A STUDY OF THE EARLY IMPLEMENTATION OF THE COMMUNITY MATRON POLICY IN THREE PRIMARY CARE TRUSTS IN ENGLAND

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SCHOOL OF NURSING, MIDWIFERY AND SOCIAL WORK
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ABSTRACT

This thesis presents a qualitative multiple case study which examines the early implementation of the community matron policy in three primary care trusts in England. The community matron was a new role in nursing, introduced by the Department of Health in 2004, as part of its strategy for the management of long term conditions (DH, 2005e). There was a paucity of research literature underpinning the policy and the implementation of the community matron role in England.

A descriptive multiple case study was used as it generates a richness of data using multiple data collection methods, ideally positioned to investigate phenomena in context and contemporaneously. In addition to documentary material, 49 participants were recruited across the three case study sites, from community matrons, active case managers, health and social care colleagues and patients. A total of 30 interviews, 33 observations and one focus group were undertaken between 2006 and 2008. Framework Analysis was used to interpret the data and critical sensemaking was applied as a heuristic to gain insight into the findings.

This study explored the early role implementation from the perspective of the community matron. It found that the community matron role had been adopted with regard to the national model but there was variation in its implementation between case study sites, seen in service structures, eligibility criteria and caseload management. Practitioners had exercised professional discretion to flex local service models to fit their ways of practice and professional decision making, although this may not have been conscious behaviour. They also expanded the role to include psychosocial support, beyond the nationally defined functions. Advanced practice was integral to the role; whilst there appeared to be a medical influence on this aspect of role development; practitioners had adopted traditionally medical tasks and incorporated them into nursing practice, making such roles their own.

Community matrons described experiencing resistance to the role initially from some district nurses and GPs, outlining how they adopted strategies to address these and promote acceptance of the role. As such, individual community matrons were the key change agents. They experienced dissonance between organisational values and professional values, which they addressed by reinterpreting collective targets such as reducing hospital admissions into individual patient outcomes related to improved quality of life.

Critical sensemaking gives a unique perspective on the implementation of national policy, through the lens of the community matron, highlighting the experience of nursing role development at an individual and team level, and the ways in which variation can occur. Further research is needed into nursing policy implementation to better understand the processes at play nationally and organisationally. Critical sensemaking might be used to inform how implementation can be effective and sustainable.
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DEDICATION

For my parents

Mum, who inspired me to become a nurse and whose example taught me the true values of nursing, and Dad, who simply asked that I try to be the best I could be in whatever I chose to do.
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My husband Robin and son Nathan, whose never ending patience, understanding and encouragement, meant that I could complete this thesis.
1.1 Background of researcher and motivation for the study

As a registered nurse and health visitor since 1987, I worked in clinical practice in a variety of settings across hospital and community nursing services, and in specialist nursing practice. I later worked in practice development and senior management within the NHS. During this time I undertook a research study into the role of the support worker in secondary care for the award of an MSc in Nursing in 1998. My interest in role development within nursing continued in relation to professional standards whilst working within nursing professional regulation and subsequently returning to senior management in the NHS.

At the outset of this study, in 2004, I was the Professional Nurse Lead within an NHS Primary Care Trust. This entailed providing professional advice to the PCT Board and senior managers of community services, leading professional and practice development in services and supporting clinical practitioners. As such the introduction of new roles and the development of nursing practice were of particular interest to me.

The new community matron role was announced by the Secretary of State for Health at the Chief Nursing Officer’s annual conference in November 2004, at which I was a delegate. As a new nursing development, being promoted to improve the management of long term conditions, I was struck by how this initiative appeared to be news to a large audience of nurse leaders. This led me to consider what was driving this new role, how it would be introduced and how this would affect existing practice and practitioners working with patients with long term conditions. So my motivation to undertake this research study was the unanswered questions about what this new role would be in practice and what its place within nursing would be.

During the course of the research study my role within the PCT changed considerably, in light of the NHS organisational reform. Community services were transferred out of the PCT as the PCTs became solely commissioning organisations. I became the executive nurse director of the PCT, continuing my role in providing professional advice but now from a commissioning perspective. As such my interest in role development in nursing has continued throughout this study. My role whilst undertaking this study is discussed further in relation to reflexivity in section 4.6.5.
1.2 Organisation of the thesis

This study explores the role of the community matron, which was announced as a new nursing role in 2004 by the Department of Health in England, as part of its strategy for the management of long term conditions. A brief background to this new nursing role and the context in which it was introduced is outlined in this introductory chapter. Chapter One also presents the questions that stimulated this study.

