SUNBURY NURSING HOMES
Thames Street, Sunbury-on-Thames
Middlesex TW16 6AJ
Tel: 01932 785414
Fax: 01932 772421
e-mail: chris@sunburynursinghomes.co.uk

www.sunburynursinghomes.co.uk

FINANCIAL INFORMATION

- SPECIMEN ADMISSION AGREEMENT
- AGE UK FACTSHEET 10
  PAYING FOR PERMANENT RESIDENTIAL CARE
- NHS FUNDED NURSING CARE CONTRIBUTION INFORMATION

Sunbury Nursing Homes Limited
Admission Agreement for <TITLE> <FIRST_NAME> <SURNAME>

Accommodation <DEPT> <ROOM>	Fees £<WEEKLY_FEE> per week	Start date <D_O_ADMIT>
Resident's Representatives <CONTACT1>, <CONTACT1_A>, <CONTACT1_2>, <CONTACT1_3>		

1 Provision of Care

1.1 Sunbury Nursing Homes will take all reasonable measures to provide nursing, health and social care appropriate to the individual needs of the resident.

1.2 The resident's needs will be assessed prior to offering a placement at the home and also following admission using information gathered from the resident, his or her relatives and other health care professionals previously involved in the care of that resident.

1.3 The assessment information will be used to devise a personal nursing care plan for the resident which will be appropriately implemented, monitored, evaluated, reviewed and updated on a regular basis.

2 Delivery of Care

2.1 The care service will be delivered in accordance with the homes' Philosophy of Care and Residents' Charter as detailed in the Resident's Handbook that is issued to residents and their personal representative on admission.

3 Services/Items included in fees:

3.1 Full day and night nursing care

3.2 Full board and lodging

3.3 Laundry including personal items

3.4 Any payment made by NHS for Funded Nursing Care should the resident be assessed as being eligible following assessment by NHS Surrey Downs CCG.

4 Services/Items not included in fees:

4.1 Medical and other specialist health care services which are not provided under the National Health Service

4.2 Medications and other prescribed items which are not available on National Health Service prescriptions

4.3 Personal professional services such as hairdressing, manicures, chiropody etc.

4.4 Personal television and telephone service in bedroom

4.5 Personal requirements such as tissues, toiletries, dental cleaning items, confectionery, biscuits, fruit cordials, newspapers and magazines.

4.6 Transport to and from the nursing home for any reason including hospital visits when NHS transport is not available.

5 Additional Services/Items

5.1 Any requirement for services/items which are not included in the fees will be provided on request and charged on the basis of cost plus 10% service/handling charge per service/item. Details of current charges are available on request.

5.2 Invoices for these services/items are issued monthly in arrears and are due for payment on receipt of invoice.

6 Payment of Fees

6.1 Invoices for fees are issued monthly in advance for the number of days applicable in the month. One full day's fees are chargeable for any day or part of day that the person is resident within the home

6.2 Invoices for fees to be paid in full on receipt of invoice or by monthly bank standing order on the first of each month.

6.3 The minimum fee period is seven days

6.4 Financial responsibility for payment of fees and personal expenses lies with the resident and his/her representative(s) who make the admission arrangements.

6.5 In the event of non payment of fees or an unagreed delay in payment of fees Sunbury Nursing Homes Ltd reserves the right to terminate the contract giving one month's notice in writing.

6.6 Should the resident become eligible for Local Authority funding at some stage after admission, fees will continue to remain liable as per this contract until an alternative contract, which will supersede this one, has been agreed and enacted with the relevant local authority. It is the company's policy not to offer reduced rates to local authorities at any stage.

7 Fees Increase

7.1 It is necessary for fees to be reviewed periodically, normally on an annual basis in April to coincide with the general increase in state benefits, and a minimum of twenty eight days notice in writing will be given of any increase in fees. The annual increase will be no higher than 5%. However, should the most recently available Retail Price Index (RPI All Items as provided by Office for National Statistics) rate at the time of the notification of increase be higher than 5%, then the increase will then be at that rate.

