible needs irrespective of the person's resources (sections 18(1) & (4) of the *Care Act 2014*).

The above points cover an apparent legal anomaly where there is the potential for a person with mental capacity but an inability to meet their own need for residential care without the right to State assistance to meet their eligible needs - in the absence of a 'right to request'. In this situation other local authority legal duties may come into play such as the civil law duty of care. It is difficult to see how a local authority could not use its discretion to assist in this kind of situation. If a local authority chooses to assist, it cannot charge an arrangement fee. The person may also be eligible for independent advocacy support.

If the local authority is going to make the arrangements, because you need help with the fees or you are unable to make your own arrangements, there should be **no undue delay** in doing so. If there is a delay, the local authority should ensure that there are suitable arrangements in the meantime.

Local authorities can no longer set local eligibility criteria (e.g. at Critical, Substantial or Moderate) as there is now a **single set of national eligibility criteria** for service users**.** It is intended by the Government to be generally similar to the previous Substantial level. To be eligible, you must be unable to achieve two or more of a list of 'outcomes' set out in the *Care and Support (Eligibility Criteria) Regulations 2014.* The term 'unable' is further defined to appear to mean having excessive difficulty. Your needs must stem from a 'physical or mental impairment or illness' and there must be a 'significant impact' on your wellbeing. The term 'wellbeing' is defined in section Part 1, section 1, of the *Care Act 2014*.

The statutory guidance, at section 6, states that you must receive a **written record** of the eligibility decision and a breakdown of your financial assessment. If you are assessed and found to have eligible needs within the criteria then the local authority has legal duty to meet these needs.

This could include a recommendation for a permanent care home placement (although the duty in these cases does not extend to those adult's with capacity whose financial resources are above the financial limit). This decision should be made after all other options to assist you to remain in your own home have been explored.

If you are assessed as needing to live in a care home that provides **nursing care** an NHS nurse will also be involved in assessing and confirming your eligibility.

Carers also now have a separate set of eligibility criteria giving rights to support services. If you have a carer, their capacity and motivation towards carrying on their caring role are central to final decisions about eligibility and recommended service provision. This subject is covered in more detail in Factsheet 41, *Social care assessment, eligibility and care planning*.

Note: Prospective care home residents with over £23,250 of eligible capital (e.g. savings and property) are expected to meet the full cost of their residential care. In April 2016 it is proposed that this figure will rise to £27,000 (where the value of the resident's home is disregarded in the financial assessment) or £118,000 (where the value of the resident's home in the community is taken into account).

It's important to be aware that your financial circumstances have no bearing on your right to an assessment of your needs by the local authority.

The 'Market shaping' duty and provider failure

Section 5 of the *Care Act 2014* contains duties requiring local authorities to ensure the supply of **diverse, good quality**, **local services**. This includes: planning for future demand and ensuring that services are high quality and sustainable.

Section 48-52 of the *Care Act 2014* creates duties to act to support all local care home residents in the event of **financial failure** and potential closure. This includes self-funders, for a fee. Sections 53-57 of the *Care Act 2014* create an activation procedure designed to assess the financial viability of **difficult to replace service providers**, in conjunction with the Care Quality Commission. There are also new powers to act quickly to reduce residents' anxiety in this context.

3 The means test

The charging procedure, sometimes called the means test or financial assessment, is the system of calculating how much you should contribute towards the costs of your placement in a care home when it is arranged by the local authority. Both your **income and capital** may be taken into account in the means test. A local authority should only look to include a service user's eligible capital and income. Chapter 8 of the statutory guidance confirms that this procedure must be carried out free of charge.

The ***Care Act 2014*** will change the means testing system in **two stages**. The relatively minor April 2015 changes have taken place and the significant Dilnot-related ones will take place in April 2016. At the time of writing (March 2015), we can only summarise the new law and outline what we know about the planned 2016 changes. The details of the 2016 means test changes will be provided for in new regulations and guidance currently under consultation.

Note: The local authority must carry out your financial assessment under the provisions of section 17 (1) and (2) of the new *Care Act 2014* and in accordance with the provisions of Parts 3 to 5 of the charging and assessments regulations. It must also have regard to Chapter 8 and Annexes A-I of the new supporting statutory guidance.

The rules for residential and non-residential care charging and assessments have now been **merged** within the *Care Act 2014* regulations and guidance, but retain some **differences**. The regulations **resemble** the old *National Assistance (Assessment of Resources) Regulations 1992* and the guidance is similar to the old *Charging for Residential Accommodation Guide* (CRAG), which has now been superseded.

The term '**usual cost'/'standard rate'** may be used in connection with the charging process. This is the maximum limit the local authority is usually prepared to pay to for your residential care to meet your assessed eligible needs. These limits vary from authority to authority, and for different levels or types of care home.

However, under the new *Care Act 2014* provisions there is no reference to 'usual cost' but rather an 'amount specified in the adult's personal budget', a 'person's personal budget' or the 'amount identified for the provision of the accommodation in the personal budget'. In practice a '**person's personal budget'** will be the usual cost of the relevant type of residential accommodation in a particular locality that will be sufficient to meet their assessed eligible.

Whatever terminology is used, the amounts set out for different types of residential care **should be sufficient** to allow your local authority to meet your eligible assessed residential care needs locally and it should be possible for them to be **varied** in certain circumstances to meet your specific needs, or where there is **inadequate local supply** to meet your assessed needs.

Chapter 8 of the new statutory guidance confirms that any **'additional payments'** must always be **optional** and never as a result of commissioning failures leading to a lack of choice. See section 9 below, and Factsheet 60, *Choice of accommodation – care homes*, for information about appropriate **top-up** and choice of accommodation arrangements.

Chapter 8 of the statutory guidance confirms that local authorities cannot generally assess the **joint resources of couples**. They can only look at your own income and capital. This will include income and savings that are in your sole name and any jointly held savings, which will be divided equally (other than property where it is the resident's actual share or beneficial interest that is taken into account).

If you move into a nursing home, the NHS is responsible for meeting the cost of care provided by a registered nurse on site. You may need to ask for clarification regarding the **funded nursing care (FNC) contribution** if it isn't clearly separated from the main fee in the fee information. If you may be eligible for **free NHS continuing healthcare**, this possibility needs to be assessed for and discussed with you as soon as possible within the process. Further information about this can be found in Age UK's Factsheet 20, *NHS continuing healthcare and NHS-funded nursing care.*

3.1 'Light touch' means test

Regulation 10 of the charging regulations sets out circumstances in which a local authority is considered to have done all it can to have carried out a means test. It also allows for 'light touch' financial assessments. This is where the local authority is **satisfied from the evidence** available to it that either the adult's financial resources do not exceed the financial limit or that they do exceed the financial limit and where the adult **consents** to a 'light touch' assessment.

This is also covered in section 8 of the statutory guidance where three circumstances in which a local authority may consider carrying out a 'light touch' means test are set out.

These include: where a person has **significant financial resources**, and does not wish to undergo a full financial assessment for personal reasons, but still wishes to access local authority support in meeting their needs; where the local authority charges a **small or nominal amount** for a particular service (e.g. for subsidised services) which a person is clearly able to meet and would clearly have the relevant minimum income left, and carrying out a financial assessment would be disproportionate; and when an individual is in receipt of **certain benefits** which demonstrate that they would not be able to contribute towards their care and support costs.

The statutory guidance states that a local authority must remember that it is responsible for ensuring that people are **not charged more than it is reasonable for them to pay** and that if a person does not agree to the charge a full financial assessment may be needed. The local authority **must inform you** if a light touch assessment has taken place and also make clear that you have the **right to request** a full financial assessment, as well as making sure that you have access to sufficient **information and advice**, including the option of independent financial information and advice.

3.2 Temporary care home provision

Temporary care home residents are treated differently in certain aspects for means test purposes, for example the main property is excluded and ongoing housing costs must be taken into account. A local authority may also choose to charge based on its non-residential charging policies outside of a care home for the first eight weeks of a short-term stay. Here, the local authority must follow the rules set down in Part 2, Regulation 8, of the charging regulations. Further guidance is also provided in Chapter 8 of the statutory guidance. For further information see the Age UK's Factsheet 58, *Paying for temporary care in a care home*.

