An evaluation of the role of the community matron: a literature review

Community Matron Literature Review.

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Abstract

This paper aims to review the current literature and evidence relating to the evaluation of the role of the community matron and the models used in the UK. The Community Matron role was introduced into the UK in 2005 in order to reduce unplanned hospital admissions of patients living with long-term conditions. The literature to date has provided limited evidence of areas of good practice however although this is mainly anecdotal. This paper aims to review the current literature and evidence relating to the evaluation of the role of the community matron and the models used in the UK.

This A literature search was undertaken in 2008 using electronic databases, reference lists and other available literature. Papers were sourced from the Medline, CINAHL, Cochrane and the RCN on line library. Key words included ‘community matron’, ‘case manager’, ‘case management’ and ‘long term conditions’ and was restricted to work published after 1999.

It was clear from the literature search that the role of the Community Matron is well documented although there continues to be some confusion as to the difference between community matrons and case managers. Evaluation of the role to date has focused mainly on the evaluation of the Evercare model introduced in the initial pilot period however there are many more in practice. Patient’s perceptions and changes in their perceived quality of life have also received limited attention. We the authors feel that it is important that the role is evaluated further.

Key words: Community Matron, Case Manager, case management, long term conditions.

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Introduction

The Department of Health realised the challenge of responding to the needs and expectations of the increasing numbers for people living with long-term conditions in their document Supporting People with Long-term Conditions: An NHS and Social Care Model to Support Local Innovation and Integration (DH 2005a). They emphasised the role of Community Matron and Case Managers, previously introduced in the NHS Improvement Plan in 2004 (DH 2004), stating that 3000 Community Matrons should be in place by 2007. However according to Snow (2007) there were just 1,348 in post in England by the date agreed. This shortfall is a result of several factors including the lack of evidence to support the role and the primary findings of the evaluation of the Evercare model used as a pilot project on nine sites throughout the UK.(Gravelle et al 2006) which concluded that it had not succeeded in reducing emergency hospital admissions or length of stay.

In reality prior to the implementation of the Community Matron there was little coordinated care for patients with long term conditions. This client group have traditionally been managed by life long regular medical reviews according to Pope (2005) who argues that the patients clinical appointments to jobs did not always coincide with the patients specific needs.

The government’s aim, through the introduction of this community matron role, was primarily to reduce the inappropriate use of acute services and bed admissions by this client group and to treat patients sooner and nearer to their home (DH 2005a). For this to happen the Community Matron would become the key worker for the client with complex needs and take responsibility for the coordination of services ensuring that their client’s needs were met and their well being increased (DH 2005b) and according to Murphy (2004) that they would work alongside other initiatives such as the Expert Patient Programme (DH 2001) in order to improve self-care and make better-informed choices for the person living with a long-term condition.

However, since its implementation the role of Community Matron has not been entirely problem free. The model chosen to introduce this role into the UK was that of the Evercare approach that was widely used in the US where this approach was developed for a different private health care system and mainly with people in residential care. Nine pilot projects were identified within the UK and ran from 2003-2004. Some of the earlier evaluations of the role have identified where the Community Matrons have failed to achieve the government targets in relation to the reduction of unplanned hospital admissions. (Gravelle et al 2006). In the literature search we refer to claims that are made about the Evercare approach and other models that have since been developed claiming to be meeting those targets. We note that many of these claims are anecdotal in their evidence.

Search methods

A comprehensive review of the literature relating to Community Matrons was conducted using electronic data bases, reference lists and other available literature. Articles were sourced from CINAHL, Medline, Cochrane and RCN online library. The search themes used were: Community Matron, Case Managers, case management and long term conditions. A total of 32,475 papers were retrieved from these online searches although many were not relevant as they did not adequately address the title and role of the Community Matron within the UK. The search did find 261 papers that referred directly to the role of the Community Matron although some of these were duplicated with each search. The literature reviewed was then refined to fifty two papers, one book and fourteen reports. Most of the work has been written in the last eight years reflecting the introduction of the post into the UK and therefore the time boundaries of the literature review spans 1999-2008.
The community matron role

