

# Nurses as Case Managers in Primary Care: the Contribution to Chronic Disease Management

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*Executive summary for the National Institute for Health  
Research Service Delivery and Organisation programme*

*March 2010*

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# Executive Summary

## Background

Chronic diseases are the leading cause of illness burden, disability and death across the world. Internationally, it is a policy priority to improve the experience of, and service delivery to, people with long term conditions and their carers through multi-disciplinary models of chronic disease management. Most of these models involve case management i.e. a professional who has responsibility for overseeing and/or delivering the processes of case finding, assessment, care delivery, monitoring and review for, and with, a patient and their family carer(s). Research on the contribution of nurses to models of chronic disease management, and specifically case management, either assumes that it is self evident what the nursing work is and never describe it, or creates new nursing roles which are represented as innovative, without any reference to existing nursing provision. There is currently little evidence available to inform commissioners or service providers as to: a) the extent nurses are undertaking case management roles with patients with long term conditions, b) what factors facilitate or inhibit them taking these roles, c) the impact for service users and their carers or d) the costs to the service if they adopt these roles.

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## Aims

This study aimed to investigate the contribution of nurses as case managers for people with long term conditions (LTC). Its objectives were to identify the range and types of nurses' involvement in case management and undertake an in-depth description of their contexts, their activities and their perceived impacts from the perspectives of patients, carers, other service providers and commissioners. Uniquely, this study compared and contrasted the experience of patients receiving different types of nurse case management.

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## About this study

The overall approach of the study drew on the principles of realist synthesis and realist evaluation. The study was conducted in two phases over three years. There were four elements:

Phase 1

An integrated review of the research evidence to establish the evidence for the effectiveness of the nursing contribution to chronic disease management.

An analysis of policy for the nursing contribution to the care of people with long term conditions in England and Wales.

A survey of the implementation of nurse specific policies across England and Wales.

Phase 2

A comparative case study, in three geographically disparate sites, that tracked the experience, quality of life, health status and use of services of patients with long term conditions (and their family carers) receiving one of three types of nurse led case management.

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## Key findings

**Review of the research evidence.** The integrated review found that the nursing contribution to chronic disease management could be categorised into three overlapping types of activity: supplementing, substituting for and complementing existing services. When there were specific problems such as fragmented care, lack of continuity in service provision or difficulties in accessing care, the nursing contribution was to supplement other services and thereby improve the overall patient experience. In situations where the aim was to relieve medical workload or try and reduce costs then the nursing contribution was one of substitution. The last type of nurse activity identified was one of complementing other services. This occurred where nurses provided care alongside other services. There were few examples of this type of nursing activity but the primary influencing factors have been the organic, historical, or evolutionary development from within clinical services rather than responses to a single defined problem.

**Analysis of policy.** The policy review identified ambivalence in UK policy networks about nurse case management models. There was an absence of discussion of existing generalist nursing services, such as district nursing and practice nursing, and the potential for their involvement in case management activities. The Welsh policy documents considered and rejected naming nurses specifically as case managers for people with LTC. In the English policy documents, case management roles were only advocated for nurses holding advanced practice skills qualifications such as independent prescribing or as specialists in a specific condition working alongside a medical consultant led team.

**The national survey.** The national survey reflected the policy analysis in that there was little activity within Wales while the English centrally monitored targets for numbers of community matrons gave impetus to the introduction of nurse case managers in English PCTs. Despite a relatively proscribed model of nurse case management from the English Department of Health, the survey identified a wide variety of nurse case management

models and nurse involvement in admission avoidance strategies for people with LTCs in England.

Phase one established that the term 'case management' was not used consistently to refer to the same types of nursing roles or activities. The range of nurse case managers, the variety of their settings and work relationships was broader than that described before in the UK. The survey identified and confirmed the main groups of nurse case managers in primary care in England as: community matrons, clinical nurse specialists, and district nurses.

**The case studies.** Through tracking the experience of patients and families in receipt of different types of nurse case management, the case studies were able to describe in detail the similarities, differences, impacts and changes over time of the different types of nurse case managers.

