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Adult Social Care Charging Policy 2024/25

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1. Introduction

Adult social care provides personal and practical support to people with care and support needs, including older people or people with a disability or a physical or mental illness. People with informal caring responsibilities can also benefit from social care support.

In the London Borough of Bexley, the core purpose of adult care and support is to help you to achieve the outcomes that matter to you in your life and to promote your wellbeing. A key aim is to support you to live as independently as possible, for as long as possible.

We provide free information and advice, relating to care and support for adults and support for carers, to enable you to make informed choices and take control of your care and support. This includes information about social care on our website at Bexley.gov.uk and at the carehub.bexley.gov.uk.

Anyone aged 18 or over or preparing for adulthood, who appears to have care and support needs, has the right to ask the Council for a needs assessment and/or a carers assessment, regardless of their circumstances or financial situation. Having an assessment can help you and others understand your needs better and will help you think through your options.

We will work with you to help you make good decisions about your care and support. In doing so, we want to ensure that you get the right help, in the right place at the right time.

We work with a range of agencies and providers in the public, independent and third sectors to ensure there is a diverse range of care and support available, which gives you choice over how your needs are met.

2. Purpose of this policy

In England, adult social care is currently means-tested and, unlike the NHS, is not free for everyone, with costs dependent on a person's level of need and their financial situation. This means that most care and support will be subject to a charge but you will only be asked to pay what you can afford. There are, however, some types of care and support provided free of charge (Section 7).This document is the London Borough of Bexley's Adult Social Care Charging Policy for non-residential services and residential services. The purpose of the policy is to explain the criteria used to determine levels of charging for particular services, including how the Council wishes to apply its discretion locally to charge people in settings other than care homes.

Our fees and charges will be reviewed annually. Our Charging Policy will be reviewed every three years and any revisions to charges and financial assessment rules will be approved by the Council as part of the annual budget setting process.

3. Legal framework

The Care Act 2014 provides a single legal framework for charging for care and support under sections 14 and 17 of the Act.

Section 14 of the Care Act 2014 provides the Council with the power to ask adults to make a contribution for the cost of their care and support.

Section 17 of the Care Act 2014 allows the Council to carry out a financial assessment to determine the amount a person can afford to contribute towards their care and support.

Under the Care Act 2014, the Council must undertake an assessment for any adult with an appearance of need for care and support, regardless of whether the Council thinks the individual has eligible needs or of their financial situation. The Council has a duty to arrange care and support for those with eligible needs, and a power to meet both eligible and non-eligible needs.

In all cases, the Council has the discretion to choose whether or not to charge a person when it is arranging to meet a person's care and support needs, or a carer's support needs, following a person's needs assessment.

Where the Council decides to charge, it must follow the Care and Support (Charging and Assessment of Resources) Regulations 2014 and have regard to the Care and Support Statutory Guidance.

The legal framework provided by the Care Act 2014 is intended to make charging fairer and more clearly understood by everyone. The main legislation, regulations and statutory guidance that apply to this policy are summarised in Appendix 1 and are also available on the Government website: www.gov.uk.

4. Principles

When making decisions on charging, the Council will take into account the principles set out in the statutory guidance, which are summarised below. The overarching principle is that you should only be required to pay what you can afford. The principles are that the Council's approach to charging for care and support needs should:

- Ensure you are not charged more than it is reasonably practicable for you to pay;
- Be comprehensive to reduce variation in the way you are assessed and charged;
- Be clear and transparent so you know what you will be charged;
- Promote wellbeing, social inclusion, and support the vision of personalisation, independence, choice, and control;
- Support you, if you are a carer, to look after your own health and wellbeing and to care effectively and safely;
- Be person-focused, reflecting the variety of care and caring journeys and the variety of options available to meet your needs;
- Apply the charging rules equally so those with similar needs or services are treated the same and minimise anomalies between different care settings;
- Encourage and enable you to stay in or take up employment, education or training or plan for the future costs of meeting your needs, if you wish to do so; and
- Be sustainable for the Council in the long-term.

In line with the Equality Act 2010, the Council will ensure there is sufficient information and advice available in a suitable format for your needs to ensure that you or your representative are able to

understand any contributions you are asked to make. The Council will also make you or your representative aware of the availability of independent financial information and advice (see Section 37).

5. Best Value

In determining how to meet needs, the Council may take into reasonable consideration its own finances and budgetary position and must comply with its related public law duties. This includes the importance of ensuring that the funding available to the Council is sufficient to meet the needs of the entire local population.

The Council may reasonably consider how to balance that requirement with the duty to meet the eligible needs of an individual in determining how an individual's needs should be met (but not whether those needs are met).

The Council may take decisions on a case-by-case basis which weigh up the total costs of different potential options for meeting needs and include the cost as a relevant factor in deciding between suitable alternative options for meeting needs. This does not mean choosing the cheapest option; but the one which delivers the outcomes desired for the best value.

6. Types of care and support

6.1 Non-residential services

Non-residential services refer to a range of care and support that is provided in your home or in the community to meet your needs and to help you achieve your identified outcomes.

Our aim is to enable you to stay independent and safe in the community for as long as possible and to promote your well-being. There are many different types of services to meet your needs, including but not limited to:

- Day opportunities and support in the community;
- Transport to and from day care and respite care;
- Telecare and community alarm services;
- Care at home services that provide support with personal care and daily living in your home;
- Other services that you may purchase directly, e.g., a personal assistant;
- Shared Lives services;
- Supported living services.

6.2 Residential services

Residential services refer to 24-hour care and support provided in a care home setting. Care provision can be on a permanent, temporary, or short-term basis.

All registered care homes are regulated by the Care Quality Commission to ensure they meet appropriate standards of care. Further information, including copies of inspection reports are available on CQC's website at www.cqc.org.uk.

If you feel you are no longer able to live independently at home even with extra support, the Council can help you to consider your options and give you advice and guidance. Even if you think you will have to fully fund your stay in a care home, it is still advisable to get in touch and, if appropriate, request a needs assessment. This will help you to decide if there are any alternatives to going into a care home.

In certain circumstances, you may only need short-term care. Where you are a short-term or temporary resident, there is a degree of discretion or modified charging rules to take account of this (see Section 17.5).

7. Non-chargeable services

The Council must not charge for certain types of care and support, which must be arranged free. These services are:

- **Intermediate care and reablement support services**, which must be provided free of charge for up to six weeks. These services are further described in the Care and Support Statutory Guidance. Intermediate care services are usually provided after leaving hospital or when people are at risk of being sent to hospital. 'Reablement' is a particular type of intermediate care, which has a stronger focus on helping the person to regain skills and capabilities to reduce their needs, in particular through the use of therapy or minor adaptations.
- **Community equipment (aids and minor adaptations):** Aids must be provided free of charge to meet, prevent, or delay needs. A minor adaptation is one which costs £1000 or less;
- **Any services which are provided as part of an individual's aftercare under section 117 of the Mental Health Act 1983**. See Section 27 for further information about these services;
- **Care and support provided to people with variant Creutzfeldt-Jacob Disease;**
- **Any service or part of service which the NHS is under a duty to provide**, including NHS Continuing Healthcare and the NHS contribution to Registered Nursing Care; and
- **Any services which a local authority is under a duty to provide through other legislation** may not be charged for under the Care Act 2014.

The Council must not charge you for a financial assessment, a needs assessment or the preparation of a care and support plan.

The Council values carers within our local community as partners in care and recognises the significant contribution that carers make. It is with this in mind that, where carers' services are provided as a result of a carer's assessment, the Council has used its discretion and will not charge or request a financial contribution from the carer.

The provision of non-chargeable services will reflect best value and be clearly linked to specified assessed outcomes.

8. Prevention services

Prevention services, like other forms of care and support, are not always provided free. In some cases, charging may be necessary in order to make a preventative service viable or keep a service running. The

Care and Support (Preventing Needs for Care and Support) Regulations 2014 allows the Council to make a charge for the provision of certain preventative services, facilities, or resources.

Where the Council chooses to charge for a particular service, we will consider how to balance the affordability and viability of the activity with the likely impact that charging may have on uptake.

When charging for any type of preventative support, the Council will take reasonable steps to ensure that any charge is affordable for the person concerned. We will adopt a proportionate or 'light-touch' approach which ensures that charges are only paid by those who can afford to do so and we will not charge more than it costs to provide or arrange for the service, facility, or resource.

9. Chargeable services

All services, whether residential or non-residential, will be chargeable except where the Council is required to arrange care and support free of charge (Section 7) or otherwise exercises its discretion not to charge for services.

The detail of how to charge is different depending on whether you are receiving care in a care home, or your own home, or another setting.

The delivery model for care homes is relatively uniform across the country and so, for people receiving care in a care home, the regulations and guidance set out fairly prescriptive rules for charging purposes, which the Council is required to follow. In contrast, for people in settings other than care homes, the Council is permitted to develop and maintain its own charging policy.