Chapter Two critically reviews the literature into the community matron role and explores theories regarding implementation and role. As this was a new nursing role, there was limited research literature on which to draw. The review reflects this by including literature available up to 2006, the time of study design and commencement of data collection. It also includes the review of policy literature as this provided the context of the role. Research literature published after the start of data collection was drawn on to support the analysis of the study findings and therefore is reflected in the discussion chapter later in this thesis.

The research questions and aims of the study are presented in Chapter Three, introducing the methodology adopted for this study. The rationale for the selection of multiple case study as the research method is discussed, reflecting its usefulness as a qualitative approach to study the phenomena of nursing. The underlying epistemology of constructivism which shaped the choice of methods and approach to analysis is also explored here.

Chapter Four discusses the case study method and its application to this study. This includes a description of purposive sampling used for the selection of case study sites and for the selection of participants. The choice and application of data collection methods is discussed. The framework approach used to analyse the data is introduced here, and is explored further in the next chapter. This chapter concludes with the consideration of ethical issues and the rigour of the study.

The application of the framework approach to analyse the data is presented in Chapter Five. This chapter also discusses the presentation of the findings and introduces the context of the case study through the descriptions of each case study site. The findings describe the outcome of the cross case analysis and are presented in Chapters Six to Nine. These are organised in the key themes that emerged from the data analysis, being the service model (Chapter Six), the role function of the community matron (Chapter Seven), relationships (Chapter Eight) and the effectiveness and outcomes of the community matron role (Chapter Nine).
Discussion is presented in Chapter Ten, which articulates the interpretation of the findings as the final stage of framework approach to analysis. Here concepts and phenomena are explored in more depth to find associations and where appropriate, explanations (Ritchie et al, 2003). The chapter draws on the concept of critical sensemaking as an overarching perspective to support the interpretation of the findings. It was not used as a theoretical framework as the themes were not identified prior to the study; rather they emerged from the findings through an inductive analytical process. As described earlier, research literature that was published after the start of this study is introduced here, to support the analysis of the findings. This chapter also considers the research questions, reflects on the use of multiple case study as a research method and the limitations of the study.

Finally Chapter Eleven offers the conclusions of the study, including recommendations for further research.

1.3 Terminology used in this study

There has been ongoing debate about nursing titles which spans from before the outset of this study and throughout its duration. Read et al (2001) reported that there was universal confusion about the appropriateness of using titles such as nurse practitioner, clinical nurse specialist and advanced nurse practitioner. Maxwell (2011) argued that there was still no consensus on the definitions of such nursing roles, indicating that confusion about definitions persists today. Therefore the definitions of key roles and terms as used in this study are discussed here.

Definitions used in this study were taken from policy documents that were current at the time the study was designed, data were collected and analysed; later references have been cited here to reflect the confusion about definitions and did not inform the definitions used, as described below.

1.3.1 Case management

The term 'case management' has been used in mental health, social and health care in the context of coordinating care programmes for patients or clients (Drennan and Goodman, 2004). Some programmes have included financial element in relation to determining funding for packages of care (Bergen and While, 2005). Drennan and Goodman (2004) listed core activities of case management to include identification of individuals who would benefit from
case management; assessment of problems and needs for services; care planning; and the coordination and review of care plans.

In relation to the introduction of case management as a role for community matrons, it was recognised that there was not an agreed definition of case management (DH, 2006). However the context in which the term case management was used in the national policy in relation to long term conditions (DH, 2005e) was:

- The identification of vulnerable people in relation to their needs in the management of long term conditions;
- Coordination and management of care in partnership with the individual, their carers and other relevant health and social care professionals
- Anticipation and addressing problems before they escalate to minimise their impact on health services and the individual’s well being.

It is this in this context that the term case management has been used in this study.

1.3.2 Community matron

The community matron was a new nursing title announced by the Department of Health in 2004, as part of the English national policy for the management of care for people living with long term conditions (DH 2004a). It was not a title that had been commonly used in nursing practice in England prior to this policy, as shown by the lack of literature in relation to the community matron (as discussed in Chapter Two). The role was also distinct from that of the ‘modern matron’ which was introduced into the hospital setting to improve standards of patient care (DH 2001b).

For the purposes of this study, the term community matron refers to a community nursing role as defined by the Department of Health:

“A community matron is a nurse who provides advanced clinical nursing care in addition to case management... to an identified group of very high intensity users through case finding” (NHS Modernisation Agency and Skills for Health, 2005, p.4).

