Community Matrons:

Caring for people with long-term conditions

Note

Healthcare practice and knowledge are constantly changing and developing as new research treatments, procedures, drugs and equipment become available. The authors and publishers have, as far as is possible, taken care to confirm that the information in this book complies with the latest standards of practice and legislation. Where examples have been taken from practice in this book pseudonyms have been used to protect the patients' identity.

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Caring for people with long-term conditions

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A division of MA Healthcare Ltd

Quay Books Division, MA Healthcare Ltd, St Jude's Church,
Dulwich Road, London SE24 0PB

British Library Cataloguing-in-Publication Data
A catalogue record is available for this book

ISBN-10: 1-85642-373-5
ISBN-13: 978-1-85642-373-1

Printed by Ashford Colour Press, Gosport, Hants

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Preface

In January 2005 the NHS and Social Care published their document entitled *Supporting People with Long-Term Conditions* (DH 2005). They reported that 17.5 million people in this country currently live with a long-term condition. Although they acknowledge that examples of local excellence are not hard to find, they suggest that we have reached a crucial junction as the number of people living with long-term conditions is set to increase.

The government is committed to improving care for these people by moving away from reactive approach based on acute systems, towards a systematic, patient-centred approach. This approach, they believe, needs to be rooted in the primary care sector, underpinned by communication and new partnerships across the whole health and social care spectrum.

To address these issues set out in the document, this book reviews the role of case manager/community matron as identified by the government. With the introduction of these roles there has been some debate about the title and role this practitioner plays. This book will attempt to identify those practitioners who take on this role, identify the differences between the case manager and community matron and draw on practical experiences from practitioners who have to make difficult decisions out in practice. The book is aimed at any healthcare professional who takes on the role of case manager or community matron.

The book also reviews where the practitioner can move the boundaries forward in their role to achieve the government goals and provide best care for their patients.

We hope that this book will provide information and some practical advice for all professional groups to understand the role of the case manager/community matron and assist those taking up the role to deliver an informed approach to implementing and caring for the person living with a long term condition.

Sue Lillyman and Ann Saxon

Reference

Department of Health (2005) *Supporting People with Long Term Conditions; An NHS and Social Care Model to support local innovation and integration*. London, DH

Acknowledgements

In producing this book we acknowledge our debt of thanks for the support of our colleagues, students, case managers and community matrons who have encouraged us to write such a book.

Introduction

This book is designed to assist the case manager or community matron with issues that they may face within their practice. It is also designed to help other health professionals in secondary and primary care to understand the community matron/case manager's role when working with patients with long-term conditions.

A patient in the latter stages of chronic obstructive pulmonary disease (COPD) identified how the case manager role had helped both him and his wife to cope better with his condition. Previously his only option was to dial 999 and end up in hospital when he felt unwell or needed some advice on his condition. Although the hospital staff could administer antibiotics he found that they were not familiar with his condition and how to manage it, so he was sent home with the same frustrations and questions as he had had before admission.

With a named case manager and specialist practitioner working together to meet his and his family's needs the man felt secure in his own home. He described how all the aids to assist living had been coordinated. A rescue pack with antibiotics for his use had been left so that he could commence treatment when needed. And he was given a phone number to call instead of the ambulance if he felt he needed extra support and advice.

Case manager and community matrons hear many such examples from patients and carers. We hope this book will inspire others to follow the example set by the authors and contributors, as they describe the process they have gone through to deliver that best care for the individual and help them cope with daily life when living with one or more long-term conditions.

Case managers and community matrons in practice have contributed to the production of this book adding a breath and variety of perspectives of the role.

The first chapter reviews the current literature and government documents that relate to this role, identifying the difference between the case manager and community matron. Chapters 2–4 have been written by case managers and identify issues that any manager/matron may be faced with. The final chapters review how the role can be pushed forward and the support systems that these practitioners may access when developing and working with this client group.

Alex Ajao

BSc (Hons) Nursing, BSc (Hons) Community Nursing, RN, PG Cert (Case Management).
Case Manager, Solihull Primary Care Trust
Alex qualified as an enrolled nurse in 1986 at East Birmingham Hospital and in 1992 undertook a BSc (hons) in Nursing at the University of Central England. She then she worked in the community as a district nurse and in 2002 was given the opportunity of visiting Kaiser Permanente in California where she was inspired by the programme of case management. When community matrons were introduced to Solihull in 2005, Alex was instrumental in setting up the service, building on the philosophy of self-management and allowing people to be cared for in their preferred place. After completing the University of Central England's postgraduate certificate in Long-Term Conditions, Alex, with Cecily Harper, formed the West Midlands Community Matron forum aimed as a supportive and learning network for this new role.

