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Advice Paper OA2
April 2012

CARE IN THE COMMUNITY LEGISLATION
FINANCIAL ASSISTANCE TOWARDS CARE HOME FEES

INTRODUCTION

This paper has been written to provide a broad outline of the current government arrangements for the assessment process and funding available towards Care Home fees. It does not cover every aspect of the procedures.

The paper is divided into three parts.

PART A: CARE IN THE COMMUNITY LEGISLATION
ASSESSMENTS FOR RESIDENTIAL AND NURSING CARE

This covers Care in the Community Legislation as it applies to those who may need to move to a Care Home following a hospital discharge or care assessment at home.

PART B: CURRENT RATES 2012/2013 AND
FINANCIAL ASSISTANCE FROM THE OFFICERS' ASSOCIATION

This describes the statutory financial arrangements and benevolence assistance available from the Officers' Association for those who are about to move to, or reside in, Care Homes.

PART C: HOSPITAL DISCHARGE ARRANGEMENTS – EXTRACTS FROM GOVERNMENT GUIDANCE

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Registered Charity 201321

The Officers' Association is a member of the Confederation of British Service and Ex-Service Organisations, COBSEO

OA2 - PART A

April 2012

CARE IN THE COMMUNITY LEGISLATION
ASSESSMENTS FOR RESIDENTIAL AND NURSING CARE

Care in Community Assessments

If you are being assessed whilst in hospital, see also Part C: Hospital Discharge Assessments, where some of the advice below is duplicated.

Local Authority social services are responsible for assessing your care needs, and making a decision on what sort of services to offer you, including Care Home placements. These services could be provided and charged for by the local authorities (except 'continuing NHS nursing care' in Care Homes), or purchased from private or voluntary agencies.

The Care Assessment

The way in which both health and social services decide whether you need help is by carrying out an 'assessment' of your needs. You are entitled to an assessment by social services if you appear to be in need of community services or if you are disabled. Your assessment will normally be co-ordinated by a social worker. The involvement of different agencies, and sharing information between agencies, should not happen without your agreement. If you have a carer, they should also, with your agreement, be involved in your assessment.

It is advisable to request an assessment of your needs even if you will be funding your own care as this can help identify what type of home will be suitable for you. If you will need local authority assistance later it is also useful to have an indication of how the authority may view your needs. Even if you will be self funding, the local authority may have a duty to arrange suitable care if it is not otherwise available to you, for example if you do not have the capacity to make your own arrangements.

The Single Assessment Process (SAP) is where the agencies responsible for assessing your social care, health, housing and other needs should work together to reduce duplication of effort in assessments. Local authorities and local health bodies should have introduced procedures for sharing information so that you do not have to give your basic details more than once. However in some areas the SAP has still not been implemented.

The SAP does not replace local authorities' existing responsibilities and your legal entitlements to help from social services are unchanged.

Assessment may seem intimidating so you might want an independent person (an advocate) to help you through the process. Whoever is co-ordinating your assessment should help you to find an advocate, there may be independent organisations in your area set up specifically to provide advocacy.

How assessment decisions are made. Both health and social services will make decisions about whether to provide you with services by comparing your needs with 'eligibility criteria'. These criteria are standards or models which set out the types of need which the authority will meet. Government guidance called "Fair Access to Care Services" has been provided to ensure that eligibility criteria are both legal and consistent across the country.

Information following assessment. You should be given a summary of your assessment, called a 'care plan'. Your care plan should set out what help you will be given, who is responsible for providing this help, who you can contact if things go wrong, and how much, if anything, you will have to pay towards services. You should be given a full copy of your assessment.

The National Health Service

(www.dh.gov.uk)

Primary Care Trusts.

Primary Care Trusts (PCTs) are responsible for commissioning and funding NHS services. These include community based services such as GPs, nurses and other health professionals, aimed towards providing primary care and commissioning hospital services. The PCTs may run community hospitals and are responsible for building strong links with the local health and social care community. PCTs are the lead NHS organisations, they are responsible for funding:

- Services for those who meet eligibility criteria for continuing NHS health care
- NHS funded registered nursing care in a care home.

NHS Trusts

NHS Trusts deliver the services commissioned by the PCTs, each run by its own board of directors. Types of Trusts include: Acute hospital; Mental health; Ambulance services.

Strategic Health Authorities (SHAs) are concerned with the overall performance and quality of NHS services within their area. As their name suggests they also have a strategic planning role. There are 28 SHAs in England and there will be varying numbers of PCTs and NHS Trusts within each SHA.

In March 2011, the Government announced that Primary Care Trusts and Strategic Health Authorities will be abolished by 2013 and control of NHS budgets given to GP consortia. At time of going to print, there is no further information, but naturally there will be implications to care home funding.

There are separate arrangements for Scotland.
Please contact Officers' Association Scotland, New Haig House, Logie Green Road, Edinburgh, EH7 4HO. Tel: 0131 557 2782

Continence Pads and other continence equipment provided by nursing homes are free.

Continuing NHS health care.
If you are assessed as having a need for accommodation and personal care but your **primary** need is for health care, your care will be the responsibility of, and be funded by, the NHS. In many instances, this care is provided in a care home and all costs - accommodation, personal care and nursing care – are the responsibility of the PCT. However, continuing NHS health care may also be provided in a hospital, a hospice or at home.