3.3 A written record of the charging decision

You should be provided with a written record of the charging decision (Section 17(6) of the Care Act). It should explain how the assessment has been carried out, what the charge will be and how often it will be made; and if there is any fluctuation in charges, the reason for this. The local authority should ensure that this is provided in a manner that you can easily understand.

4 Your savings and capital

Most forms of capital and savings are included in the means test, including bank or building society accounts, National Savings accounts, Premium Bonds, stocks and shares, and property (buildings or land).

See Age UK's Factsheet 38, *The treatment of property in the means test for permanent care home provision*, for information about whether the value of your home will be taken into account and also regarding your possible right to arrange deferred payments. **Deferred payments** rules are now provided for by: Sections 34-35 of the *Care Act 2014*; Annex B, 'Treatment of capital', in the statutory guidance; and Part 5, Treatment and calculation of capital', in the charging regulations. Chapter 8 of the statutory guidance requires deferred payments to always be offered, if suitable. However, they are now more similar to commercial loan arrangements.

4.1 The planned April 2016 means test changes

Note: At the time of writing (March 2015), a consultation on draft new regulations in support of the planned April 2016 changes is drawing to a close.

The draft regulations contain the following points discussed in this section. In April 2016, the **upper and lower capital limits** for residential care are planned to be radically changed from the present levels of £14,250 and £23,250. They will be set at between £17,000-£27,000 for where the value of the resident's home is disregarded and for non-residential care, or between £17,000-£118,000 for residential care where the value of the resident's home is not disregarded. This is intended to increase the number of people eligible for financial support from a local authority, but it will also create a much higher **tariff income calculation** (explained below), when someone's capital assets are between the thresholds. The existing figures mentioned above are contained in regulation 25 and regulation 12 of the charging regulations introduced in April 2015 in within the statutory guidance.

This interacts with the **care account** and **life-time care cost cap** (£72,000), which will also be introduced in April 2016 (Section 15 of the Care Act). When the total amount accrued in your care account reaches the cap figure, you become eligible for full funding for your care and support and will not be liable for charges. Local authorities will be required to monitor your contributions towards meeting your assessed eligible needs defined by the amount specified in your **'personal budget'** or **'independent personal budget'**.

The second of these allows you to avoid being means tested but to just register the payments that you make for your eligible care and support. The cap and your individual accrued amount will both rise with annual earnings (Section 16 of the Care Act).

The *Care Act 2014* provides **for different care cap amounts for different age groups** or a zero amount for specified categories of person (Section 15(4) of the Care Act). The new draft regulations confirm that this is zero for those under 25 in April 2016 who have eligible needs and £72,000 for all others.

A new '**daily living cost'** charge (£230 per week in 2016) will also be introduced in April 2016. This is intended to cover the costs (rent, food and utilities) that a person would have paid if they were living at home rather than in a care home. Your care account will exclude these 'daily living costs' (Section 15(6) of the Care Act). This charge continues even you reach the care cost cap (Section 15(7) of the Care Act).

It must also be noted that many people pay top-ups, either formally arranged or for other reasons, which don't count in the calculations of your progress towards the cap as the local authority only looks at what it pays or would have paid to meet eligible needs as set down in your 'personal budget' or 'independent personal budget'.

4.2 The April 2015 - March 2016 transitional arrangements

Chapter 23 of the new statutory guidance is entitled 'Transition to the new legal framework'. It provides guidance to local authorities on how to make the transition to the new system under the *Care Act 2014* as smoothly as possible. It recommends retention of the status of previous assessments and eligibility determinations, where possible; for example regarding the new single set of national eligibility criteria. This is aimed at minimising a potential increase in assessment demand around April 2016 for care account initiation by allowing the carrying out earlier assessments for this purpose.

More than £23,250 in capital

Until the major change in April 2016, you will be expected to pay the full fee (self-fund) until your capital is reduced to the upper capital limit of £23,250, at which time the local authority may have to assist with funding.

Capital between £14,250 and £23,250

Capital of between £14,250 and £23,250 is assessed to show an assumed (or 'tariff') income. For every £250 or part of £250 of capital between £14,250 and £23,250 you are assessed as though you have an extra £1 per week income. This is set down in Part 5 of the charging regulations and Chapter 8 and Annex B of the statutory guidance.

Example: If you have capital of £14,550 you will be treated as having an extra £2 per week income. If your assessed income includes tariff income make sure that your contribution is reviewed each time your capital drops into the next £250 'band'.

In April 2016, the tariff income calculation at the upper capital limit will be greatly increased - £1 for every £250 above 17,000, up to £27,000 where your property is disregarded) or up to £118,000 (where the value of your property is taken into account). At £118,000 this will require an added weekly income calculation of £404. When this is added to other income in the means test it will create a higher chance of you being defined as a self-funder due to your income than is presently the case.

Capital below £14,250 is disregarded

Until April 2016, capital of £14,250 or less is fully disregarded for local authority residential care charging purposes. However, the social security office will calculate tariff income on savings over £10,000 for Pension Credit purposes at a rate of £1 per week for every £500 or part of £500.

Other disregarded capital

Some other capital is partially or fully disregarded or ignored. Capital disregards are set down in Schedule 2 of the charging regulations and are also covered in Annex B in the statutory guidance.

Capital that is disregarded indefinitely includes the surrender value of **life insurance policies or annuities** and the value of 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 a payment for **personal injury**, including compensation for vaccine damage and criminal injuries.

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

The value of certain types of investment bond with a **life assurance element** is disregarded. If you hold an investment bond but are unsure whether it has a life assurance element, ask the company that issued the bond or your financial adviser. Age UK cannot advise on particular financial products.

The treatment of money held in trust depends on what rights you have to demand that the trust money be paid to you. The rules about trusts are complicated so **seek advice** from the trust provider if you have an interest in a trust. Trust ownership principles are also discussed in Age UK's Factsheet 38, *Treatment of property in the means test for permanent care home provision,* in section 5, on the valuation of jointly owned property.

The £10,000 compensation payment made to Far East Prisoners of War on or after 1 February 2001 is disregarded.

Since October 2011 payments made to those who caught hepatitis C as a result of contaminated blood products have been disregarded in the local authority means test.

4.3 Jointly held capital

If you jointly hold capital (e.g. savings) with another person or people, you and the other joint owners are generally treated as having **equal** interests in that capital at the time of the means test.

There is an **exception** for jointly owned property, which is calculated in terms of the present sale value of your beneficial interest. This means the part you own that could be sold with the proceeds of sale going to you.

These rules are set down in Regulation 24 of the charging regulations and paragraphs 12-13 of Annex B in the statutory guidance.

Example: If you have a joint bank or building society account with your spouse or partner you will be assessed as having half of the balance of the account. In these circumstances it is worth considering dividing any joint accounts so that each person holds their capital separately. Where one account holder uses part of their share of the account to meet care fees, dividing the remainder equally will not accurately reflect the parties' true interests in it.

4.4 Notional capital

This is capital that may be included in the means test even though you do not have it. For example, it could be capital that would be available to you on application, such as an unclaimed Premium Bond win, or capital that you have disposed of to avoid using it to pay for care – see section 5. Regulations 22-23 in Part 5 of the charging regulations and paragraph 28 of Annex B of the statutory guidance cover notional capital.

4.5 Valuation of capital

Capital will either have a **market value** – that is, 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 the asset, such as a mortgage, is deducted from the value. If, in order to realise an asset, you would incur expenses through selling it, then 10% will be deducted from the capital value for the purposes of the means test. If your capital is valued at more than £23,250 then no precise valuation is needed because you are expected to pay the full fee yourself. This is set down paragraph 20, Part 5, of the charging regulations and paragraph 14 of Annex B of the statutory guidance.

For information about the treatment of capital held in the form of property, including your former home, see the Age UK's Factsheet 38, *Treatment of property in the means test for permanent care home provision*.

Note: Compensation payments due to be made for losses due to regulatory failure for policy holders with Equitable Life will be regarded as capital if paid as a lump sum and as income if paid as a regular payment.

---

5 Deprivation of assets

If you give away assets or otherwise dispose of them in order to put yourself into a more favourable position to get local authority assistance with your care home fees, the local authority may be able to assess you as if you still have the assets. Regulation 22 of the charging regulations and Annex E of the statutory guidance allow a local authority to use its discretion when assessing the **timing and motive** for the transfer of eligible capital. The statutory guidance also confirms that eligible capital can occasionally be disposed of for justifiable reasons other than deliberate deprivation. This approach can be taken to **capital and income**. The local social security office can also consider whether assets were disposed of deliberately to qualify for means tested benefits such as Pension Credit.

