

Ageing New Zealand and Health and Disability Services 2001–2021

Background Information
International Responses
to Ageing Populations

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Introduction

All countries will be faced with an increasing, and proportionately older, population with different health and disability issues over the next 10 to 20 years. Many Western countries have recognised that the post World War II baby boomers will retire from work during this period and that this could have a significant impact on the delivery of health and disability services.

This background paper seeks to outline some of the international discussion and suggestions for responding to the increased demand for services for ageing populations. The paper focuses mainly on the United States, Canada, Australia and the United Kingdom.

The international discussion demonstrates that comprehensive responses and strategies are not yet well developed. This is possibly because of the immediate pressures in recruiting and retaining staff to meet the demands of the current environment, with budget constraints and an internationally competitive health practitioners labour market.

The United Kingdom does in fact have a well developed strategy for increasing and diversifying its health workforce, but this has occurred as a result of a decision to significantly upgrade the National Health Service rather than in response to the impacts of an ageing population. Nonetheless, it may provide a useful case study for New Zealand, and an outline of the strategy is included at the end of this paper.

The Issues

The literature highlights four potential areas that will need to change if health systems are to cope with the increasing demand for health services for ageing populations. More specifically, the changes relate to a need for:

1. more practitioners to complement increasing population sizes
2. more specialist services to deal with specific conditions associated with age, such as, cataracts and hip replacements
3. more expertise in older people's health because of the prevalence of chronic and multiple conditions
4. more support services for older people, who often need assistance with daily living.

The literature about these four areas is summarised below.

1. Need for more practitioners

The increased size in the labour market that will accompany an increase in the overall population size cannot be relied on to provide the additional health practitioners needed.

In discussing the matching of supply and demand for the services of physicians and nurses, the OECD (Simeons and Hurst 2004) reaches the following key conclusions.

- There are very different ratios of physicians and nurses to population across the OECD countries. (New Zealand has relatively low numbers of physicians but relatively high numbers of nurses per head of population.)
- Countries that have left the domestic supply of physicians mainly to the market have higher levels of staffing than countries that have planned and controlled entry into physician training for many years. (New Zealand has had capped entry to its medical schools for many years but not to its nursing courses.)
- Controlling the numbers can contain costs, but there is evidence to suggest that this will also constrain outcomes and responsiveness.
- In the medium to long term, the most effective way a country can adjust the supply of physician and nursing services to meet demand will be to adjust medical and nursing school intakes, particularly if self-sufficiency is the long-term goal.
- Better information and forecasting techniques are needed to reduce cyclical fluctuations.
- International migration of doctors and nurses can increase the flexibility of the relevant labour markets, especially in the short run, by speeding up the process of reaching equilibrium. (Forty percent of registered doctors in New Zealand were trained overseas in 2003.)
- However, international migration of the health workforces can lead to net outflows of staff from poorer countries with low and, sometimes declining, health status to richer countries with high and rising health status.

- The services delivered by physicians and nurses depend on these workers' productivity as well as numbers. Fee-for-service methods raise productivity per physician compared with salaries or capitation, but it is not clear what impact, if any, higher activity levels per physician have on the quality of care they deliver.
- Nurses are motivated more by non-pecuniary factors and conditions of service than by pay, but relative pay levels do play an important part in attracting nurses into the profession and raising their participation rates once they are qualified.
- There is evidence that some hospitals have used the power of their monopoly in the local labour markets to drive down the wages offered to nurses and this has led to lower employment levels.
- Research in the United States suggests that the workplace strategies adopted by 'Magnet' hospitals, which include influential nurse executives, flat organisational structures and investment in nurse skills, have favourable effects not only for retaining nurses but also for patient outcomes and satisfaction. (The Magnet system is being piloted in New Zealand by Hutt Valley District Health Board.)
- A review of the evidence on skill mix changes between physicians and nurses in primary care and hospital settings in the United States and United Kingdom suggests that nurses performing certain extended roles, relating to pre-diagnosed patients, can provide care that is equivalent to that provided by doctors and that patients prefer such care. However, the cost-effectiveness of different arrangements remains unclear.
- Although there is a range of policy instruments for influencing the supply of health services, there is a lack of systematic evidence about the relative effectiveness and cost-effectiveness of the different policy instruments.
- Much remains to be discovered about the best way to plan and regulate entry to the medical and nursing professions, given the tendency for training programmes to experience fluctuation mainly as a result of the lags inherent in completing professional training courses.