Intermediate Care – intended to bridge possible gaps between health and social services. Provides rehabilitation and ‘step down’ services to people who have just finished their hospital treatment.
If you are being discharged from hospital, the NHS, via the health authority, may arrange and fund a place in a private or voluntary sector care home. Those patients who meet their health authority’s eligibility criteria for NHS continuing health care do not have the right to choose where they receive the care.

See Part C for more detailed information on the NHS and Hospital Discharges

Receiving Care in Care Homes

Your assessment may conclude that going into a Care Home would best suit your needs. The local authority has a duty under the *National Assistance Act 1948, Section 21,* to provide or arrange permanent care in a home for you if you have been assessed as requiring this care and it is ‘not otherwise available to you’:

- when you cannot pay the full cost of the care home because the fees are higher than your income, and your capital is below the upper limit of **£23,250, for England and £22,000 for Wales**.
- Where your income is high enough to pay for care in full, and/or your capital is above the upper limit, but you are not able to make the arrangements yourself, and there is no one who is willing and able to do this on your behalf.

Self-Funding. If you have more than £23,250,(£22,000 in Wales) you may decide to make your own arrangements with a care home. If you subsequently become eligible for financial support because, for example, your capital has reduced as fees for the care have been paid, you should again approach your local authority social services department for help. Even while you are ‘self funding’ the NHS is responsible for meeting the cost of any care you require from a **Registered Nurse.** You should be assessed to establish the level of your nursing need and the NHS will make a payment directly to the home, which should then be taken into account in the calculation of your fees.

Adults who fund their own residential care have access to an independent complaints review service provided by the Local Government Ombudsman.

Types of care home

The Care Quality Commission (CQC) is responsible for the inspection and registration of care homes. The term 'care home' covers any establishment providing accommodation with personal or nursing care.
Not all care homes are registered to provide nursing care. Those which are (formerly known as nursing homes), are sometimes referred to as 'care homes that provide nursing care' to differentiate them from those homes which are not registered to provide such care (which were formerly known as residential homes).

A home should not provide nursing care if it is not registered for that purpose. Some homes may have some beds registered as providing accommodation, and personal care only, and other beds registered for nursing care as well.

Specialist homes for older people with some kind of mental frailty are often called 'EMI' homes. 'EMI' generally stands for 'elderly mentally infirm' or 'elderly mentally ill'. These homes specialise in care for older people with a mental illness or disorder including dementia, although not all residents with dementia live in EMI homes.

All care homes are required to be registered and then inspected by the CQC. The government's *National Minimum Standards for Care Homes for Older People* form the basis for the judgements made by the CQC in deciding whether or not a care home should be registered or not, or have its registration cancelled. This can be viewed, along with a wide range of other information, on the CQC website at www.cqc.org.uk.

Each home should have a brochure and statement of purpose that can be used to decide whether the home will meet the needs set out in your assessment. Whether your place in the home is arranged and paid for by yourself or social services, will depend on the application of national rules. If social services are arranging a place for you, you can choose which home you will live in under *the National Assistance Act 1948 (Choice of Accommodation) Directions 1992,* subject to certain conditions:

- The home is assessed as suitable for your assessed care needs;
- The home is willing to enter into a contract with the local authority, subject to the local authority's usual terms and conditions;
- The home costs no more than the local authority would normally pay for someone with those assessed needs;
- There is a vacancy.

You can also choose to enter a home that costs more than the local authority normally pays for someone with your assessed needs, if there is someone else (called a 'Third Party') who is prepared to pay the difference of this extra cost for as long as you remain living in the home. This 'Third Party' could be a relative or friend with 'Enduring Power of Attorney' (pre Oct 07) or 'Lasting Power of Attorney – Personal Welfare (LPA PW)', (replacing the 'Enduring Power of Attorney' following the enactment of the Mental Capacity Act of 1st October 07). A form can be purchased from a law stationer, or downloaded free from the Justice department at www.justice.gov.uk, click onto the 'Office of Public Guardian'. Existing Enduring Power of Attorneys will remain legally valid and in force.

If you are a hospital in-patient, before being discharged you should be assessed by both the NHS and social services to establish whether either they ought to arrange any ongoing care once you leave hospital. This can include care in a care home. You have the right to refuse to be discharged to a care home. If you do, the health and social care agencies should consider whether your needs can be met in another way. However, you do not have the right to remain in hospital indefinitely. If you are being placed in a home by the local authority and your preferred home has no vacancy and is unlikely to have one in the near future, you may have to be discharged to another home until a place becomes available. Any interim arrangement should still meet your assessed needs

Care Homes – Costs. The costs of Care Homes are split into 'hotel' and 'care'. The Government has created an additional split for 'health care' and 'personal' care, some of the first free, and the second payable. Local authority funding should be arranged in line with their assessment of residents' care needs. Some of the 'health care' is now free, see 'Nursing Care' below.

Eligibility for residential care. Should the outcome of the assessment result in your placement in a care home, the local authority social services has a duty to meet the fees up to their assessed level of your need and your financial status.

Eligibility for NHS nursing care. . Eligibility will be decided on the basis of an assessment by a registered nurse, using a standard assessment process.

If you are not assessed for residential care. You may still be assessed as in need of 'domiciliary' care. Social services departments have a statutory duty to provide services at home if you meet their eligibility criteria.

