

Capacity and consent

1. Introduction

Everyone makes decisions and it is a basic human right to be able to express one's opinion. [1] The decision-making process can be affected by many different factors. Individual decisions are often bound up in personal beliefs and values, including perceptions of quality of life (and the end of life). Ageism, and stereotypical thinking by others and the older person themselves may well influence decisions made by older people. This can be especially so where there may be an element of risk taking by the older person. Decision making is therefore a sensitive and vital issue for older people.

The law presumes that every adult has the capacity (or is 'competent') to make his or her own decisions when they have choice, the necessary tools (eg time and information) and understanding with which to decide unless the contrary is established. Sometimes, because individuals have different values and beliefs, they disagree with another person's decision. This does not necessarily mean that the person making the decision does not have capacity.

1.1 What is consent?

Consent is demonstrated when an individual (either verbally or non-verbally) indicates what they are willing to do or allow a third party to do to or for them. [2] To give valid consent, people need to be able to access, understand and process information relating to the decision they are making. Informed consent is therefore a fundamental aspect of any form of health or social care. The mental capacity of an individual is at the centre of issues relating to consent.

1.2 What is capacity?

This is now defined in law in the Mental Capacity Act [3] as 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

It does not matter if the impairment or disturbance is permanent or temporary. The ability or inability to make a decision depends on the ability or lack of ability to a) understand the information relevant to the decision, b) retain that information, c) use or weigh the information as part of the process of making the decision or d) communicate that decision (whether by talking, using sign language or any other means).

The way people weigh up information when making decisions varies according to their beliefs and the value they place on the information and choices available. People's capacity to make decisions can differ for several reasons, including a brain injury, learning disability, mental health problem or dementia. Mental capacity can also vary over time or according to the nature of the decisions to be made. Age in itself does not affect capacity, a point that has been recognised within the Mental Capacity Act which has a specific provision that lack of capacity cannot be established merely by reference to a person's age or appearance, or condition, or an aspect of behaviour which might lead others to make unjustified assumptions about capacity.

There are many factors that affect the choices available to an individual and therefore the decision that they make. This paper deals primarily with the issue of individual capacity and consent in the process of making a decision and not the issues that may affect the range of people's choices.

This paper covers the position for England and Wales as the legislation is the same for both countries. Scotland has relatively similar legislation to England which came into force in 2003. Currently there is no equivalent legislation covering Northern Ireland.

2. Policy statement

Individuals should have equal rights to choice and consultation on all issues that affect their lives, regardless of age. The five principles of the Mental Capacity Act 2005 (presumption of capacity; support to make one's own decisions; the right to make unwise decisions; decisions made on behalf of a person are in their best interests; and the least restrictive intervention) should be applied in all situations. Older people who might have difficulty in making decisions or expressing whether or not they consent should have access to independent advocacy. Where there is a statutory agency involved in making a decision for an older person the agency must show that due regard has been given to the provision of an advocate. There should be adequate safeguards built into legislation and guidance to protect older people without capacity against abuse.

3. Key facts

It is difficult to quantify exactly how many people have been deemed not to have mental capacity at any one time, because the data is not collected and because not everyone will have the same level of incapacity or indeed, be incapacitated all the time. In addition individuals may have capacity to make a decision about certain aspects of their life but not others. However, indicators of the range of people who might be affected are given below.

- Dementia affects 1 in 20 people over 65 and 1 in 5 people over 80; in total it affects about 750,000 people in the UK (18,500 under the age of 65). Of this figure 652,600 are in England and 41,800 in Wales. The number of people with dementia in the UK is expected to rise to 1.8 million by 2050 [4]
- It is estimated that there are 14,000 people of all ages with dementia among the black and ethnic minority groups [4]
- □ Approximately five in 1000 people over 65 years have schizophrenia, bipolar disorder or other severe and enduring mental health problems. Approx 2/3 will have grown old with the condition.[5]
- According to the Department of Health, in 1999 there are about 25,000 people over the age of 65 with severe or profound learning disability, and 250,000 with a mild or moderate learning disability in England.[6]
- There are approximately 13,635 people aged 60 and over who currently have a receiver appointed by the Court of Protection. In total there are 114,449 donors of 60 and over with registered EPAs although it is unknown how many of those are still active. In addition there are 487,000 claimants of state retirement pension who have an appointee to deal with their benefits. [7]

4. Current public policy

After many years of lobbying for legislation, this has been achieved with the Mental Capacity Act receiving Royal Assent in April 2005. Age Concern had an active role in both setting up the Making Decisions Alliance, an umbrella group of organisations lobbying for legislation, and in the debates as the legislation progressed through Parliament. The Act is due to come into force in April 2007. The Department of Constitutional Affairs and the Department of Health are both involved in the implementation of the Act.

