



Position Description

Position Title	Consultant Physician (Geriatrician), Health in Ageing
Work Role Grouping	Senior Medical Staff
Directorate	Specialist Health Services for Older People: 'Health in Ageing'
Service/Cluster	Medical Services
Location	Based at Tauranga Hospital within 'Health in Ageing'
Financial Responsibility	Nil
Position Status	Permanent
Report to	Medical Leader, Medical Services
Professional Link to	Medical Director, BOPDHB
Relationships:	<p>Internal</p> <ul style="list-style-type: none"> • Physician colleagues within 'Health in Ageing' (HIA) • HIA inter-professional teams • Mental Health Services for Older People • Medical Services' business, medical and nursing leaders • Other physicians within Medical Services • Other specialist consultant staff, Tauranga and Whakatane • Regional Community Services <p>External</p> <ul style="list-style-type: none"> • Patients and their families/whanau • Primary Health Organisations • Aged Care Residential Sector • Home Based Support Sector including Support Net (NASC Agency) and providers • Relevant non-government organisations e.g. Age Concern, Stroke Foundation, Alzheimer's Society,

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Background Information on Bay of Plenty District Health Board

- **Population growth and ageing.** The Bay of Plenty is growing faster than the New Zealand population as a whole. Apart from the three Auckland region DHBs it is the DHB with the fastest population growth. The Bay of Plenty has a relatively high rural population, however, most of the future growth is expected to be in the urban areas of the Western Bay of Plenty. Of note, the Māori population is growing faster than European population. The Bay of Plenty leads New Zealand in the structural ageing of the population with the Western Bay of Plenty approaching 18% of the population greater than 65 years with a particular high growth rate in the 80 years plus cohort. The ageing of the population will have a significant impact on health services and drive significant change in health service delivery.
- **Long-term conditions.** The ageing population, changing health risk factors and improvements in management and treatment are driving the need to shift the focus of the health system from providing episodic care for acute conditions to increasingly managing chronic or long-term conditions – such as diabetes, cardiovascular diseases, cancers and Alzheimer’s disease as well as asthma and COPD. Currently long-term conditions use about 70% of the health system budget, account for 80% of deaths and are the leading causes of preventable morbidity and mortality. Of note, the number of people with diabetes in New Zealand is increasing at a rate of about 4% per annum. The fastest rates of increase are in Māori and Pacific Island populations. In the ten years to 2011 diabetes prevalence will increase by approximately 60% for the European population and 132% for the Māori population and over 148% for Pacific people. Conversely, the rates of cardiovascular deaths have declined 40% from 1990 to 2004 with approximately 80% of the decline due to addressing and managing risk factors such as smoking, blood pressure and cholesterol. However, cardio-vascular disease remains the leading cause of death accounting for nearly 40% of deaths in New Zealand and the risk of death from ischaemic heart disease has not declined for Māori. Overall, the number of strokes is increasing at a rate of about 2% per annum while the mortality rate or risk of death from stroke is decreasing at a similar rate. The number of people living with Alzheimer’s disease is likely to approximately double in the next 20 years. Cancer accounts for approximately 30% of deaths in New Zealand. In the ten years from 2004 the overall risk of dying from cancer will decrease by about 15% but the number of cancer deaths will actually increase by about 12% due to structural ageing of the population.

Demography : current and future

- The current total population of the Bay of Plenty DHB area in 2008 is approximately 200,000.
- Approximately 75% of the total population live in the Western Bay of Plenty region, and 25% live in the Eastern Bay of Plenty region.
- Approximately 79% of the population live in urban areas and 21% in rural areas (compared to 86% urban and 14% rural overall in New Zealand).
- Compared to 14% overall in New Zealand, 23% of the total Bay of Plenty population identify as Māori. This population is structurally much younger than the general population.

Compared to the national population, the proportion of the Bay of Plenty DHB population that:

- Is 65 years and over is 29% larger than that for New Zealand as a whole, giving rise to a high absolute population greater than 65 years,

- Identify as Māori is 67% larger than that for New Zealand as a whole,
- Live in rural areas is 49% larger than that for New Zealand as a whole.