Nursing Care in a Care Home

Residents do not pay for 'registered nursing' care in a nursing home.
(Definition of 'registered nursing': includes care by a registered nurse and time spent in monitoring and supervising work that has been delegated; the time spent by non-registered nurses such as nursing assistants is not regarded as nursing care).
Following an assessment by a registered nurse the following flat rate "Registered Nursing Care Contribution (RNCC) Band of **£108.70 per week(lower band)** or **£149.60(higher band)** will be applied and paid for by the NHS Primary Care Trust through the Local Authority, providing the criteria have been met

Local Authorities' responsibilities.

The local NHS will fund the nursing care of those who have been assessed for such care and arranged by the local social services, even if their capital or income is outside state funding guidelines for the remainder of the care costs, i.e.:

- those whose capital level is above guidelines (i.e. above **£23,250(£22,000 in Wales)**), or do not have the ability to make their own arrangements, or their capital above £23,250 is not immediately accessible due to being tied up in property, or application being made to Court of Protection)
- those whose level of income is more than the full fees of the nursing home.

In these cases the local NHS will pay the appropriate Nursing Band Rate direct to the Homes. The 'self-funding' residents will continue to be charged for the balance i.e. accommodation and personal care costs until their financial circumstances fall within statutory guidelines. Check your contracts carefully.

Pension Credit and Local Authority Funding for Care Home Residents

There are two elements of Pension Credit: Guarantee Credit and Savings Credit, which rewards individuals for any income above the basic state pension rate up to certain maximum levels. A small proportion of Savings Credit is disregarded for Care Home residents; the rest is treated as income by the local authorities when considering funding under Care In Community legislation. See Part B for details.

Pension Credit and property. If you are a property owner and are trying to sell it prior to moving into a Care Home as a 'self funded' resident, Pension Credit can be paid for 26 weeks (or longer 'if reasonable'), provided that the office handling your claim is satisfied that you are taking 'reasonable steps' to sell it. Once your property is sold, these Pension Credit amounts do not have to be repaid.

For those assessed as needing care in a Care Home and within prescribed financial limits, Local Authorities will 'top up' their funding towards fees up to the 'assessed levels'. See Part B for further details.

Attendance Allowance or Disability Living Allowance (Care component).

If you have NOT been assessed as needing care in a Care Home, or have chosen a Home, which is non-registered, and your income is below statutory levels, it will be maintained at the standard 'appropriate amount'. You would be eligible for Attendance Allowance (or the care component of Disability Living Allowance), but it is likely that you would still not have enough income to meet the fees and would need to seek a third party 'top up'.

If you HAVE been assessed as needing care in a Care Home, but have high income and capital assets above Local Authority funding criteria, you will be a 'Self-Funding' Resident and eligible to apply for Attendance Allowance (or the care component of Disability Living Allowance). Dependent on the fee level you may have to seek a third party top-up to meet the shortfall. Once your capital assets have diminished to within legislative guidelines, you will be able to apply to the Local Authority for funding. When Local Authority funding is in place, the Attendance Allowance/Care Component of Disability Living Allowance will cease after 4 weeks.

This guidance is particularly relevant to anyone assessed for nursing care in a Care Home, whose income is such that if the registered nursing costs were deducted from your fees, you would be able to meet the fees yourself.

Temporary Residents

Some people go into a Care Home on a temporary basis – perhaps because they need a short-term break whilst they are waiting to move to somewhere more suitable, such as sheltered housing; or whilst they are recuperating from an illness. In some cases your temporary care will be part of an ‘intermediate care’ package in which case it should be free.

The *National Minimum Standards for Care Homes for Older People* state that prospective long term residents should be invited to visit homes and to move in on a trial basis before they and/or their representatives make a decision about whether to stay there. The local authority may also arrange a trial period for you if it will be helping to arrange this care. This gives you the chance to see whether moving to a care home is the right choice for you.

When the local authority is making the arrangements, your care assessment should show whether your stay is being regarded as a temporary or a permanent one. The local authority can agree that your stay is temporary for up to 52 weeks, or longer in exceptional circumstances: but this agreement that your stay is temporary must be in place throughout this time.

If the local authority agrees to arrange a temporary stay for you in a home, it can ask you to contribute towards the cost in one or two ways. It can either apply the means test to you straightaway, or for the first eight weeks it can ask you to pay an amount which is ‘reasonable’ for you to contribute. After eight weeks, it *must* apply the means test to you.

Any steps to sell or terminate the tenancy on your existing accommodation should be deferred until it is agreed that your move will be permanent. If you are a homeowner and your home is included in the means test its value should not be taken into account in the local authority means test until 12 weeks after it is confirmed that your care home placement is permanent.

April 2012

OA2 – PART B

CURRENT RATES 2012/13 WITH EFFECT FROM APRIL 2010

FINANCIAL ASSISTANCE FROM THE OFFICERS' ASSOCIATION

Independent Means/'Self-Funding'

If your income and capital/savings/investments can cover the cost of a Care Home now and in the future, you can move to any Home of your choice, and make a private arrangement to pay the fees, that is, you become a 'Self-Funding' Resident. You should ensure that a contract is arranged with the Home.

You should consider claiming the Attendance Allowance which is a non-means tested benefit.(www.direct.gov.uk)

Attendance Allowance

Attendance Allowance is for people disabled after the age of 65 who, because of an illness or disability, need help with personal care or supervision from another person. For example, help getting dressed, washing or using the bathroom.

There are two rates:-

The Lower rate	**£51.85** per week, paid 4-weekly. for those who need attention or supervision either by day **or** night.
The Higher rate	**£77.45** per week, paid 4-weekly. for those who need attention or supervision by day **and** night and would be the eligible amount should you enter a care home as a 'Self-Funding' resident. You should claim immediately on admission.

