



Cyngor Castell-nedd Port Talbot
Neath Port Talbot Council

NEATH PORT TALBOT COUNCIL

RESIDENTIAL AND NON-RESIDENTIAL CARE
CHARGING POLICY

IN ACCORDANCE WITH THE LEGAL
REQUIREMENTS OF THE SOCIAL SERVICES AND
WELL-BEING (WALES) ACT 2014 – PARTS 4 & 5
(CHARGING AND FINANCIAL ASSESSMENT)

APRIL 2021

1. Introduction

From 6th April 2016 the Social Services and Well-being (Wales) Act 2014 (referred to in this document as “The Act”) introduced one unified charging framework, which replaced all previous Acts and Regulations, relating to charging for Residential and Non-Residential Care.

Under The Act (which also incorporates Charging Regulations, and a Code of Practice), the Welsh Assembly Government gives discretion to local authorities to raise income from charging – this income will continue to be essential, in enabling this authority to manage resources effectively, sustainably, and to strive for continuous improvement in the future.

This Charging Policy should be used in accordance with the guidance provided in The Act, Charging Regulations and Code of Practice (all of which can be found on the Care Council for Wales’ Care Information and Learning Hub, and also on the Welsh Assembly Government’s website) – the relevant links can be found below:-

Social Services and Well-being (Wales) Act 2014 – referred to as “The Act”

<http://www.legislation.gov.uk/anaw/2014/4/contents/enacted>

Charging Regulations

<https://socialcare.wales/hub/sswbact-regulations>

Code of Practice (Parts 4 and 5) - Charging and Financial Assessment

<https://gov.wales/sites/default/files/publications/2020-04/part-4-and-5-code-of-practice-charging-and-financial-assessment.pdf>

Statements referring to any relevant fees, charges, hourly rates etc will be produced/updated annually (or when required), to reflect any changes to this policy, changes to The Act, or to meet any Welsh Government requirements (or changes in other legislation) - a copy of the latest figures can be found in Appendix A (at the rear of this document).

2. Charging and Financial Assessments

Since April 2016, the authority has used its discretion (under The Act) to impose a charge, or set a financial contribution, towards the costs of social care/services, and has done so, in line with the requirements of The Act.

The overarching principle is that clients financially assessed to pay a charge, would be requested to pay what is deemed affordable, and cannot be charged more than the cost incurred in providing/arranging their care and support.

A financial assessment (in accordance with The Act/Regulations/Code of Practice) calculates how much a client can afford to pay, towards the cost of their care, on a weekly basis. This authority financially assesses clients, based on both their income and capital assets (but disregarding any earnings), and a full list of the income and capital assets to be included/disregarded, in the financial assessment, can be found in The Act's Code of Practice (Annex A and Annex B).

Any assessed client contribution will be subject to a protected "Minimum Income Amount" (Community Care and Residential Care), which is set at a level intended to safeguard a clients' independence and social inclusion - the calculation of the protected minimum income amounts, are set out in the Code of Practice (Sections 9.4 and 11.3).

3. Residential and Non-Residential Charging

Although The Act provides for one unified financial framework, there are a few subtle differences to the financial assessments carried out for Residential Care, and Non-Residential Care – these are explained below:-

3.1. Residential Care

Where a client is assessed (by Care Management) as possessing a Residential/Nursing need, then a care home placement would be the most suitable way of meeting these needs. Such clients may qualify for local authority financial assistance, if they have capital below the relevant capital limit.

Clients will be considered for financial assistance from the date that a financial referral is made/requested, and (as above) this would be dependent on Social

Services firstly assessing the client as requiring a Residential/Nursing home placement.

A client who qualifies for financial assistance towards Residential Care, is required to pay an assessed client contribution, direct to the care provider, with the authority also making a financial contribution (up to the agreed contracted rate), directly to the care provider – the payment made by the authority will be net of any assessed client contribution.

Should a client choose not to declare their financial circumstances (or confirm that they possess capital in excess of the capital threshold), then they will be required to make their own arrangements to privately fund their placement (unless they request that the authority contracts with the care home, and makes the arrangements on their behalf).

Where a previously privately funded client approaches the authority for financial assistance (i.e. due to their capital assets falling below the relevant capital limit), this financial assistance will only be considered from the date of referral/completion of a Declaration of Financial Circumstances form (i.e. and not from the date that the capital assets actually reduced below the relevant capital limit).

