

CARDIFF HEALTH, SOCIAL CARE AND WELL-BEING STRATEGY

OLDER PEOPLE NEEDS ASSESSMENT

6.12 INTRODUCTION

The information in this section is drawn from the Annual Report of the Director of Public Health 2001, the Cardiff Community Profile and a Commissioning Strategy for Older People currently in preparation by Cardiff Council in consultation with partners in the health, voluntary and independent sector.

The wider context for delivering services to older people is the Welsh Assembly Government 'Strategy for Older People in Wales'¹. A key aim of the Strategy is:

"To promote and improve the health and well being of older people through integrated planning and service delivery frameworks and more responsive diagnostic and support services" (page 21).

The NHS Plan² and the Strategy for Older People in Wales¹ call for co-ordinated planning and commissioning of services that are inter linked. In addition, the publication of the National Service Framework for Older People in Wales is imminent and is expected to reflect the English version³. These key policy documents should be considered when planning the future delivery of services to older people.

The underlying values of the Strategy to be considered when identifying the needs of older people include:

- Empowerment and promoting quality of life.
- Promoting diversity and social inclusion;
- Supporting and promoting independence;
- Ensuring rights and creating choices;
- Ensuring the delivery of better care and higher standards.

This paper details the population size and structure, the range of determinants of health and the health status of older people. It also identifies services currently available to older people as well as identifying some gaps and current issues. For the purpose of this work older people are defined as aged 65 and over. The needs of older people with mental health problems are not addressed in this chapter.

THE NEEDS OF OLDER PEOPLE IN CARDIFF

Older adults are the main users of health and social care services and are considered as a distinct population group. However, they are not a homogenous group³. For example, many older people are fit, well and active citizens whilst others may experience a combination of medical conditions and social circumstances that are detrimental to their health.

Population Trends.

In 1999 there were an estimated 47,300 people over the age of 65 in Cardiff⁴. This represented about 14.4% of the total population. Although the gender balance of the whole population is fairly even, after the age of 65 women outnumber men by nearly three to two.

Over the last century changes in lifestyle, living conditions and health and social care have led to improvements in health and life expectancy resulting in many older people enjoying relatively good health and being able to live as active citizens.

Within the growth pattern of the population of Cardiff as a whole, it is expected that the older population will also increase, with an anticipated expansion of around 10% (4,654) of those over 65⁵ between 2001 and 2016. However it is anticipated that this growth pattern will only develop from 2016, with the emergence of the 'baby boom' generation entering their 60s. Indeed projections suggest a slight dip in numbers over the next three to four years.

It is also projected that the numbers of people aged 85+ will increase by 16% over the next eight years to 2011. However, thereafter, it is expected that the numbers of people 85+ will decline until 2016. There will be a further peak in the 85+ age group by 2030 as the 'baby boom' generation ages.

In spatial terms, nearly one third of the over 65s population live in the north of Cardiff.⁵ (1999 estimates), which has implications for where services are located and distributed across the city.

In addition Cardiff has a significant and diverse minority ethnic population as compared to the rest of Wales. According to the recent Census⁶ the proportion of black and minority ethnic groups in Cardiff has increased from 6.2% in 1991 to over 8% by 2001. However, it is argued that this is probably an underestimation and the actual figure is likely to be around 10%, giving a minority ethnic population of some 30,000 people. Using the 1991 Census data⁷ it was identified that 1.6% of the population of Cardiff aged 65 years and over is from an ethnic minority.

The demographic changes that are forecast will significantly change the balance of the population, offering both challenges and opportunities. Future strategies and services in Cardiff must reflect the needs of an ageing society. Older people will expect high quality, responsive services. In addition, providers will also be obliged to target services that promote the health and well being of over 50's age group in order to prevent future ill health⁸.

