Written evidence submitted by Local Government and Social Care Ombudsman (ASC0107)

LGSCO contribution to the Health and Social Care Committee inquiry into the cost of inaction on adult social care reform

About the Ombudsman

The Local Government and Social Care Ombudsman (LGSCO) investigates complaints about councils and some other authorities and organisations, including independent adult social care providers, in England. It is a free service. Our role is to investigate complaints in a fair and independent way – we do not take sides.

Our experience of dealing with situations where things have gone wrong and recommending service improvements to councils and private care providers puts us in a unique position to provide insight into what could be done to improve local public services. We welcome the opportunity to contribute to the call for evidence.

As the last port of call for complaints about both council-commissioned and privately sourced adult social care services in England, we have unique insight into the pressures facing the system. We have a dual role: to recommend redress for individual injustice and support sector improvement. Our casework is a rich source of information, which we use to publish detailed annual reviews of social care complaints, sector-specific focus reports, and an interactive council performance map. Almost all our individual decisions are also published online, in anonymised and highly searchable form.

Recent research by the University of Manchester concluded that we play an increasingly important role in identifying systemic failures in local public services and issuing service improvement recommendations that are overwhelmingly accepted by councils. It said we fill a key gap left by other forms of overview and scrutiny, and that we increasingly focus on scrutinising and making recommendations to improve the wider systems, policies and processes through which individual decisions are taken. It concluded that we positively influence councils and their delivery of services.

Executive Summary

Information from our casework has highlighted problems in individual social care assessments, provision and charging, as well as within care systems. These can all have a significant impact for the individuals involved, others in similar situations, and organisations delivering or commissioning their care.

In the last five years we have made decisions on 13,455 adult social care cases of which 5,297 went to a detailed investigation. This is a significant area of investigation for us, currently comprising 16% of all our casework. The uphold rate for adult social care complaints where we carried out a detailed investigation in 2023/24 was 80%. This has hugely increased since we started investigating these cases. Complaints about social care charging and residential care have even higher uphold rates, of 82% and 86% respectively.

We consistently find local authorities are reporting a lack of sufficient funding and resources is the primary reason that they are unable to meet their statutory adult social care duties. This has grown significantly over recent years. In our investigations we find that a lack of available or suitable funding can result in councils delaying or not providing care that is needed based on what it costs, or inappropriately charging for care.

Our casework often reflects the complexity of the adult social care system and landscape, especially where it interfaces with NHS care, the transition from children's services to adult social care, or councils' duties relating to special educational provision and mental health support for working age adults.

We have established a joint working team together with the Parliamentary and Health Service Ombudsman (PHSO) to deal with complaints where there is an inextricable link between health and social care. We recently published a joint report called "People not structures: putting people at the heart of integrated care".

Our evidence as set out below shows there are consistent and systemic problems with the adult social care system, which we see through the unique lens of our casework. Some of these problems can result in costs to individuals, groups of people, and the organisations working hard to support them.

How much is inaction on adult social care reform costing the NHS and local authorities, and what impact does this have on patients and the public?

Our uphold rate of 80% for complaints in this sector strongly suggests that the system as it is, is not working. There are well-publicised and long-standing staffing and financial challenges faced by the sector. We see staff shortages and a high turnover of staff resulting in disruption to people's care and in some cases, confusion about financial arrangements and responsibilities. Creating a sufficient social care workforce could be one way to improve adult social care services.

Our experience is also of an increasingly complex system which is often confusing not just for service users, but for the professionals involved. Many people outside the sector will think of adult social care as mainly residential care for older people, often facilitated by local authorities and provided by independent care homes.

However, the picture is much more complex. It encompasses services for working age adults as well as older people. It involves councils having duties to promote wellbeing, and prevent, reduce or delay the development of social care and support needs. Councils also have specific duties and powers around needs assessments, financial assessments, care planning, domiciliary care, residential care, day care, direct payments for people to source their own care, support for unpaid carers, safeguarding, disabled adaptations and grants.

