

Authors version post peer review

Published version

Drennan, V., Goodman, C., Manthorpe, J., Davies, S., Scott, C., Gage, H. and Iliffe, S. (2011), Establishing new nursing roles: a case study of the English community matron initiative. *Journal of Clinical Nursing*, 20: 2948–2957. doi: 10.1111/j.1365-2702.2010.03643.x

Establishing new nursing roles: a case study of the English community matron initiative

Concise title: Establishing community matron roles

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Acknowledgements and disclaimer

This project was funded by the National Institute for Health Research Service Delivery and Organisation programme (project number 08/1605/122). The views and opinions expressed therein are those of the authors and do not necessarily reflect those of the NIHR SDO programme or the Department of Health.

Contributions -:

Study Design and Funding (CG,VMD,SI,JM,CS,HG)

Data Collection and Analysis (SD, VMD, CG, SI,JM,CS,HG,)

Manuscript Preparation (VMD,CG,JM,SI,HG,SD, CS,)

Abstract

Aim and objectives

To examine the factors affecting the extent to which English policy on the introduction of community matrons for people with chronic conditions was implemented.

Background

Improving health services for people with chronic diseases (long term conditions) is an international priority. In England, the new post of community matron, a case management role was introduced. A target was set for 3,000 community matrons to be in post by 2008, but this was not achieved.

Design

A realist, pragmatic evaluation of the introduction of community matron posts

Method

The study used mixed methods at multiple levels: an analysis of national and local strategy and planning documents, a national survey and a stakeholder analysis using semi-structured interviews in three primary care organisation case study sites.

Results

National policy established targets for the introduction of community matron posts, but there was local variation in implementation. Pragmatic decisions reflected the history of local service configurations, available finance, opportunities or challenges created by other service re-designs

and scepticism about the value of the community matron role. There was resistance to ‘bolt on’ nursing roles in primary care.

Conclusions

The implementation of the community matron role is an example of how a policy imperative that valued the clinical skills and expertise of nurses was re-interpreted to fit with local patterns of service delivery. Before new nursing roles are introduced through national policies, a more nuanced understanding is required of the local factors that resist or support such changes.

Relevance to clinical practice

There is a need for consultation and understanding of local conditions before implementation of workforce initiatives. For clinicians it is important to understand how the context of care shapes priorities and definitions of new nursing roles and how their expertise is recognised and used.

Key words: nurses, nursing, community matrons, chronic disease management , new roles, policy implementation

Background

Chronic diseases or long term conditions (LTC) are the leading cause of illness burden, disability and death globally and a major focus for health policies and health care systems internationally (WHO 2005). Estimates in high income countries suggest that 65-75% of direct health care costs are attributable to chronic diseases (Public Health Agency of Canada 2003, U.S. Centers for Disease Control and Prevention 2004, Australian Institute of Health and Welfare 2005).

Government health departments in all countries of UK have placed high priority on improving chronic disease management as a way of improving patient care and reducing costs (Department of Health [DH] 2004a and 2004b, Scottish Executive 2003, Welsh Assembly Government 2005).

The overarching UK policy frameworks draw on Wagner's model of chronic disease management (Wagner *et al* 1998) which includes case management of people with multiple chronic conditions.

The concept of case management is not new in the UK and has its roots in social care (Challis & Davies 1986), where it is known as 'care management' (NHS & Community Care Act 1990).

There are examples of nurses using case management techniques:

- As part of their clinical practice tradition (Bergen 1994, Evans *et al* 2005),
- Through statutory based systems led by social services (Challis *et al* 1991)
- As specialist posts for the case management of people with multiple conditions (Lyons *et al.* 2006),
- As clinical specialists that focus on supporting people with particular diseases and/or conditions (Forbes *et al* 2003).