Normally you have to meet the conditions for six months before the benefit is paid although there are special rules for people who are terminally ill.

For more information or to apply, contact the Benefit Enquiry Line on **0800 88:22:00**
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Registered Charity 201321

Financial Assessment (statutory means test)

If the Local Authority agree to a Care Home placement, they have a duty to carry out a means test to calculate what you are able to pay towards the cost. (In essence, this is likely to be all your weekly income less the statutory personal expense allowance). However, there are factors to consider:-

Savings (April 2012/13 rates – no change to April 11/12 rates)

This includes property, bank and building society accounts, National Savings accounts, premium bonds, stocks and shares.

Savings in excess of £23,250 in England, N. Ireland (£22,000 in Wales)

- You will be expected to pay the fees in full, from income/ savings.

Savings between £14,250 and £23,250 England, N.Ireland (£22,000 single rate only for Wales – no tariff)

- Both income and savings are taken into account in the assessment, attracting an "assumed" or "tariff" income of £1.00 per week for every £250.00 or part thereof of savings, e.g. if you have capital of £16,000, you would be treated as having an extra £7 per week. If you have capital between £14,250 and £23,250 make sure that your contributions are reviewed regularly as your capital would gradually 'drop' into the next £250 'band'.

Savings below £14,250

- only income is taken into account. NB: 'Tariff' income is calculated by the local social security office on savings over £10,000 for Pension Credit purposes but at a rate of £1 per week for every £500 or part of £500.

Income

This includes: -

State retirement pension
Occupational pension(s)
Annuities
Trust fund income
Attendance Allowance (*see comments on page 11)
Income from savings
Pension Credit

Pension Credit – rates with effect from April 2012

- Standard Minimum Income for people 60 and over
- Rewards some of savings and income of some people **aged 65 and over.**
- There is an 'Assessed Income Period' (some 5 years), although recipients still need to report changes in circumstances (e.g. increase/decrease in capital, married, widowed)

Two Pension Credit elements

- **Guarantee Credit –** for those aged 60 or over
- **Savings Credit –** for those aged 65 and over who have made modest provision for their retirement**.**
- **It is possible to receive either or a combination of both elements.**
- Pension Service Freephone line **0800 99 1234**

- 'Appropriate Amount' for Standard Minimum Income: £142.70 (single); £217.90 (couple).
- Where Income is below the Appropriate Amount, it will be topped up by Guarantee Credit. '
- **Qualifying' Income** – main categories:
  State & Private Pensions
  Maintenance payments from a spouse/ex-spouse
  Income from capital, see below
- **Income from capital**. Department of Works & Pensions 'Assumed' income for Care Home residents is £1 for every £500 above £10,000 - a different calculation to Local Authorities
- **Disregarded Income**:
  ALL Charitable or Voluntary payments
  Actual income from capital (i.e. only the 'assumed' income will be counted), however interest paid into account will be counted as part of savings.
  Pre-War – 1973 War Widow/widower's supplementary pension (£81.20 weekly) plus £10 weekly War Pension disregard;
  Attendance Allowance (Higher Rate)/Disability Living Allowance: £77.45 (for 'self-funding' residents only)
  Half of the 'private' pension if a spouse remains 'at home` (provided the disregarded amount is paid to the spouse). 'Private' can mean an occupational pension, a personal pension or a payment from a retirement annuity contract.
  Armed Forces Compensation Scheme - £10pw

Savings Credit for Care Home Residents

- Rewards individuals aged 65 and over for making provision for their retirement
- Only 'Qualifying Income' is rewarded. Examples:
  State & Second pensions
  Income from annuities
  Assumed income from savings: for Care Home Residents, ie £1 per week for every £500 above **£10,000**, no upper limit.
- Disregarded for purpose of calculating Qualifying Income.
  Guarantee Credit
  Spousal maintenance.
- Rewards 60p for every £1 of qualifying income above the 'savings credit starting point', up to the gross maximum amount allowable
  "Savings credit starting point": £111.80 for single person
  (Ie basic state pension rate) £178.35 for a couple
- **Gross Maximum Savings Credit is: (changes and reduces from Apr 12 rates)**
  £18.54 for single person
  £23.73 for a couple
- Savings Credit then reduces by 40p for every £1 of income above the Appropriate Amount. See page 13 for an sample calculation.

Useful guideline: Care Home Resident <u>over 65</u> on weekly assessed income of <u>less than</u> £200 – likely to be eligible for one or both elements of Pension Credit.

Savings Disregard: When assessing a person's income as part of the assessment process, Savings Credit is taken into account as part of the total income by local authority, **who will then apply a 'Savings Disregard' of up to a maximum of £5.75 per week (couples: £8.60)**. The maximum amount will apply even for those whose income exceeds the criteria for eligibility for Savings Credit. This figures remain the same as for 2011/12.

*__Attendance Allowance (or Disability Living Allowance Care Component)__

If you are paying the full cost of your fees, you will be able to claim Attendance Allowance (or Disability Living Allowance Care Component).

If the Attendance Allowance is in issue, at either the lower or the higher rate, and the Local Authority begin assisting you to pay your fees, the Attendance Allowance will cease after 4 weeks and the relevant financial adjustment made by the appropriate increase in the Local Authority contribution.