The provision of chargeable services will reflect best value and be linked to the specified assessed outcomes set out in your care and support plan.

10. Financial assessment

If the Council wishes to charge you for meeting your social care needs (whether eligible or not), it must carry out a financial assessment. This will determine the level of your financial resources and the amount (if any) that you can afford to pay towards your care and support. However, the financial assessment must never influence the assessment of your social care needs.

The Council will consider all relevant and contributing factors to your financial circumstances whilst undertaking the financial assessment. Factors to consider include but are not limited to:

- Chargeable and non-chargeable income;
- Chargeable and non-chargeable capital;
- Applicable allowances;
- Applicable disregards.

Following the financial assessment, the Council will provide you with a written record of the assessment outcome. Some people may be entitled to free care and support, others will pay the full cost, or sometimes the cost will be shared between the person and the Council. The Council will explain how the assessment was carried out and, if you are required to pay for your care and support, what the charges will be. You will also be provided with details of the Council's appeals process and complaints procedure.

If there has been a change in your financial circumstances, you can request a reassessment at any time by getting in touch with the Council's Single Point of Contact (see Section 36 for contact details).

The Council will normally carry out an annual financial assessment review to ensure that you are paying the correct amount for the services you receive.

If you wish to make a complaint or appeal your financial assessment, a senior officer of the Council will investigate the issue raised and respond to you in line with the Council's Appeals Process and Complaints Procedure (Section 34).

If you need the assistance of an advocate and have no-one who can act as an advocate on your behalf, we can arrange access to independent advocacy services on request.

The steps in the financial assessment process are explained below (Section 11).

11. 'Light touch' financial assessment

In some circumstances, the Council has the power to choose to treat a person as if a financial assessment had been carried out. To do so, the Council must be satisfied on the basis of evidence provided by the person that they can afford, and will continue to be able to afford, any charges due. This is known as a 'light-touch' financial assessment.

If the Council chooses to complete a 'light touch' assessment, it will inform you when a 'light-touch' financial assessment has taken place and make clear that you have the right to request a full financial assessment should you so wish.

If the 'light touch' assessment indicates that the Council needs to support you towards your care costs, then the Council will require a full financial assessment to be undertaken.

We will also make sure you have access to sufficient information and advice, including the option of independent financial information and advice.

The financial assessment process

Step 1

Application and evidence:

- You will be asked to submit a financial assessment form, which will ask about your savings, investments and assets, income, and expenditure.
- You may nominate another person to represent or assist you during this process.
- If you have savings or assets, of more than £23,250 or prefer not to give the information required you will pay the full cost of your care.

Step 2

The calculation:

- We will carry out an assessment of your financial circumstances, in accordance with the regulations, to determine the weekly contribution you can afford.

Where a person has appointed an attorney or deputy to make financial decisions with them or for them, the attorney or deputy is required to consider and engage with any debt recovery on their behalf.

Where a person lacking capacity has no attorney or deputy and has substantial debts, then an application to the Court of Protection for a deputy is required (Sections 22-24).

Where a person may have difficulty in understanding the options available to them, the Council will consider the need for independent advocacy in accordance with Statutory Guidance.

In deciding how to proceed, the Council will consider the circumstances of the case before deciding a course of action. Ultimately, the Council may institute County Court proceedings to recover the debt. However, we will only use this power after other reasonable alternatives for recovering the debt have been exhausted.

The Council will seek to protect public money from fraud, misuse, or deprivation of assets and will take action to recover any monies lost as a result of such unlawful activities.

17. Charging for residential services

17.1 How we work out what you can afford

If you are assessed as needing residential care, a financial assessment will be undertaken (see Section 10) to identify the contribution you are required to pay to the care home towards your care costs.

You can contact the Council for further information or visit our website to find out about paying for residential care and how we work out what you can afford.

Where the Council has decided to charge and undertaken a financial assessment, we will help you to identify the options of how best to pay any charge. This may include offering you a Deferred Payment Agreement (Section 20).

17.2 Treatment of property

The value of your main or only home will be considered as part of your financial assessment for permanent residential care but not for any other types of care and support.

The Care and Support Statutory Guidance specifies the rules on what income and capital must be disregarded and this guidance will be followed by the Council when carrying out your financial assessment.

Your main or only property will be disregarded from the financial assessment if it continues to be the permanent residence of:

- Your husband, wife, partner, former partner, or civil partner, except where they are estranged;
- A lone parent who is the person’s estranged or divorced partner;
- A relative of the person as defined in paragraph 35 of Annex B of the Care and Support Statutory Guidance or member of the person’s family who is either aged 60 or over, a child of the resident aged under 18, or incapacitated.

The mandatory disregard only applies where the property has been continuously occupied by your relative before you went into a care home.

17.3 12-week property disregard

An important aim is to prevent you from being forced to sell your home at a time of crisis and to allow you time to consider the options available to fund your future care costs.

Where your main or only home is to be included in the financial assessment, the Council will disregard the value of the property for 12 weeks, where applicable, in the following circumstances:

- When you first enter a care home as a permanent resident;
- When a property disregard other than the 12-week property disregard unexpectedly ends because the qualifying relative has died or moved into a care home.

In addition, the Council has discretion to choose to apply the disregard when there is a sudden or unexpected change in your financial circumstances. In deciding whether to do so, the Council will consider the individual circumstances of the case.

17.4 Personal expenses allowance

The Council must leave you with a specified amount of your own income so that you have money to spend on personal items such as clothes and other items that are not part of your care. This is known as the Personal Expenses Allowance (PEA) and is not taken into account when assessing your income.

The PEA is specified in regulations made under section 14(7) of the Care Act 2014. For 2024 to 2025, the PEA is £30.15 per week and the Council must apply this to all people whose care and support in a care home is arranged by the Council under section 18 or 19 of the Care Act 2014.

Any income above this allowance will be taken into account in determining the charges you can afford to pay.

17.5 Temporary and short-term residents in care homes

Where you are a short-term or temporary resident in a care home, there is a degree of discretion or modified charging rules to take account of this.

A short-term resident is someone provided with accommodation in a care home for a period not exceeding eight weeks (e.g., where a person is placed in a care home to provide respite care). In these circumstances, if it thinks fit, the Council will assess and charge you based on the rules for care and support arranged other than in a care home.

A temporary resident is someone whose need to stay in a care home is intended to last for a limited period and where there is a plan to return home. Your stay should be unlikely to exceed 52 weeks, or in exceptional circumstances, unlikely to substantially exceed 52 weeks.

If you are a temporary resident, a financial assessment will be carried out, where appropriate, to determine what you can afford to pay. Your main or only home and certain housing related costs will be disregarded in the financial assessment as you will be expected to return to this property.

If a temporary stay becomes permanent, the initial temporary financial assessment will apply until the date that the care and support plan is amended and agreed with you or your representative.

18. Choice of accommodation

Your ability to make an informed choice is an important element of the care and support system. This extends to where the care and support planning process has determined that you need to live in a specific type of accommodation in order to best meet your care and support needs.

Where this is the case and the Council is responsible for meeting your care and support needs, you will have a right to choose the particular provider or location, subject to certain conditions. This choice only applies between providers of the same type of accommodation.

The type of accommodation must be one of those specified in regulations and applies to care homes, shared lives schemes, supported living accommodation, and extra care housing.

As part of your care and support plan, you will be allocated a personal budget. This is the cost to the Council of meeting your needs, which the Council chooses or is required to meet.

The Council will ensure that you have a genuine choice of accommodation across the appropriate provision and that at least one accommodation option is available and affordable within your personal budget.

The Council will only arrange for care in the accommodation you choose, provided that:

- the accommodation is suitable in relation to your assessed needs;
- to do so would not cost the Council more than the amount specified in your personal budget for accommodation of that type;
- the accommodation is available; and
- the provider of the accommodation is willing to enter into a contract with the Council to provide the care at the rate identified in your personal budget on the Council's terms and conditions.

This choice is not limited to those settings or individual providers with which the Council already contracts with or operates, or those that are within the London Borough of Bexley. If you choose to be placed in a setting that is outside the London Borough of Bexley, the Council will still arrange for your preferred care.

Where you choose a more expensive accommodation from the already available options, a 'top up' fee (Section 19) will need to be sought from a third party, such as a family member, or from yourself in limited circumstances. The Council must ensure that the person paying the 'top-up' is willing and able to meet the additional cost for the likely duration of the arrangement.

If you have not expressed any preference and no suitable accommodation exists at the amount identified in the personal budget, the Council are required to arrange care in a more expensive setting and adjust the personal budget accordingly. In such circumstances, the Council will not ask for the payment of a 'top up' fee.

Further information about these requirements is set out in the 'Care and Support and After-care (Choice of Accommodation) Regulations 2014' and 'Annex A: Choice of accommodation and additional payments' of the Care and Support Statutory Guidance.

