A new way of caring for older people in the community

Summary

The government’s modernisation agenda is challenging traditional practice by introducing new roles and concepts to meet the increasing healthcare needs of the older population and those with long-term conditions. Over the past two years several national pilots have been trialled to examine different models of managing care for these groups. One is the Evercare™ model, a case management approach to the delivery of care in the community for older people. This article focuses on a cohort of 12 nurses from three local primary care trusts who participated in the national Evercare™ pilot project from July 2003-April 2005. It examines the context for change, explores and appraises the development of a new role, and evaluates the educational partnership developed with a local university.

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Keywords

Community nursing; Evercare™; Nurse practitioner; Older people: nursing

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles and author guidelines visit our online archive at www.nursing-standard.co.uk and search using the keywords.

Local context

The Bristol teaching PCTs (BTPCTs) was formed in 2002 from two inner-city PCTs. Its aim is to enhance working in partnership, establish new relationships and develop projects to support staff to achieve local targets and implement the NHS Plan (DH 2000, 2002). One of its priorities is to address the growing problem of the 5 per cent of high-risk older people who take up 40 per cent of hospital bed days (DH 2005). The high-risk older person has complex health and social needs and requires a level of care that is intensive, sustained and time consuming. He or she is at high risk of unplanned or repeated admission to hospital with exacerbation of a long-term condition or perhaps through deterioration in support mechanisms.
The length of stay in hospital (bed days) is often increased or frequent because of the complexity of the older person’s needs and care requirements. These repeated hospitalisations had a significant impact on local acute trusts, including an increase in hospital occupancy rates. Coupled with a reduction in junior doctors’ hours (DH 2004), this meant that PCTs were unable to achieve targets for reducing hospital waiting times and unplanned admissions. The ‘revolving door’ patient, that is, a patient who has repeated hospital admissions, was identified by the acute trust and the PCTs as the cause of the capacity problems.

Project aims

To implement the principles of a person-centred approach as outlined in Standard 2 of the NSF for Older People (DH 2001) and to target the patient population requiring the most complex interventions, that is, older people, there was an urgent need to advance the practice of nurses in the community. Traditional methods of care delivery in the community had been considered by the DH (2002) as poorly co-ordinated and often poorly resourced, leading to unacceptable patient outcomes such as repeated hospitalisations. The opportunity arose for the BTPCTs to become involved as three of ten PCTs in England were invited to be pilot sites in the DH-funded Evercare™ national project.

The aims of this national project were to:

- Introduce new ways of working that promoted more co-operation between PCTs and local acute trusts.
- Develop nurses to undertake health needs assessments of identified caseloads and, in partnership with GPs and pharmacists, diagnose, review and prescribe drugs in an attempt to reduce re-hospitalisation, and improve the quality of older people’s lives in the community.

Philosophy

Boaden et al (2005) define Evercare™ as a model of care for frail older people, combining elements of nurse-led assessment and intensive case management. The distinctive features of Evercare™ are:

- Data analysis to identify high-risk patients.
- Job re-engineering – redesigning staff roles through a new role of advanced practice or primary nurse with extended generalist skills.
- Process re-engineering – organising care around the patient’s needs rather than around current organisational boundaries.

Evercare™ is an example of level 3 case management (DH 2005) (Boxes 1 and 2). The overall aim of the Evercare™ programme is to prevent disease and manage long-term conditions for high-risk older people to keep them healthier longer and out of hospital (UnitedHealth Europe 2003, 2004).

The Evercare™ model encompasses five fundamental principles:

1. Application of an individualised, holistic approach to maximise function, independence and quality of life.
2. Primary care will be central rather than peripheral.
3. Older people will be kept out of hospital by using a proactive rather than a reactive approach to managing health care, assisted by specific tools and techniques such as the Risk Identification and Stratification Tool (UnitedHealth Europe 2005), or locally developed prevention of admission tools.
4. Medications will be managed and reviewed.
5. There will be a robust approach to identifying, managing proactively and monitoring the outcomes of the caseload.

Fundamental to the case management approach are the specific activities required to manage the client group proactively (Boaden et al 2005). These activities are underpinned by the five core
Evercare™ competencies that were essential to the advanced primary nurse (APN) role within the project. These competencies are known as the five Cs:

- Clinician – actively delivering care, monitoring interventions, instigating care.
- Care orchestrator – co-ordinating care across agencies and boundaries.
- Communicator – with a range of professionals, the family, carers and patients, voluntary agencies.
- Coach – encouraging and supporting the patient to monitor and manage his or her own care and disease.
- Champion – acting as a liaison for the older person, actively ensuring the older person receives a quality service.