Five key principles of the Act

1. A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. The right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions.
3. That individuals must retain the right to make what might be seen as eccentric or unwise decisions.
4. Best interests – anything done for or on behalf of people without capacity must be in their best interests.
5. Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Main provisions of the Act (relating to capacity and consent)

- Assessment of capacity is ‘decision specific’ and based on assessment of whether a person can make that particular decision at that particular time – no one can just be labelled as mentally incapable.
- The Act provides a checklist of factors to determine best interests, and past and present wishes, beliefs and values must be considered (in particular any written statement made when the person had capacity); and carers have a right to be consulted.
- It allows carers to act in connection with care and treatment if they have established the person lacks capacity in relation to that act and it is in their best interests; restraint is only permitted if it is believed to prevent harm and has to be proportionate to the likelihood and seriousness of the harm.
- It introduces a lasting power of attorney (LPA) whereby a person can appoint someone to make decisions on their behalf in relation to health and welfare as well as just finances (as currently) if at a later stage they cannot make those decisions themselves; and the Court can appoint a deputy to make similar decisions if there is no LPA. A deputy is unable to refuse consent to life sustaining treatment. An LPA is able to authorise the giving or refusing of life sustaining treatment if this has been expressly provided for within the instrument creating the LPA.
- It places a duty on NHS and local authority bodies to instruct an Independent Mental Capacity Advocate (IMCA) to represent certain people who lack capacity in certain circumstances; the advocate can challenge the decision maker on behalf of the person lacking capacity if necessary; regulations can expand the role of the IMCA.

- It formalises ‘advance decisions’ and provides safeguards that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands ‘even if life is at risk’.
- It sets out parameters for research including that carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.

There are various other provisions such as the setting up of a new Court of Protection and a new Public Guardian, a new criminal offence of ill treatment or neglect and transitional provisions for current Enduring Power of Attorney.

The Act will be supported by a Code of Practice, to which certain people must have regard (those acting in a professional capacity or who are deputies appointed by the Court of Protection). It will translate how the act should work on a day to day basis.

The Act is generally welcomed by the various organisations which work with and on behalf of people who have problems making their own decisions. Age Concern supported the Making Decisions Alliance in working to improve the provisions in a number of ways, in providing safeguards and for the first time establishing a duty to provide advocacy albeit in limited circumstances. Much of the debate was in relation to life sustaining treatment and concerns that advance directives might lead to euthanasia by the back door. A number of safeguards were introduced aimed at dispelling those fears.

The reform of the Mental Health Act 1983

Unlike the welcome for the Mental Capacity Act, there has been far less welcome for the proposed Mental Health bill among the medical, legal, and social work professions, and the voluntary organisations interested in mental health. This sets out a new legal framework, including the application of compulsory powers for care and treatment in the community. As some people who have mental health problems from time to time lack the capacity to make their own decisions there is some overlap.

The last draft Bill was subject to a Joint Scrutiny Committee of Parliament, which reported in March 2005 and strongly condemned the Government plans. In July 2005 the Government rejected many of the Joint Committee’s key recommendations.

The key components of the Government’s proposals are:

- bringing in wider conditions for the use of compulsory powers which will allow more people to be forcibly treated

- removing the requirement that compulsory treatment can only be provided if there is a health or therapeutic benefit to the patient
- reducing the rights which families have in relation to the exercise of compulsory powers
- creating new powers for compulsory treatment of people living in the community
- creating new safeguards for patients, including an increased use of Tribunals and access to independent advocacy.[8]

The European Convention on Human Rights (ECHR)

Article 5 of the ECHR, the right to liberty and security of person, is the article which is the one most likely to apply to the detention of people with mental illness or with reduced capacity. There have been a number of court cases, the most notable being *HL v United Kingdom*, commonly known as the 'Bournewood case' the name of the hospital in which HL was detained. In essence the case was about a man who lacked capacity and who was placed in hospital following an episode of self harm, under the common law doctrine of necessity. He was compliant to being in hospital but he had not consented, and his admission was considered to be informal. The European Court concluded that he had been deprived of his liberty and thus his admission was not in accordance with the procedures that are set out for those who are compulsorily admitted to hospital, and he did not have the safeguards that such patients have to challenge detention.