The private care sector encompasses domiciliary and residential care, as well as supported living and other more specialised services. These can range from small businesses with a single site, to large organisations with a nationwide presence. Some will be highly specialised. Most have a mixture of private fee-paying clients and clients funded by councils and/or NHS integrated care boards (ICBs). Many of those will find that council and NHS commissioning approaches and fees vary even within the same area. Fees private providers can get for council- or NHS-commissioned care are generally lower than the fees they can charge privately paying clients.

Within a single council, adult social care often needs to interface with other services such as special educational needs, housing, children's services, local authority public health (e.g. substance misuse) services, and mental health services. A council responsible for a person's adult social care may need to work with neighbouring councils who have related responsibilities. Councils also need to work jointly with hospitals and ICBs to facilitate patient discharge and organise reablement or longer-term care. In some council areas, there might be several hospitals run by different NHS trusts, and several ICBs, all working in different ways. Councils need to work jointly with their ICBs within Integrated Care Systems to develop and maintain sometimes incredibly complex and costly longer term care

packages for individuals whose needs cannot be met using readily available care provision. As a result, a large proportion of a council's entire adult social care budget may need to be allocated to just a handful of individuals.

Unlike most NHS services, council-commissioned adult social care is often chargeable. This means an NHS continuing healthcare-funded patient in a residential care home will get their care for free, a resident placed there by a council may have to contribute towards some or all of the cost, and a resident who arranges their own care will have to pay the full cost and usually a higher fee than that negotiated by the Council or ICB.

Councils must navigate a complex blend of national law and guidance and local policies on charging. They also have significant discretion in certain charging decisions. This means that charging decisions can legitimately vary depending on which council's area a person lives in. Financial pressures on local authorities have increased over the last few years. Over a similar period, we have seen an increase in complaints relating to councils charging for adult social care. This includes complaints about how councils consider whether service users have intentionally deprived themselves of capital to avoid care fees, something we have talked about in our guidance for practitioners.

A number of different record keeping systems exist within social care ranging from handwritten notes to fully digital systems – sometimes even within a single organisation. Record keeping can be seen by some within social care as needless bureaucracy, but for care providers good record keeping is a statutory requirement. In some cases, poor record keeping can cause physical harm. Our guidance "Good record keeping – Guide for care providers" has more details on this.

In 2023/24 we made 611 decisions on adult social care complaints where we recommended personal remedies. These included apologies, backdating payments, waiving or revising charges, completing (re)assessments, (re)starting care and support provision, providing explanations, advice, information, signposting and referrals, reconsidering flawed decisions, updating records, organising independent expert reviews and valuations, considering safeguarding action, setting up deferred payment agreements, setting up instalment plans, and considering reasonable adjustment needs.

In some of those 611 decisions, we recommended financial remedies. These can be split into two broad categories: reimbursement of quantifiable losses, or symbolic time and trouble or distress payments. Our guidance on remedies sets out our approach and the typical range of symbolic payments we usually recommend. These can be higher depending on individual circumstances. In 2023/24, our adult social care decisions recommended reimbursements ranging from hundreds of pounds to tens of thousands of pounds. We also recommended symbolic payments ranging from £100 to £3,750.

In 2023/24, we also made 357 decisions where we recommended service improvements for councils and care providers. Some of those involved multiple service improvements. Examples of service improvements we recommended include:

a. improved procedures and policies relating to: needs assessment and care planning, visits from friends and family; nutrition and hydration; safeguarding; commissioning complex care packages; direct payments; financial assessments and charging; home adaptations; disabled facilities grants; deputyship arrangements; dealing with commissioned care providers giving notice; reasonable adjustments; co-operation between housing and social care departments; cooperation between health and social care organisations meeting people's cultural needs; shared lives arrangements; transferring care responsibilities between councils and the NHS; increased clarity on contracts and terms & conditions; record keeping; risk management, care home evictions;

b. improvements to practice in complaint handling and communication with service users and their families;

c. improved standard information (e.g. leaflets and web pages for service users and representatives);

d. improved monitoring of and communication with outsourced services;

e. staff training and development;

f. action plans to:

    i. address shortage of qualified occupational therapists and its impact on waiting list times for assessments;

    ii. increase supply of supported living placements in area;

    iii. address complaint backlogs;

    iv. support residents who enter the criminal justice system;

    v. reduce timescales for completing social care needs assessments and financial assessments;

    vi. improve IT systems;

    vii. improve the availability of reablement care providers;

    viii. avoid delays in meeting urgent needs for care and support;

    ix. improve the availability of care providers to support people living with dementia.