DETERMINANTS OF HEALTH

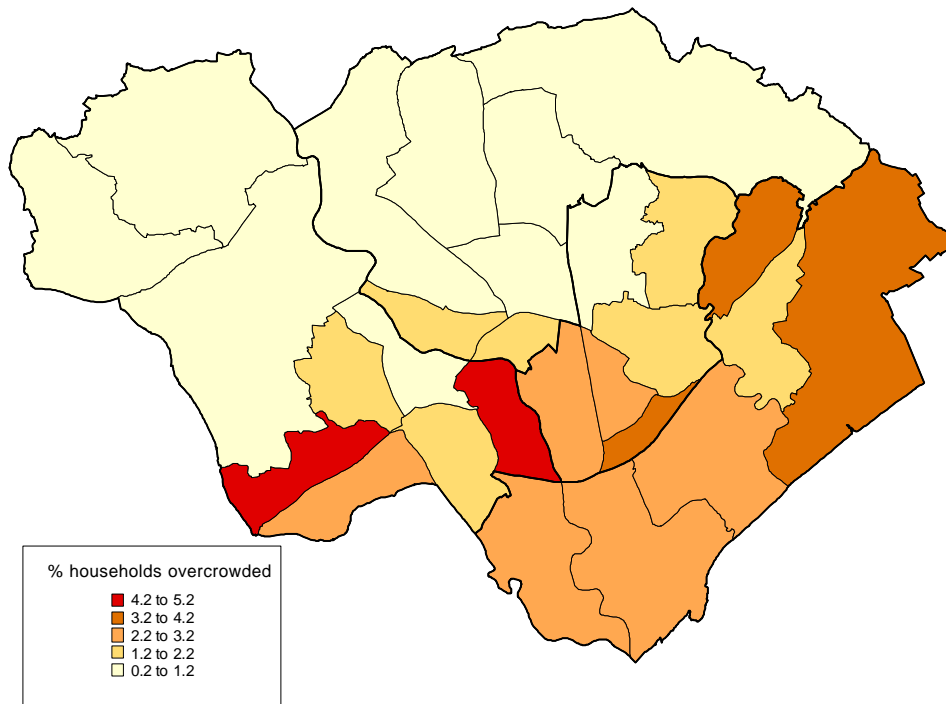
A person's health and life expectancy are largely determined by factors other than health care provision. These factors can be experienced in early years expressed many years later⁹.

Living Conditions

It is recognised that the home environment may have a significant effect on the health of older people, for example, increased respiratory problems are associated with damp housing. Nearly one in ten (9.1%) houses in Cardiff have been classified as unfit (this includes damp)¹⁰.

Overcrowding may also have an adverse effect on health by allowing the spread of infectious disease. Two per cent of households in Cardiff have been classified as being overcrowded (that is with more than 1 person per room)⁷. Data at ward level (Figure 1) shows that the areas of Cardiff with most overcrowding were characterised either by local authority housing areas or nineteenth century terraced housing areas. North Cardiff has lower proportions of overcrowded households.

Figure 1: % households Overcrowded 1991 (pre March 1999 electoral divisions)

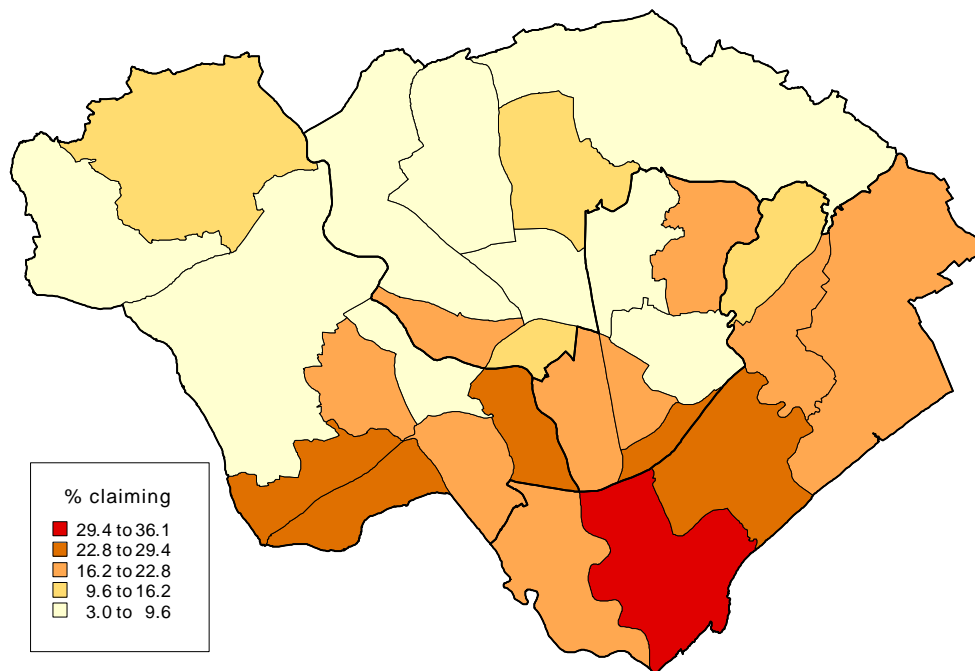


(Source: Census 1991)