In England there has been significant interest in nurses undertaking clinically focused case management roles for people with chronic diseases and pilot projects explored different forms this may take e.g. Pfizer Health Care Solutions with Haringey Primary Care Trust (Pfizer 2004), Unique Health (Matrix 2004) and the DH funded Evercare programme in collaboration with United Health (Colin-Thome & Belfield 2004). This interest was accompanied by DH policy introducing a new nurse case manager role in primary care known as a '*community matron*' in 2004 (DH 2004a), with specified competencies (DH 2004c,DH 2005a, NHS Modernisation Agency & Skills for Health 2005) to support people with multiple LTCs at risk of unplanned hospital admission (DH 2004a). The role and competencies of the community matrons were specified and a target set of 3000 community matrons appointed by 2007, later extended to 2008 (DH 2004d). The numbers were set by Strategic Health Authorities for each Primary Care Trusts (PCTs) and monitored centrally (Healthcare Commission 2007). Despite this, the employment of community matrons did not reach the target numbers (Keen 2008) (see Table 1) and central government monitoring was withdrawn in 2008 (Healthcare Quality Commission 2008).

In this paper we consider the implementation of the community matron policy. This was investigated as part of a larger study (Goodman *et al* 2010) which examined the contribution of nurses in different forms of case management roles. The UK's publicly funded and managed health care system, could suggest a 'perfect' linear policy implementation process (Hogwood and Gunn 1984). However Exworthy and Powell (2004 p283) concluded that the shift in public governance processes requires a similar shift in conceptualising: '*from [that of] one central government department instructing a local agency to consider horizontal dimensions i.e. relationships between government departments and between agencies at local level*'. One

important element at the local level is that of the relationship between the professions. Health care in the UK has been divided between professional groups in an interactive, contested system of changing boundaries (Abbott 1988). The relationships between and in professional groups have been characterised by hierarchies and gendered divisions into occupational groups, diverse forms of autonomy and different levels of authority and power (Stacey 1988, Elston 1991, Davies 1995). In primary care, for example, general practitioners (GPs) are seen as central players (Peckham and Exworthy 2003) but as operating in a system of greater complexity than a single unit such as hospital. In the UK the historical divides between the publicly funded services of general practice, community health services and local authority social services (now termed adult services) are structural elements of that complexity (Webster 2003).

This paper addresses three questions surrounding the introduction of community matrons:

- 1) How was the ‘problem’ defined and conceptualised to which nurses in community matron roles were to emerge as the policy solution?
- 2) To what extent were community matrons roles implemented?
- 3) What factors influenced local decisions to commission, employ or work with community matrons?

Methods

The study used a realist, pragmatic research design (Robson 2004, Morgan 2007) incorporating a mixed methodology (Tashikori and Teddie 1998). It sought to understand the contexts and mechanisms operating at multiple layers (Barrett 2004) through: a) a macro level review of central government policy documents; b) a national survey of key informants and documents in

local PCTs (meso-level) and c) an analysis of local strategies and stakeholder interviews in three case study sites (micro-level).

The government policy review was undertaken by documentary analysis (May 1998).

Documents produced by government departments published between 2000 and 2007 that related to the strategic plans for the health services, chronic diseases, long term conditions, health and social care for older people and nurses were retrieved. Using electronic search facilities, all statements about nurses and matrons were identified and mapped onto a ‘problem’ list derived from the policy documents and framed according to Maxwell’s (1992) dimensions of quality in health care: access, appropriateness, equity, efficiency and effectiveness. Statements about nurses as part of the workforce or training were excluded if they did not specify activities or roles for nurses.

At the meso-level, a mixed method survey was undertaken in 2006/7: this incorporated documentary analysis (May 1998) and semi structured interviews (Robson 2002). The documentary analysis was a geographically purposive sample of publicly available Primary Care Trust strategies for long term conditions management and local delivery plans in each of the 8 Strategic Health Authorities (SHAs) in England. The documents were read and data extracted (May 1998) on the types of service models for addressing LTCs, the implementation of case management, including community matrons and any related performance targets. Semi-structured telephone interviews were conducted with a geographically purposive sample of Directors of Nursing in Primary Care Trusts, as knowledgeable senior management key informants, in each of the eight SHAs (Robson 2002), to gain more in-depth detail on the current

forms of nurse case management, factors influencing implementation and any local evaluation of community matrons' posts. Interviews were recorded in note form, checked with the participant and then analysed by two researchers independently using a template methodology (Crabtree and Miller 1992). The analysis from both elements of the study was integrated in a second level of analysis comparing and contrasting the data against the research questions.