Our recommendations will all have costs or other resource implications for councils and care providers. While we recognise they are under increasing financial pressure, it is important they are fulfilling their statutory requirements. We cannot make concessions for failures attributed to budget pressures; we must continue to judge authorities in line with relevant legislation, standards, guidance and their own policies.

What is the cost of inaction to individuals and how might people's lives change with action on adult social care reform?

A significant proportion of our adult social care casework involves financial matters. This includes councils' powers and duties around providing information, financial assessments, charging, debt collection and arranging third party top-up fees. We also see complaints about faults in private providers' charging and contracts or terms and conditions.

Even when councils and private providers act without fault when dealing with financial matters, the result can leave service users feeling it is unfair that somebody in the same care home can receive the same service for free or for a lower cost, because of different funding and commissioning arrangements.

It is not difficult to see how complexity in the adult social care system can contribute to poor communication or make it difficult to always have good communication. Poor communication between various parts of the system and with service users and their families is a key theme we see in our casework. At its most benign, this is frustrating for the people and organisations involved. At its worst, it can have serious financial and safety implications and can even be life-limiting. Improved communication would not only improve people's experience but also reduce the demand on resources caused by a lack of information. When people understand what is happening and feel involved in their care, they are less likely to chase for updates or raise their concerns as complaints.

Our recent triennial review highlighted a concerning lack of signposting to our service from private social care providers. This is potentially leading to users of privately funded social care lacking the route to redress that publicly funded social care users have. In addition to the manifest unfairness of this situation for service users, this is a missed opportunity to use our expertise and knowledge to its full potential to improve the quality of private adult care services. We want to close this gap and are calling for a legal requirement for all social care providers to signpost people to our service.

Example cases

Below we set out some examples of cases we have received that help to illustrate the concerns set out above.

Case overview: 22 013 262

Mr X complained about the Council's financial assessment for his mother, Mrs Y's residential care charges and its decision to treat monetary gifts to her children and grandchildren as notional capital.

Our investigation:

We found fault in the way the Council had included notional capital in Mrs Y's financial assessment. As a result, Mrs Y was responsible for the full cost of her care for longer than she should have been. This led to significant arrears of care fees and a risk to Mrs Y's place at the care home. In the course of our investigation, we became aware of four similar cases.

Result:

We recommended a fresh financial assessment for Mrs Y and, depending on the outcome of the assessment, reimbursement including interest. We also asked the Council to review and remedy the cases of others who may have been affected. We recommended a thorough review of the Council's approach to deprivation of assets, gifting and notional capital, to ensure that its approach is robust and in line with the guidance.

Case overview: 22 010 785

Ms X complained the Council failed to offer a nursing home suitable for Mrs Z's cultural needs. She said because of this Mrs Z has suffered hair, diet and skin issues caused by the Council's commissioned care provider, a nursing home. Ms X said this has caused her and Mrs Z significant distress.

Our investigation:

We found fault in the Council's care planning, the nursing home's care provision on behalf of the Council and the home's record keeping. Mrs Z suffered hair loss and dry skin, and her family had to attend the nursing home to provide some of her care. By the time we completed our investigation, the Council had placed Mrs Z in a different nursing home, outside its area. It told us this was because there were no homes in its area that could meet her cultural needs. We considered this indicated the Council was not meeting its market shaping duties as set out in the Care Act 2014.