The role incorporates the coordination of care for patients with very complex needs due to long term conditions, for example diabetes, heart disease, chronic obstructive pulmonary disease. The role provides care and support to patients in their own home, aiming to reduce the need for patients to undergo multiple hospital admissions (Lillyman et al, 2009). The definition refers to ‘advanced clinical nursing care’, to include functions such as advanced
clinical assessment, diagnosis, prescribing and the management of acute exacerbations of multiple long term conditions (DH, 2006). The community matron role, as set out in national policy, is discussed in more detail in sections 2.5 and 2.6. The function of advanced nursing care is related to the term ‘advanced practitioner’ used in this study, as described in section 1.3.4.

1.3.3 Active case manager

In the context of the national policy for the community matron role (DH, 2004a; 2005e), a case manager would:

“...work with individuals who have a dominant complex single condition but still have intensive needs, hence their care requires co-ordination. The case manager will work as part of an integrated team and in partnership with individuals and their carers to develop a personalised plan of care. They will be responsible for planning, proactively monitoring and anticipating the changing needs of these individuals, co-ordinating their care across all parts of the health and social care system.”

(NHS Modernisation Agency and Skills for Health, 2005, p.4)

Unlike the community matron, which was stipulated as a nursing role, the case manager could be a qualified nurse, a social worker or allied health professional. In this study, the term ‘active case manager’ was used in case study sites to identify the case manager role.

The national guidance relating to the development of these two roles differentiated between the community matron role and the case manager by the level and complexity of care required by patients, requiring the community matron to provide advanced clinical nursing care over and above the case management function (NHS Modernisation Agency and Skills for Health, 2005; DH, 2006). However in practice such titles were found to be being used interchangeably within and across organisations, causing confusion (Lillyman et al, 2009).

In this study the delineation between the roles of community matron and active case manager in practice was only emerging during the course of data collection in case study sites.

1.3.4 Advanced practitioner

Por (2008) argued that understanding about the role of the advanced nurse practitioner and the nature of advanced nursing practice was unclear despite the subject of advanced nursing practice being under debate for many years. Patterson et al (2003) argued that descriptions of advanced nursing practice did not differentiate between the levels and nature of practice between advanced nurse practitioners and specialised practice. In 2008 the Royal College of Nursing (RCN) called for standards for advanced nursing practitioner practice to be set and
regulated by the Nursing and Midwifery Council but this is yet to be determined. Therefore the meaning of advanced nursing practice remains open to interpretation. This is discussed further in section 2.6.

In this study, the term ‘advanced practitioner’ was used in case study sites to define those practitioners who had successfully completed a two year advanced practitioner course to Masters level. The course incorporated preparation for advanced clinical practice as defined in section 1.3.3. ‘Advanced practitioner’ was adopted by case study sites rather than ‘advanced nurse practitioner’ because the course was open to nurses and allied health professionals.

1.3.5 Advanced primary nurse
An American model of case management called Evercare was piloted in nine sites in England prior to the national policy for the community matron role in case management (UnitedHealth Europe, 2005). The term ‘Advanced primary nurse’ was used specifically in these pilot sites to refer to the nurse role undertaking case management for people with complex needs due to long term conditions (Adler, 2005a; 2005b; 2005c). The policy for community matron role appeared to be predicated on the advanced primary nurse role. This role is discussed in more detail in section 2.5.1. Evercare is described in section 2.3.1.

1.4 Background to the study
The role of the community matron was introduced by the Department of Health in England against a backdrop of wholesale policy and organisational reform in health care, initiated when the Labour government came to power in 1997. The key challenges facing the National Health Service (NHS), namely increasing demand, increasing aging population and associated morbidity, advancing technology in health care and increasing public expectation against rising costs, have persisted since the inception of the NHS (Green and Thorogood, 1998; Weiner et al 2001). Policy themes to address these have included increasing access to health services, demand management, integration of health and social services, performance management, patient engagement and increasing professional accountability (Gillam, 2001).

This section outlines the context of the role of the community matron in relation to the English government’s agenda for transformational change of the NHS, through its health policies.

1.4.1 ‘Sea change’ for the National Health Service (NHS)
Klein (2006) argued that whilst the policy goals to address the challenges for the NHS remained consistent, there was a significant shift in emphasis and approach to government
policy in 2000 to redesign health care delivery in England. *The NHS Plan: a Plan for Investment, a Plan for Reform* (DH, 2000a) set out the ten year programme of fundamental reform and plan for investment in the NHS. The Plan set performance targets to address areas of concern, for example access, choice and waiting times for treatment. It marked a shift from reactive care to prevention, in an endeavour to address the ever increasing demand for care from an aging population and increasing prevalence of chronic health conditions. In addition it set out to optimise the use of advances in technology and evidence based practice. A central theme of reform was to respond to patient expectations and improve quality and experience of health care (DH, 1998; DH, 2000b).