At the micro level i.e. the primary care organisation level, three in depth case studies (Yin 1991) of nurse case management, including community matrons, were undertaken. Local strategies and plans regarding management of LTCs were collected and analysed (May 1998) and key stakeholders interviewed (Brugha and Varvasovszky 2000) as to their views on aspects of LTC strategies and the contribution of nurse case managers , specifically community matrons. In addition, community matrons were asked to reflect on their role and experiences through two interviews over a nine month period in 2008/9. They were recorded with permission, transcribed and then the tapes deleted. The transcripts were analysed by three researchers independently, using a framework methodology (Ritchie and Spencer 1994) and organised using NViVO software. Differences were discussed against the data until agreement was reached. The survey phase met University research ethical requirements and was not required to undergo review by a NHS research ethics committee. The case study phase was favourably reviewed by a NHS Research Ethics Committee and met local NHS research governance requirements.

Findings

Policy review: the macro level

One hundred and eleven national policy documents were published between January 2000 and December 2007 related to strategic plans, LTC and nurses. Community matrons were introduced by the Secretary of State for Health in the preface to a Parliamentary White Paper ‘The NHS Improvement Plan’ (DH 2004a). The ‘policy problem’ was the cost to the NHS of unplanned hospital admission of people with LTCs. Implicit in the White Paper was the assumption that there was poor medical management of people with LTCs. A Public Service Agreement that there would be a 5% reduction by 2008 in emergency hospital bed usage by people with LTCs was established (HM Treasury 2004), The following year it was announced that : *‘Community matrons will be key to delivering the Public Service Agreement target for long term conditions’*. (DH 2005b p70). Detailed guidance (Table 1) specified that the role was to support targeted groups of mostly older adults whose multiple conditions made them vulnerable, *‘difficult for health and social care to manage’* and *‘at risk of unplanned admissions and institutionalisation’* (DH 2005a p 13). Although the target of 3000 community matron posts was introduced (DH 2004d), there were no references in the documents retrieved to specific funding allocations, or expectations as to which resource streams would fund them.

Community matrons were cited as examples of one type of case manager for people with LTC in only three subsequent documents (DH 2005c, DH 2005d, DH 2006). Their absence from other documents published 2005 – 2007 (Table 2) and beyond, is notable.

In localities: the meso level

Thirty six published local strategies on LTC and planning were reviewed and 41 interviews with Directors of Nursing were conducted providing data from 77 (of 152) PCTs. The local strategies reflected the overarching target of reducing unplanned admissions to hospital of older

people with LTCs (HM Treasury 2004). The introduction of case management services was referred to in most but not all of the documents. They referred to a range of case management posts , some of which were named community matrons but also included clinical specialist nurses and allied health professionals. Few references were found in the 36 strategies to costs or funding for the community matrons. One identified PCT extra funds as a source of funding for implementing its new case management service. Two further PCTs referred to short term project funding from the SHA as financing the community matron posts.

All 41 participants reported that community matrons were to be introduced in their area following the announcement by their Strategic Health Authority (SHA) of PCT level target numbers of community matrons issued. They also reported that the creation of community matron posts was linked to the PCT performance targets of reducing unplanned emergency hospital admissions of people aged 75 years and over. On the whole, they reported that patients were very satisfied with the service provided by community matrons.

'We have looked at patient satisfaction with a questionnaire; which has been very positive. Patients like the continuity of having one person they see and can easily contact.' (Interview 13, North West England)

However, problems with implementing the policy were identified particularly with respect to funding the posts, finding suitable staff, the impact on existing service configurations and lack of evidence of effectiveness. ‘Business cases’ for the new posts had been made by some PCTs:

'We've introduced community matrons on an 'invest to save basis: if they can demonstrate admission avoidance the service will pay for itself'. (Interviewee 35. East of England).