19. Top-up payments

19.1 What is a 'top-up'?

Where your care is wholly or partly funded by the Council, that care will demonstrate best value (Section 5). However, the Council recognises that you have the right to exercise choice over how and where your care is provided and you may ask the provider to provide additional care or you may ask to be provided with care in a setting which is more expensive than the Council would usually pay. This is referred to as a 'top-up'.

To discharge its duties to facilitate choice, the Council operates a scheme, in line with the Statutory Guidance, that permits those who wish to do so to purchase higher cost accommodation than that normally funded by the Council, through payment of a 'top-up'. The 'top-up' payment is the difference between the actual costs of the preferred provider and the amount that the Council has set in your personal budget.

There are two types of 'top-ups', namely a first party 'top-up' and a third party 'top-up'.

19.2 First party top-up

You can make a first party 'top-up' only in the following circumstances:

- You are subject to a 12-week property disregard (but only during the period of that disregard);
- You have a deferred payment agreement (DPA) in place with the Council. The DPA agreement must reflect the first party top up arrangement; or
- You are receiving accommodation provided under section 117 of the Mental Health Act 1983 for mental health aftercare.

19.3 Third party top-up

A third party 'top-up' is paid by someone other than yourself, such as a family member, who is willing and able to meet these additional costs for the likely duration of the care arrangement.

All 'top-ups' must be expressly agreed in writing by the Council. The Council will agree to enter into a 'top-up' arrangement where:

- the Council can assure itself that the person paying the 'top up' sums has sufficiently secure financial resources to make the payments by requesting reasonable evidence; and
- the 'top-up' arrangement is sustainable for the likely duration of the arrangement.

19.4 Agreeing a 'top-up' arrangement

The person paying the 'top-up' will be required to enter into an agreement with the Council to set out the terms of the arrangement.

Before entering into the agreement, the Council will provide the person paying the 'top-up' with sufficient information and advice to ensure that they understand the terms and conditions. Where appropriate, this may include help to understand how to access independent financial advice on matters relating to care and support.

The Council will make clear in writing the responsibilities of the person making the 'top-up' payment and the consequences should there be a break down in the arrangement to meet the cost of the 'top-up'.

19.5 Consequences of a break down in the arrangement

The person making the 'top-up' payment has a responsibility to inform the Council of an unexpected change in their financial circumstances. Where a person is unable to continue making 'top-up' payments, the Council may seek to recover any outstanding debt and make alternative arrangements to meet the cared for person's needs, subject to a needs assessment.

In all cases, the Council reserves the right to move the cared for person to an alternative accommodation, where this would be suitable to meet their needs and affordable within the personal budget or local mental health after-care limit.

As with any change of circumstance, the Council will undertake a new assessment before considering this course of action, including consideration of a requirement for an assessment of health needs, and have regard to the person's wellbeing.

20. Deferred Payment Agreements

The Council operates its Deferred Payment Scheme in line with the 'Care and Support (Deferred Payment) Regulations 2014' and Care and Support Statutory Guidance.

The Council will offer a DPA to those who request one and who are entitled, meaning that the local authority pays the care home directly and defers the charges due to it from the individual. The eligibility criteria, as set out in the Regulations, include:

- The person is ordinarily resident in the London Borough of Bexley or present in the area but of no settled residence;
- The person has needs which are to be met by the provision of care in a care home. This is determined when someone is assessed as having care and support needs which the Council considers should be met through a care home placement;
- The person has less than (or equal to) £23,250 in assets excluding the value of their main or only home;
- The person's home is not disregarded for the purposes of the financial assessment carried out under section 17 of the Care Act 2014.

The Council may also at its discretion enter into deferred payment agreements with people whose care and support are provided in supported living accommodation. Further details are set out in the regulations and statutory guidance.

The Council must consider whether the individual has adequate security in place when entering into a deferred payment agreement so that the Council can be confident that the amount deferred will be

repaid in the future. Usually this requirement for 'adequate security' will be fulfilled by securing their DPA against their property.

Where the security offered is believed by the Council to be inadequate to secure the debt, the Council reserves the right to decline to enter into a DPA in line with relevant national guidance. The Council may refuse a DPA:

- where it is unable to secure a first charge on the person's property;
- where someone is seeking a 'top up' but the amount or size of the deferral requested is not sustainable, given the equity available from your chosen form of security;
- where a person does not agree to the terms and conditions of the agreement, for example a requirement to insure and maintain the property.

Where a person may lack capacity to request a deferred payment, a deputy or attorney (a person with a relevant enduring power of attorney or lasting power of attorney) may request a deferred payment on their behalf. However, the Council will not enter into DPAs with a person lacking the requisite mental capacity unless the proper arrangements are in place.

Under the arrangement, an individual enters into a formal DPA with the Council by which payment for their care and support is 'deferred', being paid in the interim period by the Council. The money owed to the Council is subsequently repaid either when the home is sold from the person's estate or when the amount due is repaid to the Council.

The DPA will clearly set out all terms, conditions, and information necessary to enable the individual to ascertain their rights and obligations under the agreement.

The individual will grant the Council a legal charge over their property or properties for the purposes of security and to facilitate reclamation of the amount due to the Council.

The individual or their representative will need to take appropriate steps to ensure that the property or properties are properly maintained, insured, and secured to maintain their market value and are not occupied without the prior consent of the Council.

The Council will use an 'equity limit' to determine the total amount that can be deferred and will take all reasonable steps to ensure that the amount deferred does not rise above this limit. The equity limit is calculated in line with national guidance, as follows:

- Value of the property less 10%, less the lower capital limit (currently £14,250) less any other outstanding charges on the property.

The Council will monitor the equity limit and when it reaches 70% of the value of the property will do the following:

- Review the cost of their care with the person;
- Discuss when the person may be eligible for means tested support;
- Discuss the implications for any top-up that there may be; and
- Consider whether a deferred payment continues to be the best way to meet the cost of care.

The Deferred Payment Scheme is intended to be run on a cost-neutral basis. The Council will recoup the costs associated with deferring fees by charging interest on the debt accrued in line with the Care and Support (Deferred Payment) Regulations 2014.

The Council will also recoup the administrative costs associated with DPAs, including legal and ongoing running costs, via an administration charge, as set out in the Council's published charges on our website at Bexley.gov.uk. The charge will be set at a level so as not to exceed the costs incurred by the Council.

21. Charging for non-residential services

21.1 How we work out what you can afford?

The Council exercises its discretion to charge for non-residential services. This is determined on an individual basis following completion of a financial assessment (Section 10), which will take account of your income, savings, and other capital to work out how much you can afford to pay towards the cost of your care and support services.

The Council will exclude the value of your main or only home in the financial assessment when you receive care and support services whilst living in your own home.

As part of this process, we will check whether you are receiving all the benefits that you are entitled to. If not, you will be able to access advice and support to ensure your income is maximised.

You can contact the Council for further information or visit our website to find out about paying for care at home and how we work out what you can afford.

21.2 Minimum Income Guarantee

If you are receiving local authority-arranged care and support other than in a care home, the Council must ensure that your income is not reduced below a specified level after charges have been deducted. The amounts are set out in the Care and Support (Charging and Assessment of Resources) Regulations 2014. This is a weekly amount, known as the Minimum Income Guarantee (MIG), which is set and reviewed annually by the Department of Health and Social Care and published in Local Authority Circulars.

The purpose of the MIG is to promote independence and social inclusion and ensure that you have sufficient funds to meet basic needs, such as purchasing food, utility costs or insurance.

The Council will charge you at a level which leaves you with the MIG and allows for any housing costs such as rent and council tax (net of any benefit provided to support those costs and after any Disability Related Expenditure).

21.3 MIG for severely disabled working-age people

The Council will use its discretion to implement an 8.8% increase in the MIG for the most severely disabled working-age people, identified by receiving higher rate PIP or higher rate Disability Living Allowance (DLA) care component. This would compensate for the lack of an inflationary uplift in the MIG in recent years for the most severely disabled working age people.

This increase has been calculated based on data on benefits uprating, which shows that PIP Daily Living enhanced rate and DLA Care Component highest rate was £82.30 per week in 2015/16 and £89.60 per week in 2021/22 (+8.8%).

21.4 Disability Related Expenditure

Disability Related Expenditure (DRE) is an allowance made in the financial assessment for additional expenses you may have due to a disability or condition. DRE can only be considered if you receive Disability Living Allowance (care), Attendance Allowance (AA) or Personal Independence Payment (PIP). In assessing DRE, the Council will comply with Annex C of the Statutory Guidance and follow the steps set out in Appendix 3 of this policy.

When DLA, AA or PIP allowance is taken into account as income for an assessment, we automatically allow £36.33 per week as DRE. This amount is disregarded from your total income to pay towards any disability related expenditure.

In Bexley, we understand that severely disabled people receive higher benefits than people who are less severely disabled. In addition, to the application of the automatic disregard of £36.33 per week for DRE, the Council disregards the difference (£35.90 per week) between the standard (£72.65 per week) and the enhanced (£108.55 per week) rate of Personal Independence Payment for severely disabled people, who are in receipt of this benefit.