8 Temporary Absence

8.1 Full fees are charged in the event of a resident being temporarily absent from the Home (due to admission to hospital for example) for up to 28 consecutive days.

8.2 In the event of absence lasting more than 28 consecutive days, then a 10% reduction in the fees will apply for the period in excess of 28 consecutive days until the resident returns to the Home or the residency is terminated in accordance with the notice provisions of this agreement.

8.3 The accommodation occupied by the resident will be kept available for him/her throughout the period of absence and not used for any other purpose unless agreed otherwise

9 Trial Period and Termination

9.1 The placement is subject to three months trial period during which time the placement may be terminated by either party giving one week's notice in writing.

9.2 One month's notice in writing must be given to terminate the placement once the trial period has been completed. It is expected that the only reasons the company would give notice of termination would be if it has been fully assessed that it is no longer able to meet the needs of the resident or because of payment default as per clause 6.5.

9.3 Fees will be charged in lieu of notice in the event of a resident leaving to take up residence elsewhere before the expiry date of the required notice period.

9.4 In the event of death fees remain payable for seven days after the date of death.

9.5 The minimum charge is one week's fees.

10 Clothing and personal requirements

10.1 The resident must have an adequate supply of day and night clothing and personal toiletries. The company will label any items of clothing as required and arrange suitable laundering of any such items. There is noa dditional charge for either of these services.

11 Medical attention

11.1 Is provided under the National Health Service unless private arrangements are made.

11.2 Prescribed medication which is not available on NHS prescription will be charged to the account.

11.3 Residents are registered with a local GP unless we are advised that the existing GP wishes to continue caring for the resident whilst in our care.

12 Cash and Valuables

12.1 Sunbury Nursing Homes Ltd cannot accept any responsibility whatsoever for residents' possessions, valuables, and personal effects of any description and should residents bring or have brought into the Nursing Homes any such items they do so entirely at their own risk and should therefore effect their own comprehensive insurance cover against loss or damage or any other insurable risk.

12.2 For reasons of security we strongly advise against residents retaining cash and valuables.

12.3 Any personal requirements can be obtained through our stores on the account thus alleviating any need for cash transactions.

12.4 Staff are not permitted to undertake shopping errands for residents on a private basis.

13 Visitors

13.1 There are no restrictions whatsoever on visiting but visitors may be asked to leave the resident's room while essential nursing or care tasks are carried out.

13.2 Visitors are welcome to take residents out with the permission of the Registered Manager or the acting Nurse Manager but do so entirely at their own risk.

14 Fixtures and Fittings

14.1 For safety reasons installation of any electrical appliance, fixture or fitting, and repairs of any kind in a resident's room must only be undertaken by our maintenance staff or appointed/approved contractors.

15 Telephones

15.1 Except for a pay phone in the Main Building telephone facilities for residents to make outgoing calls are not provided but residents may have a private line installed in their room at their own expense.

15.2 Facilities are available for residents to receive incoming calls and their relatives and friends are most welcome to telephone to enquire of the resident's progress or to pass a message.

16 Television

16.1 A television aerial point is installed in each bedroom and televisions are available for use. However, Residents are most welcome to have their own television set installed in their room subject to checking as per clause 14.1 above. There is also a communal TV in the Montford Lounge

17 Complaints

17.1 It is recognised that despite the good intentions and hard work of the management and staff, there will be occasions when the resident and/or his/her representative will have cause to make a complaint. A Complaints Procedure exists to ensure that a complaint is dealt with to everyone's satisfaction and no complaint is left unresolved.

17.2 The procedure is detailed in the Resident's Handbook and copies are available in the Front Entrance

18 Variations

18.1 From time to time either party may wish to vary these terms and any agreed variations will be recorded in writing and signed for and on behalf of Sunbury Nursing Homes Limited by a Director of the company.

Signed by ....

Christopher White for and on behalf of Sunbury Nursing Homes Limited

Signed by ....