In terms of projected future growth (2006 – 2026), for the Bay of Plenty DHB area:

- Total population growth is higher (25.5 %) compared to that for New Zealand overall (18.1%).
- The 65 year and over age group is projected to grow the most (90.5% increase in 20 years).
- Growth in the 65 year and over population is higher (90.5%) compared to that for New Zealand (87.5%).
- Growth in the 0 – 14 year population is higher (6.0%) compared to that for New Zealand (1.1%).
- The Māori population has a higher growth rate than the 'European/Other' population.
- While the Pacific Islander population is projected to have the highest growth rate, this is starting from a very small baseline currently representing 1.1% of the total Bay of Plenty DHB population.
- The majority of the growth is expected to be in the Western Bay of Plenty region, particularly Tauranga city, with the Eastern Bay of Plenty region being static or experiencing population decline.

KEY TASKS/EXPECTED OUTCOMES:

1. CLINICAL PRACTICE:

The specialist will work within the inter-professional team within Health in Ageing (HIA) and focus on both direct and indirect clinical care and the development of systems and clinical processes that enhance 'positive ageing in place'

Expected Outcomes

- Direct clinical activity will result in active, early and appropriate intervention to mitigate or prevent decline in health and/or function for the individual. Activities will include internal and external referrals to the service, inpatient responsibilities and outpatient/acute assessment (TIA) clinics.
- Congruent approaches to the cognitive and mental health of older people will be shared with Mental Health Services for Older People, primary health care teams, and carers and providers.
- Telephone advice and consultation will be provided to other clinicians within and outside the hospital, as appropriate.
- Participation in, and enhancement of, inter-professional teams will facilitate seamless delivery and transfer of services.
- Clinical practices comply with statutory requirements and accepted standards of best practice.
- The physician complies with the maintenance of professional standards as set out by the Royal Australasian College of Physicians.
- Work practices, equipment and work areas comply with health and safety guidelines and infection control protocols.
- Collaborative working with other staff facilitates the efficient, effective and harmonious treatment of patients and running of Specialist Health Services for Older People.

2. PROFESSIONAL STANDARDS

BOPDHB's standards (i.e. legislative, professional, contractual, ethical and organisational) are met by awareness of the applicable standards and undertaking any steps necessary to remedy shortfalls in practice and knowledge.

Personal professional standards in relationship to geriatric medicine are met

Expected Outcomes

- Compliance with professional standards that relate to geriatric medicine.
- The risk of harm or loss of benefit to consumers, staff and others is minimised.
- Patients and customers have confidence in the employee's standard of delivery of care and communication
- Colleagues within 'Health in Ageing', and across medical services, are actively and positively engaged in a team approach to developing quality specialist services for older people.
- Contribution to clinical and senior medical staff forums and committees supports the broader maintenance of professional and organisational quality standards within the BOP DHB.
- All service provision, documentation, research, and information management complies with Privacy of Health Information Act, Health & Disability Code of Practice, Protection of Personal Property and Rights Act, Mental Health Act and other relevant statutes.

3. CUSTOMER SERVICE/CONTINUOUS QUALITY IMPROVEMENT

- The consultant will participate in continuous quality improvement across the Health of Older People (HOP) Strategy's 'Continuum of Care'; being open and responsive to customer needs.
- New initiatives and innovative practices are integrated and aligned with Health of Older People strategies and guidelines

Expected Outcomes

- A commitment to customer service and continuous quality improvement is demonstrated through interactions with patients and other customers.
- Customer needs are identified and ideas offered for quality improvement.
- Management of customers/situations are prioritised
- Participates in departmental meetings
- Actively participates in reflection, audit and review of clinical care and health outcomes for patients occurs
- Responds positively to patient complaints, hospital investigations and any sentinel events as requested.
- Harmonious collegial relationships and satisfied patients and customers are evident

4. TEACHING RESPONSIBILITIES:

The specialist will play a key role in the transfer of specialised knowledge about the health needs of older persons in an ageing population.

Expected Outcomes

- Informs, guides and mentors colleagues in e.g. the Specialist Health Services for the Older Person, Resident Medical Officers, Senior Colleagues, Primary Sector and Community Teams; promoting achievement of learning and success and training goals.
- Provides education to staff, community groups, GPs and other providers
- With colleagues will participate in the new BOP Clinical School to become a leading source of training in gerontology and geriatric medicine as well as the management of complex co-morbidities

5. CONTINUING MEDICAL EDUCATION:

The specialist will be responsible for maintaining his/her professional knowledge and skills.