Others described pragmatic implementation decisions:

'It hasn't been viable for this PCT to introduce stand alone Community Matrons, so the introduction of case management across the board has been a struggle. You've got to work with what you've got and we are a small PCT with a big deficit'. (Interviewee 3 Yorkshire and the Humber).

A key problem reported in many areas was the difficulty in recruiting suitably qualified nurses to community matron posts and the need for further clinical skills training. At least 16 PCTs reported and 12 other PCTs planned to restructure their district nursing service to ensure: '*maximising scarce skills*' :

'We have had a complete review of the district nurse service with the brief to introduce community matrons, case management by district nurses and increase equity in access to services but within the existing finances and staff. In reality because of financial difficulties, the district nurses do not have enough staff to delegate to so they are not always case managing.'

Interviewee 19, South East England

An additional challenge in many areas was the reported scepticism regarding the value of community matron services on the part of GPs, district nurses and hospital consultants:

'The GPs have not been very receptive to the community matron role because they couldn't see what they were doing. This resulted in some difficulties for the community matrons but if the community matrons demonstrated admission avoidance and the like, then they have been more willing to work with them. ' Interviewee 15, North East England

Negative attitudes of GPs to community matrons had been exacerbated by accompanying re-organisations , where established district nurse links to general practice were dismantled.. In response they had developed strategies to engender GPs' trust, such as seeking GP champions to work with and mentor community matrons and involving community matrons in the broader objectives of practices.

'We tried not to ask for GP support to the community matrons on a monetary basis but sold the role as a bonus for practices which benefits GPs and their patients. The community matrons do some practice nurse triage work and get support from the GPs on individual cases. ' Interviewee 21, South Central England

Few interviewees were able to offer evidence of impact. One participant reported a 40% reduction in admissions on the previous year but said this had been hard to validate. Another suggested some financial benefit to the NHS:

'An interim audit has been carried out with the finance team looking at data pre-and post community matron introduction to monitor the impact financially: £25,000 was saved in the first 5 months. ' Interviewee 16, South East England

The case study sites: the micro level

The case study sites covered populations of 200,000- 250,000 people. One was an inner urban area of a major city with high levels of socio economic deprivation, the second was a rural area with small villages and some towns and the third, a coastal conurbation with a mixed demography including high numbers of elderly people. Analysis of 49 local documents in 2006/7 provided common contextual evidence of a commitment to the national targets linked to LTCs but variation in the number and orientation of new community matron (CM) roles introduced. In site 1, 2 and 3 there were 4, 6 and 12 CM posts created respectively in 2006. By the end of 2008 all three sites had re-structured the CM posts to the point where Site 1 had minimal CM activity, site 2 had a reduced number through vacancies and long term illness and site 3 had increased the numbers of staff in the CM teams but these were health care assistants and nurses with lower levels of clinical qualifications and experience.

Thirty interviews were undertaken in 2007-2008 as part of the stakeholder analysis in each of the three case study sites. Those participants with commissioning roles and management roles confirmed in all three sites that the introduction of community matrons was in response to centrally imposed targets. Managers of community matrons reported that the implementation had been slow, partly through resistance of groups such as local GPs, but also through the need to train nurses to take these roles. The managers reported that patients valued the service and some GPs reported the positive contribution the community matrons made to their patient population. However, the overall tone of all interviews was of questioning how these roles ‘fitted’ into the current service landscape and resource allocation. Analysis of the data revealed three main

themes: a) perceptions that the community matron role duplicates that of other professionals, b) uncertainty about the acceptability and effectiveness of nurse case management, c) questioning financial investment in community matrons.

Perceptions of duplication in roles

Interviews with patient representatives indicated little awareness of case management or community matrons.

'Case management by nurses. I don't know about it really....I don't think it's something we have ever discussed here... Local patient group representative 3

While some could see advantages to such posts others questioned the concept with regards to potential duplication with other trusted health professionals such as the GP and district nurse.