The OECD has examined the potential contribution to the efficient use of the health workforce and the possibility of 'skill mix' changes (Buchan and Calman 2004). Skill mix changes may involve a variety of developments including enhancing skills among a particular group of staff, substituting between different groups, delegating up and down a uni-disciplinary ladder and innovating in roles.

Much of the focus had been on the mix between physicians and nurses. Buchan and Calman's 2004 study examines skill mix changes between physicians and nurses both in primary care and in hospital settings.

A number of previous literature reviews of the role of advanced practice nurses in primary care settings have suggested the following points.

- Nurses can provide care equivalent to that provided by doctors in these settings.
- Patients are generally more satisfied with nurse consultations than doctor consultations.
- Nurses order more tests than doctors and have longer consultations with patients.

However, a review of the use of nurse practitioners in hospital emergency departments suggested that nurse practitioners were neither better nor worse than house officers in treating minor injuries.

A randomised controlled trial of an innovative nurse telephone consultation service in out-of-hours primary care suggested that the service would pay for itself in terms of reduced emergency admissions to hospitals. In contrast, an assessment of NHS Direct – a telephone consultation service introduced throughout England in 2000 – suggests that the service was offsetting only about half its costs by more appropriate use of NHS services – although patient satisfaction with the service was high.

The OECD survey relates to 16 countries and offers the following information.

- Eight countries reported some current use of nurses in advanced practice roles.
- Three countries reported that piloting is underway or being considered.
- Eight countries reported that nurses had been given limited capacity to prescribe, and one country is piloting such a role for nurses.
- Six countries reported that nurses in some advanced practice or specific roles had been granted capacity to bill patients for their services.
- Seven countries reported that nurses in advanced practice roles could refer patients to specialists in a ‘gatekeeper’ system, and one country is investigating the possibility.

The case studies of drivers, facilitators and constraints for the use of advanced nurse practitioners in the United States and the United Kingdom showed the following results.

- Some of the leading drivers were common to both countries, including staff shortages and substitution.
- In the United States, the pursuit of value-for-money was seen as a leading driver, and nurses led the spread of advanced nurse practitioners.
- In the United Kingdom, the development of new services was seen as a leading driver, and the spread of advanced nurses practitioners was led by government policy with more positive support from the medical profession than was reported in the United States.
- Major constraints included the opposition of some of the medical profession in the United States and lack of funding and shortages of nurses with appropriate training in the United Kingdom.
- One of the most striking differences between the two countries was the attitude of the medical profession – relatively hostile in the United States and supportive in the United Kingdom. This may be partly because of the predominance of fee-for-service payment of doctors in the States and the predominance of capitation and salary payment systems for doctors in the United Kingdom.
- A key issue is the extent to which advanced practice roles for nurses have been recognised under legislation, provided for in educational and training programmes, given access to direct reimbursement and specified in career ladders.

Fooks et al (2002) provides a comprehensive analysis of issues relating to the physician and nursing workforces in Canada. Appendix A of the report contains a literature review organised

into three sections: forecasting and data issues; education and training issues and professional practice and system issues.

The situation in Canada went from a perception in the early 1990s that there would be a future oversupply of physicians to a concern in the late 1990s that the country was facing a severe undersupply. The report concludes that four key shifts in thinking will be required that will take enormous effort and will need new ways of engagement. Health human resource planning:

- must become integrated into overall health system design issues
- must be done from the perspective of population health needs and not on the basis of numbers of personnel
- should be on the basis of teams of providers and not on the basis of individual professions
- requires national co-operation.