The alignment of the five core competencies with the case management role is outlined in Table 1.

Central to the success of the project and to delivering case management was the concept of the APN. Some of the skills required to implement case management effectively using the Evercare™ approach are more advanced than the current competencies required of the registered nurse (Nursing and Midwifery Council (NMC) 2005a), for example, detailed diagnostic and physical examination skills. These align more closely with those of the advanced practitioner role (DH 2002, NMC 2005a). However, the term ‘advanced nurse practitioner’ could not be used as the nurses recruited did not hold advanced nurse practitioner competencies as outlined by the NMC (2005b). It was therefore decided to use the term ‘advanced primary nurse’ (APN) to differentiate between existing community nursing roles and the APN’s role. The APNs were based in GP surgeries that had agreed to take part in the pilot and their caseload was drawn from the practice population who met the criteria of age 65 and over, two or more unplanned admissions and disproportionate use of hospital beds (Boaden et al 2005).

The congruency of the Evercare™ model with the government’s policy initiatives for the NHS is highlighted in Table 2. It is imperative that development of new ways of working, process re-engineering and the instigation of new roles for health professionals in primary care meet the challenges of these policy agendas. Process re-engineering is a method of examining the way work is done in an organisation and redesigning it to better support the organisation’s mission and reduce costs.

The adapted version of the Evercare™ prototype was instigated in the pilot areas. The main differences between the adapted UK and US Evercare™ models are outlined in Table 3.

### Local implementation

Twelve practitioners with a mixed academic profile were recruited predominantly from existing community staff, such as grade G district nurses or health visitors who were also registered nurses, to undertake the APN role. Two APNs were from acute trusts, one with a background in acute older person care and one with a background in cardiac care. Interestingly, this did not pose any significant difficulties for the two individuals despite initial concerns that they would find the transition from secondary to primary care difficult. They appeared to adapt more easily to the new role than those with experience in a community setting. This might have been because they had no preconceived ideas about how community nursing was organised, and were more easily able to transfer...
their skills without being constrained by previous knowledge of the system. As part of the project, local support systems such as group clinical supervision and mentoring were set up. It was essential to recruit GPs and specialist registrars in the care of older people as coaches and mentors. Additionally, GP mentors in the Bristol pilot were paid a fee to encourage and support the mentorship process. This worked relatively successfully, although some GPs provided more input than others.

Each APN was also mentored and assessed by an Evercare™ nurse practitioner (NP) brought from the US by the DH. In the Bristol area, the NP spent one day a month for nine months with each of the 12 APNs. Her role was to assess the nurses against agreed Evercare™ competencies, provide feedback to the APNs, act as a resource and offer advice and guidance on the developing project. To be effective in their role, it was anticipated that the APNs would eventually manage a caseload of 50 patients each. It was quickly realised that this was a difficult target to reach with the complex nature of the patient group.

Educational needs

The nurses’ educational needs were not considered at the start of the project. This was a significant oversight and one which caused a considerable level of anxiety for the APNs locally. It was expected that the APNs would be easily able to adapt to their new roles with the minimum amount of educational input. Although the APNs attended a series of assessment workshops run by Evercare™ that were intended to refresh their knowledge in anatomy and pathophysiology, it became apparent that the APNs’ level of knowledge was at an embryonic stage in comparison to their US counterparts.

At the first local clinical supervision meeting following the national preparation workshops, the APNs were critical of the programme as it used a didactic, teacher-centred approach, with little opportunity to practise skills learnt. The Bristol APNs felt that the information was not sufficient to support them in their new roles and the new skills that they required, and they expressed a need for further education to support them in their new role.

The local university responded quickly and an action learning set, within the confines of a work-based learning (WBL) module (Box 3) was established in October 2003, four months after the first APNs had commenced their new posts. Underpinning the module was a learning contract and a portfolio demonstrating achievement of the Evercare™ core competencies and reflecting on the challenges of the new role.

The focus of the action learning set (Box 3) was to stress the importance of the group identifying their learning needs. To guide the learners a self-assessment tool, incorporating a strengths, weaknesses, opportunities and threats (SWOT) analysis, allowed the APNs to map their existing skills against the Evercare™ competencies. This reassured the student group that they had many transferable skills, such as problem solving, continence assessment and change management (Box 3), that were relevant to their new APN roles.