(Resident/Resident's Representative)

SUNBURY NURSING HOMES
Thames Street, Sunbury-on-Thames
Middlesex TW16 6AJ
Tel: 01932 785414 / 787176
Fax: 01932 772421
E-mail: chris@sunburynursinghomes.co.uk

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NHS FUNDED NURSING CARE (FNC)

Anyone who is going into a nursing home is entitled, **if eligible**, to have a contribution towards the cost of the nursing care provided.

To receive this funding the person must have an assessment from a NHS registered nurse.

To apply for an assessment please contact:

NHS Continuing Healthcare Team
Surrey Downs Clinical Commissioning Group,
Cedar Court, Guildford Road, Leatherhead, Surrey KT22 9AE

Tel: 01372 201500 www.surreydownsccg.nhs.uk

It is best to have the assessment before going into the home as the nurse may suggest an alternative option that would meet all the person's specific needs.

The assessment will determine how much care is needed from a Registered Nurse and the funding will contribute to those costs. The NHS Funded Nursing Care Contribution does not cover care that may be received from other members of staff, e.g. Care Assistants. It is also possible that some people may not have care needed by a Registered Nurse and, in that case, there would be no funding available.

If the assessment has not been carried out prior to admission, the nursing home will notify Surrey Downs CCG of the admission and they will in due course carry out the assessment. It cannot be assumed that the resident will be eligible for this funding until the assessment has been carried out and the decision has been confirmed by the CCG. Please note that there will be no deduction allowed for in the weekly fee until the eligibility is confirmed. FNC should be back dated to the date of admission following the assessment process. Once eligibility has been confirmed the FNC is paid directly to the nursing home monthly in arrears and deducted from the fee at the point of invoicing.

As from 1st April 2018, the weekly rate for eligible nursing home residents is £158.16

Nursing needs may vary depending on the person's condition and reassessments are routinely performed. Special assessments may also be requested if there is a considerable change in the person's condition.

09 January 2019

Sunbury Nursing Homes Ltd
Registered at the above address - Company No 3268807
Registered with Care Quality Commission
Member of the Registered Nursing Home Association
Directors: Mr J White, Mrs J Hartland, Miss N White, Mr C White

Age UK
Love later life

Factsheet 10

Paying for permanent residential care

April 2018

About this factsheet

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

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

The information in this factsheet is correct for the period April 2018 – March 2019. Benefit rates are reviewed annually and take effect in April but rules and figures can sometimes change during the year.

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

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

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1 Recent developments

This factsheet is based on the *Care Act 2014* and supporting regulations and statutory guidance, introduced in April 2015.

Local Authority Circular (DH)(2018)1, published in January 2018, kept all the figures and financial thresholds for charging for care and support at the same levels as the previous financial year.

2 Explanation of terms used

Care homes and nursing homes

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

Charging regulations and statutory guidance

There are references to the charging regulations and statutory guidance that support the *Care Act 2014* ('*the Act*') throughout this text. These set out how a local authority must administer adult social care. These include the *Care and Support (Charging and Assessment of Resources) Regulations 2014* ('*the charging regulations*').

The other main reference source is the *Care and Support Statutory Guidance 2014* ('*the statutory guidance*'). Section 8 covers '*Charging and financial assessment*' and the Annexes include:

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

Local authority

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

Capital

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

3 How to obtain help from your local authority

If you need residential care, your local authority may have a duty to arrange it once it has assessed your needs. You are likely to have to pay something towards fees from your capital or income, or both. If the local authority is involved in arranging your placement, the amount you have to pay is worked out via a financial assessment (also known as a means test) based on national legislation and guidance.

See section 16 for your potential right to free residential care provision via NHS Continuing Healthcare.

Note
If you have more than £23,250 in capital, your local authority will not make any contribution towards your fees.

3.1 Assessment of needs

Your local authority must first carry out a needs assessment to establish your eligible needs and whether residential care is an appropriate way to meet these needs before it decides whether you can get help with the cost. If you may have needs for care and support, they must assess you, regardless of your financial situation. One way to meet assessed needs is by the provision of *'accommodation in a care home or in premises of some other type'* (Section 8, the Act).