Sandra Baines

RN, DN Cert, DPSN.
Respiratory Outreach CNS, Birmingham Eastern and North Primary Care Trust
Sandra commenced her nursing career by completing the orthopaedic certificate in 1977 at the Royal Orthopaedic Hospital in Birmingham before completing her general nursing qualification at East Birmingham Hospital. She remained in orthopaedic and general medicine until she entered district nursing in the late 1980s when she worked in the inner city of Birmingham, for 10 years on the community. Following this, Sandra worked as a tissue viability nurse before taking on the role of discharge planning and care coordinator managing, where she coordinated the discharges for patients who required complex packages of care. Sandra returned to the community as a case manager and has recently moved to respiratory outreach work in the north of Birmingham.

Diane Davies

RN, SN Cert, HV, BSc (Hons), PG Cert (Case Management).
Community Matron
Diane commenced her Registered General Nurse training at St Bartholomew's Hospital, London and qualified in 1988. She became a school nurse for Wolverhampton Health Authority and completed the School Nurse Certificate in 1990. Diane undertook the Health Education Certificate in 1991 and following this

became increasingly interested in public health work. Having qualified as a health visitor in 1993, Diane took the lead on a number of health promotion activities, e.g. pioneering the concept of baby massage in Wolverhampton. She completed a BSc Health Studies Degree in 2000 and implemented a number of health visiting service improvement initiatives. In 2005 Diane commenced the role of Case Manager in Wolverhampton City Primary Care Trust, which, through service developments, she has recently evolved into the role of Community Matron.

Cecily Harper

RN, DN cert, PG Cert (Case Management).
Case Manager, Solihull Primary Care Trust

Cecily Harper qualified as an RGN in 1975 at St Bartholomew's Hospital and qualified as a district nurse in 1978 and worked in the North of England before moving to Solihull. Cecily was part of the pilot case management project within Solihull in 2004 and this confirmed her enthusiasm to help develop a model designed to care for people with long-term conditions. When community matrons were introduced to Solihull in 2005 Cecily was instrumental in setting up the service, building on the philosophy of self-management and allowing people to be cared for in their preferred place. After completing the University of Central England's postgraduate certificate in Long-Term Conditions, Cecily, with Alex Ajao, formed the West Midlands Community Matron forum aimed as a supportive and learning network for this new role.

Sarah Knight

RGN, BSc (Hons) Nursing, BSc (Hons) community health with district nursing. PG Cert Ed (Long-term conditions).
Case Manager, Sandwell and West Birmingham NHS Primary Care Trust

Sarah's career in nursing started in 1991 when she commenced a three-year BSc (Hons) course in nursing at what used to be Birmingham Polytechnic. During her time there the title of the institution changed, so she qualified with a 2:1 class degree from the University of Central England. During Sarah's early career, she spent time working on an elderly care ward consolidating her skills, but also developing a strong need to access these patients before they reached the hospital ward. She subsequently started working as a staff nurse within a district nursing team. Sarah soon felt the need to access education to develop her professional career and by 1997 she had completed the BSc (Hons) Community Health with the District Nursing course. Over the years that followed and in between having her children she worked as a district nurse and became a discharge-planning nurse. This was one of the most rewarding parts of her career, accessing patients while in hospital and planning structured discharges for those most complex of patients to ensure they returned and remained at home. After six years within this post Sarah became a case manager. The essence of her role is to prevent avoidable

hospital admissions and to reduce length of stay. Skills she has developed in this role are the advanced nursing skills and non-medical prescribing which are seen as core to this role. Sarah is now in post as the case manager team leader covering a team of about 22 staff ranging from professionals allied to health, nurses, healthcare assistants and administration.