In addition to completion of the Declaration of Financial Circumstances form, the client will be asked to provide documentary evidence (e.g. bank statements) confirming all capital assets held – the authority will initially ask for evidence spanning 3 months (prior to the request for financial assistance/reduction in capital below the capital limit), but may request additional periods, based on the evidence initially provided.

For the avoidance of doubt, should the submission of this documentation exceed 28 days from the date of the funding request, then financial assistance will only be considered from the date that the accompanying evidence is received (i.e. financial assistance will only then be considered from this later date).

Where a client is admitted to a care home for a planned short stay (previously referred to as Respite), and this stay is to be no longer than 8 weeks (with an agreed admission and discharge date), then the client can be financially

assessed under Non-Residential Charging (please see below), subject to the client receiving a Respite Allocation from the authority - if a client enters a care home on a Long Term basis, or a planned stay in excess of eight weeks, then the client will need to be financially assessed, under Residential Charging.

For cases where the stay exceeds 8 weeks, but is less than 52 weeks, Residential Charging assessments would be carried out on an Temporary (Extended Care) basis - for cases where there is no planned discharge date (and/or the placement is known (on admission) to exceed 8 weeks), then the placement should be treated as Temporary (Extended Care) from the date of admission (i.e. and therefore treated under Residential Charging).

Should a client be known to require a Long Term placement (on admission), but subsequently move to an alternative home at a later date (e.g. through their original home of choice not initially possessing vacancies), then the client should be treated as a Long Term placement, from the date of the initial admission (i.e. the admission to the initial care home).

In addition, (and with regards to Temporary placements) the authority can make allowance for certain household expenses (that a client may still be required to meet), on a property that they wish to return to (providing that these outgoings are listed on the Declaration of Financial Circumstances form).

Therefore, although The Act has attempted to combine Residential and Non-Residential Charging (where possible), there are certain areas where Residential Charging must be different – for example, with regards to ownership of property, the value of the client's main residence will not be taken into account, when calculating a charge for Non-Residential care/services.

However, where a client enters Long Term Residential/Nursing Care, and is a Home Owner (and the property will be left empty, where the client is admitted to a care home), the authority will include the value of the property, in any financial assessment (but subject to a twelve week disregard, in certain circumstances) – in these cases, the authority would arrange to provide financial assistance, but would eventually recover all costs (from the date that the property is being included, in the financial assessment) following the eventual sale of the property.

NB It should be noted that property can be disregarded, in certain circumstances (i.e. where a partner/family member is still residing at the address), and the authority also has certain discretion to provide property disregards – however, due to the unique individual nature of property ownership (and the occupation of said properties), the Code of Practice (Annex A) should firstly be referred to, for specific guidance.

3.1.1. Deferred Payments

A Deferred Payment Agreement enables a local authority to meet a proportion (or all) of the cost of a client's Residential/Nursing Care, whilst placing a charge on the client's property, as security against the deferment. Agreements (which are described in Annex D of the Code of Practice) will be for the duration of a client's stay in a care home, such shorter period (as the client so wishes), until the equity in the property falls to the relevant capital limit, or until the client decides to sell their property, in order to pay for their Residential/Nursing Care.

In order to qualify for a Deferred Payment, the authority must firstly be satisfied that the client has an interest in the relevant property, the client's weekly income is insufficient to meet the full cost of their care fees, the client's capital is not in excess of the capital limit (which would allow the client to fund their own placement), and the value of the equity (in the property) exceeds the capital limit - additional requirements can also be found in Annex D, in the Code of Practice.

Where this authority enters into Deferred Payment Agreements, interest can be charged (the amount of which to be confirmed in the Deferred Payment Agreement), in addition to any associated administrative (including valuation) costs.

3.2. Non-Residential Care

Non-Residential Care services would consist of Domiciliary/Home Care, Domiciliary Respite Services, Residential Care based Respite Care (of up to 8 weeks), Lifelink Extra Assistive Technology package (previously referred to as Telecare/Category 3), Day Care Services, and Direct Payments.

Clients who are in receipt of more than one of the above services will be provided with a single financial assessment, based on the total cost of all of the services provided.

Clients who are in receipt of a Lifelink, or Lifelink Plus Assistive Technology packages (previously referred to as Lifeline/Category 1 and Home Safety/Category 2), will pay a **Flat Rate Charge** for the service they receive – these Flat Rate Charges would therefore be in addition to any assessed charge, and would not fall within the “single financial assessment” referred to in the above paragraph.