Property

a. **If you lived in your home alone, and you enter a Care Home permanently, then its value will be counted as capital.**

b. If you do not have enough money to pay the fees, the Local Authority can create a 'legal charge` on the value of your property. This is a formal process which means that they put a claim on the value of the property so that they can claim back the money which you owe them once the property is sold. This is called a deferred payment agreement.

c. If someone else lives in the property (in whole or in part), its value will be disregarded if the person is:

   your spouse or partner,
   a relative who is aged 60 or over, or is incapacitated.

d. In addition, the Local Authority has the discretion to ignore the value of the property when someone lives in it who does not come into the above categories. This might include situations where someone has given up their own home to care for you; or where someone over the age of 60 who is not a relative lives with you.

e. If the person living in jointly-owned disregarded property wishes to move, for instance to a smaller home, the use of the resident's capital to pay towards the new property should generally not be regarded as deprivation of assets (see para below). However the resident's share of any residual capital will be counted as capital.

Deprivation of assets

If the Local Authority believes that someone has given away assets in order to pay less for accommodation, the Local Authority may treat the resident as still possessing the asset. They will treat the person as having '**notional capital**`. In

such cases, the Local Authority must consider whether a significant purpose of disposing of the capital asset was to pay a reduced charge.

If the Local Authority decides that deprivation has taken place, and they cannot claim the money back from the resident, they may consider claiming back the value of the transfer from the person or persons to whom it has been transferred.

Liability of your spouse

The Local Authority has no power under the National Assistance Act 1948 to assess a couple according to their joint resources, therefore you should only be assessed on the value of your own (or your share of jointly-held resources). However, the Act states that a man is liable to maintain his wife and a woman is liable to maintain her husband. This means that where one partner clearly has greater resources than the other, the Local Authority can ask the spouse or liable relative, to contribute to the cost of care, and an agreement can be reached. If the liable relative does not agree to a sum the Local Authority would have to consider taking court action against them and legal advice should be sought.

It may occur that the husband moves into a Care Home and takes the bulk of the pensions with him in his assessment, thus leaving the wife with a very small income, or perhaps only her retirement pension. She may apply for benefits in her own right, such as Housing Benefit, Council Tax Benefit and Pension Credit.

Hospital Discharge Arrangements

A summary of the relevant legislation can be found at Part C

Whilst one appreciates that hospitals are not always the most appropriate places to provide long-term care for the elderly, it is important that the necessary arrangements are made prior to discharge.
NB: New legislation on Delayed Discharges is relevant, see Part C.

Choosing a Care Home

Each home should produce a brochure and a statement of purpose that can be used to decide whether the home will meet the needs set out in your assessment. Once the Local Authority have agreed to the level of assessed need, and conducted the means test you can choose:-

1. To take the place offered by the Local Authority.

2. To exercise your "right of preferred accommodation " and to find

    a. a home of your preference which satisfies the Local Authority requirements and will not cost the Local Authority more than they were prepared to pay in those offered (including one in another part of the country).

    b. To find a home which is a little more expensive and ask a **third party** to sign a **third party agreement** to pay the difference between the Local Authority rate and the fees, which is known as the **third party contribution**.

For example:-

Mrs Brown, an 85 year old widowed lady with one daughter, lives on her own in rented accommodation suffers a stroke, and is admitted to hospital. At the discharge assessment, which her daughter attends, her care need is assessed as residential. Her income is the basic state pension, and a small Occupational Pension from her late husband of £52.00 per week. Savings are £14,500. The Local Authority offers to fund her placement in a local Care Home whose charges are within their assessed level @ £350 per week. Pension Service Calculation as follows :

	£
Basic State Pension (inc age addition)	107.45
Occupational Pension	52.00
Pension Service Calculation	
‘assumed' income’ from savings	9.00
(i.e. £1 for every £500 above £10K)	
Total Qualifying Income	**168.45**

(above ‘appropriate amount of £142.70; no entitlement to Guarantee Credit)

Savings Credit Calculation:

Reward of 60p in pound above Starting Point:	
Qualifying Income	168.45
Savings Credit Starting point	111.80
Balance	56.65
Reward 60% of balance	33.19
<u>however</u> gross maximum savings credit	**18.54 = Total A**
Deduction of 40p in pound above appropriate amount:	
Qualifying Income	168.45
Appropriate amount	142.70
Balance	25.75
Deduct 40% of balance	**10.30 = Total B**
Savings Credit: Total A - B	**8.24**

<u>TOTAL INCOME = </u> (£168.45 plus Pension Credit £8.24) = <u>176.69</u>

She will then be assessed by the Local Authority as follows:

Income:	**£**
Basic State Pension inc age addition	107.45
Occupational Pension	52.00
Notional/tariff' income (from capital of £15,000	
£1 for every £250 above £14,000	1.00
Different to DWP calculation	
Savings Credit	8.24
Total Income	**168.69**

Personal expenses/Savings Credit Disregard. Mrs Brown has a statutory right to:

personal expenses allowance (PEA)	=	**23.50**
savings credit disregard maximum £5.75		**5.75**
Her weekly contribution:		
(income less PEA/savings credit disregard)	**=**	**139.44**
Local authority's contribution		**210.56**
Home fees (which are at assessed level)		**350.00**

3. If Mrs Brown had not been happy with the home the Local Authority offered which cost £350 per week and she and her daughter had found a home which costs £450 p.w. which they both preferred, her daughter could sign a **third party agreement** to pay the extra £100 p.w. (either to the Local Authority Finance Department or the Home). Mrs Brown's personal expenses, savings disregard and savings cannot be used towards the shortfall in fees.