Socio-economic, cultural and environmental conditions

A person's economic circumstances, lifestyle and living conditions have an impact on health⁹. Poor health is associated with material deprivation. For the majority of older people who are retired, resources are more limited than when they were economically active. There are wide variations experienced in material deprivation in Cardiff and these variations can explain some of the differences in health that are evident. Data on the percentage of persons aged 60 and over claiming income support gives an indication of poverty of pensioners in the city. The pattern as exhibited in Figure 2 below identifies lower percentages of older people claiming benefit in the north of the City and higher percentages in the south.

Figure 2: % Persons aged 60 and over claiming Income Support August 1999



Source: National Statistics 2001

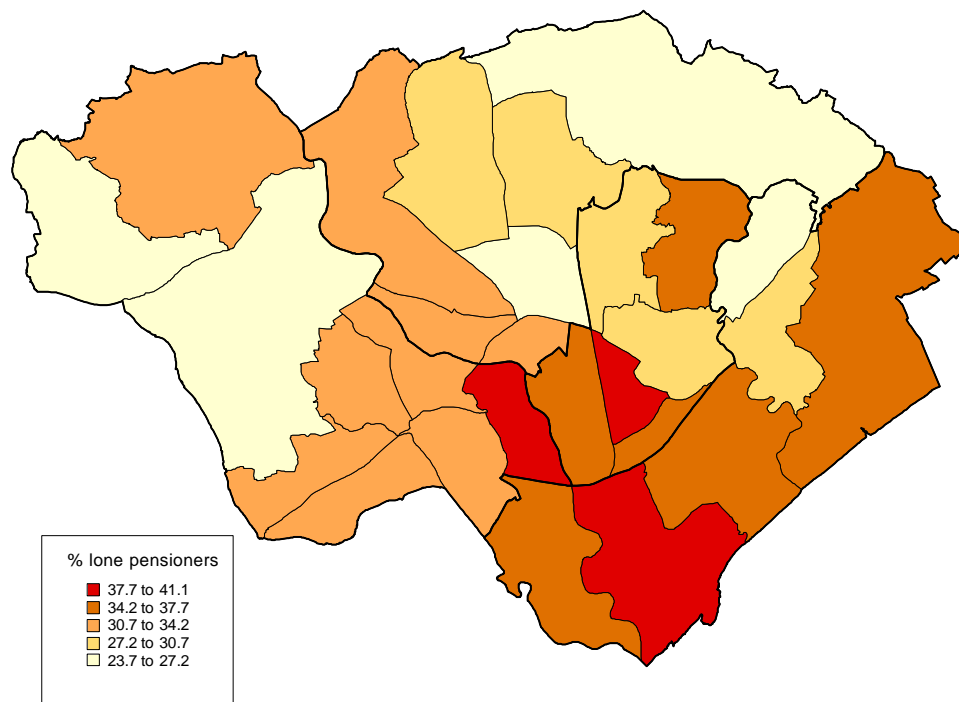
Behaviour is also a product of the cultural environment of which social class is a factor¹¹. Although it is difficult to measure social class after retirement, due to lack of routinely collected data, early inequalities in health have shown to persist throughout life¹².

Transport is an important consideration in maintaining older people's health and well-being by enabling access to a range of services including health and community services¹³ and through preventing loneliness or social isolation. Use of services often declines in proportion to distance from service.

Social and community networks

Of the 127,476 households in Cardiff, 22% are pensioner households with 32% of pensioners living alone. Figure 3 identifies considerable variations at ward level of the percentage of pensioners living alone with Plasnewydd having almost twice the proportion exhibited in Lisvane and St Mellons. In general, south Cardiff has a greater proportion of pensioners living alone. Older people living alone are likely to place greater demand on health and social care services and have a greater need for more informal care networks. Social networks play a role in the well being of older people. Voluntary agencies make a valuable contribution in this arena, for example through lunch clubs and support initiatives, such as Good Neighbour and befriending schemes. The Local Authority had a statutory responsibility for providing day centres.

Figure 3: % pensioners living alone in 1991



Source: Census 1991

Carers play a vital role in helping people to continue living at home. The 2001 Census has recorded 31,172 informal carers in Cardiff of which 24% are providing over 50 hours a week. Older people who need care are much more likely to receive that care from their partner than from anyone else. One half of all carers look after someone aged over 75 and it is estimated that one in four carers is aged 65 or over. Indeed, the Carers' National Association estimated that one in twenty carers may be aged over 80 years¹⁴.