As a result of this case the legislation requires change in order to cover this group of people who lack capacity and who are compliant but who are effectively deprived of their liberty. There has been consultation on proposals for a system of 'Protective Care' under the Mental Capacity Act rather than the Mental Health Act. The consultation acknowledged that people who lack capacity and who have been unable to consent and whose care is such that it amounts to deprivation of liberty, could also be found in care homes.

More generally, Article 6(i) of the European Convention gives the right to a fair hearing in the determination of a civil right obligation. Civil rights include all other articles of the European Convention such as Article 8 the right to private and family life, home and confidentiality. This would be a relevant factor in circumstances where a person with limited capacity needed help to be able to make their wishes or feelings about a decision known.

Elder abuse

The Department of Health guidance *No Secrets (In Safe Hands [Wales])* was published in 2000. The purpose of the guidance is to ensure that each local authority has multi-agency policies when responding to abuse. In 2004 the Health Select Committee carried out an inquiry into elder abuse and expressed grave concerns on a number of aspects. The Government committed to undertake research and look into establishing a national

recording system. The committee was particularly concerned about the possibility of over prescribing drugs in care homes in order to manage residents who lack capacity, and the use of physical restraints. The Government has introduced regular medication reviews, and stated that the systematic use of physical restraints in care homes 'is tantamount to abuse' and believes further clarity would be helpful. [9]

The Protection of Vulnerable Adults Scheme (POVA) was introduced in 2004, to act as a workforce ban on professionals who had harmed vulnerable adults in their care. As a result of the Soham murders there was a major inquiry into the further measures needed to protect children and vulnerable adults. The Safeguarding of Vulnerable Groups Bill was laid before Parliament on February 2006.

A new offence of ill treatment and neglect of people who lack capacity has been introduced in the Mental Capacity Act. There were concerns during the passage of the Bill, that there was no ability to check the POVA list in relation to deputies and attorneys. Commitment was made to consider the possibility of checks against the POVA list.[10]

5. Key issues

5.1 Age discrimination

Once over the age of 18, the law assumes that age of itself does not affect people's ability to make decisions. However, people involved in situations where decisions need to be made (for example healthcare professionals, solicitors or carers) may wrongly assume that older people do not have mental capacity on the basis of their age. Also, people who need to act on the decisions (such as doctors) may wrongly assume that older people do not wish to discuss issues particularly relating to the end of life. Although the Act coming into force in 2007 contains specific provisions against such assumptions being made regarding mental capacity, it will require a major change to alter deeply ingrained ageist attitudes.

5.2 Assessing capacity

Day to day decisions are made by a range of different carers and it is possible that, with patience and care the person could sometimes make those decisions for themselves. Professionals making decisions on someone's capacity might well because of time constraints, not spend the time required to help the individual understand the decision that needs to be made, and the duty to provide advocacy is only in limited circumstances.

Assessing people's ability to make decisions without cultural bias is a crucial issue that appears not to have been satisfactorily discussed in the proposals

for legislation. This issue will become increasingly relevant as the percentage of the older population from minority ethnic groups grows.

5.3 Communication and information

The communication of information and ensuring understanding of the implications of different choices are key elements to giving informed consent. Older people with dementia, for example, may have fluctuating capacity and may be able to understand concepts when explained at the appropriate time and in the appropriate situation. It is important therefore to consider how different approaches to communication can support decision making and maximise people's ability to make decisions.

Effective communication acknowledges cultural differences when consent is being sought. Difficulties can arise where there are cultural differences in understanding the concepts explained, which mean that consent may be given but it is not properly informed. Issues of maintaining confidentiality can arise where the older person's family is used to aid communication – for example, through translating.

There may also be specific issues around the communication needs of older people with learning disabilities and people with hearing or sight impairment.