Your personal circumstances will always be considered. If your disability-related expenditure exceeds the automatic disregard, then you can submit this information at the time of your financial assessment or ask for a full review of these costs to be undertaken at any time so that the Council can ensure you retain the ability to meet this expenditure.

Any reasonable additional costs directly related to your disability should be included on the DRE form (see Appendix 3 for more details). However, in some cases, it may be reasonable for the Council not to allow for items where a reasonable alternative is available at lesser cost.

The automatic disregard will still apply even if a full review shows your allowable expenditure is below the automatic disregard. If your allowable expenditure is greater than the automatic disregard, then that amount will apply as a disregard in the financial assessment calculation.

The DRE will not be relevant if you have agreed to pay the full cost of your care or have been assessed as not having to pay towards your cost of care.

The assessment will not result in the Council paying you an additional sum but may reduce the amount that you have to contribute towards your cost of care.

21.5 Telecare and community alarm charges

You can access Telecare and community alarm services:

- Privately via the Council currently – where full charges will apply based on the level of service requested.
- Following a Care Act needs assessment which identifies telecare/ community alarm as part of your care and support plan and is subject to charges in line with the Council's Charging Policy.

22. Where a person lacks mental capacity

At the time of the assessment of care and support needs, the Council will establish whether the person has the capacity to take part in the assessment. If the person lacks capacity, the Council will establish whether the person has any of the following in place as the appropriate person will need to be involved:

- Enduring power of attorney (made and signed before 1 October 2007);
- Lasting power of attorney for property and affairs;
- Lasting power of attorney for health and welfare;
- Property and affairs deputyship under the Court of Protection;
- Appointeeship by the Department for Work and Pensions for the purposes of benefits payments in the event that control of the adult's benefits is sufficient for the relevant decision.

People who lack capacity to give consent to a financial assessment and who do not have an appropriate person with the authority to be involved in their affairs may require the appointment of a property and affairs deputyship. Family members can apply for this to the Court of Protection or the Council can apply if there is no family involved in the care of the person.

Once the representative is identified or appointed, the Council will work with them to undertake the financial assessment.

The Council will need to see documentary evidence of Appointeeship and Court of Protection applications within the timescale outlined below in order to set up and maintain arrangements for payment of care fees.

Evidence must be provided within six weeks of starting an application for financial assistance or within one month (30 days) following a written request by the Council. Failure to comply with such a request may result in the Council withdrawing the funding and taking action to recover the full amount outstanding. The Council reserves the right to take legal proceedings to recover any accrued debt that remains unpaid or where representatives are not complying with the requirements as set out in the Charging Policy.

23. Appointeeship by the Department for Work and Pensions

23.1 Applying to become an appointee for someone claiming benefits

You can apply for the right to deal with the benefits of someone who cannot manage their own affairs because they are mentally incapable or severely disabled.

Only one appointee can act on behalf of someone who is entitled to benefits (the claimant) from the Department for Work and Pensions (DWP). An appointee can be:

- an individual, for example a friend or relative;
- an organisation or representative of an organisation, for example a solicitor or local council.

The appointee will have to set up a bank account in which the benefits are paid.

23.2 Appointee's responsibilities

As an appointee you're responsible for making and maintaining any benefit claims. You must:

- sign the benefit claim form;
- tell the benefit office about any changes which affect how much the claimant gets;
- spend the benefit (which is paid directly to you) in the claimant's best interests;
- tell the benefit office if you stop being the appointee, for example the claimant can now manage their own affairs.

Where an Appointeeship is appropriate but not in place, the Council may agree to pay the provider direct for a period (usually up to 6 weeks but it can take DWP longer to process claims) to allow the Appointeeship to be granted. The appointee will need to pay back fees that the Council has made during this period in full within 28 days of the Appointeeship being granted.

If DWP Appointeeship is not in the 'Best Interest' of the person that is assessed as 'lacking capacity' and more power is required to manage more of their affairs then please go to gov.uk for further information, which can be accessed here: 'Deputies: make decisions for someone who lacks capacity' or seek independent legal advice.

24. Lasting power of attorney and deputyship

If you have mental capacity, you can appoint an attorney to deal with your affairs. This is called a Lasting Power of Attorney (LPA). Separate LPAs are required to cover:

- Property and Financial matters
- Health and Welfare matters.

The person you appoint as your LPA for property and financial matters can make decisions on your behalf and manage your property and financial affairs, even if you do not have capacity in the future.

However, if you no longer have capacity and do not have a valid LPA in place then the only legal way in which another person can make decisions on your behalf is through an application to the Court of Protection for Deputyship.

Where a Deputyship for property and financial affairs is granted and you are a self-funder, the Deputy is responsible for contracting directly with the care home and paying all future charges.

Where the Deputyship is not in place at the time you start to live in the care home, the Council may pay the care home direct for up to six months to allow the deputyship to be granted.

The Deputy will need to repay the Council for any fees it has paid during this period in full within 28 days of the Deputyship being granted.

The Council reserves the right to take legal action where the Court of Protection Deputyship has not been granted in a reasonable period of time. In these circumstances, the Council may cease funding the care and refer the matter to the Court of Protection to appoint an alternative Deputy to manage the person's property and financial affairs.

25. Self-funders

25.1 Who counts as a self-funder?

A self-funder is someone who has to pay the full cost of their care and support. The most common situation is where you have relevant capital or other assets above the upper capital limit in force at the time (Section 14). Some of your assets (also known as capital or savings) may not count towards this figure. If you are unsure, please ask us and we will check and let you know. In some circumstances, the Council will also consider you to be a self-funder if you:

- choose not to disclose your financial information to enable a full financial assessment to be undertaken – in these circumstances you will be asked to sign a declaration that you are happy to pay the full cost of services you receive;
- fail to co-operate and/or do not provide a completed financial assessment form and the correct evidence within 28 days of the start of your care and support without good reason;
- are not eligible for financial support as an outcome of a full financial assessment;
- have been assessed for care and support needs but you are not eligible for adult social care services.

The Council will not charge you for a financial assessment, a needs assessment or the preparation of a care and support plan.

25.2 Arranging your own care and support

Following your needs assessment, you can choose to arrange and manage your own care and support by making direct contact with care providers. The Council can offer information, advice, and guidance at no charge to assist you in finding the right care and support for yourself. It is up to the care providers, who arrange and manage your care and support, to set their fees for any services provided. Therefore, it is important to check what this will cost you before agreeing anything.

25.3 Asking the Council to arrange your care and support

If you have more in capital than the upper capital limit in force at the time (Section 14), you can ask the Council to arrange your care and support for you but you will still be liable to pay for the full cost of your care.

Where this is the case and your needs are to be met by care in a care home, the Council is not required to meet those needs or arrange the care but may choose to do so on a case-by-case basis. If the Council agrees to sort out the arrangements with the care home on your behalf, you must finalise the payment arrangements directly with the care home for your individual contribution.

If your needs are to be met by care and support in settings other than a care home, the Council must meet your eligible needs, when requested to do so. However, you will not be entitled to receive any financial assistance from the Council and will be liable to pay for the full cost of your care and support until your capital falls below the upper capital limit. The Council will manage the arrangements for you by entering into a contract with the care provider. This means that the Council will pay the provider and then invoice you for the care provided to meet your eligible needs. If you ask a provider to give you additional

support for which you have not been assessed by the Council as being eligible, then the Council cannot get involved in any of the arrangements.

25.4 The self-funder arrangement and management charge

If you wish the Council to arrange and manage a community care package (not residential care) to meet your needs, you will be liable to pay an arrangement and management charge to the Council. This charge is in addition to the costs of meeting your care and support needs. The arrangement and management charge is charged based on a clear care banding system, which comprises a fixed and a variable element to the charge. This considers the fact that some costs of arranging services apply regardless of the size and complexity of the care package, while others vary. The five different bands of care are based on commissioned hours of service to reflect that the larger packages of care require more activity from Brokerage and Quality Assurance to arrange. As your needs change, then so will your charge but with the added safeguard of a cap on the maximum weekly amount that is paid in charges. The figures for the bands are as shown in Table 1 below:

Table 1 – Banded approach to self-funder arrangement and management charge in 2024/25*

Hours per week (commissioned care)	Total £ per week
Up to 7 hours	7.92
>7 – 14 hours	11.62
>14 – 21 hours	15.08
>21 – 28 hours	18.53
>28 hours (based on 28 hrs care package as maximum)	20.25

* The self-funder arrangement and management charge will be reviewed annually.

The overall calculation of the arrangement and management charge is based on the cost to the Council of arranging the packages of care for people who pay the full cost of their care and support. This means that the Council would never charge overall more than the cost to the Council of arranging and managing the packages of care. The services that are included in your charge are shown in Table 2 below:

Table 2 – Services included in self-funder arrangement and management charge

Services	Functions
Commissioning and Procurement Cost	Procurement and Commissioning – these are the services that secure care and support services, which are accredited by the Council as meeting specific standards of care and costs.
Brokerage Cost	Brokerage Support – this is the service that supports you to put the service in place in meeting your specific needs.
Quality and Performance Cost	Quality and Performance Monitoring – these are the services that monitor quality and performance for the services that the Council secures on your behalf.
Payments and Billing Cost	Payments and billing – these are the services paying providers on your behalf and arranging to invoice you so that the Council can recover its costs.

