Developing a community matron service: a neighbourhood model


Summary
NHS Blackburn with Darwen Provider Services Unit has adopted an innovative team approach to improve patient access to its community matron service. This article reviews the national picture and local development of the community matrons role.

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THE PREVALENCE OF LONG-TERM conditions varies from region to region, but it is suggested that more than 30% of people have such conditions. These patients account for 52% of all GP appointments and 72% of all inpatient bed days (Department of Health (DH) 2008).

The DH (2005) identified a national gap in healthcare services, with patients with long-term conditions missing the opportunity to maintain or improve their health and therefore avoid the need for frequent or lengthy admissions to hospital. It was found that people with complex long-term conditions experienced care that was reactive and ad hoc, as opposed to having their problems identified and managed proactively, and their care optimised (DH 2005). However, the government has begun to address the issue of long-term condition management. It set a national target that required the NHS to improve health outcomes for people with long-term conditions by offering a personalised care plan for the most vulnerable people (DH 2004a). In addition, it required a reduction in emergency inpatient bed days by 5% by 2008 through improved primary and community care (DH 2004a). The NHS Improvement Plan (DH 2004b) set out the government’s priority to improve care for people with long-term conditions by moving from an acute, episodic model to a patient-centred approach, offering closer personal attention, rooted in primary care. It highlighted the contribution to be made by community matrons in managing patients proactively to promote health and minimise crisis (DH 2004b).

To help achieve the national target, the document Supporting People with Long Term Conditions (DH 2005) aimed to help health and social care organisations take a systematic approach to improving the care of patients with long-term conditions through stratification of their care needs. The process of case management – intensive ongoing assessment, monitoring and management of care needs – and the pivotal role of the community matron lay at the heart of the government’s plans for the care of people with long-term complex conditions.

The community matron role was introduced in 2004 as a new type of practitioner who would be a highly-skilled specialist in community care and inter-agency working. The advanced clinical skills of community matrons would allow them to seek and review proactively patients who were high-intensity users of healthcare services, to identify early warning signs, to investigate and diagnose exacerbations of illness, to co-ordinate care and arrange for treatment to be implemented. Community matrons work to reduce crisis and avoidable admissions to secondary care.
models of service delivery have been developed throughout the country. This article describes the introduction and development of a community matron team in Blackburn with Darwen. NHS Blackburn with Darwen Provider Services Unit (PSU) serves one of the most deprived areas in the country. It has comparatively high death rates for many long-term conditions (Lakhani et al 2007). The health of Blackburn with Darwen is generally worse than the English national average, including increased hospital stays as a result of alcohol misuse and deaths from smoking and cancer. Life expectancy for men and women is, respectively, eight and six years shorter than the national average (NHS Blackburn with Darwen 2008).

NHS Blackburn with Darwen community matron team

The Blackburn with Darwen Teaching Primary Care Trust (PCT), as it was then known, initially recruited four community matrons in 2006 to reduce the number of avoidable hospital admissions and the length of stays. They identified that patients with certain conditions, notably cardiac and respiratory, were more prone to frequent hospital admissions. The PCT therefore recruited six more community matrons in 2007, choosing nurses from specialist backgrounds including respiratory disease, heart failure and mental health. The PSU, which now provides the community matrons service for the PCT, was established after they were recruited.

The role of these practitioners was to hold a generic caseload of patients with complex long-term physical and mental conditions, not just those related to the specialist interest of the matron. They would also offer specialist support and knowledge to colleagues in the community matron and community nursing teams, and in the wider health and social care services. The advantages of having community matrons with special interests in Blackburn with Darwen include:

- Development of strong links and collaborative working with specialist secondary care services and GPs. The community matrons with special interests have been able to work strategically in the local health economy, shaping patient services to meet local need, for example, by becoming involved with the meeting patients’ need initiative, which addresses service design and commissioning for patient groups in East Lancashire.
- Production of specialist care plans and pathways, which can be customised to individual patient need and support the care given by the non-specialist nursing and social care staff.