Carers are themselves prone to physical injury such as strained back and stress related illness. It is essential therefore that the health and social care needs of carers are met and that networks of support and information are in place¹⁵.

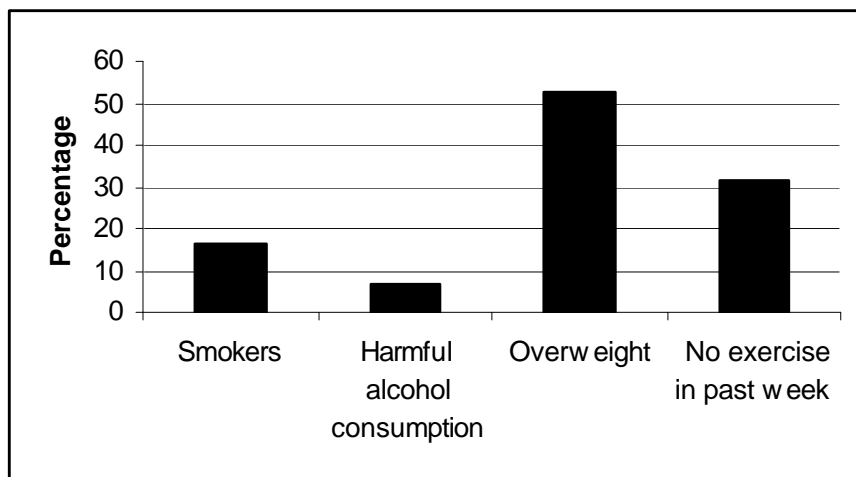
Lifestyle

Indicators for best practice in terms of promoting the health and well being of older people are detailed in the 'Strategy for Older People in Wales' and the 'National Service Framework for Older People'^{1,3}. These policies detail how service providers should ensure that older people have fair access to existing health promoting and disease prevention programmes. These include influenza immunisation, cancer screening, blood pressure management, smoking cessation, oral health promotion, hearing and pharmacy services. Supporting individuals and communities in leading healthier lifestyles should include activities that promote nutrition, physical activity and falls prevention⁹.

Promoting the health, well being and quality of life of older people, many of whom have the experience of living with multiple, chronic illness presents many challenges. Evidence suggests that proportion of older people in Cardiff have unhealthy lifestyles as Figure 4 illustrates. For example, 16.2% of people aged 65+ in Cardiff smoke. Smoking is a risk factor for a number of health problems including cancer, osteoporosis, cardiovascular disease and chronic obstructive pulmonary disease¹⁶.

Figure 4 also illustrates that nearly a third of older people in Cardiff do not carry out any physical activity on a weekly basis and that over a half are categorised as being overweight. Being overweight is a known risk factor for a number of diseases including cardiovascular disease and stroke.

Figure 4: Lifestyle factors in people aged 65+: Cardiff, 1998



Source: Welsh Health Survey 1998

A recent analysis of 55-64 year olds has shown that the proportion of people smoking has declined over time, the levels of exercise and harmful alcohol consumption have remained the same and the level of obesity have increased¹⁷.

The ‘Strategy for Older People’ provides a mandate for individuals and organisations to establish and strengthen partnerships in order to map the needs of older people in this area and to promote person centred health and well being activity. Community development networks to operationalise best practice initiatives are developing (or are in place) across the city.

HEALTH STATUS

Surveys are the best source of reliable information on common chronic disabling conditions in the older population. This section draws on the results of national and one off surveys.

General Health

The Welsh Health Survey asked individuals about their perceptions of their own health and well-being and the impact on their daily lives. Using the responses, two summary measures of physical and mental health were calculated, which for Cardiff were 38 and 51.1 respectively¹⁷ (a higher score equalling better health).

Chronic conditions

Disease prevalence usually rises with increasing age. Older people commonly experience multi-factorial, chronic illness, which impacts on health and quality of life. Figure 5 examines the prevalence of (the proportion of people with) long standing illness in Cardiff. Changes in life expectancy and population age structure suggest that there will be an increase in the number of older people living with chronic disease in the future.