Further information about intentional deprivation and the impact which this could have on you, or the person(s) to whom you have given assets, is contained in Age UK's Factsheet 40, *Deprivation of assets in the means test for care home provision*.

6 Your income

Note: Unless your income is specifically identified as being fully or partly disregarded, it will usually be taken into account in full.

If you are the person assessed as needing care in a care home, then weekly income in your name will be looked at for the purposes of the means test.

The local authority will usually make its calculations on the basis that any income that is available from benefits such as Pension Credit is being claimed so it is important to ensure that you have applied for any possible benefits. Your income and any 'tariff' income from capital between £14,250 and £23,250 will be taken into account during the initial 12-week property disregard and during any deferred payment arrangements.

In the local authority means test, income will be either:

- disregarded (ignored);
- partly disregarded; or

- included.

Part 4, Regulation 13 and Schedule 1 of the charging regulations, and Annex C of the statutory guidance, cover the treatment of income.

6.1 Disregarded income

Types of income that must be disregarded in the means test are listed in Schedule 1, Part 1, of the charging regulations. The most common disregards include:

- Disability Living Allowance (DLA) or Personal Independence Payment (PIP) mobility component. See section 7.3 for further information;
- War Widows' special payments – the special payment of £86.99 introduced in April 1990 for 'pre-1973 War Widows' (in addition to the £10 partial disregard for War Widows);
- Christmas Bonus;
- income from savings – if you have interest paid on your savings, this is added to the balance of your savings and counts as part of your capital – not as income;
- charitable and voluntary payments (which could be made by a relative);
- any payments of Child Tax Credit or Guardian's Allowance;
- any payment made because of any personal injury to a claimant or his or her partner, except where the payment is specifically intended to cover the costs of care, for up to 52 weeks from the day of receipt of the first payment. If the money is placed in a disregard location such as a personal injury trust or administered by a court the relevant disregards will apply;
- awards of certain damages, not only where those awards are held by the court but also where they are held subject to the order of direction of the court;
- discretionary payments that started being made in October 2011 to those who have been infected with hepatitis C by contaminated blood products will be ignored in the means test.

Note: Universal Credit will gradually replace benefits Income support, Housing Benefit, Income-based Job Seeker's Allowance, Income-related employment and Support Allowance, Working Tax Credit and Child Tax Credit. It will be fully taken into account as income in the means test (Annex C paragraph 16 of the statutory guidance).

6.2 Income that is partly disregarded

Some kinds of income must be partly disregarded, such as:

- £10 per week of a War Widow's, War Widower's or War Disablement Pension;
- 50% of a private or occupational pension must be ignored by the local authority (but will not be ignored for Pension Credit purposes) where the pension is received by a married person or a civil partner in a home, provided this amount is paid to his or her spouse or civil partner – and the spouse or civil partner does not live in the same residential or nursing 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 per week (£8.60 for a couple).

For individuals with higher incomes who are unable to claim Pension Credit or have been awarded less than £5.75/£8.60 per week, a flat-rate disregard of £5.75/£8.60 per week is applied. See section 6.1 for further details about Pension Credit.

6.3 Capital to be treated as income

Section 16 in Part 4 of the charging regulations lists capital to be treated as income. This includes payment received under an annuity and earnings that are not a payment of income; also 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 to them, any such, non-income, periodical payments are to be treated as income.

6.4 Notional income

Similar to notional capital, notional income is income that you may be treated as having even though you don't actually receive it, for the purpose of the means test. For instance, it could be income paid by someone else (perhaps a relative) to the local authority or to the home as a 'third party contribution'; or income that would be available to you if you applied for it, such as unclaimed social security benefits, or unclaimed occupational pension; or income that you have disposed of. These rules are set down in paragraph 17, Part 4, of the charging regulations and paragraph 32, Annex C, of the statutory guidance. For further information, see Age UK's Factsheet 40, *Deprivation of assets in the means test for care home provision.*

7 Social security and disability benefits

Whether you are single or one of a couple, the local authority will **expect you to claim** all the social security benefits to which you are entitled when you move to live permanently in a care home.

If you are already claiming a social security benefit, the local authority may ask to see details. It may also ask you for permission to request information from your local social security office. Social security benefits include the State Pension, Attendance Allowance, Disabled Living Allowance and Pension Credit.

7.1 Pension Credit

Note: The government is increasing the qualifying age for those social security benefits where provision is aligned with the age at which women become eligible for state pension. It will increase from 60 to 65 between April 2010 and November 2018. State Pension age for both men and women will then increase to 66 by October 2020. These changes affect Pension Credit and a number of other benefits. In April 2015 it is 62.5 years.

Pension Credit has two parts:

- Guarantee Credit and

- Savings Credit.

The general rules governing eligibility for Pension Credit are explained in Age UK's Factsheet 48, *Pension Credit*.

Pension Credit is means tested and eligibility is based on your income and capital. For a resident living permanently in a care home, living in their own home or temporarily in a care home capital up to £10,000 is disregarded.

The figures given below for couples refer to couples who are permanently living together.

If one of a couple enters a care home on a temporary basis (perhaps for respite or a trial period) then they will still be treated as a couple for Pension Credit purposes. The couple are treated as having tariff income of £1 per week for every £500 (or part of £500) above the lower capital limit. There is no upper capital limit. Where **one partner moves permanently** into residential accommodation Pension Credit will be paid as if he or she is a single person. For more details on couples see Age UK's Factsheet 39, *Paying for care in a care home if you have a partner.*

Eligibility for either of the components of Pension Credit is established by totalling up the person's income, including any tariff income. Most forms of income are taken into account as 'qualifying income'. Details of the items that are disregarded can be found in Age UK's Factsheet 48, *Pension Credit*.

7.1.1 Guarantee Credit

Guarantee Credit tops income up to a set level for individuals whose income is below that level. The level of income the claimant is said to need is known as the 'appropriate amount'.

The standard levels are £151.20per week for a single person and £230.85 for a couple. Extra amounts may be added to these levels if the claimant(s) is/are receiving Attendance Allowance (AA) or Disability Living Allowance (DLA) (middle or higher rate of the care component) or Personal Independence Payment (PIP) (either rate of the daily living component) and lives alone or is classed as living alone, is a carer or for certain housing costs. The amount of Guarantee Credit paid will usually be the difference between the claimant's existing income, less any disregarded amounts, and the appropriate amount.

7.1.2 Savings Credit

The Savings Credit is only available to claimants aged 65 or over who have made some extra provision towards their retirement such as though savings or an occupational pension and whose income is more than the Savings Credit threshold. If you have 'qualifying income' above a certain threshold you may be able to claim the Savings Credit. Those thresholds are currently £126.50 per week for a single person (and £201.80 for a couple).

If your qualifying income is more than this but less than your appropriate amount, Savings Credit is calculated at a rate of 60p for every £1 of income above the threshold up to a maximum of £14.82 per week for a single person (£17.83 for a couple). For incomes greater than the appropriate amount, Savings Credit is reduced from its maximum level by 40p for every £1 of income above those levels.

A single person with qualifying income above £188.25 per week, or a couple with qualifying income above £274.42 would not qualify for Savings Credit unless their appropriate amount included extra amounts for severe disability, caring or housing costs. Most care home residents would not qualify for these extra amounts.

7.1.3 Income partly disregarded – savings disregard

A specific disregard of income exists for people aged 65 and over within the residential care means test rules called a savings disregard (see paragraph 40 of schedule 1 to the charging regulations).

As described in section 6.1, people aged 65 and over can benefit from savings credit which is designed to reward those who have made provision for their old age through second pensions or similar savings. In order to reflect in part the rules that are in the pension credit scheme, a savings disregard was introduced for people aged 65 and over in 2003. The disregard applies to income and savings that count, within the pension credit scheme, towards the savings credit.

A resident who actually receives the savings credit within his or her pension credit receives up to a maximum savings disregard of £5.75 for a single person (£8.60 for a couple). So, for example, if a resident receives only £4.45 actual savings credit, it would be this figure that is disregarded. If he or she happens to receive a savings credit above £5.75 as a single person he or she would still only have £5.75 of this figure disregarded (£8.60 for a couple).