How the team works

The ten community matrons are based in four locality teams, with two or three community matrons in each area. The community matrons find patients who would benefit from the service using the Patients at Risk of Re-hospitalisation (PARR) software tool, which was developed by the King’s Fund, New York University and Health Dialog. It uses inpatient data to clarify which patients are most at risk of readmission (King’s Fund 2009).

The community matrons also use discharge summaries and analyse general practice computer systems to find patients who meet the screening criteria (notably, diagnosis of a long-term condition, previous admission to hospital or emergency department attendance record, medication and social risks). Patients meeting the screening criteria may also be referred to the service by any health or social care professional, or by self-referral.

The service operates a ‘neighbourhood’ model of working in which the community matrons in each area hold a joint neighbourhood caseload of between 180 and 270 patients. Each neighbourhood includes a band 8 and band 7 matron, complemented by a band 5 and band 6 staff nurse. Each patient’s care is overseen by a designated primary matron, who is the hub of that person’s care and is his or her key point of contact. The advantage of a neighbourhood team model, over an individual caseload approach, is one of accessibility and responsiveness to patients who require enhanced input and care during a period of deterioration. It allows the flexibility to meet peaks in demand, which could not be managed by a community matron working in isolation. This model also enables better communication, planning and collective knowledge about the caseload.

Patients are triaged daily to ensure they all receive a level of care and review appropriate to their level of clinical need. Patient assessments, individual evidence-based plans of care and
evaluations are stored in the patient’s hand-held records so are available to all staff. Community matrons have forged close working links with the community nursing staff (who are also based in four locality teams with the community matrons, but are managed separately) and the out-of-hours community nursing service, allowing additional skilled support to patients 24 hours a day. Significant changes in a patient’s condition are communicated directly to the community nursing and out-of-hours teams to ensure the patient receives good, seamless care day or night. The community matrons also access the GP practice patient computer system to ensure optimal communication between all involved healthcare professionals. Patients have direct mobile telephone access to the community matron during core hours (Monday to Friday 8am to 5pm). Special green key fobs are also given to patients, which provide the telephone number for the central referral centre for NHS Blackburn with Darwen PSU services, which is staffed by clerical workers and nurses who ensure appropriate access to all the community services. The key fobs also serve to highlight to staff in the emergency department (who make a record of patients’ valuables on admission) patients who are known to community nurses. This encourages communication with community services and potential early discharge for those patients whose care could be managed in the community, thus freeing up beds in the secondary sector and minimising patient deconditioning.

A patient information leaflet has been devised to support the service provided by the community matron team. This reaffirms and reinforces to the patient how to contact the team and what the service provides. The service is also marketed through the PSU’s website.

**Community nursing rotation programme**

The community matron team has enhanced and strengthened its links with the community nursing team by developing an innovative community nursing rotation programme. The community matron team has developed a competency framework document and training pack to support an induction day and long-term condition training for band 5 community nurses, who then rotate into the community matron team for two months. The community nurses develop skills and knowledge in long-term condition management, clinical assessment, crisis prevention and management. Clinical skills development is supported by the training package and competency framework under the close mentorship of the community matron. Staff feedback and staff and patient questionnaires have demonstrated that this initiative has had a positive effect on patients, staff and the service as a whole. It has improved morale, team working and effective communication between community matrons and nurses.

**Virtual community ward**

The DH (2005) suggests a target caseload of 80 patients per individual community matron. As the community matron team was already meeting this target in 2007, incorporating staff nurses into the community matron team has increased the capacity to accept further patients. This support structure allows the team to manage its neighbourhood caseloads effectively under the leadership of the community matrons, to provide a rapid response and prevent avoidable hospital admissions.