In 2004, the Canadian Policy Research Networks undertook an environmental policy scan of activities relating to physicians, nurses and pharmacists and included three areas of review:

- education and training
- recruitment, retention and workplace initiatives
- capacity for health human resource planning to occur at a national level.

(Fooks and Maslove 2004)

2. Need for more specialist services

Population ageing will increase the demand for health practitioners who have the specialist skills to treat conditions more likely to affect the older population.

Surgery

Dvali et al (2003) identified a significant decline in the number of medical students interested in surgery. There are many reasons for this decline in interest. Medical students favour 'controllable lifestyle' specialties such as radiology, anaesthesiology, dermatology and pathology and are less willing to accept the rigors of a surgical career.

Of particular concern is the increasing number of women entering medical schools who are disinclined to choose surgery as their specialty. Studies cite the lack of female role models, male bias and concerns about balancing career and family as the main reasons for this downward participation trend.

Care of the critically ill and patients with pulmonary disease

Two areas of medicine, care of the critically ill and management of pulmonary disease, are likely to be influenced by the ageing of the United States population (Angus et al 2000). Angus et al forecast that the proportion of care provided by intensivists and pulmonologists in the States will decrease below current standards in less than 10 years.

The shortfall is troubling because the current provision of intensivists care is arguably already low and the ageing population is likely to create similar shortfalls in other areas of medicine.

Cataracts

The number of people with cataracts will increase at a proportionately greater rate than the total population. The supply of cataract services could be augmented by increasing the number of ophthalmologists, increasing the efficiency with which cataract surgical services are delivered, or advances in technology. The demand for cataract surgery could be decreased by implementing effective primary prevention strategies, although successful strategies are currently unknown and/or untested (McCarty 2002).

Laboratories

The demand for qualified laboratory professionals will increase with the increased health-care and laboratory testing needs of an ageing population (Best 2002). Best makes a case for changing the staffing mix in laboratories.

Current enrolment levels in laboratory science programmes will be insufficient to replace current laboratory professionals. One strategy to consider is the proper deployment of medical technologists (MTs) and medical laboratory technicians (MLTs) based on the skill level required for the job. MTs are more suitable for the higher level technical and leadership roles in the laboratory. MLTs are trained and competent to assume 80 percent to 90 percent of the testing functions in most laboratories. Hospital laboratories need to move to a more appropriate technologist-to-technician ratio for many reasons, including decreasing costs, increasing efficiency, providing adequate and appropriate staffing and improving recruitment and retention.

3. Need for more expertise in older people's health

Several articles express concern about the current teaching, or lack of teaching, of gerontology in all the health professions in the United States.

- a) The older patient has unique characteristics (Fleming et al 2003). Care of the aged population requires knowledge of atypical presentation of disease, frailty, multiple co-morbidities, chronic diseases and inappropriate medication use, combined with an awareness of social needs and threats to physical function. To provide medical care for the elderly population in the year 2030, it is estimated that the number of physicians will need to double or triple from current levels, and currently the majority of physicians have had little or no geriatric training.

The geriatrician must:

- design and implement special health programmes
- administer systems of geriatric care delivery
- establish liaisons with other clinical and business services
- serve as an educator for medical students, residents, fellows and staff
- serve on formulary committees for hospitals/health care systems
- develop and manage protocols for falls, restraints, pressure ulcers, delirium and so on
- serve as clinical experts in geriatric clinics, hospital consult services, postacute care, long-term care and home health care.

Geriatric fellowship programmes last one year, and training sites are found in:

- specialised geriatric clinics
- nursing homes, home care agencies
- rehabilitation units, inpatient geriatric units
- inpatient multidisciplinary geriatric consultation teams
- outpatient primary care clinics
- hospice programmes
- senior citizen centres, adult day care centres.