So, *The NHS Plan* (DH, 2000a) had significant implications for the organisation of care, with shift of care closer to patients’ homes rather than hospitals, and breaking down the traditional boundaries between acute, community and social services. It aimed to drive greater collaborative working between organisations and professions, at the same time advocating changes to the relationship between the private and public sector. In doing so tensions and uncertainty were generated within the health care systems, where organisations and practitioners were challenged to work differently and rethink their existing roles whilst trying to interpret and anticipate the organisational, professional and personal changes ahead.

There followed a stream of policy implementation documents to support *The NHS Plan* in relation to service delivery and professional roles: service delivery changes to address key health priorities were set out in the National Service Frameworks (NSFs), for example *NSF for Coronary Heart Disease* (DH, 2000c), *NSF for Older People* (DH, 2001a), and *NSF for Diabetes* (DH, 2001b). Building on the national nursing and midwifery strategy *Making a Difference* (DH, 1999), the Department of Health for England pushed the professional agenda for nursing and allied health professions to meet the workforce challenges in delivering redesigned services through a series of initiatives entitled *Liberating the Talents* (DH, 2002; DH & CPHVA 2003; DH 2005a). These documents outlined the need for working in new ways in inter-professional teams and acknowledged that more nurses would be practising in new advanced and specialist roles.

During this period the Royal College of Nursing published its redefinition of nursing (RCN, 2003). It argued that issues had arisen from lack of clarity about nursing’s unique contribution to patient care, differentiation between professional nursing and care undertaken by others. It also expressed concern about external drivers of role extension, for example shortage of doctors, and role depletion through skill mix to contain costs. This suggests there was
confusion and concern within the nursing profession about the future direction of nursing and

determining its own destiny.

These fundamental service and professional changes were overlain with changes to the
structure of the NHS in England. *Creating a Patient-led NHS* (DH 2005b) was published just
prior to the start of the study. It brought fundamental change in the creation of practice based
commissioning where groups of general practices were given greater control over budgets for
local health services. This meant that General Practitioners (GPs) would, over time, have
responsibility for decisions about which services would be commissioned for their local
population, where such services would employ practitioners who to date had been colleagues
of GPs, for example community nurses.

English national policy to determine the NHS commissioning structure (DH 2005c) meant
there was a possibility that provider services could become independent organisations in the
long term, with the potential to be in competition with other service providers to maintain their
service contracts in the future. Practitioners, then, were working in a time of uncertainty, great
disruption and a feeling of increasing scrutiny of their practice which had not been
experienced before.

Despite the volume of top down policies, the Department of Health stressed that these were
not intended to be a ‘blueprint’ for how services should be delivered but a means to
improvement (DH, 2005d). This presented the potential for a lack of clarity between policy
and implementation; this has been referred to as the ‘implementation gap’, that is, where a
formally announced policy was not the same as what was implemented (Smee, 2005). Smee
(2005) argued that lessons had not been fully learned about implementation gaps from health
policies prior to 2000. Therefore the NHS was on a journey of substantial change but, as
Klein (2006) argued, its final destination was uncertain.

1.4.2 Changing the approach to managing long term conditions in England

Health care organisations were challenged with how to meet the demand to treat the growing
number of people with long term conditions within resource limits (Weiner et al 2001; Dixon et
al 2004). Policy strategists turned to other countries for answers, predominantly the USA and
their approach to managed care. ‘Managed care’ has been defined as ‘*an integrated system
that manages the delivery of a comprehensive health care service for an enrolled population,*
*rather than simply providing or paying for them*’ (Weiner et al 2001, p. 3). For example the
King’s Fund studied how chronic disease was managed by five leading US managed care
organisations (Dixon et al 2004). Within the National Health Service (NHS) in England there had been increasing focus on how to improve health and reduce hospital admissions, as long term conditions accounted for around one third of emergency admissions in people over 65 years old (Hutt et al 2004).

The community matron was first proposed in *The NHS Improvement Plan* (DH 2004a) in relation to chronic disease management. It stated:

‘These community matrons will work with patients with complex problems to assess their needs and the support that they need and then work with local GPs and primary care teams to develop tailored personal plans to deliver the best possible care to them.’

(DH, 2004a, p.37)

The title of matron had re-emerged in the NHS in 2000 when *The NHS Plan* outlined “bringing back matron” (DH 2000a, p. 25), four years before its association with case management for people with long term conditions. The role of the ‘modern matron’ was heralded as the way to improve standards of patient care, but it was specific to the hospital setting (DH 2001b). The modern matron, then, was distinct from the role of community matron outlined in the *NHS Improvement Plan* (DH 2004a). However the similarity in terminology and people’s previous associations with the term matron predisposed to misunderstandings of roles.