Expected Outcomes

- This will be achieved through regular discussion with colleagues, reading relevant literature, internet access, participation in professional/clinical meetings and conferences, reporting back to colleagues as appropriate
- Personal reflection identifying areas of knowledge and practice development needed for present or future service delivery
- Knowledge and skills are up to date and of a high clinical standard

5. SERVICE DEVELOPMENT AND NEW INITIATIVES:

The clinical service needs for an ageing population will be communicated with sound resource based suggestions/proposals

Expected Outcomes

The specialist shall contribute to the development of services by working with service colleagues, providers and DHB Planning and Funding on service direction, meeting Health Targets, District Annual Plans etc

7. OCCUPATIONAL HEALTH AND SAFETY

To actively support and comply with all legal, occupational and organisational standards thus ensuring own and others' safety

Expected Outcomes

- Promotion of safe practice and safe systems of work in conjunction with other staff and colleagues, through consultation, training and supervision
- Practices meet legislative and regulatory requirements and comply with organisational policies and procedures
- Adverse events and near misses are reported in a timely manner
- Participation in provision of Health and Safety training.

8. ADMINISTRATIVE & OTHER DUTIES:

Administrative duties are completed in accordance with the customary duties of a specialist working in HIA

Expected Outcomes

- Customary administrative activities of a specialist are undertaken and professional leadership to staff is provided
- Assistance and advice to planning, contracting and other organisational activities are provided, on request
- Assistance is given with budget management and costing exercises, on request
- Sound financial stewardship of health resources is practiced and advocated
- Participation in medical staff and other committees takes place as required and agreed
- Participation in quality assurance, customer satisfaction, clinical audit and peer review activities occurs, as relevant

BAY OF PLENTY DISTRICT HEALTH BOARD

PERSON SPECIFICATION

Consultant Physician (Geriatrician) for Specialist Health Services for the Older Person

ESSENTIAL QUALIFICATIONS/EXPERIENCE

- Registered as a Medical Practitioner by the Medical Council of New Zealand.
- Eligible for or already vocationally registered with the Medical Council of New Zealand
- Member of the Australasian College of Physicians or equivalent
- Relevant specialist experience in medical Health Services for Older People including an interest in the primary sector and the systems/relationships needed to implement the 'Continuum of Care'
- Has an in depth knowledge of the relevance of legislation, national strategies and guidelines pertaining to patient rights, social and cultural needs, financial and other support needs and entitlements

PERSONAL ATTRIBUTES

- Broad and balanced perspective – able to adopt a lateral approach in decision making and the development and sharing of ideas.
- High level of interpersonal skills with a focus on motivation and communication. Written and oral presentations are articulate, relevant and concise.
- Demonstrated skills in the sharing of ideas along with an open and honest communication style with colleagues and inter-professional team members; thus supporting development of teamwork and co-operation
- Effective and efficient resource management
- Able to keep a sense of proportion when working in challenging situations and make logical and realistic decisions under pressure, with a balanced sense of humour
- Responsibility and leadership skills.
- Accepts responsibility for own practice, able to create an environment that promotes innovation and motivation of other team members.
- Research, evaluation and analytical skills. Able to effectively analyse data/information and relate to the needs of the older population and health policy criteria
- Personal management skills. Demonstrates sound organisational practices including time management.
- Integrity and self-motivation with energy, initiative and enthusiasm. Able to critically reflect on own practice with realistic confidence in own knowledge and achievements.
- **Enjoys and gets fulfillment from working with older people**

Position Description

Position Title	Community Physician (Geriatrician) for Older People
Work Role Grouping	Senior Medical Staff
Directorate	Specialist Health Services for Older People: 'Health in Ageing'
Service/Cluster	Medical Services
Location	Based at Tauranga Hospital within 'Health in Ageing'
Financial Responsibility	Nil
Position Status	Permanent
Report to	Medical Leader, Medical Services
Professional Link to	Medical Director, BOPDHB
Relationships:	<p>External</p> <ul style="list-style-type: none"> • Patients and their families/whanau • Primary health care teams including general practitioners, nurse practitioners/nurse specialists for older people, practice nurses • Aged Care Residential Sector • Primary Health Organisations • Home Based Support Sector including Support Net (NASC Agency) and providers • Relevant non-government organisations e.g. Age Concern, Stroke Foundation, Alzheimer's Society, • Other community voluntary, support and advocacy groups e.g. 'Positive Ageing Tauranga' • External agencies relevant to services influencing the health or support of patients including local offices of Government departments e.g. ACC <p>Internal</p> <ul style="list-style-type: none"> • 'Health in Ageing' Community Response Team • Physician colleagues within 'Health in Ageing' (HIA) • HIA inter-professional teams • Mental Health Services for Older People