Non-physician clinicians include:

- advanced practice geriatric nurses – nurse practitioners and clinical specialists who work predominantly in nursing homes
- physician assistants – specialists who practise mostly in primary care but who can specialise in orthopaedics, cardiovascular surgery, hospital care and dermatology.

- b) Geriatrics needs to join paediatrics as a required element of training for the next generation of health care professionals (Kovner et al 2002).

“... In 2002 [in the United States] more than thirty-five million people were age sixty-five and older, and 23 percent of them reported poor or fair health. Older adults use 23 percent of ambulatory care services and 48 percent of hospital days, and they represent 83 percent of nursing facility residents. Yet 58 percent of baccalaureate nursing programs have no full-time faculty certified in geriatric nursing. Only three of the nation’s 145 medical schools require a geriatrics course.”

There is some evidence that care of older adults by health care professionals prepared in geriatrics improves outcomes for such patients, resulting in better physical, functional and psychosocial status, without increasing costs. Older patients cared for by nurses trained in geriatrics are less likely to be restrained, have fewer admissions to hospital and are less likely to be transferred inappropriately from nursing facilities to hospitals.

The Alliance for Aging Research estimates that, in contrast to the existing 9000 geriatricians, [in the United States] 20,000 geriatricians are needed to meet current demand, and at least 36,000 will be needed to treat older adults by 2030. This would be 0.55 geriatricians per 1000 population, compared with the current ratio of 0.97 paediatricians per 1000 population (0–14 year olds).

How many is enough?

- Does every older adult need a geriatric nurse practitioner, geriatrician or pharmacist certified in geriatrics? – No
- Does every older adult need a provider who has some education and training in geriatrics? – Yes
- Do these providers need access in person, by phone or via electronic communication to a geriatric nurse practitioner, geriatrician, pharmacist certified in geriatrics or other health care worker with advanced education in geriatrics? – Yes

The John A Hartford Foundation; the Geriatric Research, Education, and Clinical Centres (GRECC) programme of the VA; the Donald W Reynolds Foundation and the Hearst Foundation have provided support to attract additional students to careers in geriatrics and to the introduction of programmes to ensure geriatrics competence among practising nurses and physicians. In nursing, a programme is underway to improve the geriatrics competence of the 20 percent of practising nurses who belong to specialty associations that take care of large numbers of older adults, such as oncology, neurology, rehabilitation and critical care.

Ongoing initiatives include specialised and comprehensive geriatrics education modules, which can be completed either during specialty training or through continuing education, and the development of websites that specifically address the needs of specialty physicians for geriatric content.

Clinical settings need to change – two objectives are to get more provider organisations to employ practitioners with training in geriatrics and to get more of them to provide geriatric-specific care.

More health services research is needed to assess the effectiveness of different models of training, staffing and organisation of care and the relationship to health outcomes and quality of care.

- c) The present health care system will need to change from one that focuses on diagnosis and treatment of disease to a system that attends to the major issues affecting quality of life of older adults and their families (Bennett and Flaherty-Robb 2003). Bennett and Flaherty-Robb identify four critical areas that will influence the quality of life of older citizens.
1. Individuals need resources to help manage chronic medical conditions.
 - Chronic conditions can cause limitations in daily activities, hospitalisation, transition to a nursing home and poor quality of life, but many people who have chronic conditions lead active productive lives.
 - While medical help for treatment of chronic disease conditions is readily available, the care resources needed to manage chronic conditions in day-to-day life are not so readily available.
 - In order to balance behavioural changes, medications and system relief strategies, older adults need knowledge about what to do, the belief that they can achieve success and family (or other assistance) to help.
 2. Too few primary health care providers are educated to provide geriatric-focused care.
 - The decline in nurse numbers in the United States during the next 20 years will occur just as 78 million baby boomers retire and enrol in Medicare.
 - To prevent, or at least mitigate, the expected shortage of gerontological nurses in the United States, increased recruitment of nurses to gerontological specialties must be initiated now.
 - Most registered nurses have little or no training in gerontological nursing.

