Exploring the future of gerontological nursing outcomes

Julienne Meyer MSc, PhD, RN, RNT
Professor of Nursing, Care for Older People, St Bartholomew School of Nursing and Midwifery, City University, London, UK

Deborah Sturdy MSc, RN
Nurse Advisor for Older People, Department of Health, London, UK

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Correspondence:
Julienne Meyer
Professor of Nursing
Care for Older People
St Bartholomew School of
Nursing and Midwifery
City University
Philpot Street
London E1 2EA
UK
Telephone: +44 (0)20 7040 5791
E-mail: j.meyer@city.ac.uk

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This paper explores some of the global challenges in gerontological nursing and suggests that nurses need to be able to identify better more appropriate person-centred outcomes, to justify their own worth in caring for older people. It highlights some of the methodological difficulties of measuring outcomes for older people and, more generally, of determining the value and contribution of nursing. It argues that, to address some of these methodological challenges, more participative approaches to research are needed, highlighting the particular value of action research. It suggests that if research is to be meaningful to both older people and those caring for them, there is an urgent need for gerontological nursing research to become much more person-centred and practice/action oriented.

Key words: action research, care for older people, gerontological nursing research, nursing outcomes, person centred, value and contribution of nursing

Introduction

This paper begins by exploring some of the key challenges to caring for older people, across the globe. It suggests that if nurses are to demonstrate their value and contribution in meeting some of theses challenges, they need to be able to express and demonstrate their worth through outcomes, as well as processes. The paper reflects on some of the methodological challenges of firstly, measuring outcomes for older people and secondly, demonstrating the value and contribution of nursing. Finally, it suggests that more participative methods are needed to develop appropriate gerontological outcomes and advocates the use of action research, in particular.

Global challenges in gerontological nursing

There are a number of global challenges in gerontological nursing: a growing older population, the need for different ways of working, global migration, changing core skills and competencies, international partnerships and enabling choice. For all these challenges it is argued that the key to success is through person-centred assessment of the older person.

A growing older population

The global growth in the older population sets demands on governments and societies in developing health and social care systems to meet their needs. The world population of older people (60 years and over) will nearly triple, increasing from 606 million (2000) to nearly 1.9 billion by 2050. The greatest increase in ageing populations is within Europe and the least increase being Africa (United Nations Population Division, 2003).

Need for different ways of working

The fiscal realities and service demands are such that different ways of working are key to providing responsive and appropriate care for older people. Supporting development

of a proactive strategy to maintain and maximize functional capability of those both in receipt of care and in anticipating potential decline in functionality of an older population are paramount policies for all governments. As will ensuring that interventions will minimize and delay that decline.

Global migration

Nursing is facing its own harsh realities in the global market as countries compete for a workforce to meet the increasing demands on their health care systems. Migration of nurses across the globe is unprecedented and the decline in supply of nurses across the world is a worrying trend. In particular, European workforce potential is opening up with the new member states joining the European Union and nurses attracted by the career opportunities and financial rewards offered by the wealthier 'Western' European countries. Similarly we are seeing an imbalance in African countries as nurses seek worldwide opportunities to develop skills and experience. The crucial question has to be not only in terms of human resource recruitment and retention to meet the potential increased demands on health care systems, but in what skills and competencies are required of these nurses to meet the needs of an increasingly older population.

Changing core skills and competencies

In the UK we know that two-thirds of hospital beds are occupied by people over the age of 65 years (DoH, 2001). Looking at the demographic profile of older people across the world and the associated clinical needs of ageing it is inevitable that the majority of nursing which is and will continue to take place regardless of clinical specialism will be the essential care of older people, be that in cancer services, orthopaedics, surgery and so on. We have therefore to address the need for skills and competencies that nurses need to develop so that they can provide care specific to the needs of the older person regardless of the setting. These core skills and competencies will have the potential to affect both the patient experience of care and their outcomes dependent on the skilled intervention of nurses who manage and support the care they receive.