As stated, the government first defined the role in their improvement plan in 2004 and enforced it with the Supporting People with Long-term Conditions document in 2005a. However in 2006 the Department of Health guidance was vague as to what actual tasks are involved with case management even though core competences were defined for the Community Matron in 2005 in their document, Case Management Competencies Framework for Care of People with Long Term Conditions (DH 2005c). There appears to be some confusion as to the role of the Case Manager and Community Matron where the terms are used synonymously and there is a with a lack of clarity for their roles (Davies 2008). Some authors have attempted to define the role of Community Matrons, as Bird and Morris (2006) noted, that this new type of practitioner was one who was highly skilled and a specialist in the community care and interagency working. Other authors have described the Community Matron as highly skilled autonomous practitioners able to assess, diagnose and prescribe treatment. (Pollard 2005, Patrick et al 2006, Clegg et al 2007, Roser and Rickby 2007 and Masterson 2007a). They Community Matrons assist the patient who was living with complex long-term condition to remain within their home not only with a coordinated care package, but to gain better understanding of their condition through educating the patient and their carer encompassing the patients social and personal needs so that they can enjoy a better quality of life (DH 2005a). Government Policy document states that Community Matrons should provide clinical intervention as well as care coordination. (DH 2005a). They went on to define their role as;

‘...a qualified nurse who can provide advanced nursing and clinical care, as well as effective case management’. (DH, 2006)

However as Sargent et al (2007) found in their study the Community Matrons moved beyond this definition and their care tasks influenced: clinical care, care coordination, education, advocacy and psychological support with some clinical tasks that were located within the medical paradigm that had previously been provided by the general practitionersGPs.

Murphy, back in 2004, noted that it was going to be a tough difficult job for nurses to do well as he identified the complexity and difficulty of such a role is often underestimated. This was no better in 2007 when Murphy continued to point out that many of the studies suggest that case management the Community Matron role is still unclear.

The role of Case Manager is less well defined in the literature and the titles tend to be interchanged depending on where the practitioner is employed (Davies 2008, Zwarenstien et al 2000). The general consensus in the literature, and line with the government policy, tends to relate this role to the management of patients with one long term condition (DH 2005 a; Cook 2005) rather than the skills required for the post. According to Willison and Andrews (2005) they case managers should bring the role and skills together and refer to chronic disease management which they defined as an approach to health care that emphasises helping individuals to maintain independence and keeping as healthy as possible through prevention, early detection and management of chronic conditions.
Preparation for the role

Pateman (2005) highlighted the educational needs for the Community Matrons as formidable as they have to be a generic worker as well as working at an advanced level. It is generally agreed in the literature that these practitioners are advanced level practitioners (Pateman 2005, Banning 2006, Ball 2006, Woodend 2006, and Roser and Rickby 2007). Murphy (2004) identifies that these practitioners in the US are trained to degree level but successful schemes in the UK to date are postgraduate practitioners with further training. Banning (2006) also suggested that the training should be at masters level but not necessarily a full masters programme. Even with the variability in the education and training of these practitioners at advanced level Woodend (2006) suggests that this is a unique opportunity for the Community Matrons to lead in healthcare development. Woodend (2006) also notes that advanced nursing practice in this instance involves taking on medical skills and extending the boundaries of nursing practice although they also suggest that Community Matrons should identify their individual needs and commission appropriate training and education (DH 2005b). Ball (2006) identified in their survey of advanced practitioners that most respondents reported that the best preparation for these roles is a combination of having the right experience and having suitable educational preparation. Casey and Mackereth (2006) also highlighted in the preparation of these programmes the importance of partnership between the higher education establishments and the workforce requirements. They go onto note the importance of responding promptly to changes and developments in health policy. And as Pooler and Campbell (2006) noted the importance of ensuring that the Primary Care Trusts ensure that their Community Matrons have their learning needs assessed with work based learning to allow for appropriate development. They argued that non-clinical education should also be vital to the long-term success of the role.

Evidence of the effectiveness of the role

There are some discrepancies in the evaluation of the service and its impact on the reduction of unnecessary emergency bed admissions for people with long-term conditions in the current literature. Much of the literature relating to the effectiveness of the role is anecdotal and as As Hutt and Rosen noted in 2005 there was only weak evidence that case management reduced hospital admissions, however, they also highlighted the considerable methodological problems with evaluating such a complex interventions. This was supported by Roland et al (2005) who showed that monitoring of admission rates cannot assess intervention designed to reduce admission amongst frail older people as rates fall with out any intervention. Fireman et al (2004) reported evidence of substantial quality improvement of care for people with chronic disease but not sufficient cost saving to offset the nursing care although they also highlights the lack of rigorous evaluation especially in relation to clinical and service outcomes and patient perspectives. Masterson (2007a) and Lillyman and Saxon (2007) support this argument and suggest further research needs to be undertaken in relation to the patient’s perspective of care as well as the financial implications. Wright et al (2007) in their evaluation of the role found that the patients valued the Community Matron’s clinical skills and availability reporting an increased confidence that their condition could be managed. In turn they noted this led to a feeling of safety and security whilst increasing their quality of life and confidence over self management. In their study, Rosser and Rickaby (2007) highlighted the very positive gains from the patient’s perspectives. Staines (2007) suggested that Community Matrons are proving their worth and pockets of good practice can be identified within the UK. For example:
Lyndon (2006) suggests that Community Matrons have made a big impact in Cornwall, as did the Castlefields project (Castlefields 2004), and in places such as Leeds (Bee and Clegg 2007) and Lincoln (Agnew 2005). Although these claims are made there is a general consensus in the literature that rigorous evaluations be undertaken as much of this data remains anecdotal. In line with the Government target Parish (2005) did report a reduction in admissions, in length of stay and GP visits. The Lincoln pilot project also claims reduced admission of patients however Agnew (2005) noted that this can also be done without the Community Matron. A project carried out at the The Castlefields Health Centre in Runcorn model that was also promoted by the Department of Health as demonstrating examples of successfully providing a proactive service and reducing hospital admissions and improving patient outcomes. (Tovey 2005)