5.4 Advocacy

It is a major advance that provision of advocacy services has been placed as a duty within the Act. Currently the duty is limited to those who have no friends or family to speak up for them, and in relation to decisions about serious medical treatment, or where the NHS or local authority will be making the arrangements for where a person lives. Currently advocacy services are patchy across the country, and there is concern that funding might get channelled into those services where there is a duty, rather than leading to extension of advocacy services for a wide range of older people.

5.5 Advance Directives

The placing of Advance Directives (which allow people to state in advance, their instructions regarding what treatments they would not wish to have) on the face of the Act was one of the most contentious issues in the passage of the legislation. Older people who have made advance directives or advance statements about their wishes to receive or not receive treatment should have these respected and met. In relation to refusal of life prolonging treatment safeguards have been put in place.

This question of decision making and end of life issues is covered in detail in Age Concern's policy position paper on dying and death.[11] The Mental Capacity Act (along with the Code of Practice) has introduced a number of

provisions in relation to Advance Directives. It also allows people to expressly appoint an attorney in relation to life sustaining treatment under the LPA. For some people it may be very reassuring that they can choose someone to make decisions regarding life sustaining treatment whom they would trust implicitly to act in their best interests.

5.6 Deprivation of liberty

At present, many older people without capacity are effectively detained (for example in care homes or hospitals) without consenting. Some, by their behaviour, could not be described as compliant, and as yet have no safeguards. Assessment and care review are key to ensuring that their human rights are not infringed, and it is vital that all those who are effectively deprived of their liberty have adequate safeguards and processes to enable them (or a representative) to challenge that detention.

5.7 Elder abuse

Older people without capacity are particularly vulnerable to abuse. For example, they may be at risk of financial abuse by an attorney or appointee. If they are not asked for their consent to medical treatment for example, or are inadequately informed, so that their consent is invalid, this could be construed as physical abuse. Much work is required to develop an attitude of valuing older people who lack capacity and to end the day to day abuse which is often caused by lack of thought and ageist attitudes.

5.8 Health and social care

Consent and capacity are relevant to all day-to-day aspects of health and social care (particularly assessment, treatment and examination and information sharing) as well as at crisis points (for example, where emergency treatment is required). Although the principles of consent are clear, the practice of seeking consent may not be so clear cut.

Older people may not be aware that their needs are being assessed. This means that they have not been able to give informed consent to the assessment. This can apply to those people who have the capacity to give consent and those who lack capacity to give consent. The issue of giving informed consent to assessment was highlighted in Age Concern's response to the Department of Health's Consultation on the Single Assessment Process: guidance for local implementation. [12]

The issue of administration of medication is an area where older people can be vulnerable. Older people may not have been given adequate information to understand why they are taking particular medications, and this can lead to the inappropriate use of some medication. As many as 50% of older people may not be taking their medication as intended.[13] A recent report by the

Commission for Social Care Inspection found that nearly half of care homes failed to meet national minimum standards on the administration of medication prescribed by doctors.[14]

5.9 Finance, property and estate

Adults can indicate that they wish someone to act on their behalf regarding their finances and estate (this might be because they live abroad, for example). This is called ordinary power of attorney. The new lasting power of attorney in relation to finance will act in a similar way to the current system of enduring powers of attorney. However the major difference is that the LPA will have to be registered with the Office of the Public Guardian before it can first be used.

There has been no change to the system of appointeeship whereby the Secretary of State appoints a person to deal with benefits (and only benefits). It remains outside of the new Act. There are few safeguards in relation to appointeeship, and the fact that an officer of the Department for Work and Pensions visits to assess the capacity of the individual on a one off basis does not accord with the functional test of the Mental Capacity Act. It was agreed that officials will have to work to the Code of Practice when assessing the individual, and the DWP will look at how they can improve on monitoring appointeeship. [15]

6. Age Concern policy and objectives

Age Concern firmly supported the Mental Capacity Act and will continue to work with the Making Decisions Alliance, and the Department of Constitutional Affairs and the Department of Health to ensure that the needs of older people are given full recognition in the implementation stages. We will continue to lobby for changes where we consider them necessary.