Sue Lillyman

MA (Ed), BSc (Nursing), DPSN, PGCE, RN, RM, RNT.
Senior Lecturer, Birmingham City University

Sue is a qualified nurse and midwife and worked in clinical practice for many years in a variety of hospitals in the West Midlands before entering nurse education in 1989. Recently Sue worked as a volunteer with street boys and helped to set up a medical programme in the Amazonian jungle and has been involved in various medical programmes in the shanty towns of Lima. On returning to the UK, Sue took up a post as senior lecturer at Birmingham City University where she is the route director for the postgraduate certificate in case management of patients with long-term conditions. Sue has had an interest in reflective practice and the improvement of patients care through reflection for many years and has been involved with portfolio development of staff, accreditation of prior learning and professional development. Sue is on the international advisory board of the peer-reviewed journal, *Reflective Practice*. Her work with Reflective Practice UK helps others reach full potential in their workplace through reflection and the development of reflective workplace culture.

Linda Parkes

RN, DPSN, PGCert Case Management of People with Long-Term Conditions.
Case Manager, Sandwell and West Birmingham NHS PCT

Since she qualified as a nurse, Linda's career has evolved around managing the needs of patients with long-term conditions. This pathway began working within a care of the elderly unit and then she became a discharge planning nurse where she also acted as a care manager in the assessment and discharge of patients with complex health needs. Linda is a specialist in continuing health care, acting as a gatekeeper for the provision of resources in the community, including monitoring of services that accurately reflect the changing needs of the patient and carers. As a case manager Linda has continued to hold the responsibilities of a discharge planning nurse and manage the health needs of patients with long-term conditions. Linda currently holds the caseload of approximately 50 patients requiring complex chronic disease management in a densely populated area, where the needs of the clients are diverse and most of the patients have comorbidities that require intense and complex management.

Ann Saxon

MA Education (Health care professionals) PG Dip Education, PG Cert, BSc Health Sciences. RGN, NDN Cert, SEN
Principal Lecturer, University of Wolverhampton

Ann's career started as an Enrolled Nurse at The Birmingham Children's Hospital in 1980 and she converted to a Registered Nurse in 1983. Since then Ann's career has been focused very much in Community as a district nurse and senior nurse managing a range of staff. She moved into education in 1993 following successful completion of her first degree. Ann worked as a Community Tutor at the Birmingham and Solihull College of Nursing and then as a senior Lecturer at UCE Birmingham where she managed the BSc (Hons) Nursing RN course. Ann then moved on to head of division for continuing care post and supported staff in developing innovative ways of delivering education for health professionals. Ann has been involved in Education with colleagues in Finland, Holland and Sweden as part of the ERASMUS programme and with the British Forces in Germany health service. She has also gained a teaching fellowship while at UCE Birmingham for her work in developing discharge planning education.Her current post is at the University of Wolverhampton as Principal Lecturer for postgraduate studies. Ann's interest in case management stems from her work as a community nurse, and her interaction with staff in the hospital setting. She has found it very rewarding to be part of the very first educational programme in the country. It is an important role for nurses to lead and it can have a major impact on the quality of care for patients with long-term conditions and their carers

Sue Talbot

RGN, MSc Advanced Nursing Practice, BSc (Hons), RNT.
Senior Lecturer, University of Wolverhampton

After qualifying in 1976 Sue worked in a variety of clinical areas, including surgical and renal nursing. In 1989 she moved into nurse education, taking responsibility for a number of courses, while undertaking a BSc (Hons) in 1991 and MSc in 1993. In 1996 she became involved in developing the MSc Advancing Clinical Practice and took responsibility for the Role Development Module, for which she is still module leader. With her extensive knowledge of developing the advanced practitioner role, Sue was asked to take responsibility for Developing the Role of the Case Manager as part of the Postgraduate Certificate in Case Management.

Abbreviations

ADL	activities of daily living
COPD	chronic obstructive pulmonary disease
DH	Department of Health
EPP	Expert Patient Programme
FEV	forced expiratory volume
FVC	forced vital capacity ratio
GOLD	Global Initiative for Obstructive Lung Disease
HADS	Hospital Anxiety and Depression Scale
KSF	Knowledge and Skills Framework
LTC	long-term condition
MRC	Medical Research Council
NMC	Nursing and Midwifery Council
NSF	National Service Framework
NYHA	New York Heart Association
OT	occupational therapist
PARR	patients at risk of rehospitalisation
PCT	primary care trust
QALY	quality-adjusted life-years
RCN	Royal College of Nursing
SAP	single assessment process
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life

CHAPTER 1

Case management and community matron development

Diane Davies

The importance of improving care for people with long-term conditions has become a national priority, as the incidence and subsequently the management costs of care are set to rise (Department of Health 2000). The Department of Health (2004a) heralded the introduction of the new roles of community matron and case manager as one approach to improve the management of individuals with long-term conditions. This included anticipating, coordinating and joining up care of specific high intensity patients, while supporting new ways of working to reduce unplanned hospital admissions and contain costs (Hutt, Rosen & McCauley 2004). Rossi (2003) suggests that the tools of advanced assessment, communication and leadership are key elements of effective case management.