3.2.1. Non-Residential Financial Assessment Options

Where a client does not have a partner and is the only person in a household in receipt of a service, the financial means of other adults in the household do not need to be taken into account in undertaking a financial assessment.

Where appropriate, the relevant income and costs of the household will be divided evenly between all the adult members of the household to arrive at the allowable income and expenses for the individual.

However, situations may arise where it would be more beneficial to a client, if their contribution were to be calculated on the basis of the household. Clients will therefore be encouraged to have a financial assessment carried out on both an individual and a household basis, to determine the most financially advantageous arrangement. If the resultant financial assessment is based on the household’s income, the service user would remain responsible for paying for the care provided.

Where a client has a partner, the financial assessment will be based on the combined income & expenditure of both partners, but the client will be the partner responsible for paying for the care provided.

In these circumstances, a client may specifically request an independent financial assessment based on their individual means, in which case 50% of relevant joint costs will be taken into account to calculate the allowable expenses.

Alternatively, where there are joint or multiple clients in a household, the combined income of all clients, and the total relevant household expenditure,

will be taken into account in calculating a single financial assessment for the household. A household assessment will be based on the total cost of the combined services received by the household. In such circumstances, one member of the household will be responsible for ensuring payment is made for the care provided to the whole of the household.

If all clients specifically request independent financial assessments based on their individual means, the cost of each service and the entitlement to financial assistance will be calculated separately for each service user within the household.

The disclosure of personal financial information will enable the authority to calculate to what extent, the client is entitled to financial assistance, towards the full cost of the service. The financial assessment will also therefore calculate the amount that the client will be required to pay towards the above services – this Charging Policy therefore reflects both the level of service provided, and also the client’s financial means.

The amount that a client may be expected to pay will be based on the weekly cost of the service, less the amount that the client can afford to pay (i.e. based on their income and capital, and less any relevant outgoings/minimum guaranteed income) – each client will then be provided with a “Maximum Charge” that they would be required to pay, towards the care/services they receive (NB even where their available income is higher than the cost of the service, they will pay no more than the “Maximum Charge”).

Expenses are allowable for Housing Costs (Mortgage Payments and Rent, or equivalent) net of Housing Benefit, contributions towards Supported Living costs, and Council Tax payments (net of Council Tax Benefit) – this information must be provided (on the Declaration of Financial Circumstances form, and documentary evidence provided), in order to be considered in the financial assessment.

The client’s charge would be based on the contact/assessed hours of care (or number of Day Service attendances/sessions), by the rate charged - the rate charged will be no more than the cost of the services, it may not necessarily reflect the actual cost to the authority of providing/commissioning the service,

but in any instance, the client would not be required to pay in excess of the weekly “Maximum Charge” for the service (or combination of services).

Refunds will only be issued for notified cancelled calls (with regards to Domiciliary/Home Care services).

Clients who do not wish to take part in a financial assessment will be required to pay the full cost of the service provided, subject to a weekly “Maximum Charge”.

4. Circumstances where a Charge cannot be applied

The authority cannot charge for certain types of care and support, and these must therefore be offered free of charge. Although a full list of examples can be found in Section 5.12 (of the Code of Practice), the most relevant exemptions are:-

- Where the client is a Child, or is a Child Carer (under 18 years of age).
- Where a client receives after-care services/support under Section 117 of the Mental Health Act 1983.
- Where Reablement has been arranged, to enable a client to maintain or regain their ability to live independently at home. In this case, the client would therefore be entitled to up to 6 weeks “free care”.

However, should a Long Term package of care be identified prior to the end of the 6 week period (e.g. at week 4), the package/placement would become chargeable from the date that the recommendations were made (i.e. the package/placement would be deemed chargeable from week 4, as opposed to the client receiving the full 6 weeks of “free care”).

5. Statement (and Effective Date) of Residential and Non-Residential Charges

Assessed charges will become due from the date that the care/service is provided, but clients must firstly have been notified of the maximum amounts that they could be expected to pay (and this notification must have been provided, prior to any chargeable service commencing) - this information will be communicated to clients, by means of the “Paying for Residential and Non-Residential (Community) Care” document.

Clients who request a financial assessment will be required to complete a “Declaration of Financial Circumstances” form, and provide documentary evidence, in order to verify their income and capital assets – this information should be provided within 15 working days, and where clients fail to respond, the authority may impose a charge, up to the level of the Maximum Charge.