If older people are the main users of health services we have to embed the principles and potential for all health professionals working in adult care to be the advocates and champions for them. Without wholesale acceptance that health services provide for majority stakeholders who are older people we will not see the magnitude of change which supports transition to an acceptance, equality and access to the whole range of care services which may be required. In the UK for example a National Framework for Core Skills and Competencies (Skills for Health, 2004) has been published and this sets out the expectations of all professionals who work with older people. This framework can be used to underpin the development of education programmes locally and can be used by commissioners to ensure that they purchase the right level of skills for professionals requiring postregistration qualifications and professional and clinical development. A clear message about the expectation of what is required to meet the care needs of older people is essential. This is perhaps one of the most effective ways we can develop the best skilled workforce to meet needs.

International partnerships

There is a move within Europe to develop a core postbasic curriculum for nurses working with older people. The work is being developed with a keen group of educators who have formed a European network through the establishment of the European Nursing Academy for the Older Person. This aims to improve the outcomes for older people care and their families, strengthen gerentological nursing education, research and health policy within an interdisciplinary context (Milsen *et al.*, 2003). Development of the work is in its infancy. However this may prove a useful start to developing a core curriculum for the speciality, a shared research agenda and network of nursing experts which can have a currency and applicability across countries.

Enabling choice

Core to any developments is what older people want to themselves in terms of care provision and a choice about where that care should be provided. The shift from secondary care, to care that is provided within or close to the home has been a significant change in health care delivery systems over the past 10 years. Maximizing independence and the ongoing provision of such care will require a shift of perspective and resource and will also require a different skill set to deliver this change. Not only will there need to be a shift of human resource but we will have to consider how we develop and train future nurses if this trend is set to continue. The preparation of nurses to work in different ways including a shift in perspective from ill health to well-being and from working in high-tech supportive environments such as hospitals to patients' own homes where they will need to make effective autonomous clinical decisions will be required. Chronic disease which consumes large quantities of human and fiscal resource will have to be better managed in the future if we are to see less emphasis on secondary care, better patient outcomes and a culture where enabling people

to make informed choices and decisions about their care is the norm.

Key to success: person-centred assessment

The cornerstone of good care for older people is the assessment process. Robust assessment processes, which are shared across professionals, reflect person-centred care principles and are embedded and underpinned by IT solutions have the potential to transform the care experience of the older person. Investment in such systems will be essential if we are to ensure smooth transition, flows of patient care and a safe administration of care wherever that is required and by the most appropriate professional. Without this we will not achieve the transformation in providing a flexible and responsive person-centred service.

It is no longer a challenge for a single government but a challenge to society across the globe to value the contribution older people make and value the expertise and skill of those who work with them. This will then enable health services to change their focus to an older people sensitive service. There needs to be a drive, to challenge the status quo, develop ways of working and prepare a workforce to be equipped to provide appropriate care. We need a shift in focus from the acute to a continuum of health care where older people will be the drivers through pathways, which will be created to meet their unique and different needs. Older people span the breadth of adult health care services. We need to support investment in developing a response, which is cognizant of that. But first as gerontological nurses we have to be able to demonstrate worth through the development of nursing outcomes that are person-centred and derived in a participative way with older people. To do this, gerontological nurses need to be cognizant of the methodological challenges encountered in measuring outcomes for older people and also, measuring the value and contribution of nurses.

Measuring outcomes for older people

There are a number of factors that need to be taken into consideration when considering measuring outcomes for older people.

Multiple morbidity

A sharp reduction in infant mortality during this century, coupled with lower birth rates has produced a growing proportion of senior citizens in the populations of Western nations. Whilst most older people are fit, well and active; the majority of chronic and life-threatening diseases prevalent in Western society are the diseases of old age, for example, cardiovascular disease, arthritis, rheumatism and mental illnesses. As a consequence, a small proportion of people over retirement age will be severely disabled with multiple pathology and in need of long-term care. The multiple morbidity which can accompany old age requires a broader perspective in relation to the measurement of gerontological outcomes (Bowling, 2001). Whilst disease-specific measures will be appropriate for many older people, for those with complex needs, a greater challenge is presented.

Defining appropriate measures

Increased demand on resources across health and social care services has emphasized the need for cost effectiveness, efficiency and the provision of good quality services. This in turn has led to a proliferation of tools aimed at measuring outcomes that will provide policy makers and managers with evidence for the rationality of their decision-making. However, as with all research, the use of such structured instruments has its own limitations and, in particular, older people can present additional challenges to their appropriate use. Firstly, there is the challenge of defining appropriate measures. In the past, care for older people measures have focussed on morbidity (often measured by functional ability) and mortality (Cotter *et al.*, 1998). Whilst mortality rates can be routinely collected and are easily available, they are not always able to detect differences between institutional settings.