Individuals whose income is such that it takes them above the pension credit savings credit level (£188.25 or £274.42 for a couple) are still entitled to a savings disregard of £5.75 (£8.60 for a couple). There does not need to be a claim for or an award of Pension Savings Credit in this situation and, whilst the level of income above the threshold does not affect the entitlement to a savings credit disregard, it must be 'qualifying income' as defined by the pension credit rules (paragraph 40(6) (b) of schedule 1 to the charging regulations).

7.1.4 Pension Credit and property

While you are trying to sell a property that is not disregarded for another reason, Pension Credit can be paid for 26 weeks (or longer ‘if reasonable’), provided the office handling your claim is satisfied that you are taking ‘reasonable steps’ to sell it.

This Pension Credit does not have to be repaid when your property is sold. There is no upper capital limit for Pension Credit; it is therefore possible, but unlikely, that someone with a property with a low value might in some circumstances be able to claim Pension Credit even if the property was being taken into account.

There is no 12-week property disregard for Pension Credit. Entitlement to the benefit will cease during the 12-week local authority disregard unless the property is put on the market.

If the property is put on the market at the end of that period a further claim for Pension Credit can be made until the property is sold. The local authority will have to adjust its charges accordingly.

See Age UK’s Factsheet 38, *Treatment of property in the means test for permanent care home provision*, for further information in this subject.

Note: The local authority should charge you based on your actual income and alter the charge to take account of any changes. It is important that you check your benefits and what the local authority charges to make sure they tally.

7.2 Disability-related benefits

People who pay the full cost of their fees (self-funders or retrospective self-funders), including those in local authority care homes, are still able to claim or continue receiving AA or DLA (care component), or PIP (daily living component).

The NHS payment for NHS-funded nursing care in care homes should not affect your entitlement to AA/DLA (care component) or PIP (daily living component).

DLA and PIP Mobility Component are fully disregarded within the residential care means test because they are not related to the provision of personal care and support. As a result they should continue to be paid to a permanent local authority funded resident as well as to someone who is self-funding or who has arranged a deferred payment and is therefore retrospectively self-funding.

If you already receive AA/DLA (care component) / PIP (daily living component) and move permanently into a care home arranged by the local authority, it will be included as part of your income. However, payment of AA/DLA (care component) or PIP (daily living component) will normally stop after four weeks (sooner if it is linked with a stay in hospital or an earlier period of state-funded care) if you are receiving financial help from the local authority. If the local authority has arranged your care and made a contract with the care home but you are paying the full cost of your personal care and accommodation you should still be able to receive AA/DLA (care component) or PIP (daily living component).

AA/DLA (care component) or PIP (daily living component) will also stop after four weeks of funding under the 12-week property disregard. If at the end of the 12 weeks you continue to receive local authority funding but on an interim (ie loan) basis, under the deferred payment scheme you should ask for AA/DLA (care component) or PIP (daily living component) to be reinstated. See Age UK's Factsheet 38, *The treatment of property in the means test for permanent care home provision*, for further information on deferred payments.

AA/DLA (care component) or PIP (daily living component) can be paid while you are receiving interim or temporary funding from the local authority (e.g. while you are selling your property) provided that any assistance received from the local authority will later be repaid in full.

Point of law: The *Social Security (Attendance Allowance and Disability Living Allowance) (amendment) Regulations 2007* clarify **when you are considered to be resident** in a care home and, therefore, after four weeks not entitled to payment of AA/DLA (care component). For PIP, the *Welfare Reform Act 2012* clarifies when you are considered to be resident in a care home and *The Social Security (Personal Independence Payment) Regulations 2013* state that you cannot be paid PIP(daily living component) after four weeks. You will be considered to be resident in a care home when any of the costs of any qualifying services (accommodation, board and personal care) provided for you are paid out of public or local funds under specified legislation. 'Qualifying services' do not include services such as domiciliary services, including personal care, provided to you in your own private home. The Regulations clarify the days that count as being resident in a care home for the purpose of AA/DLA (care component) or PIP (daily living component) entitlement. If you go into a care home from the community, the days you enter and leave are counted as days in the community and the day of transfer between a care home and a hospital or similar institution (or vice versa) is treated as a day in a care home.

Pension Credit can be paid while you are receiving interim funding providing that your property is up for sale. If AA/DLA (care component) or PIP (daily living component) is being paid at the same time then the appropriate amount for Guarantee Credit should be calculated to include the additional amount for severe disability (if you are eligible for this additional amount), currently £61.85 per week, which may reduce the amount that ultimately has to be 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) should be paid as long as you will be refunding the local authority in full but eligibility for Pension Credit may be affected if your property is not up for sale.

If your AA/DLA (care component) or PIP (daily living component) has been stopped because you are getting local authority funding and you subsequently return home – or move elsewhere, for example sheltered housing – you can ask for it to begin again.

It can also begin again if the local authority no longer needs to give financial help for the cost of the fees, for example if you inherit capital. It is important to inform the appropriate authority of any changes so that you receive all the benefits you are entitled to.

Further information about AA/DLA (care component) is available in Age UK's Factsheet 34, *Attendance Allowance*, and Age UK's Factsheet 87*, Personal Independence Payment and Disability Living Allowance*.

Note: AA/DLA (care component) or PIP (daily living component) might be payable if you are temporarily away from a care home. You should always inform the social security office responsible if you want your AA/DLA (care component) or PIP (daily living component) paid again.

7.3 The introduction of Personal Independence Payments

Disability Living Allowance (DLA) is being replaced by the Personal Independence Payment (PIP). New claimants who would previously have claimed DLA must now apply for PIP. If you presently receive DLA, this will continue but if your circumstances change, you will be assessed for PIP rather than DLA. Everyone else in receipt of DLA is being assessed for PIP between April 2015 and 2018.

If you're currently receiving DLA and you were over 65 on 8 April 2013, you will stay on it for the time being.

PIP has many similarities with Disability Living Allowance. It has two components: a daily living component (similar to DLA's care component) and a mobility component, which are paid at different rates depending on the level of difficulty you have. It isn't means-tested, so it isn't affected by your income and savings. It isn't taxable. You need to be under 65 to make a claim.

For further information see Age UK's Factsheet 87, *Personal Independence Payment.*

8 Business assets

As discussed above, the presumption in the charging regulations and statutory guidance is that all of your eligible capital and income can be considered by the local authority for the residential care means test.

However, paragraph 9 of Schedule 2 to the charging regulations (and Annex B paragraph 47(a) of the statutory guidance), also allows a **26 week or longer disregard** of the assets of any business owned (or part-owned) by a new care home resident who has had to stop self-employed work due to illness or disablement. This is in the short-term where the intention is to take up work again in the future when the person is able.

With regard to permanent residents, statutory guidance at Annex B paragraphs 50 and 51 advises the local authority that it must disregard the capital value of eligible business assets for a **reasonable** period of time, providing **steps are being taken** to realise the capital value and specified information is provided (see below). If no immediate intention to realise the capital value in the business assets is demonstrated, paragraph 52 advises local authorities to take their value into account in the means test.

Paragraph 50 advises the local authority to obtain information about: the nature of the business asset; the resident's estimate of the length of time necessary to realise the asset; the resident's share of 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 the person's health, receivership, liquidation or an estate agent's confirmation of placing any property on the market.

9 Choice of accommodation and top-up

The local authority assessment and care and support planning process will have determined what type of accommodation will best suit your needs. Care home accommodation (in addition to supported living schemes and shared lives) is a type of accommodation specified in the *Care and Support and After-care (Choice of Accommodation) Regulations 2014* and as such you have a **right to choose** the particular provider or location, subject to **certain conditions** (see below).

The local authority should tell you what arrangement it can make according to its assessment of your eligible needs and your related personal budget, which should be provided with your care and support plan. It has a duty to provide suitable local residential care at the personal budget level, with section 8.37 of the statutory guidance also requiring the provision of a 'genuine choice'. It should also give you information about suitable care homes but your choice must not be limited to those settings or individual providers with which the local authority already contracts with or operates. In addition to any area in England, arrangements can also be made for placements in Scotland, Wales and Northern Ireland in accordance with Schedule 1 of the *Care Act 2014* and Chapter 21 of the statutory guidance (cross-border placements) which have been agreed by the four administrations of the UK.