Once a financial assessment has been carried out, a confirmation letter (and an attached statement providing a breakdown of the assessed charge) will be sent to the client (or financial representative).

If a client’s financial/household circumstances (or care plan) subsequently changes (including where a Residential Care client’s partner/spouse resides/resided at the client’s former address) , then this may have an impact on the assessed charge, and any such changes may therefore require for the client to be financially re-assessed – in any instance where a client’s financial/household circumstances change, then the relevant changes should be communicated to the authority (in order for a determination to be made whether a re-assessment is required, and whether the changes will affect the client’s assessed charge). Any changes in the client’s charge will be back-dated to the date that the change in financial/household circumstances occurred.

Clients will be financially re-assessed in each financial year, with the re-assessed charge for the new financial year, being sent to the client (or financial representative).

6. Deprivation of Assets (Income and Capital)

If a client deliberately deprives themselves of income/assets (in order to reduce/avoid charges or qualify for financial assistance at an earlier date), then the authority will treat the client as still possessing these, and will include the value of the income/asset in any financial assessment (Notional Income/Capital).

For example, should a client purchase a Funeral Bond which results in the client’s capital falling below the relevant capital limit (i.e. where the client would then apply for financial assistance at an earlier stage), the amount spent will be treated as Notional Capital.

Such a determination would result in a client being requested to continue meeting the full cost of their care (Residential Care), or the Maximum Charge (Non-Residential Care) for an extended period. The timing of any deprivation would impact on whether the authority would pursue the client, or the person who received the benefit of the deprivation - further guidance regarding this should be sought from Annex F, in the Code of Practice.

7. Payment of Charges

The majority of Non-Residential Charges (i.e. Domiciliary/Home Care, Day Care) will be collected by Direct Debit (calendar monthly), as this is the preferred method of payment. Any short stay (previously referred to as Respite) charges may be payable to the Care Provider (unless the client already receives an alternative service from the authority, and these charges are already collected by Direct Debit).

Where a client is in receipt of Direct Payments, the client's assessed charge (if applicable) will normally be paid directly into the Direct Payments Account (by the client), and the authority will also make payment (i.e. a net amount, following the deduction of any assessed client contribution) directly into the client's Direct Payments account – the combination these contributions will thus ensure that the client has sufficient funds, in order to meet the cost of their care/services (as set out in their care plan).

Should the client therefore wish to purchase additional care/services, outside of their care plan/agreed Direct Payment package, then they would be expected to use their own funds to purchase this additional care (please also refer to Neath Port Talbot Council's Fairness of Service Provision Policy).

With regards to Residential Care (as mentioned above), the client will be required to pay the assessed client contribution direct to the care provider, with the authority also making any relevant financial contribution, direct to the care home.

8. Additional Cost (previously referred to as a Third Party Payment)

Should the client/family/representative request a Residential/Nursing home, whose charges are in excess of the authority's agreed rate (as approved by the Social Services Funding Panel), then a family member/representative will

(unless the authority cannot commission a placement where no additional cost applies) be required to enter into/negotiate a separate arrangement (referred to as a Top Up, 3rd Party, or Additional Cost), to pay this Additional Cost directly to the relevant care provider - the payment would be required to be fulfilled for the full duration of the residency, in order that the security of the placement is maintained (i.e. as any breakdown in said agreement, could lead to alternative accommodation needing to be sought).

Further guidance on “Additional Costs” can be found in Annex C of the Code of Practice, in addition to Neath Port Talbot Council’s Fairness of Service Provision policy.

9. Review Process

Following a client receiving formal notification of their assessed charge, for Residential and Non-Residential Care, they may seek a review of the assessment (the request may be made orally, or in writing), where they feel the decision has been undertaken inappropriately, or where they feel that meeting the charge would cause financial hardship (this is dealt with in Annex E of the Code of Practice).

The authority must send the client (within 5 working days of receiving the request) a statement of acknowledgement, and request any documentary evidence, which may be required to carry out a review/re-assessment - NB the client may decide that they do not wish to pay their assessed charge whilst the review is ongoing (but must advise the authority of this, within 5 days of receiving the statement of acknowledgement).

The client has an obligation to return any requested financial documentation within 15 days of the authority’s request (or ask for additional time if the client is currently unable to present the required confirmation – NB if this is the case, the authority must offer a Home Visit to the client). If the client does not present the required information (or ask for an extension) within 15 days, the authority can reasonably assume that the client’s request has been withdrawn.