An alternative might be to use health as an outcome measure, but this can be conceptualized in a number of ways. For instance, the most common method of assessing health outcomes of care is in terms of people's ability to perform tasks of daily living. However not all older people with chronic illness can expect to return to a fully functional life in the community and it may be more appropriate to identify individual health outcomes based on realistic and achievable goals. Again, the setting can determine the appropriateness of a particular measure and whilst discharge from care might be a useful measure for acute care settings, it may not be appropriate for long-term continuing nursing care contexts. In preference to the medical model of determining outcomes in relation to survival and disease rates, others rely more on quality of life measures. However, quality of life is also difficult to define and is best determined on an individual basis. As a concept, it is also elusive in terms of validity, reliability and sensitivity of the instruments used to measure it. Further, quality of life measures often fail to discriminate between different forms of care, insofar as they tend to include measures of satisfaction and older people are known not to be very critical of their care (Centre for Policy on

Ageing, 1997). Measuring gerontological outcomes is thus fraught with methodological problems and both papers in this issue of the *International Journal of Older People Nursing (IJOPN)* by Hallberg and Kristensson (pp. 112–120) and Conway and FitzGerald (pp. 121–127) have already raised many of these challenges and difficulties.

In response to these challenges, alternative methodological approaches have been sought, as illustrated by Conway and FitzGerald. Whilst Donabedian's (1980) work on quality in health care, focussing on structure, process and outcome, still remains relevant today, Davies and Knapp's (1981) theoretical model has also greatly influenced evaluative research in this field. In their model they describe the resources and any other factors contributing to quality of care as 'inputs' and then go on to identify 'intermediate outputs' (factors contributing to quality of care) and 'final outputs' (higher order outputs relating to quality of life). Bond *et al.* (1989) used this approach in their randomized control trial of NHS nursing homes and continuing-care wards, where they identified survival and personal well-being as appropriate 'final outputs' and consumer's views of the quality of care and changes in location, self-rated health, functional ability, mental state and behavioural ability, as appropriate 'intermediate outputs'. In addition, they conducted a parallel multiple-case study and found that the amount and quality of activity taking place was the most likely intermediate output to discriminate between care settings (Bond & Bond, 1990). They argue that traditional, single-perspective approaches using a standard single method are too limiting, leave many questions unanswered and provide no justifiable prescription for action – something that is highlighted in Hallberg and Kristensson's paper in this edition. Similarly, Bowling *et al.* (1993) call for the use of qualitative methods, for example observational techniques, to provide insights into behaviour, moods, interactions and atmospheres as differential indicators of quality of life between settings. By using multiple methods and multiple perspectives, greater understanding of the structure, process and outcomes of care can be achieved. However, these methods often retain control with the researcher and it is argued here that the voice of older people needs to be heard more, through their engagement in the design of research in terms of identifying what is meaningful to them as measures of quality.

In considering outcomes, it is important to remember the particular needs of older people who may be frail and have communication disabilities. Researchers need to be aware of the impact of the research process on their participants and consider how their research can be moderated to take account of poor eyesight, hearing and so on. Lengthy tools can be exhausting and lead to error in responding. There are also ethical issues about some older people being excluded from research, in particular, those suffering from dementia. We need not only look at new methodological approaches to outcome measures, but also new ways of working with older people to include them in our studies. Dewing (2002) has done some interesting work in this area. She argues that a traditional competency-based approach to informed consent excludes older people with dementia from research. This system relies on carers providing proxy consent, often leading to conflict (see Dresser, 1994, Martin *et al.*, 1994). Proxy consent not only places inappropriate attention and responsibility on the researcher and the carer, but also, potentially undermines the personhood of those with dementia. Dewing's (2002) approach to consent is based on the principles of personhood, equality, social justice and an ethic of caring. The processes include face-to-face encounters with the person with dementia to seek and maintain permission or consent. It also involves having a level of biographical detail about the person with dementia in order to know the 'then' and 'now' aspects of their lifespan and having some knowledge of their usual portrayal of well-being or ill being. This requires time and particular skills in relating with older people who have dementia and for this reason, dementia care specialists probably need to be involved in the process of gathering data. Again, we need to make more effort to include other older representatives in research who might normally be excluded for pragmatic reasons, including those from different ethnic backgrounds. If the findings of research are to be relevant to the multi-cultural society in which we live, we need to actively include, not exclude, all representative groups of older people in research.