One way of predicting the risk of readmission was by using the Patients at Risk of Re Hospitalisation (PARR) case finding tool, developed by the Kings Fund in conjunction with New York University and An American Analytics Company Health Dialog. This tool, which enables Primary Care Trusts which helps to build an accurate picture of those patients at higher risk of emergency readmission according to Curry (2006). However McKeown et al (2006) suggested that changing the way resources are directed could save money in the long term by keeping people well and avoiding the need for clinical care.

One study by Patrick et al (2006), when viewing the use of nurse led case management, did report a reduction in admission rate in both their control group and intervention group but noted no difference in rates between the two groups. An interim report on the role on the pilot sites in the UK by the DH and NHS Modernisation Agency Matrix Research and Consultancy (2004) early on the implementation of the role in the UK stated that was ‘data rich, information poor’ but that it was beginning to show benefits in terms of reducing unplanned admissions to hospital.

It was the Kane et al report (2003) in the US that had reported findings of reduced admissions using the Evercare approach, however although critics have noted the difference in the US and UK health care systems (Woodend 2006) from a private health care system in the US to that of the NHS ‘free to all’ and suggest that the approach is not and that this approach as not directly transferable to the UK approach to care (Woodend 2006)

However the Evercare interim report (Evercare 2004) also included the advanced practitioner’s document that they had averted preventable hospital admissions, shortened hospital stays, improved patient functional status and quality of life and made medication changes to avoid adverse reactions. They had also enhanced care orchestration to reduce fragmentation among services and were able to honour patient preferences. However in the final report of the Evercare project, provided by Gravelle et al (2006), they noted that the intervention had no significant effect on rates of emergency admissions, bed days or mortality in high risk cohorts, although they did go onto point out the role had added frequency of contact with regular monitoring, psychological support and a range or referral options that had not previously been provided to frail elderly people.

__Modles, approaches and systems used by community matrons__

Hutt et al (2004) and Singh (2005) noted a variety of models in the approach to the Community Matron’s approach to care. Many can also be found in the current literature.

Willison and Andrews (2005) state that effective care programmes can prevent flare-ups or more severe episodes of illness, improving patients’ quality of life and therefore need some consideration prior to their implementation. In the literature the following approaches were noted:
Self management

It was the Departments of Health’s intention that the key policy goal was to improve the quality of care for patients living with long-term conditions (DH 2005a). It was envisaged that the Community Matron’s initiative included the self-management model encouraged by the Expert Patient Programme (DH 2001). With the two there was a potential to create a new community workforce of self-managed and self care skills for this client group. This approach was included in the Norfolk model as described by Jacobs (2006) and Kenny et al (2007) who suggested that this approach could have a major effect of the management of people with long-term conditions. Brownsell et al (2006) pointed out that with appropriate support it could make major preventable interventions practicable. Blakeman et al (2006), following their research of the General Practitioners' perceptions of self-care, noted their conflicts in the GP valuing patient involvement and sharing control in the management of health over their with other professional responsibilities for delivery of patient care.

However Taylor and Bury (2007) stated that this approach should not draw away from the social determinants and contexts of health in this client group. Griffiths et al (2005) also evaluated a culturally adapted lay-led self management programme amongst Bangladeshi population but they reported that there was limited benefit in the increase of self care behaviour and little effect on their health status. Kenny (2005) reported on the tensions for the trained lay people who become trainers that emerge from the consequences of having a long-term condition, their relationship to other occupants operating within the primary care and their structural position in the NHS. Bury and Pink (2005) also note the little agreement on how effective this approach is and Sargent et al (2007) highlighted that patients were often too ill or frail to achieve the aims of supporting self care, self management and independence.