The following themes, while not specified each time, are central to all the policy areas below:

- everyone should always assume that older people have the capacity to make their own decisions
- older people need clear and timely information presented in appropriate ways to be able to maximise their ability to make decisions
- those close to older people need clear and timely information to know how they can support older people appropriately
- older people who have difficulty making decisions should have access to independent advocacy.

6.1 Age discrimination

Age Concern believes that it is not acceptable that older people are treated differently than other adults in relation to the assessment and assumption of capacity or in relation to the information, communication or support they receive in helping them make decisions. We will be actively working with the Government and others to ensure that the principles of the Act are taken seriously in practice. Work is already in progress with the Royal College of Nursing to influence the training of nurses and promote positive attitudes in nursing older people. In the run up to implementation we will be producing factsheets for the public and briefings for Age Concern staff. We will be discussing with the DCA and DH how they will ensure that information about the Act is disseminated to groups whose first language is not English or who may have difficulties in accessing information caused by their disabilities.

6.2 Assessing capacity

Age Concern supports the functional approach to capacity because it is useful to practitioners and families of older people who need simple, obvious ways in which to determine the limits to a person's capacity.

The assessment of capacity is a key function in ensuring that older people have choice and are given all the help they need to make their own decisions.

The assessment of capacity should take into account the diversity of older people's beliefs and values and be carried out by practitioners who are adequately trained and supported to be sensitive to cultural differences.

Age Concern will be pressing the Department of Health prior to the implementation of the Act, to include explicit statements within the assessment about whether the person lacks capacity to participate in the assessment, and on what grounds that presumption has been made. It should also be made clear on the assessment form what steps were taken to help the individual to understand the assessment and whether any care plan stemming from the assessment.

6.3 Communication and information

Older people should have access to information and time to support their decision-making processes and to be able to give informed consent. This is particularly important in decisions at the end of life. Age Concern will be responding to the consultation on the Codes of Practice in the run up to 2007 and will endeavour to ensure that they cover issues that are particularly pertinent to older people.

6.4 Advocacy

Independent advocacy should be widely available and accessible to all older people in order to provide support in decision making, particularly in relation to healthcare, welfare and finances. We have used the consultation on the Independent Mental Capacity Advocate to try to widen the circumstances when an advocate must be provided. We have recommended the provision of an advocate when any party requests it, when a decision is being made about serious medical treatment or when a care decision includes the person moving. We have also recommended that advocacy must also be provided if the local authority is acting as the deputy (previously the receiver) for the person. We propose to use opportunities to amend the Act prior to 2007 to address the situation whereby a person has a receiver (deputy) who is part of the local authority which is making decisions about the individual.

We will also monitor the seven pilot projects that have been set up in advance of the Act, to test out how the IMCA scheme will work, both on a national and local level. We will be particularly alert to possible reduction of current advocacy schemes that provide advocacy to a wide range of people who lack capacity. We will, in the run up to implementation be raising how the needs of advocacy for black and ethnic minority groups will be met within the IMCA scheme.

6.5 Advance Directive

Age Concern considers the safeguards put in place in relation to advance directives in the Act to be adequate. Information on advance directives and how to write them should be developed and disseminated widely to increase understanding of the issues and implications of having or not having them. The Department of Constitutional Affairs should be responsible for the provision and dissemination of this information which should be developed with a wide range of stakeholders.

Age Concern will be pressing the DCA to offer careful guidance to those who delegate the power of making end of life decisions under the LPA. It will be vital that both the donor and the donee are clear about the exact nature of the decisions that the donor is delegating, and the need to have absolute trust in the person they have chosen to make such fundamental decisions. We will do this in our response to the consultation on LPAs which is due in April 2006.

6.6 Deprivation of liberty

Age Concern considers that the lack of safeguards for people who lack capacity and who are deprived of their liberty needs to be addressed by legislation as soon as possible. We consider that it is right that this is done through the mental capacity legislation rather than the mental health

legislation, although we are concerned that the possibility of overlap with the Mental Health Act may cause confusion and arbitrariness.

We have made strong recommendations that all older people who lack capacity and who are deprived of their liberty should have the safeguards which should not be limited to those for whom the local authority or NHS make the arrangements.

There should be provisions for an immediate review if the individual shows by their behaviour that they are no longer compliant with remaining in the institutional setting, and in all such cases an independent advocate should be involved.

We believe it is a fundamental principle that anyone who is deprived of liberty should not have to pay for their care.

