Improving the management of chronic
disease in the community

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This study explored district nursing teams’ perceptions of the current chronic conditions management model in a specific locality in Wales. Chronic diseases are now the leading cause of illness and disability across the UK, while chronic diseases are the leading cause of illness burden and disability across the world (Welsh Assembly Government, 2007). At the same time, patients’ experience of the care provided by the NHS can be variable and the number of people affected by chronic disease was predicted to continue rising if action is not taken (DH, 2004).

The term chronic disease relates to a condition that in most cases cannot be cured and is lifelong, causing continuous or episodic periods of incapacity (Webb, 2005), such as diabetes, arthritis or coronary heart disease. People with chronic conditions often end up in a vicious cycle of treatment breakdown and admissions to hospital, commonly referred to as ‘revolving door syndrome’, which not only puts a strain on the wellbeing of the individual, but also has a significant impact on healthcare services (Welsh Assembly Government, 2006).

LOCAL CONTEXT

In November 2009 a fully integrated nurse case management role for district nursing teams was introduced into the author’s locality. The aim was to facilitate the development of existing nursing skills within the workforce and thereby enhance the chronic conditions management skills of district nurses serving the local GP practice populations.

The nursing case management role used the Welsh Chronic Conditions Management Model, which is based on four increasing levels of care, which are applied as the patient’s health risk increases (Welsh Assembly Government, 2005):

- **Level 1**: primary prevention and health promotion (people at risk of chronic conditions)
- **Level 2**: population management (people in the early stages of chronic conditions)
- **Level 3**: high risk management (chronic conditions beginning to impact on everyday life)
- **Level 4**: case management (people with complex chronic conditions).

The author’s locality is a rural area with a population of approximately 47,000, while 9% of the population are over the age of 65. The area encompasses one of the most deprived wards in Wales and chronic conditions are predominant, with 23% of the population having a diagnosis of cardiac heart disease, 16% a diagnosis of chronic kidney disease, and 9% a diagnosis of any cancer. Chronic conditions are now the leading cause of illness and disability across the UK, placing an increasing demand on public services as healthcare staff try to meet the needs of those with long-term conditions. The author used action research to conduct the study, encouraging the nurse participants to critically review their practice. The findings indicated that a major overhaul of the current model of care was not required; the foundations were there and just some small steps and a shared vision led to sustainable changes for an efficient and effective chronic conditions service.

**KEYWORDS:**
- Chronic disease
- District nursing
- Nursing skills

Chronic conditions are those that, in most cases, cannot be cured, only controlled, and are often lifelong and limiting in terms of quality of life. They include:

- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Arthritis
- Epilepsy
- Coronary heart disease
- Stroke.

The impact of chronic conditions on people’s lives and services in Wales particularly is of growing concern. Wales has the highest rates of long-term limiting illness in the UK, accounting for a large proportion of unnecessary emergency admissions to hospital.

Source: www.wales.nhs.uk
There are, however, no specific guidelines or suggested models on how chronic conditions management models should be implemented and, as with many health-related initiatives/policies, implementation in practice is open to interpretation by individual teams. Ross et al (2011) recognised the confusion that the lack of one single definition can have on the understanding of exactly what case management involves, identifying models ranging from ongoing programmes (a plan of care for patients who require continual monitoring/treatment of their condition and involving regular contact between the nurse and the patient) to intensive time-limited interventions (for example, the expert patient programme, a course specifically designed to help patients self-manage).

‘The principle aim of case management is to reduce hospital admissions.’

In nursing, this problem was recognised as long ago as 1998 in a review by Lee et al. The focus on individual case management roles within district nursing teams reflects the generalist verses specialist debate, i.e. if the case management role in nursing is a specialist one, does it have the potential to de-skill district nurses within the team who might lose day-to-day contact with patients?

Although the majority of studies that recognise the potential for specialist nurses to de-skill generalist nurses relate to disease-specific roles and not to case management (Marshall and Luffingham, 1998; Mytton and Adams, 2003; Jack et al, 2004), the findings are considered to be of relevance as both specialist and case management roles have the potential to remove elements of a nurse’s job or prevent them from developing skills and knowledge.

The nursing/medical interface

General practice has a pivotal role to play in the management of chronic conditions, with 80% of consultations being related to chronic conditions and a number of studies and policies raising awareness of the need for organisational change at practice level, i.e. the need for GPs to work more closely with nurses to develop condition-specific pathways (Welsh Assembly Government, 2007; Wilcox et al, 2007; Welsh Government, 2009; Christ et al, 2010).

Burgen (1994) found that GPs’ case management role was often ambiguous, with varying degrees of involvement ranging from full to very little input due to a reluctance to engage in the management of this patient group. More recently, further evidence shows that the involvement of GPs remains inconsistent, specifically in relation to consultations with patients who have a long-term condition (Kendall et al, 2010; Ross et al, 2011).