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

The needs assessment results in a care and support plan with various elements including your personal budget. This is the amount the local authority calculates it should pay to meet your eligible needs after a financial assessment. Eligible needs are needs that meet the criteria for adult social care service provision.

The local authority has a duty to ensure these needs are met and must recommend the best way to do this. Your care and support plan documents your right to have your eligible needs met by your local authority. You should be given a copy. Sometimes, your local authority has discretion, or choice, whether to assist meeting your needs.

If your care is arranged by the local authority or the NHS, you do not have a formal contract but you should be given a statement of terms and conditions and who you can complain to if you are dissatisfied. This should form part of your care and support plan.

If a local authority carries out a needs assessment and is not required to meet your needs, it must give you a written record of the decision and the reasons for it. This may be because you do not have eligible needs, or the financial assessment finds you have to pay full fees and you can either arrange to meet your own needs or have support to do this in a safe and appropriate manner.

The local authority has a duty to provide any necessary information and advice. This can be important if you are not eligible for care and support provision and must arrange it yourself.

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

Note
See section 15 if you fund your residential care independently through choice or due to your local authority financial assessment.

4 The financial assessment

The financial assessment ('*means test*') is how a local authority calculates your contribution to care home fees, when arranged by the local authority. Your income and capital can be taken into account. The care home fee level depends on the assessment of your needs and the recommendation made to meet them.

A 'sufficient' personal budget and choice

The terms '*usual cost*' or '*standard rate*' may be used in your financial assessment. They are the maximum limit your local authority usually expects to pay for residential care to meet your assessed needs. These vary from area to area and for different types of care or nursing home.

Your personal budget must be sufficient to meet your eligible needs. In practice, your personal budget relates to the usual cost of the type of residential care in your area. The local authority must offer at least one choice to you at this fee rate. Any additional payments, known as '*top-up*', must always be optional and never due to commissioning failures leading to a lack of local choice.

It should be possible for your personal budget to be increased in certain circumstances to meet specific needs, or if there is inadequate local supply to meet your assessed needs.

Only your own resources should be considered

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

'Light touch' means test

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

A written record of the charging decision

You must be given a written record of your charging decision by the local authority (section 17(6) of the Act). It should explain how the assessment was carried out, what the charges will be, how often they are made and the likelihood of fluctuations in charges. It should be provided in a way you can easily understand, as early as possible.

5 Your savings and other types of capital

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

5.1 General points about treatment of capital

Valuation of capital

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

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

If you have more than £23,250

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

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

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

Example
If you have capital of £14,550 you are treated as having £2 a week income (two lots of £250). Ask for a review when your capital drops down to the next £250 band.

If you have below £14,250

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

Other disregarded capital

Certain capital is partly or fully disregarded on a permanent basis. This includes the potential surrender value of life insurance policies or annuities; and funds held in trust or administered by a court that can only be disposed of by a court order or direction and which derive from personal injury payments, including compensation for vaccine damage and criminal injuries. There are temporary disregards, for example, personal injury payments are disregarded for 52 weeks.

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

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

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

12-week property disregard

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

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

Jointly held capital

If you jointly hold capital (e.g. savings) with another person or people, you and other owners are usually treated as having equal interests in it.

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

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

Notional capital

This is capital that is included even though you do not have it. For example, it could be funds available on request, such as an unclaimed Premium Bond win or capital disposed of to avoid using it to pay for care home fees. If you are assessed as having notional capital, its value must be reduced on a weekly basis by the difference between the weekly rate you pay for residential care and the weekly rate you would have paid if notional capital did not apply. See section 7 for more information.

5.2 Business asset short-term disregards

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

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

The local authority should obtain information about:

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

6 Your income

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

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

Income disregarded from the financial assessment

Common income disregards include:

- Disability Living Allowance or Personal Independence Payment mobility components (not care or daily living components)
- War Widows' special payments
- Christmas Bonus
- income from savings (although interest on savings is capital)
- charitable and voluntary payments (which could be made by a relative)
- Child Tax Credit or Guardian's Allowance
- personal injury payments for up to 52 weeks from the day of receipt of the first payment, unless the payment specifically covers care costs
- awards of certain damages
- discretionary payments made to people infected with hepatitis C by contaminated blood products
- any earnings
- war disablement pension payments paid to injured veterans with the exception of any allowance for constant attendance which is awarded in cases of significant disability.