Result:

We recommended meaningful apologies and symbolic distress payments for both Mrs Z and Ms X. Because the care fell below the standards we expect, we also asked the Council to reimburse Ms X 20% of the contributed care fees she and her family paid. To improve services, the Council agreed to develop a strategy detailing how it intends to meet the cultural needs of people living in the area. It also agreed to issue written reminders to its staff and the commissioned care provider of statutory requirements regarding care planning and fundamental standards of care.

Case overview: 22 017 137

Ms Y complained about failings during planning for her father's discharge from hospital and delays in the repatriation of her mother. We investigated the actions of a council and two NHS trusts.

Our investigation:

We found the council at fault for flawed hospital discharge planning. We also found fault by both NHS trusts for failings in the repatriation process. We also found fault with one of the NHS trust's complaint handling. The faults led to avoidable expense and distress.

Result:

We asked the organisations to apologise, reimburse around £1,000 the family would not otherwise have paid, and make symbolic distress payments. We also recommended the organisations share the learning from this case with relevant teams.

Case overview: 23 001 210

Mrs Y complained about the way a council and ICB dealt with her brother Mr X's care and communicated with her family during a period when the responsibility for Mr X's care transferred between adult social services to NHS continuing healthcare (CHC). Mr X has a rare genetic condition that causes physical and learning disabilities, and challenging behaviour which poses a risk of harm to himself and others. He cannot make his own decisions about medication or care. Before the complaint to us, Mr X lived with his parents. Mr X's family felt that because of inadequate support from the organisations, they had no choice but to make him homeless because having him at home was no longer safe.

Our investigation:

We found the council at fault for failing to respond to the family's concerns or review Mr X's care plans while it was still responsible for Mr X's social care. There was no co-operative working by the Council and ICB during the transfer of care responsibilities. When these transferred to the ICB, it delayed assessing his needs and producing a care plan. Collectively, the ICB and the Council allowed concerns about the sustainability of Mr X's care at home, and potential safeguarding issues, to drift until Mr X's family reached a crisis point and felt they had no choice but to refuse to collect Mr X from his day centre. Flaws in the Council's and ICB's communication with the family added to their distress.

Result:

We asked the organisations to apologise and make symbolic distress payments. We also recommended the ICB ensures all relevant staff were aware of duties relating to: safeguarding, the Mental Capacity Act 2005, and CHC care planning. The ICB also agreed to review and if necessary update its systems for dealing with breakdowns in care provision and sourcing emergency care. The organisations agreed to jointly review and update the systems and protocols they have in place for transferring care responsibilities from one organisation to another.

Case overview: 22 015 923

Ms D complained a council, an NHS Trust and an ICB failed to plan her daughter Miss E's discharge from mental health detention, and about failures to arrange appropriate aftercare services for her. Miss E is a young woman with complex physical and mental health needs. Some of her treatment under detention was delivered in an NHS-commissioned private specialist eating disorder unit. Ms D said the delayed discharge from hospital detention had a significant impact on Miss E's mental health, led her to resume unhealthy coping strategies which placed her at risk, and affected the relationship between Ms D and Miss E.

Our investigation:

We found there was fault in discharge planning and support by all three organisations, including avoidable delay of around four months. The organisations also failed to arrange adequate aftercare for Miss E as required by Section 117 of the Mental Health Act 1983. This included failing to provide or arrange psychotherapy and speech and language therapy services

The faults caused significant avoidable distress and frustration for Miss E.

Result:

We asked the organisations to apologise, make symbolic distress payments, reimburse private speech and language therapy fees, and ensure Miss E's aftercare planning was up to date.

We also recommended the NHS Trust develops staff knowledge of applying the Care Programme Approach (CPA) to patients with complex needs and of escalation routes where professionals cannot secure the provision set out in service users' aftercare plans.

Case overview: 22 008 699

Ms Y complained the Council failed to arrange the necessary support to meet her bother Mr Z's social care and housing needs when he had early onset dementia. As a result, his health and wellbeing rapidly declined and he was eventually detained in hospital under the Mental Health Act 1983.