From a nursing perspective, any successful model of care requires engagement with GPs and open channels of communication are crucial to providing joint care plans for individual patients.

STUDY

Aims

The case management literature review resulted in the following research aims:

- To compare chronic disease management models across the UK
- To explore district nurses’ perceptions of local chronic disease management models
- To identify any aspects of the current model that might restrict or enhance the care of patients with chronic conditions.

Methodology

As the project aimed to gauge the views of district nurses on the local chronic disease management model, an action research methodology was chosen. Action research is aimed at helping professionals define their workplace needs by identifying problems and devising solutions. The intention was to get the nurses to identify any perceived barriers to a successful model of care and to develop actions to improve their own practice.
The characteristic feature of action research is the cyclical process of planning, taking action, evaluating that action, providing feedback to participants and making modifications, then beginning the process again (Coghlan and Casey, 2001). In this way, action research facilitates the critical examination of working practices by those involved and allows a consensus to be reached on what the service should provide (Cormack, 1991; Morton Cooper, 2000; Williamson and Prosser, 2002). The core aim of action research in health care is to improve standards by enhancing professional practice (Greenwood, 1994; Morton Cooper, 2000).

Sample and recruitment

Once ethical approval had been granted for the study, the opportunity to be involved was extended to all the local district nurses. All 22 participants in the study were female purely due to the female-only workforce in the district nursing teams. All prospective participants received a letter explaining the study and inviting them to participate. Anonymity was assured, but participants were informed that their comments would be used verbatim. The participants were assured of the confidentiality of the focus groups and were informed that they could withdraw at any point during the study without prejudice.

Data collection

To help the author gain a full understanding of the long-term conditions service and to collect the relevant data, qualitative focus groups were held. These groups were interactive and nurses were asked to outline their opinions about the service; the groups were semi-structured with predetermined questions developed from themes identified in the literature review. To facilitate ease of access for the nurses, the groups were held at a venue and time to fit in with their workload. They were also audiotaped and field notes were taken.

Data analysis

The author used thematic data analysis, which allows the researcher to interpret someone’s personal experience of a specific area of practice then explore it further to see where actions might be implemented. The analysis can also highlight relationships between themes and the impact they can have on the individual's experience. The identified themes were presented at the subsequent focus groups to facilitate discussion on any required actions.

Findings

Five focus groups were held initially, with 22 nurses attending. Four of the five district nursing teams who attended the focus groups had named chronic conditions management nurses embedded; these nurses were regarded as a separate entity although they worked within the team.

‘All participants reported a lack of education around the management of chronic conditions.’

Analysis of the data helped the author identify the following themes locally:
- Lack of training for the role of chronic conditions case manager
- Inconsistency in the involvement of other disciplines
- Crisis management rather than proactive care
- Lack of resources.

After the first focus groups, the nurses were asked to complete a SWOT analysis of the current model of chronic conditions management to map any strengths, weaknesses, opportunities and threats. In line with the cyclical process, in a further round of focus groups the data was fed back to the nurses to confirm that they were in agreement with the author's interpretation of their comments and also to empower them to discuss any actions or changes to practice that might be required. During subsequent focus groups, participants were able to look at the actions required in response to each theme.

Lack of training

All participants reported a lack of education around the management of chronic conditions. Similarly, those staff named as chronic conditions management nurses reported having been told they were to carry out the role but without any preparation, while appointment to the role appears to have been based on clinical banding rather than interest, experience or skills:

‘I was just told to carry out the role and was given no prior training.’

One team, however, felt strongly that the knowledge and skills they had developed through chronic conditions management had improved their day-to-day work, while another team stated they had refocused since the programme had been introduced and that the team was now more aware of problems and often drew attention to issues on routine visits.

Variance in the involvement of other disciplines

Involvements of GPs with the nursing teams varied; some were actively working with the nurses, others had to be approached if issues arose. Meetings about chronic conditions did take place in all but one of the GP practices, however, the frequency of these meetings varied from monthly to three-monthly, while the involvement of the GPs was easier if the team were based in the same building. The team that stated it did not have meetings with their GP practice did, however, feel that the practice was very good at managing patients with chronic conditions:

‘We do not have a formal meeting with the GP practice to discuss chronic conditions, however, I do feel that they are good at managing these patients.’

In relation to specialist nurses, their input varied from regular visits to the teams to being available by telephone only. This was reiterated at all of the focus groups:

‘Some specialist nurses visit the clinics but the majority are only available by telephone.’

Crisis management instead of proactive care

Due to workload, the patients
requiring district nurse input had to take priority, therefore, it was felt that managing patients with chronic conditions had to take second place and that this often led to reactive crisis management rather than proactive care:

‘The day-to-day caseload has to take priority and this means chronic condition assessments get put back.’