Income that is partly disregarded

Common types of income partly disregarded include:

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

Note

Universal Credit is replacing: Income Support, Housing Benefit, Income-based Job Seeker's Allowance, Income-related Employment and Support Allowance, Working Tax Credit and Child Tax Credit. All are taken fully into account (except Child Tax Credit) when considering what you can afford to pay towards your care.

Capital treated as income

Some capital assets are treated as income (section 16 of the charging regulations). This includes payments under an annuity, earnings not paid as income and pre-arranged third party payments to pay for residential care, but not voluntary payments, for example to remove arrears.

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

Notional income

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

7 Deprivation of assets

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

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

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

8 Social security and disability benefits

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

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

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

8.1 Pension Credit

Pension Credit has two parts:

- Guarantee Credit and
- Savings Credit.

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

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

If you are a member of a couple and one of you moves permanently into a care home, each of you are treated as single people for Pension Credit. If you are a member of a couple and you enter a care home on a temporary basis (e.g. for respite or a trial period), you remain treated as a couple. For more information see factsheet 39, *Paying for care in a care home if you have a partner*.

For more on Pension Credit see factsheet 48, *Pension Credit*.

8.1.1 Guarantee Credit

Guarantee Credit tops up your income if it is below a level known as your '*appropriate minimum guarantee*'. The appropriate minimum guarantee is £163.00 a week for a single person and £248.80 a week for a couple. Extra amounts can be added if one or both of you receive AA, DLA (middle or high rate care component) or PIP (daily living component). You receive extra if you live alone, are a carer and for some housing costs.

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

8.1.2 Savings Credit

Savings Credit is abolished for people reaching State Pension age on or after 6 April 2016. If you reached State Pension age before 6 April 2016, you can still apply for Savings Credit.

If you are a couple where at least one person reached State Pension age before 6 April 2016, you only get Savings Credit if one of you was already getting it immediately before 6 April 2016 and has been entitled to it at all times since this date.

Savings Credit was for people who had made extra financial provision towards retirement through savings or occupational pensions and whose qualifying income was above a threshold and below the appropriate minimum guarantee. The current threshold amounts for existing claims are £140.67 a week for a single person and £223.82 a week for a couple.

8.1.3 Income partly disregarded – savings disregard

An income disregard exists for people aged 65 and over in the residential care means test rules, called a savings disregard.

If you receive Savings Credit, a maximum amount of £5.75 a week for single people or £8.60 a week for a couple is disregarded from the local authority means test.

If your Savings Credit is lower than these amounts, the actual amount you receive is disregarded. If your income is too high for Savings Credit, you are entitled to this disregard, whether you claim Savings Credit or not. If your income is too low to qualify for Pension Credit Savings Credit the disregard does not apply.

8.1.4 Pension Credit and property

While you try to sell a property, the value can be disregarded when calculating your Pension Credit for up to for 26 weeks (or longer '*if reasonable*'), provided the Pension Service is satisfied you are taking '*reasonable steps*' to sell it.

For more information see factsheet 38, *Property and paying for residential care*.

Note

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

8.2 Disability benefits

Attendance Allowance (AA), Disability Living Allowance (DLA) and Personal Independence Payment (PIP) are benefits paid if you have certain care and/or mobility needs. AA can only be claimed by people aged 65 years and over and does not have a mobility component. If you claim DLA or PIP before reaching 65, you can continue to receive it after your 65th birthday, even if your payment includes a mobility element.

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

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

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

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

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

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

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

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

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

For these benefits, you are considered to be resident in a care home when any of the costs of any qualifying services (accommodation, board and personal care) provided to you are paid for by the NHS or a charitable body.