Where a local authority is responsible for meeting your care and support needs and your needs have been assessed as requiring a particular type of accommodation you must have the right to choose between different providers of that type of accommodation provided that:

- the accommodation is suitable in relation to 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 of the accommodation is willing to enter into a contract with the local authority to provide the care at the rate identified in your personal budget on the local authority's terms and conditions.

The new, single set of national eligibility criteria allows for a **portability** of care and support packages with a **continuity of care** as defined under Sections 37-38 of the *Care Act 2014* and the *Care and Support (Continuity of Care) Regulations 2014*.The receiving local authority must have regard to the existing care package and must honour it until it has carried out outs own new needs assessment. Carers have a separate set of criteria.

Regulation 2 of the choice of accommodation regulations extends the choice of accommodation rights to **shared lives, supported living and extra care housing** settings where this is the specific type of accommodation recommended to meet assessed needs.

See Age UK's Factsheet 60, *Choice of accommodation – care homes*, for further details. This Factsheet is largely based on Annex A of the statutory guidance entitled 'Choice of accommodation'.

9.1 Third party contributions

If your 'preferred accommodation' costs more than the local authority has specified in your 'indicative personal budget' – the amount that it would normally pay for someone with your assessed eligible needs, it must still make the arrangements for you in that home as long as someone else (and in some cases yourself – see below) can make up the difference between that figure and the home's fee by making a third party contribution. This is also known as an 'additional payment' or **'top-up'**. In this context 'indicative' means the assessor's initial estimation of the cost of meeting eligible needs within the care and support planning process.

This does not mean that local authorities can set **arbitrary ceilings** on the amount which they will pay so that you are *required* to have a 'top-up' in order to meet the cost of the care home. The authority must be able to demonstrate that care and support suitable to meet your assessed eligible needs can be arranged *within* the amount specified in your personal budget. Under the *Care Act 2014*, this means that the personal budget must contain a **realistic figure** capable of allowing your residential care needs to be met locally.

Note: Chapter 8.37 of the statutory guidance states that third party payments "must always be optional and never as a result of commissioning failures leading to a lack of choice."

If there is no care home which can meet your assessed eligible needs within the amount that the local authority has set as your 'indicative personal budget', it must agree to **increase your actual personal budget** to meet the extra cost. A more expensive home might be necessary, for example, if you have **particular needs** which cannot be met within your indicative personal budget (for example, religious or dietary needs, or the need to be near relatives such as your spouse), or if **market pressures** mean that there are no homes in the area accepting residents at the rate the local authority has set in your indicative personal budget.

Where you have **chosen** a care home that costs more than the amount in your personal budget because you prefer it and a third party agrees to meet the additional cost, the local authority is obliged to make a contract with your preferred home subject to the conditions outlined above. However, the third party will need to show that they can reasonably expect to be able to contribute for as long as the arrangement lasts – i.e. for the length of time the resident is in the home.

The third party and the local authority will also need to agree what will happen if the home's fees are raised: the local authority will not necessarily agree to pay for all, or even part of, such an increase. If the third party additional payments cannot be continued for some reason, you may have to **move to another home** but the local authority should carry out an assessment of the risks involved before taking this course of action.

The Care and Support and After-care (Choice of Accommodation) Regulations 2014 and Annex A of the statutory guidance also confirm that additional payments and choice of accommodation have now been **extended** to those being placed for **'after care'** under section 117 of the *Mental Health Act 1983* "where the cost to the local authority of providing or arranging for the provision of the preferred accommodation is greater than the amount that the local authority would expect to be the usual cost of providing or arranging for the provision of accommodation of that kind"*.*

The rules about preferred accommodation and when local authorities can legitimately ask for top-up payments are explained in more detail in Age UK's Factsheet 60, *Choice of accommodation – care homes*. Age UK's Factsheet 29, *Finding care home accommodation*, provides further information on finding accommodation suitable to meet your needs.

Residents' contributions to more expensive accommodation

It is not generally possible for residents to self-top-up ('first-party' top-up) to meet the additional costs of more expensive accommodation, for example by using the personal expenses allowance, or disregarded capital or income.

However, residents whose property is subject to the 12 week disregard or who have entered into a 'deferred payment agreement', or where they are receiving accommodation provided under S117 for mental health aftercare, *can* make additional payments themselves. This exception is made to the usual rule for people in those specific circumstances as they are considered to have enough resources themselves to pay for more expensive accommodation once the value of their home is realised (or, for those provided with non-chargeable aftercare, from their resources which they retain).

Funding reform proposals (under the *Care Act 2014*) due to be implemented from April 2016 and currently subject to consultation, allow for the restrictions on 'first party' top-ups to be lifted where a resident can afford and sustain ongoing top-up payments from their own financial resources.

Further information about deferred payments can be found in Age UK's Factsheet 38, *Treatment of property in the means test for permanent care home provision.*

Also see Age UK's Factsheet 60, *Choice of accommodation – care homes,* the information guide *How to find a care home,* and the *Care home checklist*.

10 Personal Expenses Allowance

The local authority has to allow the resident to retain a Personal Expenses Allowance (PEA) of £24.90 per week (Part 2, Regulation 6 of the charging regulations). You should not be asked to put your PEA towards the basic cost of your care if you are a permanent or temporary resident.

Local authorities have a discretionary power to vary the Personal Expenses Allowance (PEA) above the national set level in a range of circumstances. The local authority must adhere to the statutory guidance set down in Annex C paragraphs 41 to 44. Paragraph 44 provides an illustrative list of examples to assist local authorities in the use of the discretionary power to vary the PEA.

For more information about how the PEA could affect you if you are part of a couple see Age UK's Factsheet 39, *Paying for care in a care home if you have a partner*.

11 The means test calculation

Once the local authority has all the information about your income and capital, it can calculate how much you should contribute towards the costs of your care, making sure that you are left with a weekly PEA of £24.90. The local authority should provide you with written information setting out how it has calculated the amount you should pay, including the level of your personal budget. The following basic examples are given to help you work out how much your contribution might be.

Example 1

The local authority arranges for you to move permanently into a care home run by a charity. Your personal budget has been set at £600 to meet your assessed eligible care and support needs. The home costs £600 per week. You are 83 and single, and live in a rented flat. You have capital of £5,000 and your weekly income is the basic State Pension of £115.95 (including the 80+ age addition of 25 pence) and PC Guarantee Credit of £35.255 to give an assessable amount of £151.20 per week.

What is ignored: Your capital is ignored by the local authority because it is less than £14,250 (£10,000 for Pension Credit once you are permanently living in a care home).

The local authority calculation	**£**
Total weekly income (£115.95 plus £35.25)	151.20
Less PEA	24.90
Your weekly contribution to personal budget	126.30
Local authority's contribution to personal budget	473.70
Cost of the home	600.00

Example 2

The local authority agrees to arrange a permanent place for you in a care home that costs £650 per week. Your personal budget has been set at £650 to meet your assessed eligible care and support needs. You are married, aged 82, with a weekly private pension (£200). Your wife will remain living in the flat you jointly own.

Your State Pension is £115.95 per week (including the 80+ age addition of 25 pence). You have a savings account in your name of £10,400 and a joint account with your wife of £8,000. (If this describes a situation similar to your own, see also Age UK's Factsheet 39, *Paying for care in a care home if you have a partner*).

What is ignored: The value of your flat is ignored because your wife continues to live there. Half of your private pension will be ignored by the local authority if you pay this half to your wife.

What is included: Your savings of £10,400, together with half of the balance of the joint account you hold with your wife, i.e. £4,000 are included in the local authority calculation. Your total capital will be assessed as £14,400, so you will have a tariff income of £1 per week. Your State Pension and the other half of your private pension are included are included.

Because of the level of your weekly income you will not qualify for Pension Credit Guarantee Credit (income above £151.20) or Savings Credit (income above £188.25). However, as your assessed income is more than £188.25 per week the local authority must disregard £5.75 per week of that income (in addition to allowing you to retain a PEA of £24.90).