- The number of nurses who specialise in care of older adults is even more acute in advanced practice nursing.
 - Other disciplines have a similar shortage of geriatrics-educated professionals:
 - Only 14 of the 145 medical schools require a course in geriatrics for medical students.
 - Less than 5 percent of medical schools faculty are geriatric specialists.
 - Only 720 of 200,000 pharmacists have geriatric certification.
 - While it is estimated 5000 geriatric psychiatrists are needed to meet today’s mental health care needs of older adults, there are currently about 2400 geriatric psychiatrists practising in the United States.
 - New policies that could improve the geriatric knowledge of the health care workforce include:
 - mandating a specified number of credits as a condition of license renewal
 - initiating new continuing education programmes in academic institutions to attract professionals without geriatric training
 - working with state licensing boards to implement requirements for geriatric course content in nursing, medical and pharmacy education.
3. Financial issues drive health care choices for many older adults.
- Financial resources may be drained by having to pay for multiple prescriptions for chronic conditions, more visits to physicians and mental health care and by the lost work and productivity of unpaid family caregivers.
 - Help is needed for daily activities such as cleaning, cooking and personal care in order for older adults to remain in their own homes.
4. Cultural values do not give priority to providing services and support for older adults.
- Ageing is still viewed by many Americans with fear and trepidation, and many are not prepared for the natural ageing process of physical decline, loss and grief.
 - Life course planning is common in financial planning but has not been applied to improving self-care competency and learning the skills of relationships, care giving and care receiving.
 - The focus of current care design is on urgent and emergent conditions rather than preventive services or support for management of chronic conditions.

4. Need for more support services

“The paraprofessional long-term care workforce – nursing assistants, home health and home care aides, personal care workers, and personal care attendants – forms the centrepiece of the formal long-term care system ... Low wages and benefits, hard working conditions, heavy workloads, and a job that has been stigmatised by society make worker recruitment and retention difficult.” (Stone and Wiener 2001).

The following are some factors that affect the supply and quality of workers.

- How society values the job – the public views frontline worker jobs as low-wage, unpleasant occupations that involve primarily maid services and care of incontinent, cognitively unaware old people.
- Labour market conditions – several studies have identified the strength of the economy as a major predictor of turnover rates in long-term care. Many trained nurse assistants leave to work in higher-wage jobs.
- Health and long-term care policies – the amount spent by funders plays a substantial role in determining provider wages, benefits and training opportunities.
- Regulatory policy – policy focuses on protecting consumers rather than responding to workers’ concerns. Regulation tends to emphasise entry training and disregards continued career growth or developments.
- A major policy issue is the extent to which nursing assistants are allowed to perform certain tasks currently performed by nurses (for example, administering medication or providing wound care). Giving frontline workers added responsibility and autonomy may motivate them to remain in the job or encourage others to enter such positions.
- Programme design features can affect the size of the labour force by making it easy or hard for relatives and friends to be paid for care.
- Labour policies – governments invest in programmes to prepare primarily low-income and unemployed individuals for new and better jobs, sometimes to the detriment of the long-term care industry by requiring that the programme graduates secure wages that are higher than typical frontline salary workers.

State initiatives to recruit and retain frontline long-term care workers have become a priority in many states and include:

- establishing ‘wage pass-throughs’ in which a state designates some proportion of a public long-term care programme’s reimbursement increase to be used specifically to increase wages and/or benefits for frontline workers
- increasing worker fringe benefits, such as health insurance and payment for transportation time
- developing career ladders by establishing additional job levels in public programmes, training requirements or reimbursement decisions
- increasing and improving training requirements

- developing new worker pools, including former welfare recipients
- establishing public authorities to provide independent workers and consumers with ways to address issues about wages and benefits, job quality and security.