Interestingly there had been no reference to the new role of community matron within nursing in the strategic documents leading up to the *NHS Improvement Plan* (eg. DH, 2001b; DH, 2003). *Liberating the public health talents of community practitioners and health visitors* (DH and CPHVA 2003) described chronic disease management as one of the core functions of such existing practitioners. The title ‘Modern Matron’ was used in *Liberating the talents in primary care* (DH, 2002) with regard to the hospital role, but not in relation to managing long term conditions. Whilst Hayes (2004) presented positive views from patient organisations, such organisations acknowledged the potential for misunderstandings of the community matron role and people’s associations with the title ‘matron’. Therefore disparity between emerging policies suggested an immaturity of the concept of this new role and its place in the existing workforce.

It was not until seven months later that the community matron was presented in more detail as the key driver for case management in *The NHS and Social Care Model for Long Term Conditions* (DH 2005e). It depicted three levels of intervention, namely: supported self care, disease-specific care management and the use of case management to support those with
highly complex multiple long term conditions. Government targets were set for each primary care trust to introduce the role, so that 3000 posts would be established in England by 2007. In addition the Long Term Conditions Model had a specific Public Service Agreement (PSA) target to reduce inpatient emergency bed days by 5% by March 2008 (DH, 2004b); the community matron role was seen as pivotal if the NHS were to achieve this.

The delay between the first announcement and the subsequent policy about the community matron role gave rise to debate across the nursing, medical, social care and health management media. Commentaries in professional journals began to highlight the level of speculation about the role (Agnew, 2004a; Wilkinson, 2004; Fisher, 2005; Hunter, 2005) and predictions of failure before its inception, suggesting that the role could not be effective in reducing hospital admissions (Murphy, 2004). So the fuelling of doubt about the role within and external to the profession was a potential factor to affect role implementation.

Leaders of nursing professional bodies, namely the Royal College of Nursing (RCN) and the Community Practitioners and Health Visitors Association (CPHVA), whilst agreeing with the principles of case management, were concerned that existing practitioners would be disempowered, and there was already insufficient capacity within nursing to fill 3000 new posts (Agnew, 2004a). So although the new community matron had been launched as a high profile nursing role, the top down policy was perceived by the profession as a threat, with the potential for resistance to its implementation.

Similarly issues of duplication were expressed by GPs, suggesting the duties of the proposed role were already fulfilled by doctors, and funded via the new general practice contract (Meldrum, 2005). Nursing also noted the risk of duplication, but with other specialist nurses rather than GPs (Agnew, 2004a). There was criticism from practitioners in social care too, for the lack of recognition and inclusion of social care in the proposed model for case management (Young, 2004; Hudson, 2005) despite being heralded as a model for collaborative working. So the presentation of the new role had not considered its impact on existing functions and how these would work together in providing care, nor had the policy articulated its unique position within an existing service system. This was likely to raise issues about role boundaries and working with others for practitioners undertaking the new role and for those working with them.

The delay between the announcement and the publication of the policy created a risk of misunderstandings about the expectations and requirements of the role; for example,
Wilkinson (2004) reported that GPs would have to initiate the care plan for community matrons to implement. This suggests a lack of recognition of nursing being able to be the lead practitioner for patient care, so it would not be seen by the GP as a legitimate role for a nurse. This may reflect issues about the inter-professional relationships that might present a barrier for future community matrons. Some community matrons already working in chronic disease management did not have clinical caseloads and acted as agents for change in service redesign (Hayes, 2004). So it appeared that the delay in the policy had already generated different interpretations and variation in implementation of the role.

As a new policy for role implementation in nursing across England, the community matron role was still a concept rather than an established role in community nursing. Thus investigation was needed to explore how the proposed role of the community matron was interpreted and implemented. Therefore this research focused on how the new role of community matron had been understood and interpreted by organisations, by practitioners undertaking the new role and by colleagues working with community matrons.

1.5 Questions stimulating the study
Questions arose from the policy set out in the *NHS Improvement Plan* (DH 2004a) and the *NHS and Social Care Long Term Conditions Model* (DH 2005e) to introduce the role of the community matron. These were:

- How does a community matron undertake this new role?
- How does the introduction of this new nursing role affect existing practitioners working in the management of long term conditions?
- How have community matrons negotiated their role boundaries and has this affected the boundaries of other community nursing roles?