Where sufficient information has been provided, the authority must carry out the review within 10 working days (by an officer other than the person who made the original decision), and communicate the decision to the client – if the

review leads to an amendment in the charge, the authority must send an amended statement of charge to the client.

(NB Where the authority is unable to carry out the review, within 10 days, it must advise the client that (the client) may elect not to pay the assessed charge, whilst the review is being completed (the authority cannot later recover any accrued arrears during a period that it was at fault in failing to carry out a timely review, regardless of the eventual determination).

Where the review leads to a lesser client contribution, any overpayments should be credited to the client. Where the review leads to no change (or a higher assessed client contribution), the client will be asked to repay any arrears that may have accrued (i.e. if they decided to suspend their payment, pending the outcome of the review), and also any additional costs (if the client contribution has increased). Before requesting any accrued/additional costs be paid, the authority should decide whether repayment would cause the client any financial hardship (offering to agree a suitable repayment plan, if applicable).

Where a client still remains unsatisfied with the authority's determination, they will be entitled to make a formal complaint (which will be considered through the formal Social Services complaints procedure).

10. Formal Recovery of Charges

Where an invoice has been raised and/or a debt is/remains outstanding, the authority will take all reasonable steps to collect the debt – this will include communicating with/visiting the client, offering a suitable repayment plan, and ascertaining the reason that the debt has not been paid (i.e. not merely assuming that the client has made a deliberate decision not to make payment).

Should the above steps prove unsuccessful, the authority has recourse (dealt with under Annex F in the Code of Practice) to place a Charge on a client's property (if applicable), or to undertake Court Action, i.e. in order to collect any outstanding debt.

Neath Port Talbot's Debt Recovery Policy should also be consulted for further/specific guidance on these matters.

Schedule of Rates

Charges for Services – April 2021

Long Term Residential Care

Fees Paid to Providers of Residential Care (Per Week) To 31st Mar 21 1 April 2021

Residential Care	£596.12	£619.96
Nursing Care	£603.43	£627.57
EMI Nursing Care Supplement (added to above figure)	£31.40	£32.66
Residential Care for Under 65's (Basic Fee)	£596.12	£619.96
Adult Family Placement	£459.00	£459.00
Pobl Homes (Basic Fee)	£745.87	£756.21
Pobl Homes (Spot Purchase)	£774.43	£785.19

Charges – Service Users per Week (Max Charge)

Pobl Homes – Existing Residents (admitted prior 01/04/12)	£601.50	£625.60
Pobl Homes – New Residents (admitted 01/04/12 onwards)	£790.00	£821.60
Residential Care – All Other Providers	£593.26	£619.96
Nursing Care – All Other Providers	£600.53	£627.57

Charges – Other Local Authorities (Per Week)

Learning Disabilities Accommodation	£1,893	£1,969 week
Additional Hours RCO	£17.00	£17.32 hour
Additional Hours NCO	£24.34	£24.81 hour

Non-Residential Care Charges

* Highlighted Charges below are subject to £100 maximum per week (following approval of WG Regulations)

*Short Term Residential Care

*Up to 7 seven days	£100.00	£100.00
*Every week or part week thereafter (up to 8 weeks)	£100.00	£100.00

Any stay longer than 8 weeks the whole period will be charged as per long term residential care

Non-Residential Services

*Domiciliary Care	£16.50	£17.00 hour
*Domiciliary Respite Services	£16.50	£17.00 hour
*Direct Payments	value of direct payment	

	<u>To 31st Mar 21</u>	<u>1 April 2021</u>
<u>Community Alarm/Telecare – Per Week</u>		
Lifelink (previously Lifeline/Category 1) – Flat Rate	£2.70	£2.70
Lifelink Plus (previously Home Safety/Category 2) – Flat Rate	£3.95	£3.95
*Lifelink Extra (previously Telecare/Category 3)	£5.70	£5.70
<u>Day Care Services – Per Attendance</u>		
*Day Care (Per Attendance)	£31	£32
<u>Other Local Authorities Only – Per Day</u>		
Day Care Training and Employment (Excluding Transport)	£79.00	£83.00
Day Care Complex Needs Service	£180.00	£188.00
<u>Other Charges</u>		
<u>Meals</u>		
	£4.60	£4.60
<u>Rent Cluster Houses (per week)</u>		
Southville Road	£79.70	£79.70
<u>Hillside Secure Unit (per day)</u>		
	£1,100	£1,150