Age Concern will be monitoring closely how far any new provisions (once they are laid before Parliament) will meet the requirements of the European Convention on Human Rights, and will work with others such as MIND and the Law Society to continue to lobby if we consider that individuals are not adequately safeguarded.[16]

6.7 Elder abuse

Age Concern believes that there should be a wider definition of vulnerable persons, as currently some local authorities limit their safeguarding provisions to those who get community care services, rather than those who need community care services. Older people who are losing capacity are exactly the people who might well be targeted for financial abuse, and yet might not be receiving local authority services because they have the means to provide their own care. Any new definition of 'vulnerable adult' should take account of the social and environmental context within which a person lives and not be dependent on the use of social services. [17]

We are concerned that what is considered to be an acceptable outcome for a Commission of Social Care Inspection investigation into adult abuse is often more limited for older people. For instance it does not include avoiding or taking steps to respond to impairment of development caused by abuse as it would for a younger adult, but merely the avoidance of physical injury. We would want older people who have been victims of abuse to have their emotional needs addressed over the longer term. [18]

There needs to be greater joining up of the Office of the Public Guardian, the Lord Chancellors Visitors and local authority Adult Protection Teams in cases where abuse is suspected. The Public Guardian Office has recently set up an investigation team to deal with abuse, and Age Concern will via the consultative forum of the PGO continue to monitor the work it does. Age

Concern is planning to research the information needs of new attorneys and receivers during 2006, in order to obtain greater knowledge of financial problems arising from the loss of capacity, and to provide more appropriate information to those newly taking over the management of another's finances.

Age Concern is a member of the Elder Abuse Strategic Alliance, a group of voluntary organisations, working closely on all aspects of elder abuse, to raise its profile.

6.8 Health and social care

It will be a major challenge to health and social care bodies to meet all the principles of the Mental Capacity Act. It should be a matter of routine that where there is doubt about whether a person can understand the assessment or proposed care plan, that there should first be an assessment of their capacity.

Guidance produced on consent by the DH will need to be updated in the light of the Act and Age Concern has expressed an interest in being involved.

Following the implementation of the Act, Age Concern will be feeding in to any Government commissioned research as a result of the Act. We are particularly interested in ensuring that research covers the way assessments are carried out.

6.9 Finance, property and estate

Age Concern was disappointed that the system of appointeeship was not incorporated into the Act as we consider all financial aspects should be brought within the legislation dealing with capacity, rather than under separate benefits legislation. We will monitor action in the run up to 2007 to ensure that commitments made in debates in relation to greater protection, and monitoring of appointeeship are acted upon.

We will continue to work with the Office of the Public Guardian, the Visitors and Adult Protection teams and solicitors to ensure that as much protection as possible is given against financial abuse.

We are working with the British Banking Association to try to promote better practice under the current system, and to help develop awareness of bank staff to the problems we envisage under the LPA.

References:

1. United Nations Declaration on Human Rights (1948) Articles 18 and 19.
2. *Oxford paperback dictionary*. Oxford University Press (1995) Oxford.
3. Mental Capacity Act 2005 section 2.

4. Alzheimer's Society Website - <http://www.alzheimers.org.uk/>
5. *Prevention and Service Provision: Mental Health Problems in Later Life. 2005.*
6. *Valuing People.* Department of Health 1999.
7. Statistics supplied by the Public Guardianship office and the department for Work and Pensions.
8. Mental Health Alliance.
9. Government Response to the Health Select Inquiry into Elder Abuse.
10. Hansard. House of Lords. 8 February 2005.
11. *Dying and Death Policy Position Paper.* Age Concern. December 2005.
12. *Age Concern's response to the Department of Health's Consultation on the Single Assessment Process: guidance for local implementation.*
13. *Medicines and Older People.* National Service Framework, Department of Health. 2001.
14. *Handled with Care?* Commission for Social Care Inspection 2006.
15. Hansard. House of Lords. 8 February 2005.
16. *Age Concern's response to the Department of Health Consultation on Bournemouth 2005.*
17. *Age Concern's response to the Department of Health Social Care Green Paper 'Independence, Well-being and Choice'.* July 2005.
18. *Age Concern's response to the CSCI consultation 'Inspecting Better Lives'.* January 2005.

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