Implementing the role of the community matron

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About 17.5 million people in the UK are living with a long-term condition. Part of the government strategy to improve outcomes for these people was to introduce the role of the community matron. This article builds on previous research by examining the community matron role across nine PCTs.

Approximately 17.5 million people in the UK are living with a long-term condition (Department of Health, 2005a). Part of the government strategy to improve outcomes for people living with long-term conditions was the introduction of the community matron (CM) role (DH, 2004).

Guidance issued by the DH has sought to clarify the role (DH, 2005b) and the competencies required (NHS Modernisation Agency and Skills for Health, 2005). However, little is known about the delivery of the role within the community. Smaller studies have been conducted on the experiences of nurses working as CMs in specific regions (Alder, 2005a; 2005b; 2005c; Carnwell and Daly, 2003) but this study builds on previous research by examining the CM role across nine PCTs.

Evercare is a nurse-centred chronic disease management programme initially developed in the US by the United Health Group. The DH commissioned UHG to pilot the Evercare programme in 10 PCTs in 2003-2004 (Boaden et al, 2005). As part of the first phase of evaluation we interviewed 14 advanced practice nurses, six clinical leads and all nine nursing pilot project leads (Boaden et al, 2005). This process yielded a large volume of information on the role of the advanced practice nurse (APN), which is now referred to as the CM role (Box 1, p24).

What do community matrons do?

Provide clinical care

A distinctive feature of the Evercare model is that all case managers for long-term conditions are clinically trained. The way that the model was implemented in England required CMs to have advanced nursing qualifications or to commence training in advanced clinical skills once in post.

CMs conduct top-to-toe physical examinations, full psychosocial and environmental assessments, take patient histories and review medications. One respondent commented: ‘We do a full examination, a history and a full review of systems. Then we look at particular illnesses that they have so that you have a good idea of the causes.’

The advanced clinical skills of CMs allow them to identify early warning signs, investigate and diagnose exacerbations of illness and arrange for treatment to be implemented.

Coordinate care

CMs lead the development of care plans with patients, carers and GPs. Once a care plan is agreed the CM ensures that services such as social care are put into place to meet identified needs. The CM then continues to monitor the patient according to their risk level. Key benefits of the care coordination role include one person knowing almost everything...


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about that patient and there being a proactive approach to care. One respondent commented: ‘we are looking at a whole chronic disease pathway. It is looking at the patient in a different way – we are being very much a proactive service.’

Regular monitoring helps ICs identify and resolve small problems before they become serious exacerbations of illness. The care coordination role of ICs covers a wide spectrum of input, from relatively straightforward referrals for equipment through to complex working with specialist services.

Supporting patients and their families

An important part of the CM role is to support patients and their families. This includes acting as an advocate for patients within other services. One respondent commented: ‘With patients who have an outpatient appointment, I’ll try and send a letter and say what’s happening so the patient doesn’t then have that responsibility.’

ICs also provide information and education to support patients and their families. Patients are educated about their condition and encouraged to be alert for early signs of illness. Patients and families are provided with practical instruction from correct inhaler technique through to how to cope with panic attacks. ICs also provide patients with information and referrals to other services.

The single and regular point of contact provided by the CM has both physical and psychological benefits for patients. Patients can telephone the CM if they have a health concern. This helps patients to feel reassured. One respondent commented: ‘They have access to my mobile phone and can ring with anything that bothers them, so they feel safer.’

Effective communication and trust is integral to the development of supportive relationships with patients and their families. CMs commented that they have reduced patient anxiety by spending time with them and listening to their concerns. In this way CMs provide socially isolated patients with an important source of psychological support. One respondent commented: ‘Quite often they do ask to see me and it’s not necessarily on anything medical or nursing, it’s more of a social issue. If they have a problem where they’re feeling low then they would see me.’

Working with other service providers

The CM role involves working with people from a wide range of organisations. This can be challenging yet it is fundamental to the role. One respondent commented: ‘You do have to fight your corner. You do have to follow up referrals – as an APN I hound them until we get what we want.’

From the time of a patient’s first assessment onwards the CM must liaise with a range of other professionals. This may necessitate the development of new relationships across service boundaries. One respondent commented: ‘Part of the initial assessment includes discussing the management plan with the patient, their GP, the practice pharmacist, the social worker, a district nurse and any of the specialist nurses involved, such as the heart failure nurse or respiratory care nurse.’

The intention is not to take over but to ensure that care is effectively and seamlessly coordinated. This not only improves the quality of care but promotes task sharing and reduces duplications.

Some CMs also liaise with secondary care services when patients are admitted to hospital. The CM provides staff with information about the patient’s medical history and usual functioning as well as liaising with discharge planning teams.

The role of the community matron

Participants in the research recognised elements of traditional community nursing roles in the CM role. However, the role was thought to differ in a number of ways. First, the role was seen as combining aspects of the medical model together with traditional nursing care. One respondent commented: ‘It’s kind of a combination between the medical and nursing model. And so we have to learn some medical aspects, some clinical assessment skills and about drugs.’

Second, the CM role allows nurses to develop advanced knowledge and skills and to work in a highly autonomous way.

Third, CMs ‘have the time’ to deliver proactive, holistic patient care, whereas district nurses are ‘far too busy’. One respondent commented: ‘I think this role forces you to look at the patient in a whole way. To go to a patient with oedema as a district nurse you think well, “you’ve got leaky legs, let’s dress them”. But it’s looking at it in a different way – it almost forces you to look at the patient holistically.’

Finally the CM role was also seen to differ from other nursing roles in that it combines a dual focus as both a ‘generalist’ and ‘specialist’ in the management of long-term conditions.

One respondent commented: ‘You can’t really say that you’re a generalist with specialist skills but that’s what it is – it’s a generalist who specialises in older people’s health and chronic disease management really.’

BOX 1. KEY COMMUNITY MATRON ROLES

-Coordinate care
-Provide clinical care
-Support patients and their families
-Liaise with other health professionals

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