The financial situation would then become:-

Mrs Brown's pays		£139.44
Local Authority pays		£210.56(balance to assessed level)
	=	£350.00 - cost of assessed level
Third party pays		£100.00
	=	£450.00 - cost of preferred accommodation

4. Mrs Brown's capital should be regularly monitored and as her 'assumed income' decreases, her income should be recalculated by the Pension Service and the local authority.

Financial Assistance by the Officers' Association

In the event that the fees in private/independent care homes increase to above the assessed level, the Officers' Association Benevolence Committee may be able to consider assistance to the Third Party.

Each case will be considered on its own merits. In other words, the Officers' Association Benevolence Committee can consider applications for financial assistance, through a Third Party, towards fees for an eligible applicant to exercise their right to preferred accommodation when they would otherwise be unable to afford to. The Third Party, on behalf of the applicant, would be required to complete the Association's application form, with personal and financial details and supporting documentation.

Although every case can be considered on its own merits, the Committee uses the following guidelines:-

a. Applicants should be in receipt of the maximum Pension Credit and Local Authority funding available.

b. **The Officers' Association cannot sign a Third Party agreement** since the use of charitable monies requires regular reviews and approval by the Association's Benevolence Committee on each occasion the Association is approached. The Third Party agreement is usually signed by a family member or a friend with either an Enduring Power of Attorney (pre-October 07) or a 'Lasting Power of Attorney – Personal Welfare, (LPA PW) (see page 4) (in cases of difficulty please telephone the Officers' Association). A copy of the Local Authority's Contract and Third Party Agreement should be forwarded as part of the application to the Officers' Association whenever possible.

c. When an applicant for charitable assistance has a spouse/partner 'at home' the resources of **both** partners will be taken into account by the Benevolence Committee when considering the case, in order to assess the level of spouse/partner's capital savings and income which might be available towards total Third Party contribution.

d. It should be recognised that due to limited resources and total reliance on voluntary donations, benevolence charities' guidelines are of necessity lower than the state's. The OA will require next of kin/Enduring Power of Attorney/Lasting Power of Attorney contributions when there are savings above £10,000, or when the shortfall is exceptionally high. A shortfall of £120pw is considered a maximum weekly amount when considering help towards meeting this shortfall.

e. In cases where the applicant has family members, who have independent incomes and are not themselves in receipt of means tested benefits, the Association will expect some contribution from them towards the applicants' fees, at a level to be negotiated/discussed with the benevolence department.

f. The fees must be reasonable. **It should be noted that help towards excessive fees is unlikely** unless there are strong mitigating circumstances.

g. Where there is a considerable third party contribution to be considered the Officers' Association may seek further assistance, in co-operation from regimental, relevant professional and general charities. Income from charities towards the third party contribution is **fully disregarded** by the Local Authority.

h. Applicants should be aware that a case may take some time to 'set up`, and they should make provision to cover part of the shortfall for up to four months. In cases of difficulty contact the Officers' Association.

i. **The Officers' Association is not usually able to assist those who move to a Care Home which is a registered charity in its own right**. Please telephone for further advice.

j. All grants are reviewed by the Committee when circumstances change and not less than annually (in March/April). Those undertaking responsibility for a beneficiary's affairs must keep the Officers' Association informed of any changes in the beneficiary's circumstances, both health and financial.

k. The Officers Association will pay all shortfall payments by Bank transfer(BACS) to a nominated account(usually the LPA PW/EPOA) on a calendar monthly basis, in arrears.

Future Increases in Fees - Charitable Help

Whilst future increases in fees may be met by the periodic uprating of statutory benefits there is no undertaking that charities can meet any increase in the shortfall between fees and income. In cases where charitable help is already being provided the Officers' Association should be informed as soon as details of a future fee increase, (or any other changes in financial circumstances) is known, so that consideration is given on whether any increase in charitable help can be provided.

Advice

If you should have any questions concerning any information contained in this advice paper please do not hesitate to write or telephone.

Further Information

AgeUK Tel; 0800 169 8787. www.ageuk.org.uk

Free Information sheets and Factsheets are available

Counsel and Care Tel: 0845 300 7585 (Monday to Friday 10 a.m. to 1 p.m.)
A charity which provides advice for elderly people and their families.
www.counselandcare.org.uk

April 2011

OA2 – PART C

HOSPITAL DISCHARGE ARRANGEMENTS
EXTRACTS FROM GOVERNMENT GUIDANCE

This part can be read in isolation from the rest of OA2, but if you need further information on State Funding and other aspects of Care in Community Legislation, please ask for Parts A and B.

Hospital Discharge Arrangements

The Delayed Discharges (Continuing Care) Directions 2004
As part of the normal discharge process, a hospital must officially notify social services if the patient is likely to need continuing care services on discharge from acute hospital care. The Delayed Discharges (Continuing Care) Directions 2004 relate to this stage in the discharge process: NHS bodies with responsibility for the discharge of patients must have first assessed the patient's continuing health needs and compared them with the local continuing NHS health care eligibility criteria. They must then notify the patient of their decision, **before** they notify social services

During early 2005, an independent review body identified 9 Strategic Health Authorities who have not been consistent with application of eligibility criteria for 'Continuing NHS Health Care' and 'Free Registered Nursing Care'. Some NHS bodies appear to regard entitlement to continuing NHS health care as simply the top band above the highest band for free nursing care. This was unsatisfactory and the Ombudsman directed that more work was needed.