Crucial to the success of the pilot and the APN role was ensuring that the practitioners had the specific skills required for the job. The skills deficits that had been identified through the self-assessment were addressed by a series of advanced clinical skills workshops. These focused on physical assessments, for example,

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<tr>
<td><strong>National policy initiatives</strong></td>
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<td>NSF for Older People (DH 2001)</td>
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<td>Monitor medicines and polypharmacy.</td>
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<td>Person-centred care.</td>
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<td>Establish links and liaise with secondary care services.</td>
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<td>Multiprofessional working.</td>
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the cardiovascular system. The workshops also included practical sessions on performing a physical assessment correctly, which had been a significant source of anxiety for the APNs.

These specific skills support some of the key competencies identified by Mundinger (2002) as necessary for the advanced practice role. Read et al (2001) state that professionals in new roles must have appropriate educational preparation if they are to perform competently in their new role. As well as the focus being on the acquisition and development of physical examination skills, the workshops also provided opportunities to reflect on role development and issues arising from practice (Glaze 2001). Some examples of these issues are examined below.

One significant challenge for the nurses was to learn to use medical terminologies of the systems approach. This meant taking a patient history in a systematic structured way, working from head to toe together with a physical examination. This information was recorded in a more ordered way using medical terminology, and focused on physical findings such as heart or breath sounds. The mastery of such language was felt to increase the APNs’ credibility among medical colleagues. Some APNs encountered tribalistic behaviour, such as reluctance to agree to medication reviews and resistance to change among other professionals, including medical colleagues and nursing staff, during the first nine months of the 18-month project. An example of this resistance was demonstrated by several staff who branded the new role as pointless. This was exacerbated by a lack of clarity and information about the role in the early stages of the project. Such problems are articulated by Read et al (2001), who highlight the importance of communicating to staff the purpose of new roles.

Mentorship was another significant issue. This appeared to be dependent on the enthusiasm of individual workplace mentors. One of the key problems related to mentorship in the Bristol cohort was the speed with which the role was instigated and the lack of communication between some GPs, the mentor and the project leads about the purpose of the project.

Many members of the healthcare team were not keen to support the cultural shift that the new roles required. This included the relinquishing of tasks and roles traditionally undertaken by other members of the team, for example, medication reviews. In addition, many of the APNs struggled to relinquish their district nurse role, despite accepting that their remit had changed to one of a more autonomous practitioner with advanced assessment skills.

Reflection played a key part as learners progressed and developed within their roles. As adult learners the skills of reflection are vital to advanced practice (Johns 2002, Daly and Carnwell 2003) and the APNs reflected on their learning within their portfolio. The portfolio was the culmination of the learning achieved throughout the WBL module and contained examples of key learning achieved, through assessment of Evercare™ competencies or through investigation of specific issues such as medication changes.

### TABLE 3

**Differences between the UK and US Evercare™ models**

<table>
<thead>
<tr>
<th>United States</th>
<th>United Kingdom</th>
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<tr>
<td>A for-profit health insurance company which has a vested interest in reducing cost and maximising profit.</td>
<td>The NHS is a non-profit organisation, with health care being determined by need and delivered free at the point of entry to the system.</td>
</tr>
<tr>
<td>Patient group: nursing homes. However, there is a community-based model but this has some significant differences when compared to the UK model, for example, first contact is via telephone; patients are less sick; care is delivered by social workers or registered nurses; funding for care is via a health maintenance organisation such as Medicare.</td>
<td>Patient group: mostly in patients’ own homes, some residential and nursing home patients. Patients in their own homes are much sicker or frailer than their counterparts in the US.</td>
</tr>
<tr>
<td>Nursing homes provide a much higher level of intensive treatment to frailer patients than UK nursing homes at a greater cost.</td>
<td>UK nursing homes provide a lower level of intensive treatment as a result of the difficulties in obtaining medical cover.</td>
</tr>
<tr>
<td>Community patients are first assessed via the telephone.</td>
<td>Community patients are first assessed via a home visit.</td>
</tr>
<tr>
<td>Master’s educated nurses following specific nurse practitioner programmes.</td>
<td>Some undergraduate degree nurses, but in the Bristol pilot none have higher degrees. No specific nurse practitioner education programme.</td>
</tr>
<tr>
<td>Title of nurse practitioner.</td>
<td>Title of advanced primary nurse (APN) as not registered as advanced nurse practitioner with the NMC.</td>
</tr>
<tr>
<td>Medical model of care predominates, that is, patient care is considered in the context of a disease focus.</td>
<td>Social model of care predominates, that is, patient care is considered in the context of their social background.</td>
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Successes of the role

The primary aim of the national project was to pioneer new ways of partnership working between PCTs and acute trusts to meet the increasing healthcare needs of the older adult. In this respect locally the project achieved some success. Role re-engineering (Box 3) resulted in the successful development of an advanced nurse in primary care working autonomously, who is able to identify the health needs of a caseload of frail older people, and instigate measures to improve their quality of life through the five core competencies outlined in Table 1.