The teams described how non-clinical tasks such as documentation took many hours to complete, taking over their day-to-day work and reducing the time available to manage chronic conditions:

‘Documentation takes a considerable time to complete; the volume of documentation required to apply for continuing health funding is huge and contacting care agencies for the required costing and availability all takes over from clinical care.’

Although each team had implemented the chronic conditions management model in slightly differing ways, they all reported that the workload was shared within the team.

**Lack of resources**

The teams discussed lack of resources, in particular having to share certain pieces of equipment between teams, which meant that extra time was taken to collect equipment. Nurses tried to order the equipment in advance so that they could complete a number of assessments at the same time, however, day-to-day care often took priority and occasionally prevented this:

‘Some of the equipment is bulky and we have to share it. You have to take time out to collect it from the team who have it at that time.’

The dedicated chronic conditions nurses also took on a team leader role and had to fulfil their management responsibilities and support the team in addition to this.

**Actions**

During the second round of focus groups, the nurses were able to discuss responses to the themes listed above, while identifying the possible actions themselves empowered them to make the necessary changes to practice. The actions agreed included:

- The development of an in-house educational programme
- Implementing a model of care in one GP practice whereby the management of patients on the chronic conditions register was shared between district nurses, practice nurses and the GP
- Reserving set days for the management of chronic conditions where day-to-day tasks would be reduced, releasing nurses to carry out assessments and review patients with chronic conditions
- The purchase of fresh equipment identified as necessary by the nurses was also approved.

‘The teams described how non-clinical tasks such as documentation took many hours to complete.’

**DISCUSSION**

Although patients diagnosed with a chronic condition may have a broadly descending health trajectory, their care can fluctuate between district nurses and those nurses who manage chronic conditions. To support patients and ensure nurses maintain their skills, a team approach is required (Sargent et al, 2008; Chapman et al, 2009).

The findings from this study support a team approach for a number of reasons. First, this approach demonstrated benefits for both nurses and patients as skills can be maintained and patient knowledge is retained. Second, patients benefit because a team approach prevents duplicate visits from district nurses and chronic conditions nurses.

For some years now, the political challenge has been how to facilitate a fundamental shift in the way chronic conditions are managed to improve patients’ quality of life and to reduce the burden on the NHS. However, some years later this does still not appear to have been achieved. The findings in this study indicate that the reasons are multifactorial, including day-to-day workload pressures leading to reactive rather than proactive care, and a lack of engagement from other disciplines in the care of patients with chronic conditions.

Similarly, all of the nurses who managed chronic conditions in the study were appointed as a result of grading rather than previous knowledge or skills and no training was provided in preparation for the role; rather any knowledge was developed after their appointments.

Barriers to the effective management of chronic conditions were identified in the study and included the excessive amount of documentation and the demands this placed on nurses’ ability to visit patients. The documentation was also felt to be repetitive and took a considerable amount of time for nurses to complete.

The involvement of GPs was also inconsistent, with data indicating that this varied from regular contact with the nursing teams, to only becoming involved if requested to do so.

**Actions**

**Excessive documentation**

The documentation used by all the teams to process and manage patients was reviewed and any repetitive or unnecessary forms or information was removed. This helped to reduce the amount of documentation required.

**Lack of GP involvement**

One local GP agreed to implement a model whereby patients on the practice’s chronic conditions register were jointly managed by district nurses, practice nurses and GPs. This model was successfully introduced and subsequently proposed for roll-out across the locality.

The study did have its limitations as the findings only relate to one locality; similarly, the findings are unique to the participants and therefore generalisation is not possible. However, it is likely that the issues identified would be seen in all teams to differing degrees.
CONCLUSION

The findings of the study indicate that a major overhaul of the current model was not required as the foundations were there; however, small steps and a shared vision could potentially result in sustainable changes for an efficient chronic conditions service.

The findings also indicate that the current model of care was not without its challenges and that a model that is successful in one area may not be successful in another. Consideration has to be given to the specific needs of a local population and their social and epidemiological differences. Modernising services to meet these needs has to be a key aim.

The themes identified in this study are echoed in the literature from other studies both in the UK and internationally. The findings of this study suggest that with a little investment, the potential to achieve an improved service for patients experiencing chronic conditions is there.

REFERENCES


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KEY POINTS

- This study aims to explore district nursing teams’ perceptions of the current chronic conditions management model in a specific locality in Wales.

- Chronic diseases are now the leading cause of illness burden and disability across the UK, placing an increasing demand on public services as they try to meet the needs of those with long-term conditions.

- The author used action research to conduct the study, encouraging all participants to critically review their current clinical practice.

- The findings indicated that a major overhaul of the current model of care was not required; the foundations were there and just some small steps and a shared vision led to sustainable changes for an efficient service.