1.6 Aim of the study
The questions led to the focus of the study to be:

To develop insight and understanding of the role of community matron, and its implementation within three primary care trusts

A literature review was undertaken to reveal research that could inform this study, to avoid duplication of existing findings and to inform the research design. This review is outlined in Chapter Two.
CHAPTER TWO: LITERATURE REVIEW

This chapter critically analyses and evaluates the theory and evidence pertaining to the community matron role that was available up to 2006, at the start of data collection in this study, as this informed the preliminary themes in the study design. Research evidence published subsequently was used to inform the discussion of findings and can be seen in Chapter Ten. Policy literature has been presented in Chapter One to provide the contextual background of the community matron role and is also considered in this chapter with regard to the role function of the community matron and policy implementation.

There was a paucity of research evidence specifically about the community matron role, with a predominance of descriptive articles and commentaries to be found, at the start of this study. The focus of the study, (that is how the new role of community matron has been implemented), has guided the literature search approach with regard to key concepts. These were role implementation; role boundaries and multi-professional working in relation to community nursing in England. The management of long term conditions and nursing was also considered.

2.1 Approach to literature search

Narrative or descriptive reviews can be used for describing the history or development of a problem from the literature (Fink, 2005). They are used to identify and interpret similarities and differences in the literature, particularly where research evidence is limited (Fink, 2005). This was considered to be the appropriate approach for this review as the role of the community matron was new within nursing in England and there was limited evidence about the role prior to the start of this study. In light of the limited evidence available, a broad and inclusive approach to the review was used to explore associated theory and evidence that could provide insight into role implementation in community nursing. It was also considered that a narrative review would support case study method by contextualising the extant literature that was available up to the start of data collection.

2.1.1 Literature search strategy

Searches were made of the following databases: CINAHL, Medline, British Nursing Index, Embase, PsychInfo, SWAB (Social Work Abstracts), Social Care Online and Ovid full text journals from 1995 to 2006 for the initial literature review (a second review was conducted when concepts and themes began to emerge during analysis). English texts only were included. Articles and research were excluded that pertained to case management in mental
health, paediatrics, midwifery; that were clinical guidelines, or were hospital focused. The literature search also focused on UK literature rather than including nursing roles from the United States. The rationale for this exclusion was, in the context of this study, it was considered that the differences between health care systems in the UK and the US meant that roles were not directly comparable with those roles developing in the UK health care system. The only exceptions made to this were roles within the Evercare model (as referred to in sections 1.3.5 and 2.3.1), as these roles were directly linked to the role of the community matron. Key search terms can be seen in Table 1 and a flowchart depicting the search strategy for the initial review can be seen in Figure 1 on page 27.

### Table 1: Key search terms for literature review

<table>
<thead>
<tr>
<th>Key search terms for literature review</th>
<th>Long term conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matron and United Kingdom</td>
<td>Nursing and social care</td>
</tr>
<tr>
<td>Matron and nursing management</td>
<td>Inter-professional working</td>
</tr>
<tr>
<td>Matron and community</td>
<td>Collaborative care and nursing</td>
</tr>
<tr>
<td>Community matron</td>
<td>Role development</td>
</tr>
<tr>
<td>Advanced primary nurse</td>
<td>Advanced practice and nursing</td>
</tr>
<tr>
<td>Evercare</td>
<td>Extended role</td>
</tr>
<tr>
<td>Castlefields</td>
<td>Role boundaries</td>
</tr>
<tr>
<td>Case manager(s)</td>
<td>Role theory</td>
</tr>
<tr>
<td>Case management</td>
<td></td>
</tr>
<tr>
<td>Chronic disease management</td>
<td></td>
</tr>
</tbody>
</table>

The search included articles and reviews in addition to primary research as it was considered that articles would help inform the context in which the community matron role was developing. In light of the community matron role being a new policy initiative in nursing in primary and community care, searches were also undertaken on the websites of the Department of Health, NHS Networks (which hosts a web based Community Matron forum), the Nursing and Midwifery Council and the Royal College of Nursing for theory and evidence specifically referring to the community matron role.

### 2.2 Outcome of literature search

The search yielded 62 articles and documents specific to the community matron role. The types of documents can be seen in Table 2. The limited amount of research evidence about the community matron role reflected the infancy of its implementation at the start of this study. The largest proportion of documents was found to be commentaries and opinions; these were excluded from literature analysis but have been reflected in setting the context of the study, as seen in section 1.2.
Figure 1: Results from literature search strategy

Data sources searched
Limits:
- English language

Databases
British Nursing Index CINAHL Medline Embase PsychInfo Social Care Online Ovid full text journals AMED

Websites
Dept of Health Nursing and Midwifery Council Royal College of Nursing NHS Networks

Exclusions
Mental health Paediatrics Midwifery Clinical guidelines Hospital focused Already included Outside UK (except Evercare)