Figure 5: Percentage of older people with selected disorders by age group and sex

Disorder	Age Group	Males	Females
Depression (treated by GP) ¹⁸	65-74	6	14
	75-84	8	17
	85+	8	17
Untreated cataract ¹⁹	65-74	14	24
	75-84	37	44
	85+	60	66
Diabetes ²⁰	65-74	3	2
	75-84	4	3
	85+	5	3
Hypertension (treated by GP) ¹⁹	65-74	21	23
	75-84	19	26
	85+	7	15

Source: as referenced

An increase in blood pressure is associated with both cardiovascular disease and an increase in complications for non-insulin dependant diabetes²¹. Over 1 in 5 people aged 65 years and over reported that they had been treated for high blood pressure. Using prevalence figures from previous surveys and studies, estimated numbers of older people with certain chronic conditions have been calculated. These are presented in Figure 6.

Figure 6: Estimated number of people aged 65+ in Cardiff with selected chronic diseases: based on 1999 population estimates

Chronic Disease	Estimated Number
Depression (for 3 months or more)	3,720
Dementia ²²	3,670
Cancer	6,390
Bronchitis (spells for over 3 years)	4,870
Diabetes ²¹	1,730

Source: Welsh Health Survey 1998, except where otherwise referenced

Disabling conditions

Physical disability occurs when a person cannot perform activities of daily living and is a frequent consequence of a chronic condition. The prevalence of disability increases with age. An individual living with a disability can have care needs that require input from a number of health, social care and voluntary agencies. A national study estimated that 25% of 60-69 year olds, 40% of 70-79 year olds and 70% of 80 year olds have a physical sensory or behavioural disability²³. Estimated numbers relevant to Cardiff are presented in Figure 7.

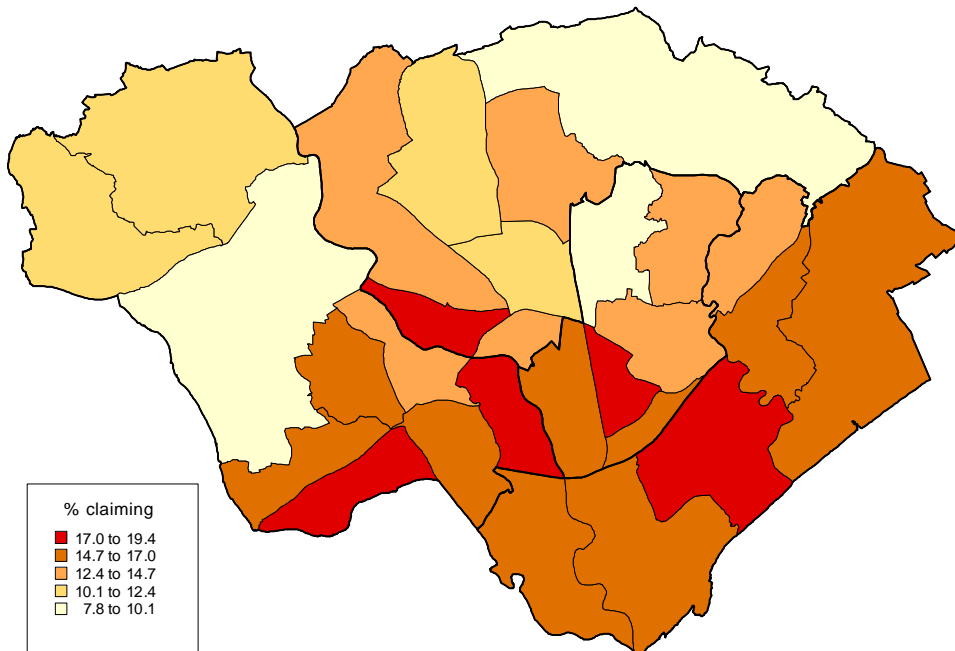
Figure 7: Estimated number of people aged 65+ in Cardiff with selected impairing or disabling conditions: based on 1999 population estimates

Condition	Estimated Number
Back Pain ¹⁸	16,740
Untreated cataract ²⁰	15,460
Bladder problems/Incontinence ²⁴	6,720
Suffering a disability ²³	24,000

Source: as referenced

Attendance allowance may be claimed by people who are disabled, aged 65+ or who need help with personal care because of their illness or disability. Data at electoral division level (Figure 8) identifies wide variations in the proportion of persons claiming this benefit, with the highest levels of percentage claimants being in south Cardiff.