Providers in the United States are experimenting with a range of interventions, such as programmes in nursing homes and home care settings, although few have been evaluated. For example:

- Pioneer Homes tries to link the facility to the outside world and create a community – plants and animals abound, children interact with residents and workers are respected as an essential part of the care team
- the Wellspring model has a three-pronged approach that includes intensive clinical training, periodic analysis of outcomes data to monitor quality and management/job redesign efforts, in which nursing assistants become essential members of care teams and are empowered to make certain decisions
- Co-operative Home Care Associates, a worker-owned company, is staffed largely by former welfare recipients. After three months' employment, a worker can purchase shares in the company. Wages are higher than average for home care aides, and workers receive fringe benefits as well as guaranteed hours. Workers are encouraged to advance their careers and earn higher pay and status as associate trainers or by assuming administrative positions
- many frontline workers have developed their own initiatives to improve their status, compensation and job opportunities. Unions have made major inroads in organising both nursing home and home care workers in selected states across the country.

The Australian Approach

In April 2000, the Minister for Aged Care, the Hon Bronwyn Bishop, published a comprehensive discussion paper, *The National Strategy for an Ageing Australia*, which dealt with the current and future directions for the health and aged care system in that country.

The paper identifies that “healthier lifestyles, better coordinated services, higher retirement incomes, more appropriate housing and transport and other improvements to social infrastructure have the capacity to keep older people healthier, independent and in their homes for longer. This is in the best interests of both older people and the community”.

A range of strategies have been introduced to encourage healthier lifestyles and improve population health, including Active Australia and the Food and Nutrition Policy and a framework for the prevention of chronic disease.

In 2004, the Commonwealth Department of Health and Ageing commissioned a comprehensive review of the aged care workforce. The review (Richardson and Martin 2004) concludes that there are few signs that the labour market is in crisis, or even under serious stress, but that there are some indications of stress in the aged care labour market.

- The nurses, especially registered nurses, are substantially older than the typical female worker.
- Nurses are less content in their jobs in aged care than personal carers and allied health workers.
- A relatively high level of vacancies for registered nurses suggests some recruitment difficulties.
- There is a relatively high turnover of direct care staff, especially personal carers.
- However, the short training period for personal care workers means that the supply of workers for these jobs is quite responsive to changes in pay and conditions.
- Recruitment and retention of staff in aged care facilities would rise substantially if the overall Australian labour market became tighter.

The United Kingdom Approach

The NHS Plan: a plan for investment, a plan for reform, published in 2000, provided a blueprint for a radical new approach to developing the health workforce in the United Kingdom. It led to the establishment of the Changing Workforce Programme within the NHS Modernisation Agency.

The impetus behind the reforms was the need to upgrade health services in the United Kingdom and, in respect of the workforce, the impact of the European Working Time Directive (that limits the number of hours that junior doctors may work) rather than a serious regard for the implications of an ageing population on health services. However, the approach is similar to that required to develop policies to meet the needs of an ageing population – an assessment of the needs of patients, the health services that will be needed and the workforce needed to deliver the services.

The Changing Workforce Programme set up a flexible career framework to help redesign the roles of the health workforce and supported a series of pilot projects in different provider locations throughout the United Kingdom.

Much of the new approach is based on a research project that produced three reports in a series entitled *The Future Health Workforce*. The third in the series specifically covers new roles in services for older people and takes a service-needs, patient-focused approach (Cochrane et al 2002).

The report identifies an urgent need for changes to address the problems of a fragmented service and workforce – the lack of continuity of care, the delays and confusion for patients and the waste of resources. It proposes the development of new professional roles designed specifically for older people's services: a practitioner for older people (Appendix 1) and an assistant practitioner (Appendix 2). It describes how the roles should work in practice across existing professional boundaries and across health and social care.

A more comprehensive description of the roles and current status of the assistant practitioner for older people is included in the *Changing Workforce Programme Pilot Sites Progress Report* available on the NHS Modernisation Agency website (www.modern.uk/cwp).