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

Disability benefits and Pension Credit for self-funders

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

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

Introduction of Personal Independence Payment

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

9 Personal Expenses Allowance

The local authority must let you to keep a Personal Expenses Allowance (PEA) of £24.90 a week. You should not be asked to put your PEA towards the cost of any of your basic care if you are a permanent or temporary care home resident. It is for your own personal use. See section 13 about paying for extra services and the PEA.

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

10 The means test calculation

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

The following examples show what your contribution might be.

Example 1

You are 83, single and live in a rented flat. You have capital of £5,000 and your weekly income is State Pension of £125.95 and PC Guarantee Credit of £37.05, to give an assessable amount of £163.00 a week.

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

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

The local authority calculation	£
Your total weekly income (£125.95 plus £37.05)	163.00
Less PEA	24.90
Your weekly contribution to personal budget	138.10
Local authority's contribution to personal budget	561.90
Cost of the home	700.00

Example 2

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

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

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

Your weekly income means you do not qualify for Pension Credit Guarantee Credit or Savings Credit. As your assessed income is more than £195.50 a week, the local authority must disregard £5.75 a week of that income as well as allowing you to retain a PEA of £24.90.

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

11 Choice of accommodation and top-up

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

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

As well as any area in England, arrangements can be made for placements in Scotland, Wales and Northern Ireland (*Schedule 1 of the Act, Chapter 21 of the statutory guidance*). In this situation, you have the right to choose between different providers of that type of accommodation provided that:

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

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

11.1 Third party contributions and the 'usual cost'

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

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

This means the personal budget must contain a realistic figure capable of allowing your residential care needs to be met locally and that you have at least one choice. If no care home can meet your assessed eligible needs within the amount the local authority sets as your '*indicative personal budget*', it must increase your actual personal budget to meet the extra cost. '*Indicative*' means an early estimation of the cost of meeting your assessed eligible needs.

A more expensive home may be necessary if you have particular needs that cannot be met within your indicative personal budget. For example, if you have specific religious or dietary needs, or a particular need to be near relatives or friends to maintain your wellbeing. Your assessment must consider all the needs you have and your local authority must be adequately flexible in the way it responds to ensure they are met.

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

The third party and the local authority must agree what will happen if the home's fees are subsequently increased. The local authority will not necessarily agree to pay for all, or even part of, an increase. If the third party additional payments cannot be continued, you may have to move to another less expensive home. The local authority should carry out an assessment of the effect on your wellbeing and any risks involved before taking this course of action.

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

Residents' contributions to more expensive accommodation

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

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

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

Your PEA should not be spent on board, lodgings and care contracted by the local authority. This does not stop you buying services from the care home if they are genuinely additional to local authority contracted services or assessed as necessary by the NHS. Find out exactly what care has been arranged in the contract. If you are in a nursing home, check if the NHS registered nurse contribution (£155.05 a week in 2017/2018) has been included as this should be taken off your fees.

12 Arrangements for paying the care home fees

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

The local authority generally pays the full fee and then collects from you the amount you have been assessed to pay towards your personal budget, including any benefits received.

If a '*top-up*' is required for your accommodation and all parties agree (you or the 'third party' paying the top-up, the local authority and the home), you and the local authority can each pay your respective share directly to the provider. Statutory guidance states this is not recommended.

13 NHS and other care services in care homes

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

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

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.

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

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

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

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

14 Non-means tested assistance with care costs

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

14.1 Fully funded NHS continuing healthcare

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

If you might be eligible for NHS continuing healthcare, the professionals involved in your care (for example GP, nursing staff or social worker) must actively consider this possibility.

They should inform you or your representatives of your rights and carry out an appropriate assessment based on the *National Framework* for NHS continuing healthcare guidelines and its assessment tools. To move to a social care means test without addressing your potential right to free NHS service provision may constitute poor professional practice and can be challenged.

Note
If you think your need for NHS continuing healthcare has not been addressed but should have been, you should ask to be assessed using the checklist tool set out in guidance.