This chapter will outline the new roles and how — through reflection – practitioners can analyse the impact of such new roles.

Analysis of the Case Manager/Community Matron Role

Case management is seen as pivotal in the success of chronic disease management and has been identified as one of the key roles in cost containment strategies developed by the National Health Service (Robinson & Yegian 2004). Dixon et al (2004) note that by focusing on the range of services that need to be in place for chronic disease management and by tailoring the intensity of care provided to match the severity and complexity of care needed, the number of hospital admissions can be reduced. Community matrons and case mangers have been identified as one of the key professionals to implement this new way of working (Goodwin 2006). However, this raises a number of issues relating to the developing case manager role.

Case management is described as a method of proactive care delivery in the community that involves identifying individuals in the population

who are at high risk of unplanned admissions, and who have complex and enduring health and social care needs (NatPact 2004). Cesta and Tahan (2003) argue that many health and social care professionals currently undertake case management roles, therefore individuals may be recruited if they have the appropriate skills. However the Department of Health (2006a) state that individuals with complex needs will require input from a community matron defined as:

> *'...a qualified nurse who can provide advanced nursing and clinical care, as well as effective case management'.*
>
> *Department of Health, 2006a*

Robinson (2005) suggests that district nurses or practice nurses are ideally placed to undertake the role of the case manager, as they are already have the clinical assessment skills required for the job, which would negate the need to involve other professionals and thereby reduce duplication. However, O'Dowd (2006) argues that the use of these practitioners will take from the already diminishing pot of nurses in the community and will create gaps in the workforce.

Collaborative Approach

Hutt, Rosen & McCauley (2004) suggest that any discipline with collaboration and communication skills would add a holistic approach to case management. Adams (2005) promotes the successes of case management by working in a team of social workers, therapists and nurses. The Department of Health (2005) acknowledges that the different models of case management could be offered by differing health professionals but tends to emphasise the benefits of a nursing background. Goodwin (2006) suggests that this is short-sighted, that it raises issues about health and social care models of care and undervalues partnership working.

Education Framework

Recently, the Department of Health (2006) *Education Framework for Community Matrons and Case Managers* clarified the specific domains required to undertake the new roles. A distinction between roles needed by community matrons and case managers has been made, notably with the acquisition of advanced assessment skills for the former. This illustrates the

importance of the title, although Sands (2007) argues that in future nursing careers would be focused on patient pathways and nursing roles, rather than a title. However, this requires role clarity, which currently appears to be lacking in the development of community matrons and case managers.

Furthermore, the change in title and need to acquire advanced assessment skills and clinical interventions may have increased accountability for some practitioners. Schmitt (2005) suggests that clarity of expressions and boundaries associated with the new role and the meaning ascribed to accomplish these transitions, as a loss or gain of function. This can influence the process of role transition and the degree of role strain experienced. Individual environmental moderators such as personality, social networks, support for learning and availability of resources can also exacerbate or diminish the experience of role strain (Daley 2001).

Development of New Roles

Resistance to change has been identified as a common barrier to role development (Bryar & Griffiths 2003). Bridges (2003) suggests that many attempts to implement change in nursing fail because of the unstructured approach adopted by innovators. O'Dowd (2006) noted that the current transition of this new role into the community had not been smooth.

The different approaches to case management and choice of models, in conjunction with the differing expectations of the case management approach, have led to resistance from other health and social disciplines who do not see a place for the role (Murphy 2004). Anecdotal evidence supports this and highlights the need for a more structured approach. Consistent information-sharing and effective communication are required if individuals, teams and organisations are to undertake the cultural shift of relinquishing traditional roles to accept and support new roles (Hudson & Moore 2006).

Developing New Skills

Evidence suggests that in developing a new role, practitioners are often isolated and lack support, both professionally and educationally (Reade *et al*. 2001). Clegg and Bee (2006) noted that underestimating this can cause practitioners unnecessary anxiety and negatively impacts upon the process of role transition. Senge (2000) suggests that individuals need to be supported in their 'discomfort zone', and by providing a safe environment in which to learn, the psychological process of transition can be nurtured.