25.5 Terms and invoicing arrangements

You will be invoiced when your service starts and you will receive an invoice every four weeks.

The terms of the charge will be set out in a formal letter of agreement from the Adult Social Care Brokerage Team. If you do not agree to the terms of the charge or understand the charge, or you wish to arrange your own care, you will have four weeks from the date of this letter to let the Council know.

If you think you are paying more than you should, please contact the Council. We will look into your situation and issue a refund, usually in the form of a credit, if this is the case.

25.6 What if your circumstances change?

You have a responsibility to let the Council know if your circumstances change, including any changes in your care needs. You will also need to provide the Council with evidence of changes in your financial situation so that this can be reassessed.

Your charge will be updated if your circumstances have changed or you are no longer a self-funder. However, please note that we cannot stop the charge right away, as you will need to complete a financial assessment first.

25.7 Reviewing these arrangements

A review of your current financial position will be undertaken to ensure the charge you are paying reflects the right charge at the point of your assessment or review.

An Annual Review of the Council's administrative costs will also be undertaken to ensure the policy remains updated and reflects any local or national changes that may impact on these charges.

26. Continuing healthcare

NHS Continuing Healthcare (CHC) is a package of ongoing health and care and support that is arranged and funded solely by the NHS, where the individual has been found to have a 'primary health need', as set out in the National Framework for NHS CHC and NHS-funded Nursing Care.

The Council cannot lawfully fund services that are clearly the responsibility of the NHS (e.g., care provided by registered nurses and services that the NHS has to provide because the individual is eligible for NHS continuing healthcare).

If a person is assessed as eligible for CHC funding by an Integrated Care Board (ICB), the ICB must legally provide that funding and health and social care costs are paid by the ICB. If the person is not eligible for CHC, the Council and the person may have to pay the social care costs instead.

Where it appears to the Council that a person may be eligible for CHC, the Council will refer the individual to the relevant ICB. Eligibility for CHC is a decision to be taken by the relevant ICB, based on an individual's assessed needs. A person only becomes eligible for CHC once a decision on eligibility has been made by the ICB. At that point, the person will receive health and care support from the NHS free of charge in line with the NHS Act 2006.

27. Aftercare under section 117 of the Mental Health Act 1983

Under section 117 of the Mental Health Act 1983 (the 1983 Act), the Council together with the relevant ICB have a joint duty to arrange the provision of mental health after-care services for people who have been detained in hospital for treatment under certain sections of the 1983 Act free of charge.

Aftercare services cannot be charged to the individual. Aftercare services must have both the purposes of 'meeting a need arising from or related to the person's mental disorder' and 'reducing the risk of a deterioration of the person's mental condition and, accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder.' Aftercare needs will be subject to regular joint reviews carried out by the Council and NHS partners to ascertain whether the adult is still in need of these services and discharge them if they are not.

Whilst the aftercare must be provided free of charge, an adult has the right to choose a setting that is more expensive than that identified by the Council and can pay a top up (see Section 19) to cover the difference in cost.

An adult may have certain needs for care and support which are not aftercare needs but are eligible needs for the purpose of the Care Act 2014. These needs will be met under the Care Act 2014 subject to an assessment and/or review of the adult's needs and will be chargeable in accordance with this policy.

28. Personal budgets and direct payments

If you have been assessed as needing care and support, you will be offered a Personal Budget. A Personal Budget is an estimate of how much money will be needed to meet your assessed needs and agreed outcomes under the Care Act 2014. It sets out the total amount of funding that the Council will pay you and what amount (if any) you will contribute towards your care.

There are several ways you can choose to receive your Personal Budget, including as a payment into a Direct Payment account (pre-paid card), which you can use to purchase care and support services from providers of your choice.

If you receive a Direct Payment via a pre-paid card and have been assessed as making a contribution to your care and support, you will need to pay the contribution on to your card so it is available for you to spend on your care and support. Further instructions will be given about how to do this.

If you receive a Direct Payment via a dedicated bank account and have been assessed as making a contribution to your care and support, your Direct Payment will be paid net of any assessed contribution. Where this is the case, you should pay your assessed contribution into this bank account to ensure that your care needs are met in full.

If you choose to use a service or pay for support which is more expensive than is set out in your Direct Payment (e.g., to pay your Personal Assistant above the National Living Wage), these are choices for you to make and you can decide if you wish to 'top-up' your Direct Payment to meet these additional costs.

If you prefer not to receive your Personal Budget as money in the form of a Direct Payment and, instead, you want the Council to make your arrangements for you, we will use the money to pay for your support from Council-commissioned providers. This is called a Managed Service.

It is possible to use a combination of both a managed service and a part-Direct Payment so that you can choose to purchase some of your own care and support but ask the Council to arrange other services for you.

Other options are also available, such as Individual Service Funds and Personal Health Budgets (the latter provided from the NHS), depending on what best meets your needs.

The Council publishes a Guide to Personal Budgets and Direct Payments, which is available on request. This guide sets out your options and the criteria for care and support being managed in this way. Further information about Direct Payments is also available on the Council's website at Bexley.gov.uk.

Anyone who is paying for the full cost of their care will be given advice on their care and support plan.

29. Information and advice

The Council will ensure that you have access to information and advice, including information about how to access independent financial advice in relation to funding your care and support (see Section 37).

The Council will also take steps to identify people who may benefit from financial advice or information as early as possible and will seek to raise broader awareness about how care and support for adults is funded in Bexley.

30. Safeguarding and the financial assessment process

Under sections 42-47 of the Care Act 2014, the Council has a duty to safeguard adults at risk of abuse or neglect. This includes financial abuse, and the Financial Assessment Team will examine bank statements and financial documentation for signs of financial abuse.

When an adult lacks capacity to manage their own finances, there will often be a Deputyship, Lasting Power of Attorney, or registered Enduring Power of Attorney in place. The person appointed will have a responsibility to act in the best interests of the service user always, and this will be laid down in the Deputyship Order or Power of Attorney document. In these cases, the Council may need to speak to the individual managing the service user's finances in relation to specific transactions.

In these circumstances, the Council may need to share information with the Office of the Public Guardian, or the Department for Work and Pensions in relation to any State Benefits received.

The Council strongly advises all third parties managing finances on behalf of the service user to retain receipts for all items of expenditure made on behalf of the service user.

The Council may request to see receipts at any time. The Council recognises that financial abuse will not occur in most circumstances but reserves the right to make these checks to protect service users from this risk.

31. Gaps in service

The following will apply, if there is a period of time where you do not have any service provided (for example, when in hospital):

- If less than 3 months gap, it will be assumed that your financial circumstances have not changed, and we will continue to charge based on your current application for financial assistance.
- If more than 3 months, we will contact you to check if there has been a change in circumstances, unless an annual review has already been scheduled. If circumstances have changed, a new application for financial assistance will need to be completed.
- If more than 12 months, a new application for financial assistance will need to be made.

32. Variations

Variations to a planned service will occur from time to time for many reasons, such as if you are unwell or if you are visiting relatives when you would not require your usual care and support. However, this does not automatically mean that the weekly service contribution will be reduced or not be payable.

A reduction to the assessed weekly contribution will only be considered when reasonable notice of absence has been given or you have been admitted to hospital or short-term care in an emergency.

In other cases, when a planned service is not delivered, you will be expected to continue to pay your assessed contribution. In some cases, it may be possible to arrange for the care to be provided at other times in lieu of missed visits, but this will need to be pursued with the provider in question.

If it is established that a missed care call or inadequate care call is the fault of the provider and not your fault, and you need to be reimbursed for this (i.e., where you have paid the full cost of service), then the provider should be asked to provide the Council with a credit note for the reimbursement.

If an adjustment is required to the assessed contributions, you will need to notify the Brokerage Team to arrange this. The original assessed contribution will need to be paid until the adjustment is agreed, and this will be made on either the current invoice or the invoice in the following month. The contact details of the Brokerage Team are given in Section 36 of this Charging Policy.

33. Approach to setting and reviewing provider fee rates

The Council has a responsibility for managing the local care market and negotiates fee rates with contracted providers each year in line with good practice guidance and legislation. This should have due regard to the actual costs of providing care, whether services represent best value, and other local factors.

When setting and reviewing fee rates, the Council goes through a process of market analysis to determine an appropriate level of inflationary uplift, where applicable, upon which to base our contract negotiations.

Two main inflation indicators have been used in the recent past, each applying to an element of the cost base for providers:

- Increases in the National Living Wage;
- National inflation linked to the retail price index, which has traditionally been a point of reference with December being the reference month.