One older person stated: *'I can't really work out why the district nurses can't do some of that stuff [that a community matron does]... The idea is good: one nurse who looks after it all for you, except I think the GP should be doing more of than in the first place.'*

The risk of duplication was echoed in the interviews with GPs many of whom saw themselves as clinical case managers: *'As a GP I am involved in all aspects of managing chronic conditions with patients.I see it as the complete package. I will follow through wherever a patient needs it and if a patient has a chronic illness I see my role as being to provide medical care and referral for all their health needs. I also refer on or write letters to social services and housing and so on, if a patient says they need it.'* Stakeholder 16 GP

These issues caused not only tensions between professionals but also confusion for patients: '*I know I have some patients who are in the community matron's caseload and they sometimes get confused about whether to contact her or to call the surgery to see me.*' Stakeholder 11 GP

GPs' perceptions of duplication and overlap between district nurses and community matrons differed according to the local organisation of district nursing. Those with closely linked, long-time district nurse(s), who also used shared patient records with the practice, were viewed as already undertaking a nurse case manager type role:

'I have an excellent district nurse linked to this practice. I think she does what you might call case management as well. She identifies some of my patients who have complex needs and talks to me about what extra care they might need and goes out to those patients more than she would normally.' Stakeholder 20 GP

This contrasted with the views of other GPs who experienced loosely linked district nursing teams with high staff turnover and little communication with the GP or the practice: '*Patients with multiple problems require telephone to telephone or face to face contact...a 5 minute chat is better than a fax which is what we get now from the district nurses.*' Stakeholder 29 GP

Like the GPs, the Local Authority Adult Services participants questioned whether community matrons were duplicating/overlapping the work of social workers/care managers. However, they could see benefits of nurses as case managers (rather than social workers) in some situations when a person had complex health needs.

The community matrons reflected these accounts in trying to establish their place in the health and social care system:

'I have a problem because my main GP tends not to refer to me, but I'm working on it slowly and hope that he may do more as time goes on...our (CMs) main problem seems to be in helping other services understand what we can do for patients and that we are a distinctive and independent service in our own right'. Community matron B

Acceptability and effectiveness of nurse case management

Some patient representatives questioned how acceptable the community matron role was to older people:

'What about if you are, you know, one of those independent sorts. I'm thinking of my neighbour hereshe wobbles and wheezes her way around and won't accept anything to help her. I wonder what someone like that would think of a nurse who wanted to come in and sort everything out just because they could?' Local patient group representative 6

All GPs interviewed were sceptical as to the extent community matrons could reduce hospital admissions or impact on GP workloads with the very complex, often 'chaotic', patients. Only one GP could identify a reduction in demand from some, but not all, patients with multiple conditions receiving community matron services:

'I was pretty sceptical in the very early days about community matrons, I have to say. They seemed to be thrust upon us with very little planning and having a new service of that nature suddenly having to fit in with our existing patterns of working was quite a challenge. However, they have worked very well and I value what they do highly. They cater for that proportion of

our patients who need more than we as a surgery can realistically provide in such depth and have become an integral part of what we do.(Stakeholder 12 ,GP).

The community matrons all reflected the, often, slow process of becoming accepted and the interconnectedness of their work with medical practitioners, usually general practitioners:

'One of my patients has improved ...she had an angioplasty following my referral of her to her GP and his referral onto a heart specialist and that's helped her a lot. I feel that this patient may have helped the GP see that I can do a professional job and he's been a bit more accepting of me the past few days. He even made me a cup of tea and brought it to my office, which is unheard of.' Community Matron D

Financial viability of community matrons

The Local Authority Adult Services Managers. Commissioners (PCT, local authority and practice based) displayed ambivalence to community matron posts and questioned whether the resources were being used most effectively for the population as a whole or whether more money would be better spent on interventions at an earlier stage. . They reported considering other services, such as tele-monitoring and emphasised the need to deliver more self-management education. Health service commissioners questioned financial investment in community matrons:

Now we have struggled with the evidence that they (community matrons) prevent x amount of admissions which would pay for the service..... we've asked for evidence and it's not there so now we're quite sceptical. Stakeholder 14 PCT commissioner

All but one of the GPs questioned the value of a ‘stand alone’ community matron post. They suggested alternative models where nurses with advanced level skills were part of practice teams or intermediate care teams, a view echoed by Local Authority participants. The one GP who did not offer this view had a community matron based in and working solely with his practice’s patients.