The local authority calculation	
Your weekly income	**£**
State Pension	115.95
50% private pension	100.00
Tariff income from capital	1.00
	216.95
Less Personal Expenses Allowance (PEA)	24.90
Less disregard of qualifying income for Pension Credit	5.75
Your weekly contribution to personal budget	186.30
Local authority's contribution to personal budget	465.80
Cost of the home	650.00

12 Paying for ‘extras’ in care homes

You should make sure you find out exactly what care the local authority is arranging for you when it makes a contract with a home, and in the case of care homes with nursing (nursing homes), confirm whether or not the NHS registered nurse contribution (£110.89 per week in 2014/2015) has been included in the basic contract price – you shouldn’t have to pay for this. The basic contract price should cover all essential care but may not, for instance, cover such things as clothing or hairdressing. The local authority may expect you to use your Personal Expenses Allowance of £24.90 to cover costs such as these.

The statutory guidance states that there is a difference between paying for more expensive accommodation and paying for ‘extras’ that do not form part of the care package. The purpose of the PEA is to ensure that a person has money to spend as they wish. Annex C, paragraph 43 of the statutory guidance states that “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”. It should not be spent on aspects of board, lodgings and care that have been contracted for by the local authority. This does not preclude residents buying extra services from the care home, where these are genuinely additional to services that have been contracted for by the council and/or assessed as necessary by the council or NHS.

13 Arrangements for paying the care home fee

Note: Where a local authority is meeting needs by arranging a care home, it is responsible for contracting with the provider. It is also responsible for paying the full amount, including where a ‘top-up’ fee is being paid (Chapter 8.33 of the statutory guidance) as part of its duty to meet eligible needs.

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, including any benefits you receive.

However, if there is a ‘top-up’ element required for your accommodation and all parties agree (you or the ‘third party’ paying the top-up, the local authority and the home), then you and the local authority can each pay your respective share directly to the home. However, paragraphs 25 and 29 of Annex A to the statutory guidance states that this is not recommended.

14 NHS and other social care services in care homes

The NHS is responsible for providing community health services to people in care homes on the same basis as to people in their own homes. These services include district nursing and other specialist nursing services and advice on incontinence or stoma care, as well as providing (where necessary) incontinence supplies and nursing aids, physiotherapy, speech and language therapy and chiropody.

Where such services are provided by the NHS, they are free of charge. The NHS will cover the cost of any equipment for you that is not provided as standard within the home, if you are assessed as needing it. See section 13 for further details of NHS responsibilities towards residents in care homes that provide nursing care.

Each Clinical Commissioning Group (CCG) should have its own criteria for the type of help it will provide, based on guidance issued by the Government. These criteria should be published.

Local authorities should also provide other personal social care services to people in care homes based on their eligible needs. This could include short-term rehabilitation or the provision bespoke disability equipment such as specialist seating - beyond what the care home has a legal duty to provide. This is based on each resident’s general right to a social care needs assessment where they live.

Action: If you have difficulty obtaining information or feel that you have been incorrectly charged for products and services, consider making a complaint. Both local authorities and local health bodies are required to operate formal complaints procedures and should provide you with details of these procedures.

---

15 Non-means tested assistance with care costs

In this section exceptions to the means tested funding requirement are set out for elements of residential care and related services.

15.1 Fully funded NHS continuing healthcare

Note: In certain circumstances, the NHS is responsible for meeting the full cost of someone's care in a care home. This is called for NHS continuing healthcare or 'fully funded care'.

To be eligible a resident must have a significantly high level of needs in a number of areas (known as 'domains' in the assessment tool) resulting in their **'primary need' being health-based** – thus entitling them to free health care rather than means-tested social care.

The assessment procedure is contained in the *National Framework for NHS continuing healthcare and NHS-funded nursing care* was introduced in October 2007 (revised in November 2012).

If you might be eligible for NHS continuing healthcare, the professionals involved in your care (for example the GP, nursing staff or social worker) must actively consider this possibility. They should also inform you or your representatives of your rights and carry out an appropriate assessment based on the National Framework guidelines and its assessment tools. To move to the social care means test without addressing the 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 care has not been addressed by those working with you, and should have been, you should ask to be assessed initially using the checklist tool as set out in the guidance.

For more information see Age UK's Factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

15.2 Rehabilitation – intermediate care and reablement

Part 2 of the charging regulations in support of the *Care Act 2014* confirm that rehabilitation services, often called intermediate care or reablement, must be provided free of charge for the first six weeks.

This short-term service is often provided to prevent hospital admission or after discharge from hospital to maximise independence, where a rehabilitation potential has been identified. It may be provided in your own home or in residential care. There should be an initial plan and reviews throughout to gauge progress.

Rehabilitation does not normally last longer than six weeks, but may occasionally need to be extended. At the end of this period you may qualify for fully funded NHS continuing care, or require other social care services for which you may be charged.

For more information see Age UK's Factsheet 76, *Intermediate care and reablement*.

15.3 Care provided by registered nurses in care homes

Note: The NHS is responsible for meeting the registered nursing costs of all residents in care homes that provide nursing care (nursing homes).

Nursing care is the care given by a registered nurse in providing, planning or supervising your care in a care home with nursing (also known as a nursing home). It does not include time spent by any other staff involved in your personal care. Responsibility for meeting the cost of your nursing care lies with your Clinical Commissioning Group (CCG). If you move to a home in a different CCG area, you will become the responsibility of that CCG when you register with a GP there.

For 2015/16 the NHS Funded Nursing Care (FNC) elements are:

- £110.89 per week - Standard rate
- £152.61per week - Higher rate

The vast majority of people receive the Standard rate. The Higher rate has been retained from the previous multi-level system, which ended in 2007, for those who were receiving the Higher rate at that time.

The NHS does not make these payments to you, but makes them to the care home or local authority. 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 within the statement of terms and conditions that they provide. You may need to ask if the fee quoted includes or excludes the payment made to them by the NHS for NHS-funded nursing care.

For further information see Age UK's Factsheet 20, *NHS continuing healthcare and NHS-funded nursing care*.

15.4 Mental health 'after-care' services

If you have previously 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 of this Act. Local authorities cannot charge for after-care provided under Section 117 and this has been confirmed by the House of Lords. Section 117 places a joint duty on health and social services authorities to provide these after-care services.

The *Mental Health Act 1983* has been 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 the conditions in the regulations are met. The regulations give people who receive mental health after-care broadly the same rights to choice of accommodation as someone who receives care and support under the Care Act 2014 although there are no restrictions upon when the resident themselves can pay a 'first party' top-up.

Points of law: 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 that the individual no longer needs such services. The judge felt that it was difficult to see how such a situation could arise where the illness is dementia. The Ombudsman has found maladministration where a local authority sought to discharge a person from section 117 who is in a care home on the grounds they had 'settled' - Complaint number 06/B/16774 against Bath and NE Somerset Council 2008.

15.5 Continence services

The NHS is responsible for providing continence services to residents in homes providing nursing care and for meeting the cost of any continence supplies (such as continence pads) that those residents are assessed as requiring, including any equipment needed.

Community health services such as continence supplies and district nursing should be provided to residents of care homes that do not provide nursing care using the same criteria as for people living in their own homes.

15.6 Specialist assessment and bespoke equipment

Care homes have to provide an appropriate range of equipment to meet the needs and ensure the safety of their residents, and to meet Care Quality Commission standards. This may include manual handling, lifting and mobility equipment. The basic equipment types will be different in care homes with and without nursing. For example, a care home with nursing would generally be required to provide a pressure reliving mattress because it is likely to have residents in need of this type of equipment. Care homes should not accept people whose needs they are unable to meet.

If you require equipment that is not supplied by the care home because it is designed to meet needs that are specific to you and it is bespoke, the NHS or the local authority should provide it on the same basis as they would if you were in your own home.

This is usually in the form of a loan from the local NHS and local authority equipment store for as long as you need it, with no charge. Provision of specialist equipment may require an assessment from an occupational therapist from the local authority or district nurse. Examples of this could be where someone needs bariatric care (for obesity) and they need extra wide and extra strong equipment or where specialist seating designed to provide a specific type of body support is required.

15.7 Assistance for war veterans

Veterans UK, formerly the War Pensions' Welfare Service, can pay towards the cost of a care home possibly providing nursing care for War Pensioners in specific circumstances. If you have a high rate of war pension and think you may need residential care, seek advice from this service (see section 21).

16 The local authority information and advice duty

Section 4 of the *Care Act 2014* requires each local authority to establish and maintain an information and advice service relating to the care and support needs of service users and the support needs of carers in its area. The service must provide information and advice on the following areas:

- the local care and support system and how it operates;
- the choice of types of care and support, and the choice of providers available to those who are in the authority's area;
- how to access the care and support that is available;
- how to access independent financial advice on matters relevant to the meeting of needs for care and support; and
- how to raise concerns about the safety or wellbeing of an adult who has needs for care and support.