Consideration will also need to be given to any uplift to direct payments, which for financial planning purposes, is recommended to be in line with the uplift applied to home care.

Like other councils, there is no guarantee that a percentage cost increase will result from our review of provider fee rates, and based on this review, we can propose a reduction.

In considering annual inflationary uplifts, the Council also needs to be mindful of its level of available resources and its statutory duty to set a balanced budget.

Our approach aims to work with the care home market, support its continued stability and ensure the Council has sufficient beds available for new placements that are of good quality and represent value for money.

Through an integrated commissioning approach, we work closely with the NHS to ensure consistency of offers where we commission both NHS and social care placements or packages from the same provider.

We also take into account decisions made on a wider scale, such as the London Any Qualified Provider (AQP) rate, which is negotiated by the London Purchased Health Care Team on behalf of Continuing Healthcare commissioners for nursing care beds across London.

34. Appeals and Complaints

34.1 Asking the Council to review a decision you disagree with

If you are dissatisfied with a particular service, we ask that you contact the relevant service or the officer you have been dealing with. We want to resolve issues quickly and effectively and put matters right as soon as possible.

In the first instance, you may want to contact the relevant team so that someone can explain in more detail how your charge has been calculated.

If the issue relates to your financial assessment, please contact the Financial Assessment Team. The contact details for the Financial Assessment Team are given in Section 36 of this Charging Policy. To have your assessed contribution reviewed by the Financial Assessment Team, you will be asked to explain in writing why you think the charge should be different and to provide evidence(s) to support this. We will then review your contribution using the information you have given us and inform you of our decision in writing. After this review, if you feel that you are still being overcharged, you will have to confirm this in writing to the Financial Assessment Team with details and proof of what you feel is incorrect and this will be looked at by an alternate member of staff at the Council.

If the issue relates to the Council's arrangement and management charge, please contact the Council's Brokerage Team. The contact details for the Brokerage Team are given in Section 36 of this Charging Policy. If you wish to appeal against the Council's arrangement and management charge, then you should put forward in writing to our Brokerage Team why you do not feel your charge is correct. The Council's

Adult Social Care Appeals Panel will then consider any individual circumstances which affect your charge and review that the policy has been applied fairly. The Appeals Panel will have the power to agree discretionary arrangement and management charges but these will be applied by exception and based on individual extenuating circumstances.

34.2 Complaints

Our formal complaints process begins where you are not satisfied with how the service area or officer has responded to your issue, or where you decide to immediately make a formal complaint.

For complaints relating to the core Adults' Social Care functions, we follow the Adults' Social Care Statutory Complaints procedure. We aim to acknowledge your complaint within two workings days of receipt. The Head of Service will investigate the complaint and will aim to provide you with a response within 15 working days.

Further details about how to make a complaint are available on the Council's website at Bexley.gov.uk.

The contact details for the Complaints Team are given in Section 36 of this Charging Policy.

35. Local Government and Social Care Ombudsman

If you are dissatisfied with the outcome of your appeal or complaint once it has completed the Bexley Appeals Process and Complaints Procedure, you have the right to ask the Local Government and Social Care Ombudsman to consider your complaint.

You can approach the Ombudsman at any time during the complaints process for advice and assistance. However, usually, the Ombudsman will not normally look into a complaint until the Council have had an opportunity to resolve it through the Bexley Appeals Process and Complaints Procedure.

The contact details for the Ombudsman are given in Section 37 below.

36. Contact details

Team	Contact
Customer Contact Centre	Address: Civic Offices, 2 Watling Street, Bexleyheath, DA6 7AT Telephone: 020 8303 7777 E-mail: customer.services@bexley.gov.uk Open from 8am to 5pm Monday to Friday.
Adult Social Care Triage Hub / Single Point of Contact	Telephone: 020 3045 5159 Triage Hub E-mail: adultsocialcaretriagehub@bexley.gov.uk or Single Point of Contact e-mail for Adult Social Care referrals: screeners@bexley.gov.uk Bexley Care Single Point of Contact e-mail for health referrals: bexleycare.spc@nhs.net
Brokerage	Duty number: 0203 045 3033 Duty e-mail: BrokerageCommissioningTeam@bexley.gov.uk
Finance Assessments	Address: Finance Assessments, Erith Town Hall, Erith, Kent, DA8 1TL Telephone: 020 8068 7640 E-mail: Bexley.Finance.Assessments@capita.com

Team	Contact
Emergency out of hours service	Telephone: 020 8303 7171 Please note this service can only help with genuine emergencies which cannot wait until normal opening hours.
Complaints Team	Address: The Complaints Team, London Borough of Bexley, 2 Watling Street, Bexleyheath, DA6 7AT Telephone: 020 8303 7777 E-mail: complaints@bexley.gov.uk (please ensure you quote your address and telephone number).

37. Further sources of information

Organisation	Contact
Age UK	Website: https://www.ageuk.org.uk/ Telephone: 0800 055 6112
Bexley Carers Partnership	Website: https://bexleycarers.co.uk/
Care Quality Commission	Website: https://www.cqc.org.uk/ Telephone: 03000 616161
Carers UK	Website: https://www.carersuk.org/ Telephone: 0808 808 7777 E-mail: advice@carersuk.org
Citizen's Advice	Website: https://www.citizensadvice.org.uk/ Telephone: 0800 144 8848
Connected Bexley	Website: https://connectedbexley.co.uk/
Gov.uk	Website: https://www.gov.uk/
London Borough of Bexley	Information about social care for adults: https://www.bexley.gov.uk/services/health-and-social-care/social-care-for-adults Bexley Care Hub: carehub.bexley.gov.uk
Local Government and Social Care Ombudsman	Website: https://www.lgo.org.uk/ Telephone: 0300 061 0614
Mencap	Website: https://www.mencap.org.uk/ Telephone: 0808 808 1111 E-mail: helpline@mencap.org.uk
Money and Pensions Service	Website: https://www.moneyhelper.org.uk/en Telephone: 0800 011 3797
OneBexley	Website: https://www.onebexley.org/ Telephone: 020 4530 6580 E-mail: OneBexleyPathways@bvsc.co.uk
Society of Later Life Advisers	Website: https://societyoflaterlifeadvisers.co.uk/ Telephone: 0333 2020 454
The Law Society (Find a Solicitor)	Website: https://solicitors.lawsociety.org.uk/ Telephone: 020 7320 5650

Appendix 1 – References to legislation, regulations and guidance

1. **The Care Act 2014:** The Council's Charging Policy has been produced in accordance with the legal requirements set out in Primary Legislation called the Care Act 2014. The Care Act 2014 provides a single legal framework for charging for care and support under sections 14 and section 17. Section 78 of the Care Act 2014 requires that local authorities act in accordance with the statutory guidance unless they have clear reasons for not doing so. It enables a local authority to decide whether or not to charge a person when it is arranging to meet a person's care and support needs or a carer's support needs.
2. **Care and Support (Charging and Assessment of Resources) Regulations 2014 (SI 2014/2672):** These Regulations govern the scope of the local authorities' power to charge for meeting eligible needs and for financial assessments under the Care Act 2014.
3. **Care and Support (Deferred Payment) Regulations 2014 (SI 2015/2671):** The Deferred Payment Regulations set out the criteria that local authorities must apply when deciding whether they are obliged to offer individuals a deferred payment agreement. These Regulations also set out the rules for security and equity limits.
4. **Care and Support (Preventing Needs for Care and Support) Regulations 2014:** These Regulations make provision under the Care Act 2014 for when a local authority can make a charge for the provision of services, facilities, and resources.
5. **Care and Support (Personal Budget: Exclusion of Costs) Regulations 2014 (SI 2014/2840):** These regulations provide that the costs of intermediate care and reablement services must be excluded from an individual's personal budget (in certain circumstances) and where the local authority is not permitted to charge for those services under section 14 of the Care Act 2014.
6. **Care and Support (Direct Payment) Regulations 2014 (SI 2014/2871):** These Regulations provide the conditions applicable to the provision of direct payments to service users. (together referred to as the "Regulations") Statutory Guidance.
7. **Care and Support Statutory Guidance (October 2018) as amended:** The statutory guidance sets out the principles guiding local authorities in applying the Care Act 2014 and the Regulations.
8. **Local Authority Social Services and NHS Complaints Regulations 2009:** The social care complaints process is based on the Local Authority Social Services and NHS Complaints (England) Regulations 2009, made under powers in sections 113 to 115 of the Health and Social Care (Community Health and Standards) Act 2003.
9. **The London Borough of Bexley's Adult Social Care Charging Policy:** The purpose of the Council's Charging Policy is to explain the criteria used to determine levels of charging for particular services, including how the Council wishes to apply its discretion locally to charge people in settings other than care homes. Any aspect of charging for care and support, which is not explicitly mentioned within this policy, will be dealt in accordance with the legal framework provided by the Care Act 2014 and the Care and Support Statutory Guidance. This policy should be read alongside the Statutory Guidance. Any reference to the "Law" in this policy shall mean reference to the following:
    - The Care Act 2014 and the Care and Support Statutory Guidance
    - The Regulations (as defined above)
    - The Equality Act 2010