Evercare/ Kaiser model

Evercare was developed in the USA to improve the quality of life for vulnerable older people and was piloted in nine UK sites in 2004 with what Hudson (2005) refers to as a ‘hybrid Anglo-US model’. The Department of Health suggests this approach reflects the strengths of the infrastructures and services of the UK (DH 2005b). Evercare was designed as a model of care for frail older people where care is organised around the patients needs. Another US model, Kaiser Permanente is similar to Evercare however this puts more emphasis on the integration of inpatient and output patient care allowing patients to move between hospital and the community. Talbot-Smith et al (2004) argued that the NHS is not similar to Kaiser in coverage, cost or performance however Ham et al (2003) suggests that the NHS can learn from Kaiser’s integrated approach.

Hudson (2005) notes the shift from previous approaches where he suggests the focus has been on disease-specific models rather than generic models. In the UK the Community Matron may have a caseload of around 50-80 patients with the most complex needs and they may be involved with more than one general practice. Murphy (2007) reported in her study that there is a need to review organisational approaches to care, develop patient centered approaches to care and provide educational support for managers. This was supported by McCormack (2003) suggesting that care for older people should be person centered and holistic, based on autonomy, respect, choice and the promotion of independence.
Approaches and systems employed within case management

Linking with secondary care

Challis and Hughes (2002) highlighted that the most effective scheme of case management was to have close links with secondary care allowing ready access to clinical assessment by specialists. This involves comprehensive assessment and reassessment by specialist doctors, have access to the multidisciplinary clinical team and funding levers to substitute hospital care by home care according to Johri et al (2003). Murphy (2004) also argued that without the active involvement of hospital specialists, local social services and the right financial levers Community Matrons would not be able to make much impact on hospital admissions.

Motivational interviewing

Masterson (2007b) suggested including self-care management of these patients with the use of motivational interviewing to help them plan for change bringing this in line with McCromack and McCance’s (2006) person centered approach.

Virtual wards

Lewis (2007) included the approach model used in Croydon where Community Matrons assess the patient at home and move them between ‘virtual beds’ providing different degrees of nursing according to their clinical condition. They suggest that offering preventative care via this method can reduce the demand for hospital admission.

Targeting clients

The Leeds approach model, reported by Bee and Clegg (2007), is reactive and identifies people with complex needs who are already having difficulty managing their conditions. They target specific population group whilst gaining local intelligence and practice profiles in order to design a predictive, proactive model of case management. This according to Lipley (2004) assists in the Senior Nurses being central to delivering the public health agenda.
Telecare and Telemedicine

This approach was described by Garcia-Lizana and Sarria- Santamera (2007) as interventions of using information and communication technologies for managing and controlling chronic diseases. In their study they found that the systems for improving education and social support were effective in this client group however they also reported that the evidence about clinical effectiveness was limited. Whitten and Mickus (2007) found in their study that patients were satisfied with the technology but there was no significant predictor of health and well-being as opposed to Horton (2008) who reported that the benefits for their client group included a rapid access to care, increased sense of personal safety and security and the continuity of care. However Garcia- Lizana and Sarria- Santamera (2007) found the opposite to Whitten and Mickus (2007) reporting that the equipment was not ‘user friendly’ and was bulky. Murphy (2007) reviewed this from a different perspective of being a team approach to care rather than one person’s role but also reported of one approach where it was only one nurse on the end of a phone.

CONCLUSION

The role of the Community Matron is a very real concern for the continued support of this client group and area for debate for the NHS with the increasing amount of people living with one or more long term condition. The concern in relation to the effectiveness of the role has been extended in relation to the published findings of the Evercare model of care implemented as a pilot study across the UK. Understanding the role and its value on the quality of life for patients with long term conditions is crucial in the support and development of this role across the UK. Our current understanding of the role is that it continues to develop but at different stages and in different directions across the country. In this paper we have highlighted some of the claims made using the different approaches and current evidence in relation to the role. However as Willison and Andrews(2005) noted there should be some consideration of the model or approach that is to be implemented if they are to be effective in preventing flare-ups of chronic conditions or more severe episodes of illness. What is clear from this review is the evidence to support the effectiveness of the role of the Community Matron is mainly is that there is much anecdotal evidence to support the role however there is with little evidence based research. As we have shown depending on the literature read and relating to the model the role has conflicting evidence in its evaluation of reaching government targets set out in the 2005a document.

It is hoped that the role will be considered further in relation to its value to the patient as well as its ability to meet government targets and that further research is required prior to dismissing the role and running the risk of losing a valuable service to this client group.
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