ARCO | Setting Standards for Retirement Communities

30 October 2015

Associated Retirement Community Operators Limited
The Heals Building, Suites A&B
3rd Floor, 22-24 Torrington Place
London WC1E 7HJ

Telephone: 020 3697 1204
Email: info@arcouk.org
Internet: www.arcouk.org

Tim Spencer-Lane
Law Commission
1st Floor, Tower
Post Point 1.54
52 Queen Anne's Gate,
London SW1H 9AG

via email: tim.spencer-lane@lawcommission.gsi.gov.uk

Re: Response to consultation on mental capacity and deprivations of liberty

Dear Tim,

With this letter, ARCO (the Associated Retirement Community Operators) is responding to the Law Commission's consultation on "Mental capacity and deprivations of liberty".

In **summary**, our response is as follows:

- Overall we **welcome proposals that make easier the process of gaining authorisation for deprivation of liberty** (and now restrictive care) in supported living settings.
- We would like to commend the Law Commission's work in an area of great legal and intellectual complexity. We recognise that the Law Commission has produced a comprehensive analysis of the current situation, and would like to congratulate the Commission on having produced a system that tries to capture the complexities involved.
- However, we are concerned that the **language of the consultation** does not reflect the amount of agency that older people usually have with regards to living in a supported living setting, and uses only the situation of state-funded individuals as its default starting point.
- We feel there are various areas in the consultation where **more clarity and understanding is required with regard to the role of housing providers**.
- We are particularly concerned that current proposals **do not adequately understand and account for the role that housing providers** may have in **making referrals for assessments** and implementing **activities that would be classed as restrictive care and treatment**.
- We feel that a number of **unintended consequences** are possible, particularly concerning regulation of the system.
- In particular we are concerned that the proposal of CQC having oversight for the whole system may **broaden the Care Quality Commission's remit to go**

Company registered number: 8209801
Company registered office: The Heals Building Suites A&B, 3rd Floor, 22-24 Torrington Place London WC1E 7HJ

VAT number: 157 4987 57

beyond the regulation of personal care in supported living settings. We believe that this would add further confusion to care inspections, and possibly create undue burdens for housing providers.

- We are also concerned that **charging proposals may create perverse incentives for individuals or their families to falsely have themselves or their relatives declared lacking capacity** in order to avoid paying for accommodation.
- We also think **further clarity** is need on the **'triggers' for supportive care** once someone has already moved into a supported living setting.
- Finally we have **concerns** regarding the **scope of the proposals**, and also **regarding the practicality of the proposals**, particularly due to the uncertain assumption made in the document that self-funders will already be receiving assessments from local authorities as a matter of course.

About ARCO and housing-with-care for older people

Founded in 2012, ARCO (the Associated Retirement Community Operators) is the main trade body representing providers of housing-with-care developments for older people. Currently, ARCO has 24 members who provide housing-with-care to more than 25,000 people in the UK. Our members are both private companies and not-for-profit organisations, and represent approximately 50% of the housing-with-care market in the UK.

Retirement communities provide housing-with-care for older people, and sit between the traditional retirement housing model (where no care is delivered and support is limited) and care homes (where care is delivered but people do not live in their own homes). An ARCO-registered member community is distinguished by a set of characteristics, the most significant one being that the delivery of care and support is an integral part of each scheme. Alongside the 24/7 presence of staff, our members also provide a variety of communal facilities including dining and recreational services.

1. Introduction

ARCO welcomes the overall impetus to reform the laws surrounding Deprivation of Liberty. We agree that the current process of authorising deprivations of liberty is poorly functioning, and that it is especially cumbersome outside of care homes and hospitals. Anecdotal evidence also leads us to agree that there are low levels of understanding of the current system amongst members of the public and professionals from all sectors. We welcome reforms to the system which make the process of gaining authorisation for deprivation of liberty (and now restrictive care) easier. The Law Commission's work in this area was sorely needed, and we recognise the effort which will have gone into producing the comprehensive consultation report.

However we are concerned with a number of aspects of the proposals for the new 'Protective Care' system. These are outlined below. These are focussed purely on those issues affecting housing-with-care for older people, and only relate to the proposals for 'supported living' settings.

2. Language and assumptions regarding choice and 'placement' in settings

We would argue that the language of the consultation document assumes that people are 'placed' in care or supported living settings. For example 7.31(3) gives an example of restrictive care as when "the person either is not allowed, unaccompanied, to leave the premises in which *placed* (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted" (p.68) [our italics].