All community managers reported that GPs thought the current model of community matrons was resource intensive and questioned whether the resources might be used to better effect in other ways.

‘There are some GPs who believe that the introduction of the CMs was at the expense of district nursing and therefore they have a fundamental problem with the concept as they see it robbing another budget...’ Stakeholder 24 community services manager

They also confirmed that the wider commissioning community questioned the value of community matron posts, as currently configured:

‘It is not likely that the community matron service will be increased and we are worried that as community matrons leave, for whatever reason, they may not be replaced - case management is seen as low priority because it caters for so few people at such high cost.’ Stakeholder 26 community services manager

The community matrons described themselves as committed to improving the quality of their patients’ and their carers’ lives and demonstrated how they helped this improvement, despite the demoralising impact of repeated scrutiny and reorganisations. Some felt there was never enough

time to embed the service or to learn from changes. ‘*Now that GPs are moving to practice-based commissioning some of them would like community matrons to go to the surgeries and set up there so that they can share responsibilities over to the community matrons. Whatever happens we just have to go with it and make it work, but it’s frustrating because it means we can never settle down to do what we want to do.*’ Community matron F

Discussion

This study provides insight from the national and local levels into the implementation of a centrally defined policy for a new nursing role. The concept of community matrons arose from central NHS policy to address the problem of costly unplanned hospital admissions for people with multiple LTC and complex needs. However, there was no consensus that a new group of nurses was the solution and within two years, the community matron role had markedly disappeared from policy documents. The multiple forms of enquiry that spanned England show that the majority of local strategic plans introduced the community matron role to meet centrally monitored targets. However, there was slow, uneven and limited establishment of community matron posts across England, which can be understood as a pragmatic response to: a) resistance to a contested role amongst clinicians, managers and commissioners and absence of any local ‘demand’ for such posts, b) limited financial resources and the absence of dedicated funding for the posts, c) the presence of existing locally-developed service improvements in LTC and concerns about how the community matron role would fit into the existing service landscape and team configurations and d) the scarcity of suitably qualified and experienced nurses to fulfil matron roles in some community settings.

The findings of this study are in line with other investigations of the community matron role.

Although, the introduction of community matrons generated interest (Morgan 2005), early doubts were expressed about the viability of the role (Murphy 2004). This scepticism was compounded by the publication of the interim report of the national Evercare pilots which indicated that while there was some anecdotal evidence of patient level benefit, unplanned admission to hospital was not reduced by intensive nurse input to people with complex needs (Gravelle *et al* 2007). Early reports of community matron initiatives described the processes of setting up services (Bee and Clegg 2006), personal experiences (Clegg *et al* 2006) and education needs (Drennan *et al* 2005). Subsequent evaluations reported positive patient feedback (Wright *et al* 2007, Bowler 2009) and successful training programmes (Girot and Rickaby 2008).

The study has several limitations such as the sampling of Directors of Nursing only at the meso-level may not have offered the widest views on implementation and those willing to be interviewed in the case study sites may only have been those with strongly held negative views. However, meticulously gathered evidence from multiple levels, through a variety of sources and a wide range of stakeholders have secured a full picture of the utilisation of nurse case managers. Hence the analysis of the introduction of the community matron role is conducted in the wider context of service delivery and policy making at national, regional and local levels.