Figure 8: % Persons 65+ Claiming Attendance Allowance August 1999

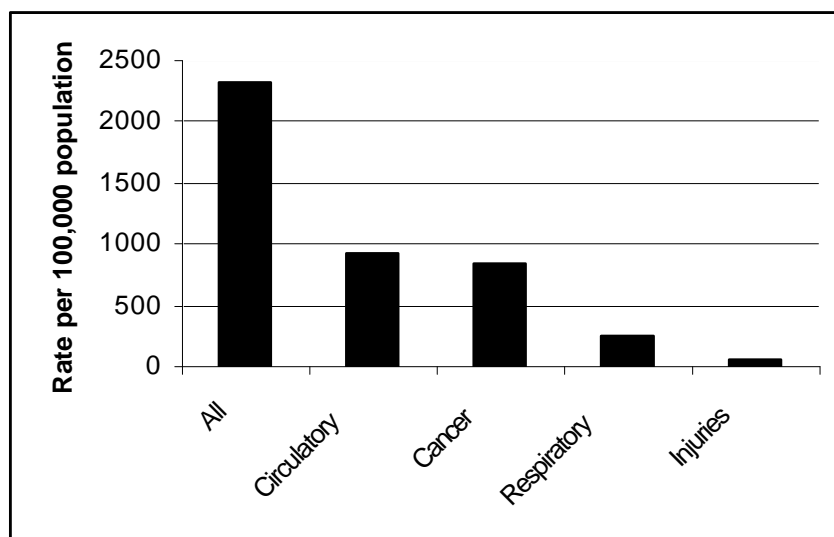


Source: National Statistics 2001

Premature death

Death rates from common conditions are decreasing but concern about premature death remains. Figure 9 illustrates years of life lost from all causes and circulatory disease, cancer, respiratory disease and injury among 65-74 year olds²⁵.

Figure 9: Potential years of life lost in 65-74 year olds as a rate per 100,000 potential years of life: 1999.



Source: based on Office for National Statistics population estimates²⁵

Whilst Figure 9 suggests a low incidence of deaths from injury, the rate of deaths from accidents is higher in older people than in any other age group, the largest cause being falls. In 1999 there were 55 deaths from falls in Cardiff. Most of these were among frail, older people²⁶. Falls resulting in fractures are increasingly placing demands on the resources of orthopaedic services in Wales as Figure 10 illustrates. This has implications for elective orthopaedic and rehabilitation services and waiting lists.

Figure 10 Falls Data, Cardiff and Vale NHS Trust

- Over 3,000 over 65 year olds present to Cardiff A&E each year with injuries which result from falls.
- Half of over 65 year olds presenting to Cardiff A&E with a fracture are admitted.
- Half are sent home but need increased care or social services support as a result of increased dependency.
- Half of admissions to the Trauma unit are over 65 year olds with fractures, 90% of which result from simple falls.
- Each year over 1,000 people are admitted to UHW and Llandough Hospital after a fall.
- 26,000 bed days or the continuous occupation of 70 beds
- Annual cost to NHS in excess of £5m
- 48% of patients on the orthopaedic waiting list require major joint replacement, however, 2/3rds of orthopaedic workload is trauma, not elective surgery.

Source: Project Proposal to Cardiff and Vale NHS Trust, Integrated Falls Service, 2002²⁸

Although the evidence highlights that over 3,000 people over the age of 65 attend A&E every year following a fall, many falls also go unreported if there is no apparent physical injury. Whilst many falls may not result in a physical injury there may be far reaching consequences for the individual including fear, isolation and loss of confidence. Even if individuals have no immediate injury, other physiological complications may occur if they are on the floor for prolonged periods, unable to get up. These include pressure sores, infection and hypothermia. Linked to all these factors the evidence suggests that once an older person has fallen they are at a higher risk of falling again.²⁹

SERVICE PROVISION TO OLDER PEOPLE

Older people are some of the most frequent users of health care. Health services must be proactive in planning for the change in population structure. The number of contact with a doctor or nurse is about 50% higher in 65 year olds and over than for younger adults and the average length of stay in hospital increases with age.¹⁷

Health Care Provision

Currently 56 general medical practices, 67 general dental practices, 48 optometry practices and 75 pharmacies provide primary care service provision to older people. Acute medical, surgical and trauma beds for older people are provided at the University Hospital of Wales.