The patients of the community matrons had the highest levels of co-morbidity, but all the nurse case managers' caseloads had patients with equivalent needs. The findings demonstrated that the nurse case managers irrespective of type could all identify that they were undertaking the six elements of case management. However the frequency, the intensity and resulting costs of using all six elements varied between the types of case managers. Only the community matron undertook all elements for all of their patients.

The majority of the patients recruited to the study and frequently also their family carers, were considerably disabled by their conditions. Over the course of the study, all of the patients became frailer and a fifth died. The transition from being a patient who could benefit from case management to that of a patient in need of palliative care could be problematic, threaten continuity of care and create confusion as to who was the nurse case manager, particularly in service delivery models that had a specific disease focus.

The patients and their family carers were experienced users of health and social care services and this informed their judgements about the different types of nurse case management. They valued nurse case management for: a) the nurse's clinical expertise, b) the nurse's assistance in providing continuity of care and acting as intermediary with multiple services and c) the therapeutic effect of the nurse's as psycho-social support. Patient defined outcomes of nurse case management were articulated as: a) increased confidence in managing their conditions, b) acquisition of self management techniques that made their lives easier, c) their (patient and carer) priorities were addressed, d) patient and family carer time and energy was saved and e) having a professional delivering their care who knew their 'story'.

Some patients however who received community matron case management were concerned that it was a form of surveillance. The evidence suggested that some patients and carers asserted their independence by refusing services offered by nurse case managers.

Nurse case managers in all the models valued their role. While all undertook all the elements of case management, some placed greater emphasis and time on the assessment and referral elements over the monitoring and review responsibilities. There was also evidence of increasing nurse to nurse referrals over the time of data collection, as nursing care was divided into task based care and assessment and monitoring activities. Over the nine months of the study the nurse case managers who were engaging in all case management activities, sought to delegate or refer some of their patients to other nurses i.e. there was progressive disaggregation and dilution of the case management work overtime. It was within the discretion of the practitioner or the service how the case manager role was interpreted.

Case management when carried out by nurses who exclusively undertake this work was expensive. The factors that increased individual patient service costs were hospitalisations and intensive nurse case management contact. This may reflect that the intensively case managed patients were in fact towards the end stage of life. There is substantial evidence that the highest use of health services and thus costs are in the last year of life, irrespective of age. Some but not all of the patients who received intensive nurse case management input reported lower use of other services. This together with the evidence that community matrons had higher rates of referrals to other services raises the question as to whether nurse case managers facilitate access to more services rather than reduce demand on acute and other services.

The list of factors that supported the nurse case managers in achieving their roles with patients reflect key features of any change management strategy e.g. planning of the service, training, managerial support. However four additional factors for these roles stand out:

1. The presence of a mandate to undertake case management activities that was recognised by others who were providing or commissioning services to those patients,
2. A close working relationship (including sharing patient records) with a multidisciplinary team, including the GP or a medical consultant,
3. Advanced clinical skills,
4. Designated and protected time for case management.

Perhaps the last factor that supported all the nurse case managers in their roles was stability and continuity in mandate. It was apparent that for many of these nurses, stability was not recognised as important by their employing organisation. Community matrons were particularly susceptible to their role being redefined and realigned with other services and almost all the nurses, and particularly district nurses identified how organisational turbulence negatively affected their ability to embed their case management services and maintain continuity of care.

## **Disclaimer**

This report presents independent research commissioned by the National Institute for Health Research (NIHR). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NHS, the NIHR, the SDO programme or the Department of Health

## **Addendum**

This document was published by the National Coordinating Centre for the Service Delivery and Organisation (NCCSDO) research programme, managed by the London School of Hygiene and Tropical Medicine.

The management of the Service Delivery and Organisation (SDO) programme has now transferred to the National Institute for Health Research Evaluations, Trials and Studies Coordinating Centre (NETSCC) based at the University of Southampton. Prior to April 2009, NETSCC had no involvement in the commissioning or production of this document and therefore we may not be able to comment on the background or technical detail of this document. Should you have any queries please contact [sdo@southampton.ac.uk](mailto:sdo@southampton.ac.uk)