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| | <ul style="list-style-type: none"> • Medical Services' business, medical and nursing leaders • Other physicians within Medical Services • Other specialist consultant staff • Regional Community Services including the Allied Health Leader |
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The Community Geriatrician Role: is the 3rd phase of a phased DHB funded development of a community arm of Specialist Medical Health Services for Older People, Health in Ageing (HIA).

The addition of a Consultant Community Physician signals a critical change from a nursing and allied 'Community Response Team' into an 'HIA Community Team with a response capability' thus growing the service under the consultant leadership.

The demography of the Bay of Plenty has population > 65 years well in excess of the national average with significant growth in absolute numbers and a growth in the > 80 years cohort that all place increasing pressure on secondary capacity.

Service outcomes:

- The provision of a community consultant geriatric service (including consultant geriatrician and gerontology nurse practitioner roles) to the Western Bay of Plenty as part of a comprehensive HIA consultant service covering a range of sub-speciality interests.
- This will support the primary and secondary sectors, as well as wider community, in service redesign to accommodate 'Population Ageing'
- The community component will have a special focus in working alongside Primary Health Organisations and the continuing-care residential sector as a clinical service and advisory resource. This will address the need for gerontological and geriatric medicine knowledge and facilitate 'continuum of care networks' within the community
- Amelioration of increased acute admissions for older people due to improved ambulatory primary care interventions
- Potential to develop a community based slow stream rehabilitation service to reduce hospital bed capacity requirements
- Goal 2 of the SHSOP Guideline 'Contributing to an integrated continuum of services' is now feasible. Potential extension to all parts of the district (Eastern District and rural areas) alongside Goal 3 'Supporting ongoing quality improvement and sustainability' can occur - contingent on resourcing
- The community component within HIA will leverage modern models of clinical service delivery and care and 'Ageing in Place' across the district (an existing integral part of SHSOP culture)
- In conjunction with the development of other components of SHSOP (reference Guideline, SHSOP Service Specification) this phase allows for progress to be made towards the implementation of the 'Health of Older People Strategy' and the underpinning 'continuum of care'. Concomitant development of other SHSOP components will also be needed.

KEY TASKS/EXPECTED OUTCOMES:

1. CLINICAL PRACTICE:

The specialist will provide a community based service focusing on both direct clinical care and the development of systems and clinical processes that enhance 'positive ageing in place'; thus mitigating the resource impact of population ageing on the health sector.

Expected Outcomes

- Direct clinical activity will result in active, early and appropriate intervention to mitigate or prevent decline in health and/or function for the individual; whilst reducing hospital presentation and residential sector admission.
 - Activities may include community assessment (including a leading role in the developing HIA Community Response Team), primary sector teaching clinics, rural satellites clinics, out-patient assessments e.g. falls and TIA clinics, and facilitating a range of community clinical group work. Access to Health in Ageing in-patient beds, facilities and other supports will be available as needed.
- Indirect clinical activity will result in increased capacity and capability of the primary, residential and community sectors to meet the needs of the ageing population. This will be achieved through mutual knowledge sharing, developing relationships, and partnerships.
 - Locally relevant clinical management guidelines and referral pathways for common presentations will be developed.
- Congruent approaches to the cognitive and mental health of older people will be shared with Mental Health Services for Older People, primary health care teams, and carers and providers.
- Telephone advice and consultation will be provided to other clinicians within and outside the hospital, as appropriate.
- Clinical direction and leadership in *community based* specialised medical services for older people will be provided; supporting the requirements of the Health of Older People Strategy, national service Guidelines, service specifications, and other relevant national planning documents e.g. Accident Prevention, Diabetes and Cardiovascular Quality Improvement Plan (Stroke and TIA Guidelines).
- Participation in, and enhancement of, inter-professional teams will facilitate seamless delivery and transfer of services.
- Clinical practices comply with statutory requirements and accepted standards of best practice.
- The physician complies with the maintenance of professional standards as set out by the Royal Australasian College of Physicians.
- Work practices, equipment and work areas comply with health and safety guidelines and infection control protocols.
- Collaborative working with other staff facilitates the efficient, effective and harmonious treatment of patients and running of Specialist Health Services for Older People.