By incorporating a ‘virtual community ward’ concept, patients are allocated in the team daily and are triaged according to their needs. This ensures that care is co-ordinated and patients’ level of care intensity is stepped up or down. The community matron reviews ongoing tests and medication changes in liaison with the GPs to ensure that care is optimised. Patients in the neighbourhood community matron caseload are categorised as red, amber or green depending on the severity and stability of their condition, and the frequency that monitoring visits are required (Box 1). Daily allocation in a team means that all patients are seen according to their level of need.

Working as the hub of each patient’s clinical, psychological and social management, the community matron liaises with medical, therapy and social care staff, undertaking investigations and prescribing treatment as appropriate to ensure that patients receive the best possible care at home or in a respite setting. Where service gaps are identified, community matrons are

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**BOX 1**

**Community matron caseload triage categorisation tool**

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Red</strong></td>
<td>Patients who are acutely unwell or unstable (physically, psychologically or socially) and who may need daily or weekly review.</td>
</tr>
<tr>
<td><strong>Amber</strong></td>
<td>Patients who have complex needs that require frequent monitoring and/or intervention to maintain optimum health and wellbeing. Such patients may be visited monthly or bi-monthly.</td>
</tr>
<tr>
<td><strong>Green</strong></td>
<td>Patients whose condition and situation has been stabilised, through optimisation of therapy with a personalised self-management plan devised by the community matrons, introduction of standby rescue therapy, such as antibiotics and initiation of a care package. Monitoring visits for such patients may take place at least once every three months, but a plan of care will be instigated so that the patient or carer will contact the community matron should the situation change outside defined boundaries.</td>
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instrumental in addressing the deficit, for example by establishing an acute nebulised therapy service to enhance domiciliary management of patients undergoing exacerbation of chronic obstructive pulmonary disease (COPD). If hospital admission is clinically indicated, the community matron will arrange for the patient to be admitted directly to the assessment unit for review by secondary care medical staff and will review the patient to ensure early discharge as soon as the clinical condition allows. Clerical support is available in each neighbourhood team to ensure that patient contact time is maximised.

**Evaluating the Blackburn with Darwen community matron team**

Audits are conducted annually to monitor the community matron team’s effect on the management of long-term conditions and associated reductions in hospital admissions. An audit undertaken in 2009 demonstrated a 67% reduction in emergency admissions in patients who were accepted on to the community matron caseload. The audit will be published in the forthcoming annual report for Blackburn with Darwen PSU.

To enable the delivery of patient-centred care that is responsive to user feedback, a satisfaction questionnaire was distributed to 200 patients on the community matron caseload in May 2008. The results, based on responses from 105 patients, are encouraging. All respondents stated that they had a better understanding of their medical condition as a result of community matron input, reporting that they found the verbal and written information satisfactory and easy to understand. All respondents were aware of how to contact the community matrons. The majority (90%, n=95) reported an improvement in access to other services facilitated by the community matron, and they reported that they felt involved in the decision-making process about their health care. Patients said they were less likely to visit the GP or attend the emergency department since being admitted to the community matron caseload, as they would contact the matron directly if unwell.

**Future developments**

The community matron service is now implementing a scheme of using telehealth technology to assist with the proactive case management and triage of patients. Starting with a pilot targeting patients with COPD, patients will be able to record their vital signs at home, with the readings being sent to the community matron via email, where they are triaged against set individual parameters. Early unpublished data from this pilot have indicated that telehealth supported the community matrons in avoiding eight hospital admissions, with an estimated saving of £14,792 during the three-month pilot based on the current tariff for non-elective spells for COPD admissions.

**Conclusion**

NHS Blackburn with Darwen PSU has established an innovative model to deliver a community matron service in a deprived, mixed urban and rural area. By case managing a group of often vulnerable service users using a neighbourhood team approach, the service has demonstrated a reduction in avoidable hospital admissions and is highly valued by the patients it serves. This model could be transferable to other NHS providers.

**Acknowledgements**

The success of this service is accredited to all members of the community matron service and community nursing team.

**References**