The role of assistant practitioner encompasses:

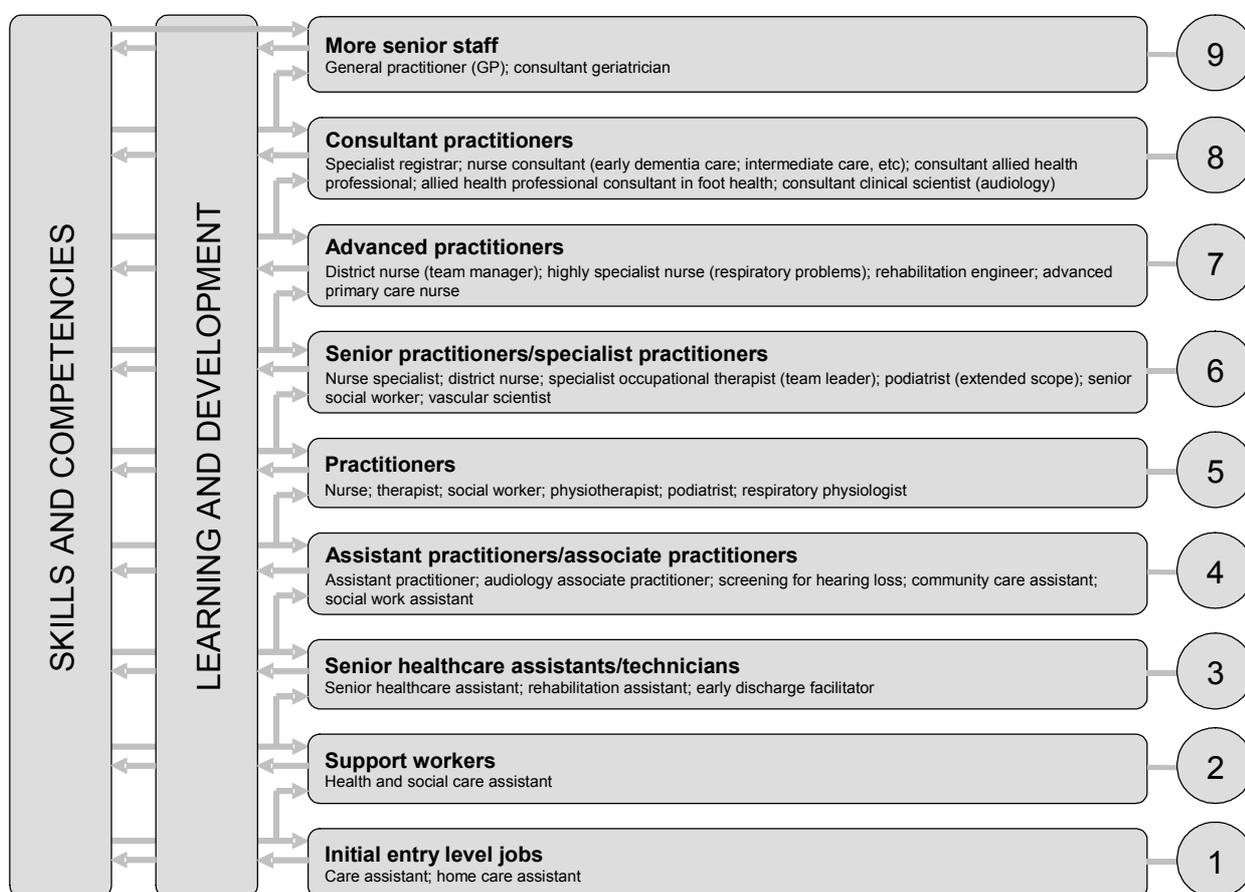
- home helpers
- supervision of administration of medication by home helpers
- clinical care co-ordinators
- nurse consultants in early dementia care
- stroke support workers
- patient/carer support nurses
- nurse specialists for older people in primary care
- occupational therapy information workers
- community pharmacists linking in with home help managers and district nurses for medication.

The latest version of the NHS Modernisation Agency's *Career Framework for the NHS* (June 2004) includes illustrative examples of career frameworks for practitioners working in the areas of Older People, Stroke Units, Cardiology and Mental Health. The framework for older people from that report is set out in Figure 1.