Rehabilitation

The Cardiff and Vale NHS Trust provides for a range of in-patient rehabilitation need that can be categorised using Audit Commission specifications³⁰ into:

- acute - treatment of acute illness and the medical stabilisation of patients
- medium/intensive - concentrated, focused rehabilitation with specialist medical and nursing support in the hospital setting
- low technological - meeting a range of needs for the medically stable with a focus of 'confidence building' (slower stream rehabilitation, transitional care)

The model of rehabilitation care across Cardiff varies due to a number of factors including current organisation of medical teams and access to services as Figure 11 illustrates.

Figure 11: Current General Rehabilitation Services

Rehabilitation category	Location	Ward areas/numbers	Designated beds
Acute rehabilitation	UHW	Ward C7 - medicine*	(38)
Medium/Intensive rehabilitation	Llandough Hospital	Stroke Unit (Ward E3)	23
	West Wing Hospital	Stroke, Orthopaedic & Medical Rehabilitation Wards	79
	Rookwood Hospital	Medical Rehabilitation Ward 6	20
Low technological rehabilitation	St. David's Hospital	2 wards	50
	West Wing Hospital	1 ward	40
	Barry Hospital	1 ward	24
		Total beds	236 (274)

* beds managed by Integrated Medicine at UHW

Additionally, the service provides outpatient, day hospital and outreach services for neuro-degenerative patients with movement disorders, including Parkinson's Disease, and Memory Team services for people with cognitive disorders.

It should be noted that rehabilitation programmes are also currently provided in acute wards, neurological rehabilitation wards, day hospitals and out patient departments.

Continuing Health Care

The majority of continuing health care is provided by NHS Trusts in hospitals and/or community settings. General Practitioners also have a role in the provision of continuing healthcare.

Cardiff Local Health Board (LHB) purchases continuing inpatient care through long term agreements with main provider Trust. These services are provided at St David's and Barry Hospitals. Continuing inpatient care of older people with dementia and mental illness is also provided at Whitchurch and St David's Hospitals. Continuing inpatient care is also provided for patients in non-designated beds.

Palliative care is provided in a variety of settings that include statutory, independent and the voluntary sector. Primary Health Care Teams and NHS Hospital Trusts provide a range of palliative care services. The voluntary sector, notably the Macmillan Nursing Service, Holme Towers, The George Thomas Trust and 'Tenovus' receive funding from the NHS voluntary hospice allocation. Specialist palliative care teams provide services to people in their own homes or in residential and nursing homes.

Although most beds are not designated as such, respite care is provided at Barry, Rookwood, Whitchurch and St David's hospitals. Cardiff LHB also provides a financial contribution to some voluntary organisations for the provision of respite services including night sitting services in patients' own homes. Specialist support services, specialist equipment and transport are also commissioned through provider Trusts.

In some circumstances existing services may not be available or be inadequate to meet the needs of the individual. In these cases Cardiff Local Health Board considers requests to fund an individual's care in alternative provision usually, but not always, in the independent sector.

There are a number of issues concerning continuing health care, which include:

- The lack of appropriate provision for a number of categories of patients, requiring these individuals be placed with independent providers often at very high cost and attendant difficulties in monitoring the quality of care being delivered.
- Improved clinical treatment and prognosis has increased the demand and cost for appropriate services for patients with more complex and intensive health care needs.
- The current Continuing Health Care Policy will need to be reviewed in light of recent ombudsman cases, criticising the application of the continuing health care process and its variation in eligibility criteria. According to anticipated Welsh Assembly National Guidelines it is likely that following this review the number of patients being assessed as requiring continuing health care will increase significantly.
- There is a need for the joint commissioning of services for patients with complex health and social care needs.

Intermediate Care Services

There are a number of Intermediate Care Services currently provided by the Cardiff and Vale NHS Trust. These include day hospital services, the Elderly Care Assessment Service (ECAS), Acute Response Team (ART), Community Respiratory Resource Unit (CRRU), community based therapy services and the Cardiff Rapid Response and Reablement Team. The Rapid Response team has a capacity of 20 new users per week; the Reablement Scheme can provide services for 15 people at any one time.

Outpatients Services

Outpatient services are provided on the UHW and Cardiff Royal Infirmary sites and include clinics for, General Geriatric Medicine, Bone Treatment, Stroke Prevention, Parkinson's Disease, Continence, Syncope and Wound Healing.

Community nursing

The majority of community nurses are practice based and provide skilled nursing care within the patient's own home and in residential homes. They offer a limited night sitting service for terminally ill patients. Older people also receive support from community elderly mental health and learning disability teams if appropriate.