- The Data Protection Act 2018 (and subsequent legislation)
- The Mental Capacity Act 2005
- The Mental Health Act 1983
- The Freedom of Information Act 2000

Appendix 2 – Non-Residential Charges 2024-25

Service	Type	Charge	Frequency
Conventional Home Care (per visit)			
15 minutes to 60 minutes each	Discretionary	Dependent on financial assessment	minutes
Reablement Home Care (per visit)			
Up to 6 weeks of reablement provision is provided to the client free of charge (dependent on individual progress).	Discretionary	If reablement provision continues beyond six weeks, it becomes chargeable.	per hour
Emergency Link-Line (per week)			
Gold Service	Discretionary	£6,30	per week
Telecare Gold Services	Discretionary	£7.60	per week
Silver Service	Discretionary	£4.95	per week
Telecare Silver Services	Discretionary	£6.40	per week
Day Care			
Cost is dependent on the particular contract used	Discretionary	various	per session
Respite Care			
The rates for respite care are subject to change and are variable.	Discretionary	various	per week

Appendix 3 - Guidance on charges for non-residential care services

Paying towards the cost of social care for adults living at home

The government has produced guidelines that all Councils in England must follow when charging for non-residential care. These guidelines ensure that all Councils follow the same rules so that all service users are assessed in the same way. This is called the Care Act Statutory Guidance. In Bexley, Social Services and the Financial Assessments Team work together to ensure that we provide appropriate care for you and charge you in accordance with the government's guidelines.

We hope that this document tells you everything you need to know about charging for non-residential care, how we calculate your contribution and what your next steps may be.

The details provided are correct for the period up to 31 March 2025.

Why we charge

Providing adequate social care for everyone that needs it can be very expensive. In order to help meet this expense and ensure a high-quality service, we charge for some of the services provided.

The charging policy covers all non-residential care services.

What is the full cost of your care?

The full cost of care varies depending upon which services you want or need. The cost of your care is always worked out as the cost of the service you need multiplied by how often you need it. We review our service prices each year to reflect the cost of providing that service. You will be advised of the maximum cost of your Individual Weekly budget.

Will you have to pay the full cost of your care?

You will not necessarily have to pay the full cost of your care. This is why we need to carry out a financial assessment. However, if you have capital (assets) of more than £23,250, you will have to pay the full cost of the services that you receive. We do not include the value of your main home in this assessment.

If you are required to pay the full cost for your community care services. In addition to the cost of your care there is also a fixed weekly management charge which covers the council costs in monitoring and arranging your care package. This will show as a separate line on your invoices. The management fee varies dependant on the number of hours of care and support you receive.

The weekly costs are laid out below.

Service Level	Weekly Cost
Management Fee - Band 1 - Up to 7 hours	£7.92
Management Fee - Band 2 - 7 to 14 hours	£11.62
Management Fee - Band 3 - 14 to 21 hours	£15.08

Management Fee - Band 4 – 21 to 28 hours	£18.53
Management Fee - Band 5 – Over 28 hours	£20.25

Please note you do not have to have your care arranged through the Council; you could have this arranged directly with the care providers. You can talk with your Social Worker or Brokerage Team for further information on this.

If you do not think you have this amount of Capital, you can apply for a financial assessment in order to see how much financial support you are eligible for. In this assessment we work out the amount you should contribute towards the cost of your care in line with the government guidelines used by all local authorities in England.

Are there any exceptions when we do not charge?

There are occasions when we will not ask you to make a contribution towards the cost of your care. These include:

- Intermediate care, including reablement, which will be provided free of charge for up to six weeks;
- Care and support provided to people with variant Creutzfeldt-Jacob Disease;
- After-care services/support provided under section 117 of the Mental Health Act 1983;
- Any service or part of service which the NHS is under a duty to provide. This includes Continuing Healthcare; and
- Assessment of needs and care planning.

What information do we need?

In order to assess your charge, we will need to know your financial situation. This information will only be used in order to complete your financial assessment. We take our responsibility to protect your information seriously and will not under any circumstances reveal your personal details to any third party without your prior permission.

In order to complete the assessment, we will require you to provide evidence of your savings, income and expenditure. Documents we are likely to need to view copies of include:

- savings and bank account statements;
- national savings certificates;
- pay slips;
- proof of benefit entitlement; and,
- receipts (as listed on the disability expenditure form).

What happens if you do not wish to provide your financial information?

If you do not wish to provide us with the information that we need in order to complete a full and accurate financial assessment, we will assess you as having sufficient funds to pay the full cost of your care.

This means that you will be liable to pay full cost of your care. The arrangement fee will also be charged. In order to show that you understand and consent to this, you should complete and sign the relevant section on the first page of the assessment form.

Will your partner's income be taken into account?

We assess your finances as an individual. We do this because services are provided on an individual basis.

As a general rule we will assume that joint bank accounts and assets are held in equal shares with your partner. If this is not the case, we will need you to provide us with evidence of this. If you hold an account or an asset in your own name, this will be assessed as your sole personal property unless you provide us with evidence to the contrary.

If both you and your partner are receiving care, we will still assess you as individuals. We do this because care is provided individually, and you are likely to need different types of care either now or in the future. This ensures that both of your financial assessments are as fair as possible.

How does the assessment work?

In order to make a fair assessment, we will need details of all your income, savings and expenditure.

First, we look at your assessable income. We ask you for details of all your income but we may not take it all into account, for example we do not count anything you earn as result of paid work as we do not want to remove your incentive to work. We will always calculate your income after tax and National Insurance contributions have been made.

We then calculate your assessable savings. We will ignore the first £14,250. If you have more savings than this, we will add £1 per week 'tariff income' for every complete or partial £250 savings you have up to £23,250 to your income assessment. We do this to represent the amount of capital you have between the upper and lower levels. When we work out your charge we will add this tariff income to your assessable income. This combined amount is your total assessable income.

After we have done this, we will look at your expenses. People receiving local authority-arranged care and support other than in a care home need to retain a certain level of income to cover their living costs. Under the Care Act 2014, charges must not reduce people's income below a certain amount, but local authorities can allow people to keep more of their income if they wish. This is a weekly amount and is known as the MIG (Minimum Income Guarantee).

If we have taken into account any income related to a disability you may have, we will also make an additional standard allowance of £36.33 a week for extra expenses that you incur as a result of that disability (Disability Related Expenditure). However, if you incur expenses greater than £36.33 a week you will be able to request additional amounts to be taken into account. You will be asked to supply documentation to support these.

We also take account of some of your housing costs. These will include your rent or mortgage repayments and council tax. As stated above, if you are one of a couple, we will assume that half of all joint expenses are yours and will make allowances accordingly.

This assessment will provide us with a figure that will be your maximum weekly contribution towards the cost of your care. This is the most you will be asked to pay. We will not collect an assessed contribution of less than 50p per week.

If, during the financial assessment, we consider that you may not be claiming all the benefits to which you are entitled we will refer you to the Department for Works and Pensions who can help you claim.

The cost of your care is worked out simply by multiplying the cost of the services you receive by the how often you receive them. For example, if each week you receive two full hours of home care that costs £18.52 per hour, the weekly cost of your care will be £37.04.

We will then charge you either the maximum assessed contribution or the full cost of your care, whichever is smaller. So, if your cost of care is £37.04 but your assessed maximum contribution is £14.00, we will charge you £14.00. Likewise, if the cost of your care is £37.04 but your maximum assessed contribution is £40.00, we will charge you £37.04.

Disability Related Expenditure

Disability Related Expenditure (DRE) is an allowance made in the financial assessment for additional expenses a service user may have due to a disability or condition. Disability Related Expenditure can only be considered if a client receives Disability Living Allowance (care), Attendance Allowance or Personal Independence Payment.

When Disability Living Allowance/Attendance Allowance/ Personal Independence allowance is taken into account as income for an assessment, we automatically allow £36.33 as Disability Related Expenditure. This amount is disregarded from your total income to pay towards any disability related expenditure. If expenditure exceeds more than this amount, then a DRE form can be completed to determine whether these extra expenses can be considered. (See Appendix A for more details)

The Disability Related Expenditure will not be relevant if you have agreed to pay the full cost of your care or have been assessed as not having to pay towards your cost of care. The assessment will not result in the Council paying you an additional sum but may reduce the amount that you have to contribute towards your cost of care.

When do you have to pay?

You only have to start paying from the time that you start receiving care. We always aim to complete the assessment before you start receiving care so that you know in advance exactly how much you will have to contribute. If for whatever reason we can only assess you after you started to receive care, we will still ask you to pay from the date that you start to receive care.

If you do not provide us with financial information when you start to receive care, we will assume that you have sufficient capital to pay the full cost of your care. You will also be charged the fee for arranging care services. If you wish to have an assessment at a later date, all you need to do is contact the Financial Assessments Team and we will be happy to help you.