Our investigation:

We found faults by the Council relating to mental capacity issues, considering advocacy needs, failing to conclude a care needs assessment, a lack of joined-up and collaborative planning by different departments, and a failure to have regards to Mr Z's human rights. The faults caused significant uncertainty and contributed to Mr Z's prolonged residence in unsuitable hotel accommodation without access to cooking facilities. Mr Z sometimes acted inappropriately towards others, leaving him vulnerable to retaliation. He was once attacked following an altercation with a member of the public. While living in the hotel, Mr Z also had reduced access to NHS mental health services who were integral in managing his medication.

Result:

Sadly, Mr Z died before we completed our investigation. We required the Council to consider our report at its full Council, Cabinet or other appropriately delegated committee of elected members and to report back to us on the action it would take in light of it. We also recommended staff training, as well as an apology and a symbolic payment to Ms Y.

Case overview: 23 013 310

Mr X, a person with disabilities and complex needs, complained about the Council's response when he became homeless. Mr X said the lack of support with housing and his care needs adversely affected his mental and physical health, which meant he spent several weeks in hospital.

Our investigation:

We found the Council's adult social care team was not proactive enough in working with its housing team and failed to properly assess and record Mr X's overnight care needs. We also found faults in the way the Council carried out its homelessness duties. We considered the Council failed to have due regard for Mr X's human rights in its handling of his case. Because of the Council's faults, Mr X did not receive any support for his care needs after the morning call on the day he was evicted and on another weekend when he had no accommodation. As a result of Council failings, Mr X slept in his car for several weeks, did not always receive his care package, and incurred avoidable costs.

Result:

We recommended redress for Mr X including apologies, a symbolic distress payment of £8,500 and reimbursements totalling about £1,500. The Council also agreed to remind housing staff about correct procedure in cases like Mr X's, review its processes, share our report with relevant staff in its housing and adult social care teams. The Council also agreed to review how it provides services to homeless people with care needs, which is reported to a relevant committee of

elected members.

Case overview: 23 013 400

A private nursing home incorrectly withheld fees, had no clear contract setting out what happens when a person is awarded NHS funded nursing care payments (FNC), did not provide a statement of account for money it still held, increased its fees to include FNC without notice, and failed to respond properly to complaints. This left a woman's estate out of pocket.

Result:

One of our recommendations to the care provider was to reissue a final invoice with NHS payments deducted and reimburse the woman's estate if there was a credit. The provider refused but agreed to reduce the outstanding balance of the account by 50%. We were not satisfied the care provider fully remedied the financial injustice. We issued an adverse findings notice and shared our findings with the Care Quality Commission.

Case overview: 22 027 306

A private nursing home failed to provide adequate care to a resident (Mr Y) or keep adequate records. A safeguarding investigation found there were acts of neglect and omission in Mr Y's care. This caused him avoidable pain and suffering, and his family avoidable distress.

Result:

We recommended the care provider reimburse some of Mr Y's fees and make a symbolic distress payment to his daughter. The care provider refused to implement our recommendations. It also refused to publish our adverse findings notice as required by law. We therefore published the notice, sought our publication costs from the provider as the law allows, and shared the notice with the Care Quality Commission.

Case overview: 22 000 034

A private residential care home sent rude and threatening responses to legitimate complaints, wrongly threatened to appoint enforcement agents to recover a disputed debt, threatened to send enforcement agents to a vulnerable older person's property after the complaint was escalated, and failed to tell the complainant about their right to complain to LGSCO. As a result the complainant suffered injustice in the form of intimidation and distress.

Result:

We recommended the care provider apologise and make a modest symbolic distress payment. The care provider refused to implement our recommendations. It also refused to publish our adverse findings notice as required by law. We therefore published the notice, sought our publication costs from the provider and shared the notice with the Care Quality Commission.

We hope this evidence and information will be of use to the inquiry and would welcome an opportunity to elaborate on any of the points in our submission if that would assist.

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Local Government and Social Care Ombudsman for England
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