In contrast many people who the laws will apply to actively choose their own place of living and/or care, and self-funders may not have had any local authority involvement in that decision whatsoever. For example an elderly individual may actively decide to move into a retirement community whilst in their seventies and in good health, and may be funding their own living and any care themselves and receive no local authority input. They may then develop a disease such as Alzheimer's which may cause them to lose some mental capacity and require restrictive care within their home.

We therefore feel that the current language, found at various places throughout the document, paints an unrepresentative account of how a large (and growing) number of people in supported living or care settings, and that it will not therefore ring true or feel obviously applicable to the many individuals who choose their own care and living settings, or the staff who work with them.

We therefore believe that the report and new legislation needs to:

a. Take a closer look at the implications of the proposals for self-funders, but also those who have **chosen** to live in a particular setting, even if they are in receipt of state funding.
b. Use language that reflects the above, moving away from language that assumes that people are 'placed' in services or supported living settings with little individual agency or will.

2. Unclear definition of 'supported living'

The current definition of 'supported living' (provided under the Care Act 2015) is not sufficiently clear for these purposes, and the report fails to accurately acknowledge the variety – and differences – between the sorts of housing and care options for older people. At the moment we would assume that retirement communities fall within the Care Act definition of supported living, but there is also room to argue that they could be classed as 'domestic settings'.

Retirement communities are housing provision for older people which allows older people to own and/or rent an entire property, with all the independence that this entails. However retirement communities also provide residents with access to communal facilities such as leisure services and restaurants and cafes, 24 hr staff on site, and also an on-site domiciliary care provider for when care is required. Residents of retirement communities may own their properties just like those in a normal block of flats, and many may never need care services, or may not need them for the majority of their lives. In them there is a real separation between the care a person receives and their accommodation, and the legal agreements for the provision of care and accommodation are separate. The difference to a regular block of flats is that care facilities are located on-site should residents need them, and that there are other leisure and wellbeing services also onsite.

It is even more unclear if *retirement housing* settings would be classed as 'supported living' settings or 'domestic' settings because these typically do not have personal care provision onsite. Retirement housing is housing provision for older people where older people may rent/own their own home with a concierge in a development of similar homes, but in these settings there is usually no registered domiciliary care provider or other services on site.

Both these sorts housing options may have been adapted with features such as wider doors, for example, to allow easier access in case people develop care needs that might require a wheelchair – but this varies from setting to setting.

We therefore call for:

a. More clarity as to the definition of 'Supported living' and what types of older people's housing falls within this, and a clear framework for deciding whether a setting should fall under the new regulations or not.

3. A need for further consideration of the role of housing providers (rather than care providers or healthcare workers) in implementing restrictive care, and lack of clarity regarding the different roles and responsibilities of housing providers and health and social care providers

In the current document an example of 'restrictive care and treatment' given is that "the person either is not allowed, unaccompanied, to leave the premises in which placed (including only being allowed to leave with permission), or is unable, by reason of physical impairment, to leave those premises unassisted".

In many housing settings (supported living and other domestic settings), housing staff (such as receptionists or grounds managers) may play a role in putting in place restrictions which count as 'restrictive care and treatment' under these guidelines. For example, a receptionist/warden staff (who would typically be employed on the housing provider) may be involved in preventing residents (who

had been declared as lacking mental capacity, and for whom it was in their best interests) from wandering outside in cold or icy weather. At the moment we do not feel that the role of housing staff is clear or adequately reflected in the documentation. This will not usually be part of a care plan, but may nevertheless occur from time to time.

This is particularly the case relating to referrals. We agree that care providers should have a duty to refer an individual for assessment. However there is a lack of clarity around housing providers.

Additionally we feel there may be too much reliance on a 'care plan' as a means for recording mental capacity status and authorisations of restrictive care and treatment. Whilst we can assume that in most cases people who have lost their mental capacity will also be in receipt of personal care, this may not always be the case. For example they may be quite able to look after themselves, but sometimes have moments of reduced capacity where they may wonder out onto a busy or icy road, for example. Therefore they may not be known to a social care worker nor have a care plan but may nonetheless need restrictive care and treatment. We feel that the current guidance assumes that people who will fall under restrictive care and treatment will already have a care plan in place.

We therefore call for:

a. Language and scenarios that reflect the role of housing providers in dealing with people who may have lost their mental capacity (including implementing restrictive care and treatment actions) and which clarify the roles and responsibilities of housing staff.
b. Clarity regarding the role of housing providers and care providers in making referrals for mental capacity assessments. We believe that when care professionals and housing professionals are both engaged with residents, the duty to refer should rest with the care provider if they are concerned that they lack mental capacity. If an individual does not have a care provider, there is a need for clarity about the role of the housing or support provider. We believe that in these instances any duties placed on housing providers should not be onerous or different to those placed on housing providers in 'normal' settings.
a. Clarity as to the processes needing to be followed if people do not have a care plan in place already when they are referred to the AMCP and if they are not in receipt of personal care. (E.g. if they then have a care plan made, and who owns this and has access to it).