By using newly acquired advanced practice skills, the APN is able to deliver a holistic approach in accordance with the Evercare™ philosophy, and in congruence with the policy initiatives outlined in Table 2. Coaching support in the form of case discussion and practical application of clinical skills from specialist registrars and consultant nurses in local acute trusts has helped the APNs to develop a proactive holistic approach in the management of their caseloads. This has fostered positive and enabling relationships, which have helped to dismantle some organisational barriers such as the poor communication experienced by the APNs between primary and secondary care when a patient was admitted to hospital for example.

The second aim of the project relating to the development of new skills has been more successful locally. Through the combination of a nursing and medical model, the APN has been able to develop skills in physical assessment and diagnostic reasoning, eliciting the underlying cause of the disease, rather than just treating symptoms (Boaden et al 2005). A significant number of patients (75 per cent) identified and case managed by the APNs were previously unknown to existing primary and social care services (Hudson 2005). These patients were identified from matching the criteria for two or more unplanned admissions, over the age of 65 and not active on the community nurses’ caseload.

A reduction in GP workload has been identified as a positive benefit of the new role (UnitedHealth Europe 2005). Patients who previously required frequent visits by the GP are now seen first by the APN who reviews the case and manages the appropriate care interventions, liaising with the GP regarding medication reviews. The clear focus on delivering the NSF for Older People (DH 2001) and Supporting People with Long-term Conditions (DH 2005) means that care delivery can be benchmarked or audited against the national targets identified in these policies thus working towards delivering quality care outcomes. This process includes having a key worker (the APN) managing a caseload and co-ordinating services between a number of agencies and service providers. The older person stays on the APN caseload as his or her treatment is not time limited as it may be in standard community nursing care where the community nurse may discharge a patient following completed interventions. This enables the APN to get to know the older person. The patients interviewed by UnitedHealth Europe (2005), in its final evaluation of the project, rated this aspect positively.

Other benefits include: improved knowledge of the older person; early identification and management of problems; and medication reviews and management in conjunction with pharmacists and GPs. These factors enable a proactive rather than a reactive approach to problems, fulfilling the tenets of the Evercare™ philosophy (UnitedHealth Europe 2004).

Conclusion and implications for nursing

Local anecdotal evidence suggests that the new APNs were starting to make a difference. A long-term evaluation by UnitedHealth Europe (2005) and a report undertaken by Boaden et al (2005) have confirmed that the project has had a positive effect on reducing readmissions and resulted in shorter hospital stays. However, this evidence is anecdotally reported rather than systematically collected and analysed, and should therefore be treated with caution.

The flexibility of the work-based learning module enabled the group of mixed ability...
practitioners to develop their skills and learning at their own pace while undertaking a new and evolving role. Time to reflect enabled the practitioners to explore alternative actions when faced with complex and challenging issues within the safety of the action learning set (Box 3).

This type of learning has given the APNs the space to reflect on their role transition and establish new ways of working in the community such as moving from a task-oriented approach to a more holistic, person-centred approach. For the two nurses recruited from the acute sector, an important realisation was that their specific skills were transferable to the new context of primary healthcare.

However, clarity is required over the educational needs of potential future APNs. Clearly defined educational paths encompassing advanced practice skills are needed to ensure the sustainability and credibility of these roles. The expectations of practice are high and it should be remembered that success cannot always be measured in terms of quantity of patients kept out of hospital, or the number of bed days saved. Less tangible, but arguably more important, is the quality of the care delivered to the older person by the APNs.

There is still some way to go in ensuring a seamless flow of information sharing between primary and secondary care providers and, with regard to secondary care, understanding the autonomy of the APN (Boaden et al 2005). The behaviour of some physicians may reflect an unwillingness to let go of tasks traditionally within their domain. The APNs will need to keep developing and reaffirming their position within the healthcare team, and build a trusting relationship with the physicians, to enable them to fulfil the Evercare™ philosophy.

Locally the APNs’ educational development continues and the next stage is to complete the extended nurse prescribing course, and the master’s degree in advanced practice. It is evident that the three Bristol PCTs have embraced the ethos and philosophy of the APN role and have recruited further APNs. This is a positive move and will seek to endorse older person care in the community and, along with community matrons, puts APNs at the forefront of new and developing roles in the management of long-term conditions NS

References