Having looked at some of the issues concerned with the measurement of outcomes for older people, the next section will explore the debates around measuring the value and contribution of nursing. This is important in order to shed light on the future of nursing gerontological outcomes.

Exploring the value and contribution of nursing

Internationally the nursing literature has discussed the imperative for nursing to prove its value in the face of governmental programmes aimed at containing the cost of health care through maximizing the effectiveness of clinical practice (Griffiths, 1995). It could be argued that the best way of evaluating quality in nursing is to demonstrate improvement in those patient outcomes that are influenced by nursing. However, there are some serious problems with this type of research, not least of which is the difficulty in isolating those outcomes that are unique to nursing. Once again, the need for multiple methods and multiple perspectives in

research and, in particular, more participative approaches needs to be highlighted.

Issues related to nursing sensitive outcomes

It is widely recognized that the field of nursing outcomes research is fraught with difficulties (Spilsbury & Meyer, 2001). However, attempts have been made to measure patient outcomes attributable to nursing care and in the US work has been conducted on establishing a nursing outcomes classification system (Maas *et al.*, 1996). Nurse-led initiatives have been identified in a variety of settings and studies suggest better care and outcome for patients (e.g. Griffiths & Wilson-Barnett, 1998; Read & Shewan, 1998). However, there is a little coherence in definition and measurement between studies measuring patient outcomes and a lack of consistency in how work is classified (Meyer & Spilsbury, 1998). This assertion by Meyer and Spilsbury is further reinforced by Hallberg and Kristensson's paper in this issue of *IJOPN*. Findings are therefore difficult to generalize. Studies tend to focus on measuring nursing outcomes in relation to behavioural components of nursing practice and it is argued that this ignores the more complex and 'invisible' aspects of nursing care (RCN, 1996), such as co-ordination of care, managing the bureaucracy, providing leadership and clinical judgement. Further, it is recognized that the organizational context in which health is delivered has implications for patient outcomes (Aiken *et al.*, 1997) and therefore one can understand the reasons why Conway and FitzGerald make such a strong case for process evaluation set within a utility-led framework. Outcome research also seems to be preoccupied with what health care professionals view as favourable outcomes, rather than incorporating what patients value.

Issues related to skill mix

Skill mix continues to be an important area of debate in nursing because of the current crisis in the nursing workforce and increasing demands for nursing care created by demographic changes (Seccombe & Smith, 1997). Indeed, it has led to the global migration of nurses. There is some evidence to suggest that the quality of patient care has been directly associated with the number of higher grade nurses (Carr-Hill *et al.*, 1992) and it has been suggested that a smaller fully trained workforce improves care and is cheaper than diluting skill mix (O'Byrne, 1992). However, there is also conflicting evidence suggesting that training health care support workers to National Vocational Qualification (NVQ) III may also provide high-quality care (Warr *et al.*, 1998). McKenna (1995) conducted a review of the research literature to explore the relationship between skill mix substitution and quality of care, highlighting the inherent limitations of many studies. Grade does not always take into account quantity and level of previous experience, therefore it may not be appropriate to compare a newly qualified nurse with a health care assistant of many years experience. As Registered Nurses' roles evolve in response to change (Richardson & Maynard, 1995), the roles of health care assistants are also changing (Boyes, 1995). Whilst there remains a gap in research about the effect of such changes on patient care and outcomes, it is recognized that nurses have an important role to play in the supervision and support of health care assistants (Ahmed & Kitson, 1993), but this is not always achieved in practice (Rhodes, 1994).