The Health Select Committee's inquiry concluded that despite considerable investment by Government in researching, reviewing and change systems for funding of long term care, it seems we are no closer to a fair and transparent system that ensures security and dignity for people who need long-term care, and promotes independence. There are no national eligibility criteria. Each of the 28 Strategic Health Authorities in England has set their own, to be used by the Primary Care Trusts in their area. Should you be in any doubt, you should challenge the decision, to ensure that there is no confusion.

In March 2011, the Government announced that Primary Care Trusts and Strategic Health Authorities will be abolished by 2013 and control of NHS budgets given to GP consortia. At time of going to print, there is no further information, but naturally there will be implications to care home funding.

Hospital Discharge Assessments
Statutory Directions on hospital discharge assessments will include the following:

- Every patient should be assessed against local criteria and a record should be made of that assessment, with a copy given to the patient.
- Having assessed the needs of the patient, the local authority should consult the patient, gain agreement to the care plan where possible and provide information on costs to the patient. The local authority should 'take all reasonable steps to reach agreement'.

- Where the discharge plan is a care package in the person's own home, social services are to review the discharge care package, including that provided to the carer, within a maximum of two weeks to check that post-discharge care has been adequate and is working.

Government guidance requires the discharge procedures to include the following, for patients and as appropriate, their carers:

- Organising transport, including someone to travel with the patient if necessary;
- Giving adequate notice of the time and day of discharge from hospital, and agreeing these decisions with patients and carers;
- Giving a contact name and telephone number in case any difficulties arise following discharge;
- Providing information on diet, medicines, follow-up appointments and contact with GPs; arrangements should be made for any such information to be provided to those with particular communication needs;
- Supplying and fitting any necessary aids and adaptations, and instructions on use;
- Taking steps to activate/reactivate services such as home care, meals at home and ensuring they commence on the required date; this might include an intensive package of support at home after acute hospital treatment has ended;
- Making arrangements to ready the home of patients who live alone where necessary;
- Contingency plans for discharges on Friday afternoons or weekends, for those unwilling to be discharged, or self-discharges;
- Ensuring that care plans accompany patients transferring to care homes;
- Making sure written discharge summaries are sent to GPs within 24 hours of discharge;
- Making sure that copies of agreed care plans are passed to all services involved in meeting individuals' continuing health and social care needs.
- The patient, family and any carers should be kept fully informed about how procedures for hospital discharge and any assessment for services will work.

Information following assessment. You should be given a summary of your assessment, called a 'care plan'. Your care plan should set out what help you will be given, who is responsible for providing this help, who you can contact if things go wrong, and how much, if anything, you will have to pay towards services. If you have questions about how these decisions have been reached, you might find it useful to obtain a full copy of your assessment.

Types of Care following Discharge from Hospital

National Health Service

NHS Continuing Health Care Services. Eligibility to receive NHS services is based on medical need. Your needs will be assessed and then compared to your Primary Care Trust's eligibility criteria. If you meet the criteria and your needs are best met in a care home, the NHS will meet **all** the care home costs, not just the health care costs. However the Direction on Choice does *not* apply to NHS-funded placements, you do not have the right to choose where you receive the care. This is the case for any NHS hospital (or inpatient) care, where patients can sometime need to be in a hospital some distance from where they live because there is no suitable clinical alternative nearby.

Free NHS (Registered) Nursing care. All nursing care provided by a registered nurse should now be free i.e. funded by the NHS. However, the NHS will not pay for nursing care provided by a care assistant under the direction of a nurse (unless you are receiving NHS continuing health care).

Right to review of decisions. If you disagree with the decision that you do not meet your health authority's criteria for NHS-funded continuing care, you have a 'right to review' of the decision. Information about the review procedure should be made available to you.

Palliative health care. Term used to describe care for people (and their families) whose life threatening disease is no longer responding to treatment. This care is concerned with ensuring the best quality of life, including pain control and provision of emotional support during and beyond the duration of the illness. Services include Macmillan nurses, home care nurses, doctors and other health professionals.

Rehabilitation and Recovery services. Aimed at promoting recovery and maximising independence following major surgery, heart attack, stroke or acute episode of long term illness. It may be provided in a nursing home or in a person's own home. Services may continue for weeks or months and may include speech therapy, physiotherapy, or occupational therapy. There may also be a period of recovery after acute hospital treatment to help patients regain confidence about going home.

Intermediate Care. Intended to fill a similar role to rehabilitation and recovery services but is strictly time limited. This care is intended to provide rehabilitation and 'step down' services to people (older people in particular) who have finished their hospital treatment but who would benefit from a short period of rehabilitation, and is likely to be limited to a maximum of six weeks. Intermediate care provided by the NHS will be free, including all care home fees if it is provided in a care home. It should not be the only rehabilitation and recovery service available, due to its time limit, and some people may need a longer rehabilitation period. Intermediate care must involve active therapy, treatment or an opportunity for recovery. It is not intended to be used while you are simply waiting for a care home place to become available or for home care services to be put in place.

Respite health care. Respite health care describes a period of care for someone who is normally cared for at home, usually by a relative or close friend. It may be provided when the usual carer is ill or to give the carer a break. If you do not meet the local Primary Care Trust's eligibility criteria for respite *health* care, **respite care** can still be arranged by the local authority. In this instance you may be asked to pay towards this care.
Crossroads, a voluntary, charitable organisation, can also help arrange respite care – domiciliary rather than residential – either with or without social services involvement. You may be asked to pay for this service. (Crossroads-Caring for Carers, 10 Regent Place, Rugby, Warwickshire, CV21 2PN, tel: 0845 450 0350; www.crossroads.org.uk)

Other NHS services.