With regard to the duty, a local authority must have regard to the importance of identifying local people who would benefit from this service to ensure that its provision enables people to:

- to identify matters that are or might be relevant to their personal financial position in this context;

- to make plans for meeting needs for care and support that might arise; and
- to understand the different ways in which they may access independent financial advice on matters relevant to the meeting of needs for care and support.

The information and advice provided or arranged by the local authority must be accessible and appropriately.

'Independent financial advice' means financial advice provided by a qualified person who is independent of the local authority in question.

17 People who can act on your behalf

17.1 Appointeeships for benefits

If a person receiving social security benefits is unable to manage his or her affairs, the Secretary of State for Work and Pensions (through the local social security office) can appoint someone else to make claims and receive benefits on behalf of the resident. An appointee would normally be a close friend or relative who visits the older person regularly.

As a 'last resort', the care home owner can act as appointee, but in such cases he or she must keep a record of the money collected on the person's behalf. An appointee's powers only extend to the management of social security benefits. The claimant and the prospective appointee will be interviewed before any appointment is made.

17.2 Your right to independent advocacy

Someone you know may need to enter a care home, but may have difficulty expressing their views or making decisions for them-self. It is important to try to represent the person's point of view as well as possible. Sometimes this might involve friends or family speaking on behalf of the resident. Under section of the *Care Act 2014*, there must be access to local independent advocacy, if needed.

Local authorities must form a judgment about whether a person has "substantial difficulty in being involved" with the care and support processes and if it is thought that they do, and that "there is no appropriate individual to support and represent them for the purpose of facilitating their involvement, then the local authority must arrange for an independent advocate to support and represent the person". (Chapter 7.8 of the statutory guidance) This links with the local authority's duty to maximise your involvement in the assessment and care planning process, and the means test procedure. The duty is triggered where a person would experience substantial difficulty:

- understanding the relevant information;
- retaining that information;
- using or weighing that information as part of the process of being involved;
- communicating their views, wishes or feelings (whether by talking, using sign language or any other means).

This is similar to the duties triggered under the *Mental Capacity Act 2005* to provide an Independent Mental Capacity Advocate but it is not just confined to that definition.

An appropriate person must be provided by the local authority to fulfil this role.

17.3 Mental capacity – advocates and attorneys

Note: While you are able to make decisions and express your views, you may wish to consider how you would want your affairs dealt with if you lose the mental capacity to do this in future.

In October 2007, the ***Mental Capacity Act 2005*** was implemented in full along with a Code of Practice. It replaced the previous system of Enduring Power of Attorney (which covered financial and property affairs) and Receivership under the Court of Protection, with a **Lasting Power of Attorney** (LPA) and the new role of **Deputy** under the Court of Protection. An LPA still enables you to choose someone to take financial and property-related decision on your behalf but you can now choose someone to take welfare and healthcare decisions.

If there are issues to do with mental capacity regarding the arrangement of a care home placement, it is necessary for all those supporting or working with an individual to adhere to the **'best interest' standards** set out in the *Mental Capacity Act 2005*. The Act sets out a **legal test** to assist with the decision as to whether an individual lacks mental capacity and therefore may need to have a 'best interest' decision made on their behalf.

It also establishes the following **principles about mental capacity**: a presumption of mental capacity until proved otherwise; a person's right to be supported to make their own decisions by all reasonable means; the right to make what may appear to be eccentric or unwise decisions; any decision made or action taken on a person's behalf must be made in their best interests; and anyone making a decision for or on behalf of a person without capacity should consider all effective alternatives and choose the one that is the least restrictive of the person's basic human rights and freedoms.

The Deprivation of Liberty Safeguards (DOLS) came into force in April 2009 under amendments to the *Mental Capacity Act 2005* in response to a decision by the European Court of Human Rights. They relate to those who lack mental capacity and who are deprived of their liberty in any way in a hospital, care home or supported living arrangement. Section 10 and Annex H of the statutory guidance cover this subject, for example setting out how to act in the least restrictive manner in terms of a person's human rights and also how to appropriately administer the required authorisation process. A recent Supreme Court case decision held that a person may be deprived of their liberty when they are under continuous supervision and control and are not free to leave, and they lack capacity to consent to the arrangements.

Local authorities have to appoint an **Independent Mental Capacity Advocate (IMCA)** where someone who lacks capacity to make a decision about moving into a care home and has no friends or relatives to support them. This subject is covered in section 7 of the statutory guidance.

Note: Independent advocacy under the duty flowing from the *Care Act 2014* is similar in many ways to independent advocacy under the *Mental Capacity Act 2005*. The Care Act guidance and regulations have been designed to enable independent advocates to be able to carry out both roles.

For further information see Age UK's Factsheet 22, *Arranging for others to make decisions about your finances or welfare* and Age UK's Factsheet 62, *Deprivation of Liberty Safeguards*.

18 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. However, if you want the NHS to pay for your nursing care (see section 14) or think you may qualify for NHS continuing care, you will need an assessment to establish your eligibility.

From April 2016, under the *Care Act 2014*, all payments made by you to meet your assessed eligible care needs, up to the level of your 'personal budget' (if the local authority are arranging your care and support and recovering the full cost from you) or 'independent personal budget' (if you are making your own arrangements), will be registered in your new care account. These payments will accrue towards the new care cost cap (£72,000 in 2016), above which the state will meet your care fees. Payments to meet the new daily living cost fee (£230 per week in 2016), will not count towards the cap and will have to be paid until residential care is no longer needed where a local authority is involved. You will need to be assessed by your local authority and found to have eligible needs to activate a care account.

Between April 2015 and March 2016, if you have savings of more than £23,250, you will be expected to pay the fees for your accommodation and personal care in full until your savings drop below this level. This upper capital limit figure is expected to rise to £27,000 (for non-residential care and support or residential care where the value of the resident's home is disregarded) or £118,000 (for residential care where the value of the resident's home is not disregarded) in April 2016.

If you are self-funding but your capital is falling towards £23,250, you should approach the local authority and ask for an **assessment** of your care needs. This may take some time to arrange so it may be worth approaching the authority a few months before your capital reduces to £23,250.

Local authorities have been told that in this situation they must undertake an assessment **as soon as is reasonably practicable** and, if necessary, take over the arrangements to ensure that a resident is not forced to use up capital below the upper limit. The Department of Health has advised that authorities may be liable to reimburse residents for extra expenditure incurred as a result of the authority delaying in making arrangements. The lower capital limit below which capital is disregarded in the means test is £14,250. This will rise to £17,000 in April 2016. Your capital should not fall below this if proper procedures are observed.

You may be able to claim receive AA/DLA (care component) or PIP (daily living component) if you are not receiving funding assistance from the local authority. NHS payments for registered nursing care may not affect your right to receive AA/DLA (care component) or PIP (daily living component). Depending on your capital and income you may also be able to claim Pension Credit. See section 6 for further information or contact Age UK to discuss benefits you may be entitled to.

If the home in which you have been self-funding **costs more than the local authority is usually prepared** to pay for that type of care this may cause difficulties if you have to apply for local authority assistance later on. The local authority may require a third party to make up the difference and, if none is available, suggest that you move to a cheaper care home.

If either of the above is suggested, 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 also look at the **risk** of moving you. If your existing care home is found to be **the only one** that can meet your assessed needs, then the full cost should be met by the local authority.

If you moved into a care home in a **different local authority area** from where you lived before and have since been self-funding, the local authority in the area you now live will usually be responsible for assisting you.

See Age UK's Factsheet 60, *Choice of accommodation – care homes*, for further information.

19 Complaints, standards and protections

If you are not satisfied with any aspect of the service that you receive from a local authority or a care home, you can make a **complaint**. This could relate to the processing of the means test, the need for clear and transparent information, standards of communication and possible delays. This could be via the local authority complaints procedure or the internal system in your care home. Residents who arrange and fund their own residential care can complain directly to the **Local Government Ombudsman.**

From April 2016 a new appeals system is due to be implemented which will enable decisions taken by a local authority under Part 1 of the *Care Act 2014* to be challenged and reviewed.