There is currently one continence adviser employed by the Trust. There are a number of practice nurses with a special interest in this topic and some commercially sponsored nurses are active in the field.

Demand for Local Authority services to older people

Data detailing the current demand for Local Authority services is drawn from existing information systems and quarterly returns from Commissioning Centres. The following outcomes resulted from assessments of older people.

- From 5,919 older people assessed for Community Care needs in 2002/3, 41% were assessed as meeting the criteria for residential or nursing care.
- 2903 older people were assessed by Occupational Therapists for equipment and adaptations.

- 2040 people had a package arranged: 8% in nursing homes, 16% in residential homes and 76% domiciliary care packages. (400 people remained on caseloads for social work service only).

The current levels of service generated by the assessment process are summarised as:

- 435 older people in nursing care
- 98 older people in local authority residential homes
- 706 older people in independent residential homes
- 1306 older people with in-house home care packages
- 767 older people with home care packages from the independent sector
- 2 of these are using Direct Payments
- 861 older people receiving meals at home
- 777 older people in day centres (including non-assessed users)
- 3004 older people with Community Alarms

In total 3310 individual assessed users over 65 years old were supported at home. The ratio of people supported at home to those in residential care is thus roughly 3:1.

Day Care services are available from 9 centres for older people across the city and have a total capacity of 472 places a week. All the centres except Oldwell Court have two levels of usage, users who attend the centre as part of a Community Care package following an assessment and users who are able to “walk in” and use the facility without an assessment. The non-assessed users using the day centres as a social centre are currently about 40% of the users.

Independent Sector Provision

Residential Care (following a needs assessment) for older people with physical disabilities is currently commissioned from 3 Local Authority Homes and 38 independent sector residential homes plus 12 dual registered homes. The capacity of Local Authority homes is 99 beds and the independent sector has 1,101 beds. A total of 1, 077 beds are registered for older people in Cardiff.

Nursing Care (following a needs assessment) is provided by the independent sector. At present 190 beds in 4 Nursing homes and 546 beds in 12 dual registered homes are registered. There are a total of 736 registered beds for older people.

Voluntary Sector Provision

There are a variety of organisations for example, Age Concern, Crossroads, Alzheimer’s Society who provide support and care to older people and their carers within the community setting. The large part that these organisations play in meeting the needs of older people is recognised.

IMPLICATIONS FOR COMMISSIONING SERVICES TO OLDER PEOPLE

In the light of existing policy^{1,2,3} most notably the 'Wanless' Report⁸, the commissioning implications can be summarised as:

- There is a growing number of people aged 50+ in the city. Commissioners must explore the potential to target healthy living and health promoting activities in order to enable older people to be proactive in planning for a healthy older age and delay the onset of dependency.
- Older people must be central to the process of decision making and to community life.
- The specialist needs of the over 85+ age group will put considerable pressure on services in the medium term to 2011, although the numbers will drop thereafter for a considerable period. Services will need to be planned to be flexible to meet this change.

- Services will need to be flexible and appropriate to meet the differing cultural and religious needs of older people from black and ethnic minority communities.
- Considering the spatial distribution of services to those in the more heavily populated north, but balancing this with the greater economic deprivation experienced by pensioners in the South of the City.
- Planning to meet the needs of carers, many of who will be older themselves, without whom the formal caring services could not provide sufficient care.
- There are significant gaps in local authority provision in home care, day centres and residential/nursing homes. Issues of capacity, flexibility and providing a person-centred service should be a key consideration.

CONCLUSION

In summary, future commissioning needs to be orientated toward greater specialisation in the short term for those aged 85 and continuing longer term specialisation for black and minority ethnic elders. At the same time broader more universal and socially inclusive services for the over 50's age group need to be developed by partners in the local authority, health, housing, leisure and education services.

The current service patterns of use of residential and nursing care may not persist into the future and the next generation of older people may demand different and more modern facilities to meet their expectations and aspirations. Whatever solutions are generated in the short term there needs to be flexibility enough to cope with changing demand and expectations.

The introduction of the single (unified) assessment process during 2003/04 should deliver a longstanding goal of integrated health and social care. This will change the pattern of individual commissioning and is likely to generate much better information on the assessment and care management process. A dedicated IT system will process information gleaned from the unified assessments to produce a more accurate and aggregated picture of the needs of individuals and the community. In turn this will greatly assist in commissioning more appropriate and sensitive services.

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