- **Specialist transport to/from hospital or other health care facilities**
- **Transport when you leave hospital and afterwards, if an emergency or temporary admission to a care home is needed**
- **Incontinence pads – free**
- **Specialist equipment used by nurses.**

Social Services

Local authorities (the council) provide social services. They are separate from health services. Social services can provide home care, meals delivered to your home, day centres or places in care homes. They can also provide respite care and can provide services to a carer as well as to the person cared for. Social services might provide these services themselves or purchase them from a private or voluntary agency. Social services can charge for services. Alternatively they can make payments to a person who needs help, or in some circumstances, to their carer, so that they can arrange their own services. These are called "Direct payments".
Regulations exist which stipulate that certain services be free. Local authorities are required to provide equipment, minor adaptations of £1,000 or less. The Department of Health has issued guidance to local authorities on these regulations. It reminds authorities that they should set their eligibility criteria in line with *Fair Access to Care Services.*

Services that may be offered

One or a combination of services from the NHS and/or social services may form part of a care package.

- **Rapid Response teams –** on 24 hour basis, rapid assessment of needs and rapid access to short-term nursing support or personal care at home. The team may be based in the community and will often have close links with hospital accident and emergency departments or the ambulance service. Input from community equipment services and/or housing based support services may also be called upon.
- **Hospital at home** - intensive support in your own home, including investigations and treatments not normally available through your GP or community based staff.
- **Residential rehabilitation** – a short term programme of therapy in a care home which may include physiotherapy, speech therapy, occupational therapy.
- **Day rehabilitation** – a programme of therapeutic support, similar to that offered in residential rehabilitation but provided in a day hospital or day centre.
- **Supported discharge** – a short term programme of personal and/or nursing care to support your recovery at home.

If you are offered an 'intermediate care package', there is no charge for any health and social care services included in the package for up to and including 6 weeks.

Discharge to a Care Home. Your assessment may conclude that going into a Care Home for either residential or nursing care would best suit your needs. Each care home should produce a brochure and a statement of purpose that can be used to decide whether the home will meet the needs set out in your assessment. Whether your place in the home is arranged and paid for by yourself or social services, will depend on the application of national rules. If social services are arranging a place for you, you can choose which home you will live in under the Direction of Choice, subject to certain conditions:

- The home is assessed as suitable for your assessed care needs;
- The home is willing to enter into a contract with the local authority, subject to the local authority's usual terms and conditions;
- The home costs no more than the local authority would normally pay for someone with those assessed needs;
- There is a vacancy.

You can also choose to enter a home that costs more than the local authority normally pays for someone with your assessed needs, if there is someone else (called a 'Third Party') who is prepared to pay the difference of this extra cost for as long as you remain living in the home. This 'Third Party' could be a relative or friend. However if you are in hospital and your chosen home has no current vacancy or is not likely to have a vacancy in the near future, then it may be necessary for you to be discharged to another home until a place in your chosen home becomes available.

If you do not want to go into a Care Home. Social services have a duty to meet your needs (as established by assessment) but they are entitled to decide how they will do this. Sometimes they will decide that your needs should be met by residential care because this is the only alternative. However, it may also be because it is the cheapest option. Often there will be financial limits to how much care will be provided in your own home.

You cannot be forced to go into a care home. The exception to this is a small number of patients placed under Part II of the Mental Health Act 1983. However, social services might then argue that they have discharged their statutory duties and therefore do not have to provide services. You could however argue that a care home would not meet your needs (e.g. psychological needs). Another alternative might be to consider sheltered housing. Sheltered housing usually offers a warden service, and there are an increasing variety of schemes often called 'extra care' that provide additional services such as home care or meals.

Right to refuse discharge to a Care Home. If you have been assessed as *not* requiring further acute care or NHS continuing health care, you do not have the right to occupy an NHS bed indefinitely. However, you *do* have the right to refuse to be discharged from NHS care to a Care Home. However if you refuse to enter a home but *cannot* insist on staying in hospital, the question then arises of what happens next. In such cases the local authority social services department should work with hospital and community based staff, and you, your family and any carer(s) to explore alternative options. If these options are rejected, it may be necessary for the hospital, in consultation with the health authority, social services department and where necessary housing authority, to implement discharge to the patient's home or alternative accommodation, with a package of health and social care within the options and resources available. You should note that you might be asked to pay towards services arranged or provided.

If someone's care needs change. There may be times when your condition changes, perhaps because there is deterioration in your health. This could mean that, although initially you did not meet the health authority's criteria for any NHS continuing care services, you might meet it at a later date. If so, you could ask for a new assessment of your health care needs. If it was found that you now met the criteria for NHS–funded care, then that care should be put in place.

Right to review of decisions. If you disagree with the decision that you do not meet your health authority's criteria for NHS-funded continuing inpatient care, you have a 'right to review' of the decision. Information about the review procedure should be made available to you.

Disputes and complaints to the NHS. You can try to resolve any problems by using the NHS Complaints procedure. Information should be available from your local NHS Trust or health authority. The local Community Health Council may also have information and may be able to help.

Complaints about social services. Social services have a separate complaints procedure which you can use if you are not satisfied with the help that you are offered or the quality of service provided. You should contact their complaints officer.