Issues related to changing roles

Throughout health and social care services, the traditional boundaries between professional groups are being broken down and more flexible roles are being encouraged. A number of studies have attempted to map out these new roles and functions (Waller, 1996; Read *et al.*, 2001) and research has attempted to evaluate the contribution these new roles make to patient care. However, most research has focused on the contribution Registered Nurses make to patient care and there appears to be a gap in work examining the interface between Registered Nurses and support workers and the subsequent effect on patient outcomes (Spilsbury & Meyer, 2001). Further there is a lack of clarity as to what constitutes 'fundamental' or 'basic' nursing care and 'non-nursing' duties and the implications for patient care when these duties are performed by different level workers are not known. A major problem in building a robust evidence base on changing roles is the fact that it is difficult to generalize findings of studies, which have looked at role titles. Titles in one setting can mean different things to those in another, a fundamental problem raised by Hallberg and Kristensson in measuring the outcomes from case management interventions.

The case for more participative methods

From the above discussion, it can be seen that measuring outcomes for older people is complex and to overcome some of the methodological problems, older people, including those who may be frail and have communication difficulties, need to be much more involved in the design of research in terms of identifying what is meaningful to them as a measure of the quality of care. Linking this to the future challenges of gerontological nursing practice, the key to success may again lie in person-centred assessment process. If, as suggested by Hallberg and Kristensson in this issue of *IJOPN*, a more

salutogenic, rehabilitative and family oriented approach to case/care management is taken, which involves older people and their informal carers having a greater part to play in determining what criteria should be used to determine their own quality of life and what care interventions are required to achieve this quality, then we will get much closer to identifying appropriate outcome measures for older people. Advances in information technology should allow these individual data sets to be collated, analysed and shared to determine how policy is meeting the needs of older people collectively, at the local, national and international level. This would require greater partnership working not only with older people, but also between researchers and policy makers.

More participative methods are required also in determining the value and contribution of nursing, an argument that has also been put forward by Conway and FitzGerald in this edition of *IJOPN*. Gerontological nurses need to be aware of the limitations of the scientific method and embrace other methodologies (for example, practitioner-centred research approaches) which have the capacity to capture the more invisible aspects of nursing better (Spilsbury *et al.*, 2001). In the same way that we need to listen to the voices of older people, we also need to listen to the voices of staff. Too often, by limiting their work by a particular method (quantitative or qualitative), researchers are in danger of ignoring and even victimizing practitioners or as Conway and FitzGerald have argued, the data collection takes precedence over the activity of listening to the voice of the practitioner. Researchers do not always comprehend the realities of everyday practice and these misunderstandings can generate findings of doubtful applicability (Holman *et al.*, 2004). Practitioners need to be involved at all stages of the research process to ensure that the research is useful, the findings are valid and that they are not exploited in the process.

However, it is not only participative methods that are required, but also more action oriented methods, such as action research (Meyer, 2000). Reflecting back on some of the global challenges for gerontological nursing caused by the increasing ageing population, global migration and the need for different ways of working, gerontological nurse researchers cannot afford to do theoretical research that may or may not influence practice. Instead they need to be more active at the development end of the research and development continuum in order to keep abreast of the enormity of current changes in practice and make their contribution through evaluation. Further, flexible approaches to research are essential to allow researchers to respond to naturally occurring events in the field. Gone are the days of attempting to measure nurse-led change, using more traditional quantitative methods. The nature of nursing is constantly changing and attempts to create quasi-experimental research designs in practice are in danger of being thwarted by the constantly changing environments in which they are conducted. Instead as Conway and FitzGerald have argued earlier, research needs to go with the flow and capture what it can (structure, process and outcome) as the realities of health and social care environment allow.

Concluding comments

As nurses and their assistants change their core skills and competencies to meet the needs of older people better and deal with the challenges created by global migration, we need to blur the boundaries between research, practice and education in order to inform each of these important aspects of nursing and to better support those individuals who take on these new roles. This is not to say that gerontological nursing research should become atheoretical and unsystematic. Indeed it has been argued that in-depth case studies, especially those generated through action research (Sharp, 1998) lend themselves well to systematic analysis and theoretical generalization. However, if research is to be meaningful to both older people and those caring for them, there is an urgent need for gerontological nursing research to become much more person-centred and practice/action oriented. Only then will we derive outcomes that are valid for older people, capture the invisibility of nursing and convince others of the value and contribution of gerontological nursing.

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