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

14.2 Short-term rehabilitation in a care home

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

It is often provided to prevent hospital admission or after discharge from hospital if a rehabilitation potential is identified. The charging regulations describe its purpose as enabling *'the adult to maintain or regain the ability needed to live independently in their own home'*. There should be an initial agreed rehabilitation plan and reviews throughout to gauge progress, and an agreed future action plan at the end.

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

14.3 Care provided by registered nurses in care homes

The NHS is responsible for meeting registered nursing costs for residents in care homes that also provide nursing care, known as nursing homes. Nursing care is care given by a registered nurse in providing, planning or supervising your care. It does not include time spent by other staff involved in your general personal care.

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

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

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

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

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

Choice of accommodation

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

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

After-care and dementia

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

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

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

15 Arranging and paying for your care yourself

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

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

Each care home must adhere to standards set out by the Care Quality Commission CQC based on legislation. An example of this is Regulation 10 of the *Care Quality Commission (Registration) Regulations 2009* on fees requiring the provision of a written copy of the terms and conditions to be provided prior to the placement commencing.

If your funds run down to the upper capital limit

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

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

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

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

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

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

If you move areas for care home accommodation

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

Benefits entitlement

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

You have a right to information and advice from the local authority to help make decisions about how to meet your needs.

16 The local authority information and advice duty

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

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

This general local authority duty links with other broad local authority duties, for example to do with prevention and cooperation with local health and housing services.

'*Independent financial advice*' is financial advice provided by a qualified person who is independent of the local authority in question, for example they are regulated by the Financial Conduct Authority.

17 People who can act on your behalf

Independent advocacy

If you have substantial difficulty being involved with the care and support process and have no one to assist you, the local authority must provide an independent advocate to support and represent you. The duty is triggered where you experience substantial difficulty:

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

Mental capacity – advocates and attorneys

While you are able to make decisions and express your views, you might think how you would want your affairs dealt with if you lose mental capacity in future.

This can be done by creating a Lasting Power of Attorney (LPA), which can be for finance and property and/or health and welfare. If these powers need to be created after you have lost mental capacity, an application can be made for a Deputyship with the Court of Protection.

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

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

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

Appointees for benefits

If you receive social security benefits but are unable to manage your affairs, the DWP can appoint someone else to make claims and receive benefits on your behalf. An appointee is usually a close friend or relative who visits you regularly. Your local authority may also be able to act as your appointee.

As a last resort, your care home owner can act as appointee, but in such cases, they must keep a record of the money collected on your behalf. You and a prospective appointee are interviewed before any appointment is made. An appointee's powers only extend to the management of social security benefits.

18 Complaints

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

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

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

If you have arranged and funded your placement independently, you can complain to the Local Government Ombudsman about your care home.

You can raise a safeguarding alert with the local authority if you have concerns about abuse or neglect.

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

Useful organisations

Care Quality Commission
www.cqc.org.uk
Telephone 03000 616 161 (free call)

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

Carers UK
www.carersuk.org
Telephone 0808 808 7777

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

Citizens Advice
www.citizensadvice.org.uk
Telephone 0344 411 1444 (England)

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

Department of Health
www.gov.uk/government/organisations/department-of-health
Telephone 020 7210 4850

Government department with overall responsibility for social care.

EAC FirstStop Advice
http://hoop.eac.org.uk/

Provide information on housing options for older people and signposts to relevant advice organisations.

Equality Advisory Support Service
www.equalityadvisoryservice.com
Telephone helpline 0808 800 0082 Mon-Fri 9am-7pm, Sat 10am-2pm

Funded by the Equality and Human Rights Commission, the EASS Helpline provides information and advice about the *Equality Act 2010*.

Age UK

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

Age UK Advice
www.ageuk.org.uk
0800 169 65 65
Lines are open seven days a week from 8.00am to 7.00pm

In Wales contact

Age Cymru Advice
www.agecymru.org.uk
0800 022 3444

In Northern Ireland contact

Age NI
www.ageni.org
0808 808 7575

In Scotland contact

Age Scotland
www.agescotland.org.uk
0800 124 4222

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