How do you pay?

There are many ways in which you can pay your contribution to your cost of care. These include by cheque, online, by telephone, in person and by direct debit. We will give you full details when you need them and we hope that this allows you to pay in the way that best suits you.

We usually ask for payment every four weeks.

What happens if you cannot pay?

If you cannot pay your assessed contribution or think we have made a mistake in your assessment, you can apply to have your contribution reassessed. Before you do this, you may want to contact the Assessments Team so that someone can explain in more detail how your charge has been calculated.

To have your charge reviewed, please contact the Financial Assessment Team in writing to explain why you think the charge should be different and provide evidence(s) to support this. We will then review your contribution using the information you have given us and inform you of our decision in writing.

After this review, if you feel that you are still being overcharged you will have to confirm this in writing to the Financial Assessment Team with details and proof of what you feel is incorrect and this will be looked into by an alternate member of the Council.

Will your charge change after it has been assessed?

We will review your charge annually (Every April), this is in line with the Department for Work and Pension increases. If you are paying the full cost, then you are not reviewed annually but you can request to be reviewed at any point.

Your charge may also change if you start to receive more, less or different care than when you were first assessed or if your circumstances change.

Your circumstances have changed: what should you do?

If your circumstances change, we may need to reassess your charge to ensure that you are still being asked to contribute a fair amount.

We will need to know if there are changes to your income, savings or expenses. We will also need to know if the makeup of your household changes, this could be if you are no longer living as a couple, if a family member moved out or any other changes in your family make up.

For this reason, you should notify us (the Financial Assessments Team) as soon as any of the circumstances change that may affect your financial assessment so that we can make sure you are being charged the correct amount.

Individual Budgets

We like you to have as much control over how your care is provided as possible. Individual Budgets, delivered as Direct Payments (DPs) allow you to choose not only the type of care you receive, but also who provides it and how frequently.

If you have a direct payment, you may still pay a contribution towards the cost of your care. This will be deducted from your direct payment before we pay you. If you are a full cost payer you will not be entitled to receive a direct payment from the Council. For more details on direct payments please speak to your social worker or the person that arranges your direct payment.

Feedback

We appreciate your feedback on all aspects of our service. Your comments on this guidance and on the service, we provide will help us to improve. If there is anything we could improve or things you would like to stay the same, please contact us to let us know.

Appendix A.

Disability Related Expenditure – Guide of expenses

DRE will be considered when:

- The extra cost is needed to meet a service user's specific need due to a condition or disability as identified in the service user's care assessment; and
- The cost is reasonable and can be verified. Receipts may be requested.

Below are some examples of Disability Related Expenditure which could be considered.

The level of expenditure to be allowed will be looked at and it will be decided if these costs are reasonable and necessary to maintain an acceptable quality of life. Please note there are maximum allowances that can be given.

Item	Description	Evidence
Private/ Domestic Care (e.g., cleaning and Help with shopping).	Relates to any private arrangements regarding personal care, e.g., bathing. Can only be considered if it is confirmed the care is part of the Care Plan and Council supported care is reduced accordingly.	Receipts.
Domestic Care.	Relates to expenses incurred for the provision of assistance for cleaning, etc, if these are not provided by a family member and where the user has little or no choice other than to incur the expenditure, in order to maintain independence or quality of life.	Receipts.
Washing/Laundry.	If extra laundry is needed.	Confirmation of whether laundry is carried out in home or externally.
Special Dietary Needs.	Discretionary as special dietary needs may not be more expensive than normal.	Details/reasons of dietary needs and amounts of specific dietary needs.
Special Clothing/Footwear.	This can be given if a client spends money on new clothes regularly because of regular replacements needed or special clothing needed.	Receipts.
Regular Replacement of Bedding.	This can be given if a client spends money on regular replacement of bedding due to incontinence.	If cost seems high receipts needed.
Garden Maintenance.	Client unable to maintain garden due to disability and not lifestyle choice.	Receipts.
Incontinence pads.	Can be considered if these are not provided by NHS.	Receipts.
Transport.	Costs should be covered by benefits of DLA /PIP Mobility component. Only costs exceeding this will be acceptable. Costs must be incurred as a result of disability for journeys covering an essential need.	Receipts.
Other Costs	Other disability related expenditure may be allowed with good reason and will be looked at to see whether these will be taken into account.	

For your safety, please note Bexley Council Financial Assessment Officers / Team, **do not** undertake home based interviews.

Disability Related Expenditure assessment form

First name

Last name

Address

Post code

Ref number (Office use)

Type of Expenditure	**Details/Description of Expenditure**	**Cost £**	**Per W/M/Y**	**Office Use Only £**
Community Alarm charge			W/ M/ Y	
Privately arranged care services (details/receipts needed)			W/ M/ Y	
Specialist washing or laundry (Please confirm whether laundry is carried out in home or externally.)			W/ M/ Y	
Special dietary needs (details needed)			W/ M/ Y	
Special clothing or footwear			W/ M/ Y	
Regular replacement of bedding			W/ M/ Y	
Garden Maintenance			W/ M/ Y	
Domestic Help e.g., cleaning (details needed)			W/ M/ Y	
Maintenance, repair of equipment (details needed)			W/ M/ Y	
Transport (details needed)			W/ M/ Y	

Incontinence pads not provided by NHS			W/ M/ Y	
Other Costs (please give details)			W/ M/ Y	
Other Costs (please give details)			W/ M/ Y	
Other Costs (please give details)			W/ M/ Y	
Other Costs (please give details)			W/ M/ Y	
Total Allowances:				£

Please advise in the table below which property you live in

Household Type	
Flat /Terraced housing	
Semi-detached housing	
Detached housing	

I confirm that a Disability Related Expenditure Assessment has been completed to take account of the extra costs I incur due to my disabilities. The outcome of this assessment is shown above and, subject to any necessary checks or calculations, I will be informed of the results of this assessment in due course.

Should my circumstances change, I should inform the Council immediately.

Signed

Date

If signed on behalf of client, please write name

Relationship

Signature

Appendix 4– Residential Allowances and Charges 2024-25

1. Introduction

If you are assessed as needing residential or nursing care, a financial assessment will be undertaken to identify the contribution you are required to pay to the care home towards your care costs. The amount of the contribution is based upon an assessment of your income and capital.

2. Capital limits

For 2024 to 2025, the upper limit is £23,250 and the lower limit is £14,250.

If you have more than £14,250 but less than £23,250, we'll calculate how much you can afford based on £1 a week for every £250 (or part of £250) you have in capital.

For example:

- If you have £18,000 saved. Since we ignore the first £14,250, we'll count that as £3,750 saved.
- For each £250 (or part of £250) of that, we'll count £1 a week. So, for £3,750, we'll treat you as if you could pay £15 a week from your capital.

3. Allowances

As well as the savings allowance, we make sure you keep the Personal Expenses Allowance (PEA) the Department for Work and Pensions has set. For 2024 to 2025, the PEA is £30.15 per week.

You might also keep some of your benefits and pensions. But, if you are already receiving benefits, some of them could be affected.

4. What happens to my benefits?

If you are over 60 and contributing to the cost of your care, you should apply for Pension Credit.

If you are under 60 and contributing to the cost of your care, you should apply for Income Support.

If you do not pay the full cost of your care, you will only be entitled to Attendance Allowance and the care component of the Disability Living Allowance for the first four weeks of your stay in the care home. That also applies to Constant Attendance Allowance, Exceptionally Severe Disability Allowance (from an accident at work), Disablement Benefit and War Disablement Pension.

If you are living in a care home and receive Attendance Allowance and Disability Living Allowance but have agreed in writing to sell your house, you can get a Deferred Payment Agreement. That means that you will pay back your fees at the end of the exempt period and will not be entitled to Income Support.

It is your or your representative's responsibility to let the Benefits Agency and Pension Service know you're moving into a care home so they can change your benefits.

5. Residential and Nursing Care

People placed in a residential or nursing care home by the Council will be in independent sector care homes. The rate for residential or nursing care varies between providers so cannot be listed here. You can contact the Council for further information or visit our website to find out about paying for residential care. Where applicable, charging will start on the first day of care and is paid direct to the care home or invoiced by the Council.

6. Deferred Payment Scheme

The Council operates its Deferred Payment Scheme (see Section 20 of the ASC Charging Policy) in line with the 'Care and Support (Deferred Payment) Regulations 2014' and Care and Support Statutory Guidance. Under the legislation, the Council is allowed to charge interest on the amounts deferred and an administration fee. From 1 April 2024, the following charges will apply:

- Initial fee: £1,082
- Re-valuation, if required: £370
- National maximum interest rate: as set by the Government.

The London Borough of Bexley uses the maximum allowable Deferred Payment Agreement interest rate, as defined in the Statutory Guidance, and which is set by the Government twice a year each January and July at 0.15% above the market gilts rate specified by the Office for Budget Responsibility.