The creation of the new community matron nursing post echoes the central government creation in England of ‘modern matrons’ and ‘nurse consultants’ (DH 2000) and suggests the opportunity to create another form of nursing clinical leader was grasped by ‘policy entrepreneurs’ (Mintrom and Norman 2009). Despite the announcement of the community matrons at the highest level,

there was no associated ring fenced funding (Ladyman 2004). Within six months they were cited as only one type of case manager and after three years the central monitoring target was removed (Healthcare Quality Commission 2008) A mix of factors at different levels of the health service explains why the numbers of community matrons employed have never achieved even half the originally intended numbers. Local level pragmatism led to significant variation and compromise in implementation. The impression from this analysis is not that there are powerful influences subverting the intention of the central policy – although that may be true in some areas - but that overall the horizontal relationships between local agencies and other contextual factors, such as existing service configurations and budgetary conditions, resulted in a more pragmatic approach to local decision making. This combined with the lack of local evidence of a causal link between community matron activity and the rate of unplanned hospital admissions, made the community matron service and posts more likely to be re-configured. The influence of contextual factors has been described in other studies examining the implementation of government directed nursing roles (Coster *et al* 2006, Ashman *et al* 2006). The extent to which nurses adopted case management roles has been associated with four interrelated variables: (1) clarity of policy guidance; (2) concordance with professional (nursing) values; (3) local practices and policies; and (4) the personal vision of the community nurse (Bergen and While 2005). This study of the implementation a clear nationally defined policy for new nursing role suggests other aspects of context also need to be accounted for, such as the influence of commissioners of nursing services.

Conclusions

Evaluation of policy implementation should ideally be conducted over long periods of time (Sabatier and Weible 2007). While this paper considers the implementation of one policy over

five years, community matrons are still in post and their numbers have slowly grown. The original descriptions of community matrons emphasised their supporting role, as experienced nurses, for people with multiple LTCs who were experiencing poor quality of life and worrying exacerbations of complex problems. The survival of community matrons in some areas suggests that they have made valued contributions. It remains to be seen whether local decision makers see this of value to the local health and social care system. In primary care there is a long history of creating or adapting nursing roles to address policy priorities and shortfalls in practice provision (Aranda and Jones 2008). The implementation of the community matron role is an example of how a policy imperative that valued the clinical skills and expertise of nurses was re-interpreted to fit with local patterns of service delivery.

Relevance to Clinical Practice

This study demonstrates the need for consultation and understanding of local conditions before implementation of new nursing roles. For practitioners it is important to understand the ways in which the local commissioning, service configurations and economic climate shape the priorities and definitions of new nursing roles. Practitioners need to engage with the breadth of the stakeholders in health care to ensure their expertise and contribution is recognized. Centrally directed service redesigns should be based on local consultation and trials of feasibility and acceptability and evidence of likely cost – effectiveness.

Conflict of Interest

None declared

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Table 1Table 1. **Numbers of Community Matrons in England 2006-2008**

Community matrons	2006	2007	2008
Headcount	366	619	1,521
Fulltime equivalents	351	571	1,422

Source: NHS Information Centre for Health and Social Care 2009

Figure 1

Figure 1

Community matrons and case management

'The case management work of community matrons is central to the government's policy for the management of people with long term conditions. In this type of case management, community matrons:

- Use data to actively seek out patients who will benefit
- Combine high level assessment of physical, mental and social care needs
- Review medication and prescribe medicines via independent and supplementary prescribing arrangements
- Provide clinical care and health promoting interventions
- Co-ordinate inputs from all other agencies, ensuring all needs are met
- Teach and educate patients and their carers about warning signs of complications or crisis
- provide information so patients and families can make choices about current and future care needs
- Are highly visible to patients and their families and carers and are seen by them as being in charge of their care
- Are seen by colleagues across all agencies as having the key role for patients with very high intensity needs.' DH (2005a). p13

Figure 2

Figure 2

Examples of Department of Health documents published 2005-7 in which nurses as case managers or community matrons were *not* mentioned

Department of Health 2005, The National Service Framework for Renal Services – Part Two: Chronic Kidney Disease, Acute Renal Failure and End of Life Care, Department of Health, London.

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Department of Health 2007. Choice Policy Team. Generic Choice Model for Long Term Conditions. London, Department of Health.

Department of Health 2007, National Stroke Strategy, Department of Health, London.

Department of Health 2007, Urgent care pathways for older people with complex needs, Department of Health, London.

DH Care Services Improvement Partnership 2007, Commissioning Services for People with Long Term Neurological Conditions, Department of Health, London.