4. Unintended consequences of CQC role in oversight

Whilst we believe the system needs to be regulated, we have considerable concerns about the impact of the proposed regulatory approach on the housing-with-care sector. We believe that the way in which the new scheme may be regulated may blur the boundaries as to what is within CQC's regulatory remit.

At present most supported living settings are registered with CQC as providers of 'personal care' rather than 'accommodation for persons who require nursing or personal care'. This is because there is a clear separation between the provision of accommodation to residents and the provision of personal care. Domiciliary care agencies which provide personal care to people are regulated by CQC. The physical environment of older people's own homes in retirement communities and the communal developments of which they are a part are **not** regulated by CQC.

New guidance from CQC clarifies this, stating that within housing-with-care settings, only he domiciliary care should be registered and regulated as 'personal care' providers given there is a clear separation between the provision of accommodation and provision of care services. [1]

Whilst this new guidance should reduce confusion, we are concerned that if CQC were to regulate restrictive care in supported living settings (if these are defined so as to include retirement communities) this could possibly extend into the monitoring the activities or decisions carried out by housing providers (such as receptionists – see previous point) rather than care providers.

This could therefore blur the boundaries of their remit to inspect and regulate activities beyond the provision of 'personal care', once again adding confusion to the current inspection regime and possibly placing new burdens on housing providers.

The cause of this confusion may lie in the assumption that all actions relating to deprivation of liberty are recorded in a care plan – this is not necessarily the case, as the case of e.g. a receptionist demonstrates.

Therefore:

a. We think there needs to be further thought into monitoring of the different roles and responsibilities of housing and care providers in providing or implementing restrictive care and treatment.
b. We do not believe that CQC should monitor restrictive care and treatment activities where this is beyond the remit of 'personal care', and constitutes activity by housing staff.

5. **Possible perverse incentives and unintended consequences of charging proposal**

The consultation includes a provisional proposal at 15.71 that the state pay for the accommodation costs of those deprived of their liberty in their best interests

[1] http://www.cqc.org.uk/sites/default/files/20151023_provider_guidance-housing_with_care.pdf

and receiving restrictive care. We think if it were put in place it might create perverse incentives whereby people (or their relatives) might seek to be declared as lacking capacity in order to have their care paid for by the state.

6. **Lack of clarity in regards to transitions from 'supportive' to 'restrictive care' and 'triggers' for supportive care**

   The proposals need to more clearly flesh out what 'triggers' a move from supportive care to restrictive care. There is considerable scope for interpretation that could cause confusion and legal uncertainty. This is also something that anybody monitoring this will need to come to grips with, and therefore it is vital that there is clarity around the transition points as otherwise this may be open to too much interpretation.

   In particular:

   a. More clarity is needed to define what would 'trigger' the implementation of supportive care for those who chose to move into supported living with full mental capacity (thus having clearly consented to the move), but whose cognition declines once they are in the setting.

7. **Assessment of self-funders**

   The consultation assume that most people lacking capacity will have had a local authority assessment already, because the introduction of the care cap would have provided individuals with an incentive to approach councils for assessment. However the care cap has been delayed (and it may be delayed further) so the number of people that will seek contact and assessment with the local authority is likely to be lower than assumed. If this results in the proposed mechanisms not taking effect as there is no state involvement, other mechanisms may need to be sought to bring self-funders into the system.

8. **Practicality of the proposals**

   We hope that the new system decided upon is sufficiently realistic and clear to be enacted. A less ambitious but realistic improvement to the system may well be preferable to a more ambitious system that may not be implemented due to funding pressures or legal difficulties.

I hope the issues raised above will inform your thinking on this issue. We would like to stress that we have focused on the points of concern for us, and would like to reiterate that we commend your efforts to clarify and simplify an immensely complicated subject area. Please don't hesitate to contact us if you have any queries regarding the information that we have provided.

Yours sincerely,

Michael Voges
Executive Director

ARCO members

- Anchor
- Audley
- Berkeley Healthcare
- ExtraCare Charitable Trust
- Family Mosaic
- Genesis
- Guinness Partnership
- Hanover
- Housing & Care 21
- Jewish Care
- LifeCare Residences
- MHA
- Middleton Hall Retirement Village
- Midland Heart
- One Housing Group
- Orders of St John Care Trust
- Rangeford
- Renaissance Villages
- Retirement Security
- Retirement Villages
- Richmond Villages
- Sanctuary
- St Monica Trust
- Trafford Housing Trust