Using community matrons to target long-term conditions

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ABSTRACT Bird, D., Morris, T. (2006) Using community matrons to target long-term conditions. Nursing Times; 102, 23: 19–20. The community matron is a new type of practitioner, one who is highly skilled and a specialist in community care and inter-agency working. It is considered that this new role will support new ways of working to reduce unplanned hospital admissions and support the most vulnerable people in our communities. The role is not simply one of coordination but will extend to undertaking clinical interventions, making referrals, prescribing medicines and requesting investigations.

The policy document The NHS Improvement Plan – Putting People at the Heart of Public Services (Department of Health, 2004) first introduced community matrons in June 2004. The objective of this document was to capitalise on the service modernisation that started in 1997 and to continue to develop a health service that was fairer, faster and offered better care. An area of particular development was the care and management of the estimated 17.5 million people in the UK who live with ‘complex and long-term conditions’ (DH, 2005a; 2004). This group of people is often exposed to care that can be reactive and uncoordinated, with episodes of unexpected admission to hospital.

Patients with longer term and chronic conditions are classified into three broad groups (DH, 2005b): level one people take an active role in managing themselves and are self-caring with minimal input from healthcare workers; level two require active intervention and can be considered more high risk; level three are those viewed as highly complex.

People in the level three group are the target of community matrons. A significant proportion of this group are older people with multiple chronic diseases requiring considerable intervention. The extent of these diseases is sufficient to disrupt their ability to maintain activities of living.

It has been estimated that 2% of people with chronic disease account for 30% of unplanned hospital admissions (Murphy, 2004). When associated with an ageing and more dependent population and considered alongside the estimate that 78% of all healthcare money is spent on long-term conditions, the pressure on resources is evident. To tackle this situation the government has set targets of reducing unplanned hospital admissions by 10–20% and reducing emergency inpatient bed days by 5% by 2008 (Mayor, 2005; Murphy, 2004). The community matron is viewed as pivotal in achieving these goals.

The role of the community matron
The community matron is a new type of practitioner, who is highly skilled and a specialist in community care and inter-agency working. The role will support new ways of working to reduce unplanned hospital admissions and support vulnerable people in our communities. A community matron will identify those at risk, assess and plan their care and coordinate this care with other providers. They will be responsible for integrating care to meet all the individual’s health and social needs. Case management will be used to undertake this role.

If the community matron is to reduce unplanned hospital admissions then there must be close collaboration between the primary care setting, the
secondary care setting and social services. The community matron will coordinate this inter-agency cooperation. It will be a highly visible and accessible role for both the patient and the other members of the team. The role is not simply one of coordination but extends to undertaking clinical interventions, making referrals, prescribing medicines and requesting investigations. Box 1 provides a summary of the role.

**Case management**

To ensure that the care provided is coordinated, structured and more accessible, the community matrons will use case management. The NHS variant of case management, based upon a system used in the US, will provide the at-risk individual with a personalised care plan that is comprehensive and synchronises multi-agency input.

Each community matron will take responsibility for 50 people who have ‘high level needs’ (DH, 2005a). They will be based within the primary healthcare team and work closely with the individual’s GP. They will monitor the individual’s situation and respond as required, liaising and collaborating with other professionals. They will ensure early recognition of a deteriorating situation and work to prevent further decline within the individual’s own home.

In summary, case management will:

- Identify and support the most vulnerable individuals within the community;
- Enhance primary care strategies;
- Identify individuals who are at risk of unplanned admission to hospital;
- Ensure seamless care as the individual moves through the healthcare system;
- Allow a personalised plan of care to be developed, tailored to meet their unique needs.

**Role evolution and development**

Many PCTs have not introduced community matrons, so it is difficult to ascertain whether this role has met the objectives set out in *The NHS Improvement Plan – Putting People at the Heart of Public Services* (DH, 2004). A thorough role evaluation both locally and nationally is many years away. But discussion is starting on the role’s function and future. The British Medical Association and the Royal College of General Practitioners have expressed concerns that there is great risk of role overlap and duplication between GPs and community matrons (Murphy, 2004). This duplication might confuse patients and result in multiple entry points into the healthcare system.

The goal of recruiting 3,000 community matrons might also prove problematic. The ideal candidate would need experience in both primary and secondary care as well as in case management. As case management is a relatively new concept for nursing practice it is unlikely that there are many practitioners that are familiar with it. Consequently, community matrons will require a lot of support and training to ensure that case management is used appropriately and to its full potential (DH, 2005c). The ability of case management, the linchpin of the community matrons’ role, to reduce unplanned hospital admissions has also been questioned. When reviewing case management, the King’s Fund found scant evidence that it was able to reduce unplanned hospital admissions (Hutt et al, 2004). Hutt et al (2004) acknowledge that case management might help prevent unplanned hospital admissions. However, this raises concerns that a ‘one size fits all’ approach might not be the solution. Instead, PCTs should be given the ability (and discretion) to develop systems that suit their local population and all healthcare-providing stakeholders.

**Conclusion**

People suffering from long-term conditions will benefit from the community matron role. But its introduction into the primary care sector comes at a time of transition and change. Integrating a new role into any existing team can be problematic and, if its full potential is to be realised, it must avoid role duplication and ambiguity. This might prove difficult when the NHS itself is changing simultaneously with the launch of this role.