Community matron OR (matron AND UK) OR (matron AND community) OR (matron AND management) AND UK = 288
AND case management/manager = 369
AND (Role development OR role theory OR expanded role OR extended role) AND nursing AND UK = 97
AND (Interprofessional OR collaborative care OR role boundaries) AND nursing AND social care AND UK = 182

Chronic disease management OR long term conditions = 2165

Titles/abstracts screened = 208
Excluded = 178
Other sources = 3
Papers selected for relevance = 6
Papers selected for relevance = 6
Papers selected for relevance = 3
Papers selected for relevance = 12
Total number of papers selected = 45

50 Duplicate
180 Duplicate
10 Duplicate
3 Duplicate
23 Duplicate

Titles/abstracts screened = 238
Excluded = 219
Other sources = 1
Papers selected for relevance = 8

Titles/abstracts screened = 208
Excluded = 178
Other sources = 3
Papers selected for relevance = 33

Titles/abstracts screened = 12
Excluded = 3
Other sources = 1
Papers selected for relevance = 10

Titles/abstracts screened = 79
Excluded = 58
Other sources = 0
Papers selected for relevance = 21

Titles/abstracts screened = 94
Excluded = 59
Other sources = 4
Papers selected for relevance = 39

Titles/abstracts screened = 156
Excluded = 126
Other sources = 2
Papers selected for relevance = 32

Titles/abstracts screened = 79
Excluded = 58
Other sources = 0
Papers selected for relevance = 21

Titles/abstracts screened = 94
Excluded = 59
Other sources = 4
Papers selected for relevance = 39

Titles/abstracts screened = 156
Excluded = 126
Other sources = 2
Papers selected for relevance = 32

Total number of papers selected = 45
Table 2: Types of documents relating to community matron role 1995-2006

<table>
<thead>
<tr>
<th>Type of document</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research</td>
<td>3 (all reporting on one study)</td>
</tr>
<tr>
<td>Policy documents</td>
<td>5</td>
</tr>
<tr>
<td>Reviews</td>
<td>3</td>
</tr>
<tr>
<td>Descriptive and personal accounts, discursive documents</td>
<td>20</td>
</tr>
<tr>
<td>Articles, commentaries, opinion and editorials</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

In light of the limited evidence specifically related to the community matron role, the wider issues of role implementation in community nursing, the nursing role in the management of long term conditions in the community and associated concepts, for example role theory, were explored.

2.3 Models for the management of Long Term Conditions (LTC)

There has been a variety of service models adopted across England to support the management of long term conditions (Singh and Ham, 2006). These include the Kaiser and Evercare models from the US. The Kaiser approach focuses on integrating health services across primary and secondary care for people at all stages of their illness. People with long term conditions are stratified according to need across three categories with intensive management targeted at those most at risk. This is presented as a pyramid, which has been used to underpin the strategic approach to the management of long term conditions nationally (Colin-Thomé and Belfield, 2004) and the NHS and Social Care Model (DH, 2005e) as seen in Figure 1. The Kaiser model for service delivery is predominantly medically led.

Figure 2: The long term conditions pyramid
(taken from DH, 2005e)
The Evercare model targets people at highest risk and so centres on providing case management to those individuals in the top sector of the pyramid. Case management is led by nurses in specialised roles. This model focuses on integration of health and social care to meet an individual’s needs (Singh and Ham, 2006).

Singh and Ham (2006) surveyed long term conditions leads in all 28 English Strategic Health Authorities (SHAs) in December 2005, as part of a wider review of frameworks and service models for the management of long term conditions. They found that SHAs had adopted different styles to developing their approaches to the management of long term conditions. PCTs also adopted a wide variety of approaches to support implementation of the NHS and Social Care Model (DH, 2005e), including Evercare, Kaiser, and Unique Care/ Castlefields, the latter being a model developed in England. Whilst there was a good response rate (71%), the varied quantity and quality of responses to the questions prevented analysis of which models had been adopted most frequently. It was unclear whether the survey tool had been validated; the variation in response quality may reflect the limitations of the questionnaire design which appeared to have open ended questions, and also the short time allowed for responses. However particular interest was reported by respondents in developing case management drawing on Evercare, Unique Care/ Castlefields and similar approaches. It could not be determined from the report whether interest in these approaches was associated with the requirement to implement the community matron role, so the relationship between the policy and implementation remained unclear.