2. PROFESSIONAL STANDARDS

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Personal professional standards in relationship to geriatric medicine are met

Expected Outcomes

- Compliance with professional standards that relate to geriatric medicine.
- The risk of harm or loss of benefit to consumers, staff and others is minimised.
- Patients and customers have confidence in the employee's standard of delivery of care and communication
- Colleagues within 'Health in Ageing', and across medical services, are actively and positively engaged in a team approach to developing quality specialist services for older people.
- Contribution to clinical and senior medical staff forums and committees supports the broader maintenance of professional and organisational quality standards within the BOP DHB.
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3. CUSTOMER SERVICE/CONTINUOUS QUALITY IMPROVEMENT

The consultant will play a leading role in community based continuous quality improvement across the Health of Older People (HOP) Strategy's 'Continuum of Care'; being open and responsive to customer needs.

New initiatives and innovative practices are integrated and aligned with Health of Older People strategies and guidelines

Expected Outcomes

- A commitment to customer service and continuous quality improvement, is demonstrated through interactions with patients and other customers.
- Customer needs are identified and ideas offered for quality improvement.
- Management of customers/situations are prioritised
- Participation in departmental meetings, both clinical and business
- Actively participation in reflection, audit and review of clinical care and health outcomes for patients occurs
- Positively responds to patient complaints, hospital investigations and any sentinel events as requested.
- Harmonious collegial relationships and satisfied patients and customers are evident

6. TEACHING RESPONSIBILITIES:

The specialist will play a key role in the transfer of specialised knowledge about the health needs of older persons in an ageing population.

Expected Outcomes

- Informs, guides and mentors colleagues in e.g. the Health in Ageing Community Response Team, Resident Medical Officers, Senior Colleagues, Primary Sector and Community Teams; promoting achievement of learning and success and training goals.
- Provides education to staff, community groups, GPs and other providers
- With colleagues will participate in the new BOP Clinical School to become a leading source of training in gerontology and geriatric medicine as well as the management of complex co-morbidities

5. CONTINUING MEDICAL EDUCATION:

The specialist will be responsible for maintaining his/her professional knowledge and skills.

Expected Outcomes

- This will be achieved through regular discussion with colleagues, reading relevant literature, internet access, participation in professional/clinical meetings and conferences, reporting back to colleagues as appropriate
- Personal reflection identifying areas of knowledge and practice development needed for present or future service delivery
- Knowledge and skills are up to date and of a high clinical standard

7. SERVICE DEVELOPMENT AND NEW INITIATIVES:

The clinical service needs for an ageing population, from a health community perspective, will be communicated with sound, resource based development suggestions.

Expected Outcomes

- The specialist shall contribute to the development of services by working with service colleagues, providers and DHB Planning and Funding on service direction, meeting Health Targets, District Annual Plans etc

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Expected Outcomes

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- Participation in provision of Health and Safety training.

8. ADMINISTRATIVE & OTHER DUTIES:

Administrative duties are completed in accord with the community service development component of the role and the customary duties of a specialist

Expected Outcomes

- Customary administrative activities of a specialist are undertaken and professional leadership to staff is provided
- Assistance and advice to planning, contracting and other organisational activities are provided, on request
- Assistance is given with budget management and costing exercises, on request
- Sound financial stewardship of health resources is practiced and advocated
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- Relevant specialist experience in medical Health Services for Older People including an interest in community practice, the primary sector and the systems/relationships needed to implement the 'Continuum of Care'
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PERSONAL ATTRIBUTES

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- Demonstrated skills in the sharing of ideas along with an open and honest communication style with colleagues and inter-professional team members; thus supporting development of teamwork and co-operation
- Effective and efficient resource management
- Able to keep a sense of proportion when working in challenging situations and make logical and realistic decisions under pressure, with a balanced sense of humour
- Responsibility and leadership skills.
- Accepts responsibility for own practice, able to create an environment that promotes innovation and motivation of other team members.
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