Concerns about social care service providers can also be communicated to the **Care Quality Commission** (CQC) who will have a local representative responsible for monitoring the service standards of care home providers. Residential care providers must adhere to the standards set down in the new ***Fundamental standards*** to retain their legal right to be registered to provide services. These replaced the existing *Guidance about compliance, Essential standards of quality and safety* on 1st April 2015. They form part of the CQC's response to the recommendations of Sir Robert Francis following his enquiry into poor care at the Mid Staffordshire NHS Foundation Trust. The relevant documents can be viewed on the CQC's website. The CQC has also recently introduced a new, simpler, care home rating system following its inspections, which can be viewed on its website alongside recent inspection reports.

The **age** element of the ***Equality Act 2010*** became legally enforceable in health and social care on 1st October 2012. Under the Act, it is unlawful to discriminate against someone in the provision of goods and services unless a practice is covered by an exception from the ban, or good reason can be shown for the differential treatment, known as 'objective justification'. However, there are no specific exceptions to the ban on age discrimination for health or social care services.

This means that any age-based or related discriminatory practices by the NHS and social care organisations must now be able to be objectively justified to ensure their legality. Other equality areas such as **disability** or also included within the Act. See the section 20 for the contact details of the **Equality Advisory and Support Service**, which has a helpline.

Equalities often interact with human rights. For more information about both, and complaints, see Age UK's Factsheet 59, *How to resolve problems and make a complaint about social care*.

Sections 42-47 and Schedule 2 of the *Care Act 2014* contain new laws and national procedures on **safeguarding** intended to improve and standardise the existing system. There is a generally low threshold triggering the local authority duty to investigate and respond appropriately when it becomes aware of a safeguarding issue.

20 Appendix

There are four sources of new primary legislation, secondary legislation and statutory guidance on which this factsheets is based:

1/ The *Care Act 2014, Part 1*

http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

Part 1 of the new Act is the main source for this factsheet as it replaces over 60 years of adult social care legislation. The *Care Act 2014* has 4 Parts.

2/ *Care and Support Statutory Guidance, issued under the Care Act 2014:*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf

This large document supports the *Care Act 2014* and the regulations listed below. A local authority must have regard to its relevant sections when administering the charging system.

There is significant overlap in this document with some of the regulations below, for example regarding section 8 'Charging and financial assessment' and the Annexes at the end of the document, particularly B and C on the treatment of capital and income.

3/ *The final negative regulations under Part 1 of the Care Act 2014:*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/376204/2903119_Care_Act_Negative_Regulations_Master.pdf

This document contains many new regulations including the *Care and Support (Charging and Assessment of Resources) Regulations 2014*.

4/ *The final affirmative regulations under Part 1 of the Care Act 2014:*

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366048/43738_2902999_Regs_Affirmative_Accessible.pdf

An important regulation within this document is the *Care and Support (Eligibility Criteria) Regulations 2014.*

Note: The terms 'negative' and 'affirmative' refer to the regulations' status prior to finally coming into force in April 2015.

---

21 Useful organisations

Care Quality Commission (The)

The independent regulator of adult health and social care services in England, whether provided by the NHS, local authorities, private companies or voluntary organisations. It also protects the rights of people detained under the Mental Health Act.

CQC National Customer Service Centre, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA
Tel: 03000 616 161 (free call)
Email: enquiries@cqc.org.uk
Website: www.cqc.org.uk/

Carers UK

National charity providing information and advice about caring alongside practical and emotional support for carers. Also campaigns to make life better for carers and influences policy makers, employers and service providers, to help them improve carers' lives.

20 Great Dover Street, London, SE1 4LX
Tel: 0808 808 7777 (free call)
Email: info@carersuk.org
Website: www.carersuk.org

Carers Trust

Website: www.carers.org/scotland

Carers Wales can be contacted at:

Tel: 029 20 811370
Website: www.carerswales.org

Citizens Advice

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

In Wales there is a national phone advice service on 0344 477 2020. It is available in some parts of England on 0344 411 1444. In Scotland, there is a national phone advice service on 0808 800 9060.

To find details of your nearest CAB check your phone book, or in:
England or Wales, go to www.citizensadvice.org.uk
Northern Ireland, go to www.citizensadvice.co.uk
Scotland, go to www.cas.org.uk

Visit www.adviceguide.org.uk for online information

Department of Health

Government department with overall responsibility for social care including residential care homes.

Tel: 020 7210 4850 (national call rate)
Website: www.dh.gov.uk

Elderly Accommodation Counsel

Provides information on all forms of accommodation, support and care for older people.

EAC FirstStop Advice, 3rd Floor, 89 Albert Embankment, London, SE1 7TP
Tel: 020 7820 1343
Email: info@firststopadvice.org.uk
Website: www.housingcare.org

Equality Advisory and Support Service

This new service replaced the helpline run by the Equality and Human Rights Commission in October 2012.

FREEPOST Equality Advisory Support Service FPN4431
Tel: 0808 800 0082
Textphone: 0808 800 0084
Website: www.equalityadvisoryservice.com

Independent Age

Provides an information and advice service for older people, their families and carers, focusing on social care, welfare benefits and befriending services.

6 Avonmore Road, London, W14 8RL
Tel: 020 7605 4200
Adviceline: 0800 319 6789
Email: charity@independentage.org
Website: www.independentage.org/

Relatives & Residents Association (The)

The Relatives & Residents Association gives advice and support to older people in care homes, their relatives and friends.

1 The Ivories, 6-18 Northampton Street, London, N1 2HY
Tel: 020 7359 8136
Email: info@relres.org
Website: www.relres.org

Veterans UK

Website bringing together services for veterans including advice on pensions, compensation and welfare services.

Tel: 0800 1914 2 18
Email: veterans-uk@mod.uk
Website: www.gov.uk/government/organisations/veterans-uk

22 Further information from Age UK

Age UK Information Materials

Age UK publishes a large number of free Information Guides and Factsheets on a range of subjects including money and benefits, health, social care, consumer issues, end of life, legal, employment and equality issues.

Whether you need information for yourself, a relative or a client our information guides will help you find the answers you are looking for and useful organisations who may be able to help. You can order as many copies of guides as you need and organisations can place bulk orders.

Our factsheets provide detailed information if you are an adviser or you have a specific problem.

Age UK Advice

Visit the Age UK website, www.ageuk.org.uk, or call Age UK Advice free on 0800 169 65 65 if you would like:

- further information about our full range of information products
- to order copies of any of our information materials
- to request information in large print and audio
- expert advice if you cannot find the information you need in this factsheet
- contact details for your nearest local Age UK

Age UK

Age UK is the new force combining Age Concern and Help the Aged. We provide advice and information for people in later life through our, publications, online or by calling Age UK Advice.

Age UK Advice: 0800 169 65 65
Website: www.ageuk.org.uk

In Wales, contact:
Age Cymru: 0800 022 3444
Website: www.agecymru.org.uk

In Scotland, contact Age Scotland
by calling Silver Line Scotland: 0800 470 8090
(This line is provided jointly by Silver Line Scotland and Age Scotland.)
Website: www.agescotland.org.uk

In Northern Ireland, contact:
Age NI: 0808 808 7575
Website: www.ageni.org.uk

Support our work

Age UK is the largest provider of services to older people in the UK after the NHS. We make a difference to the lives of thousands of older people through local resources such as our befriending schemes, day centres and lunch clubs; by distributing free information materials; and taking calls at Age UK Advice on 0800 169 65 65.

If you would like to support our work by making a donation please call Supporter Services on 0800 169 87 87 (8.30 am–5.30 pm) or visit www.ageuk.org.uk/donate

Legal statement

Disclaimer and copyright information

This factsheet has been prepared by Age UK and contains general advice only which we hope will be of use to you. Nothing in this factsheet should be construed as the giving of specific advice and it should not be relied on as a basis for any decision or action. Neither Age UK nor any of its subsidiary companies or charities accepts any liability arising from its use. We aim to ensure the information is as up to date and accurate as possible, but please be warned that certain areas are subject to change from time to time. Please note that the inclusion of named agencies, websites, companies, products, services or publications in this factsheet does not constitute a recommendation or endorsement by Age UK or any of its subsidiary companies or charities.

Every effort has been made to ensure that the information contained in this factsheet is correct. However, things do change, so it is always a good idea to seek expert advice on your personal situation.