Two other initiatives are being implemented at the University of Southampton, Common Learning, in conjunction with the University of Portsmouth, and a Foundation Degree in Health Care.

The Common Learning programme (www.commonlearning.net) recognises that in order to deliver services specifically around the needs of patients/clients, it is vital to improve communication and working relationships between young professionals.

Figure 1: A career framework for practitioners (older people)



From *Career Framework for the NHS* (NHS Modernisation Agency 2004)

Foundation Degrees developed from an initiative of the Department of Education and Skills in the United Kingdom to improve the skill levels of young people and adults. They are intermediate level, vocational higher-education qualifications that will integrate academic and work-based learning through close collaboration between employers and universities/colleges (www.foundationdegree.org.uk).

Appendix 1: Role Outline: The Practitioner for Older People in the United Kingdom

This role integrates primary, community and intermediate care across health and social services. It has been designed to improve the quality of patient care – to increase continuity of care, reduce confusion for patients and eliminate the overlaps and fragmentation of the current service. It also aims to improve workforce supply by improving the status of staff who work with older people.

The main elements of the role are:

- developing comprehensive health and social histories:
 - evaluating developmental maturation
 - physiological and functional status
 - psychosocial status
 - risk factors for illness
 - activities of daily living (instrumental and functional)
- conducting physical examinations, including:
 - observation of the patient’s condition
 - palpation
 - auscultation
 - percussion
- ordering and performing diagnostic tests and interpreting test results
- diagnosing and making decisions:
 - drawing together and analysing all relevant data
 - discriminating between normal findings/normal changes of ageing and pathological findings
 - developing a differential diagnosis and prescribing in line with care pathways
 - admitting and discharging in line with care pathways
- developing a care plan to promote, maintain and restore health and also to meet social needs; arranging a contract of care with the patient/carer
- implementing a care plan, including, for example:
 - re-ablement and rehabilitation including, for example, mobilisation, positioning, orientation and cognitive and memory problems
 - nutritional review and advice and feeding – including swallowing difficulties
 - skin integrity
- co-ordinating all services that are required across the health and social care settings
- evaluating the client’s response to the care plan and modifying as required
- promoting health and education to the patient, carer, colleagues and assistants
- confirming death and care of relatives
- researching and auditing: applying research findings to practices and the development of care pathways.

Adapted from *Cochrane et al. 2002. The Future Health Workforce: The Third Report*. London: Chamberlain
Dunn Associates

Appendix 2: Role Outline: The Assistant Practitioner for Older People in the United Kingdom

This role integrates primary, community and intermediate care across health and social services. The assistant practitioner will work in support of the practitioner and will play a key role in implementing the care plan. The aim is to reduce the overlaps and lack of continuity associated with current roles.

The main elements of the role are:

- monitoring the patient's condition and outcomes and reporting to the practitioner
- conducting diagnostic tests:
 - venepuncture
 - ECG
- conducting clinical observations and providing treatment in the following areas:
 - observations: temperature, pulse, blood pressure, weight, blood glucose
 - tissue damage: monitor and treat
 - wound management
 - urinalysis
 - catheter care: including insertion
 - bowel movements: monitor and treat
 - nutrition: monitor food intake and advise
 - set up naso-gastric feeds and gastroonomy tubes
 - collect specimens
 - anti-embolic stockings
- assisting with rehabilitation:
 - assistance and support in daily activities: dressing, washing, oral care, toileting, feeding, kitchen and so on
 - mobilisation
 - positioning
 - exercises: passive and muscle relaxing
 - swallowing difficulties
 - orientation, memory and cognitive problems
- co-ordinating the patient's personal hygiene
- promoting health and education to the patient and carer on the aims of the care plan, exercises, walking aids and so on
- health education and promotion
- co-ordinating formal documentation: assisting with benefit claims and so on.

Adapted from *Cochrane et al. 2002. The Future Health Workforce: The Third Report*. London: Chamberlain Dunn Associates

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