2.3.1 Evercare approach as a model for case management in long term conditions
The Evercare model is a system of active case management, developed in the United States and centres on the role of the Advanced Primary Nurse (APN) as the case manager. The APN role is discussed further in section 2.5.1. Although different models of case management, namely Kaiser, Evercare and Pfizer, were piloted in England by the Department of Health (Singh and Ham, 2006), the policy direction appeared to be closely aligned to the Evercare model. Indeed, there appeared to be political endorsement with the Health Minister John Hutton quoted saying that the English version of Evercare was “the right one for the NHS” (anon, 2005). In addition, the Evercare model was actively promoted by its parent company, UnitedHealth Group, to SHAs, PCTs and NHS trusts across England (Boaden et al, 2005). This pre-empted full evaluations of the Evercare model that were due to complete in 2006 (National Primary Care Research and Development Centre, undated).
The Evercare pilots in England were evaluated positively by Evercare’s parent company (UnitedHealth Group Europe, 2005). Almost all patients and carers (95%) reported an improvement in the patient’s ability to cope with health problems since receiving the services from the APN, and 96% of APNs thought that the programme had improved the quality of care for patients. There was a 38% fall in the rates of unplanned admission to hospital in patients who had previously had two or more emergency admissions. However the evaluation reported that this level of reduction could not be attributed to the interventions of the APNs, as this could only be determined over a longer time period. The report offered limited description on methodology and analysis so the rigour of the evaluation could not be determined. The report was flawed in that it did not address bias: postal survey response rates were variable (86% from APNs; 57% from patients; 38% from carers; 38% from GPs), so bias could be generated in the results, with APNs potentially having a disproportionate voice in the findings. Also the issue of bias by the authors in presenting the findings, being the parent company of Evercare, could not be discounted. So overall the report was not robust in demonstrating the outcomes of the evaluation and did not provide further insight into the implementation of the role of the community matron.

Further evaluation of Evercare focused on emergency admissions (Roland et al, 2005) rather than the role of the APN, which did not add further knowledge about the APN role or those practitioners undertaking the role, to inform this research.

2.3.2 Community nursing roles in managing long term conditions
Singh (2005a) conducted a ‘rapid review’ to assess the evidence about interventions to improve care for people with long term conditions. The review focused on the impact of selected initiatives on patient satisfaction, quality of care, clinical outcomes and healthcare resource use. It did not focus on specific long term conditions. Whilst ‘rapid review’ was not defined, the review process was clearly described with regard to the search of ten databases for articles that addressed systems of care. A total of 32,520 papers were found from which 560 were selected using inclusion/exclusion criteria applied. Descriptive reports, before and after studies, and cohort studies were omitted. As the studies assessed in Singh’s review (2005a) were predominantly randomised controlled trials and systematic reviews, they were comparative in nature and limited to this dimension, and so qualitative issues were not considered in any depth.

In relation to nursing roles, the review concluded that there was inconsistent evidence about the benefits of care by specialist nurses. Comparisons were made with care provided by other
teams or practitioners, for example a Cochrane review compared specialist nurse care for people with diabetes with usual care provided by clinics or primary care (Loveman et al, 2004) and found no difference in patients’ blood glucose levels at 12 months, emergency hospital admissions or quality of life. Similarly there was inconsistent evidence about the effects of nurse-led strategies in managing long term conditions, including nurse-led follow up by telephone or in person. However these findings were not specific to community nursing roles.

In a second ‘rapid review’, Singh (2005b) considered the role of community and primary care nurses in case management. The overall review included 172 primary research and systematic reviews, selected for inclusion from a search of ten databases, and websites which had yielded 28,355 potential reports. Singh (2005b) reported that there were no high quality trials that explicitly compared the relative merits of different staff as case managers, such as nurses versus doctors or health visitors but found 14 studies that described in detail case manager roles undertaken by primary care nurses. Singh (2005b) concluded that evidence about the effects of primary care nurse case managers was inconsistent and did not necessarily improve clinical outcomes. However, most studies suggested that primary care nurse managers may have some impact on satisfaction and quality of care. Of those cited in the report, eight were from the US, one from Canada and one from Denmark. There were no cited examples from the UK. Given the caveat in the report that examples from the US or Europe would work in different contexts and health care systems, the findings of this review, in relation to primary care nurses’ role in case management, did not provide any further insight into the developing community matron role.

In a narrative overview, Drennan and Goodman (2004) described examples of six models of case management with primary care nurse involvement in England, as shown in Table 3. However research evidence to underpin these models was not apparent. Evercare, Kaiser and Pfizer models were part of the pilot programme in England, but the full evaluations were still to be published (Drennan and Goodman, 2004). The models did, however, highlight the potentially different nursing roles and levels of practice within case management. It was unclear how the choice of model for case management would affect the implementation of the role of community matron.
Table 3: Models of case management with primary care nurse involvement (from Drennan and Goodman, 2004)

<table>
<thead>
<tr>
<th>Nursing role</th>
<th>Example in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist nurse as case manager</td>
<td>Evercare pilot programme, where role works across GP practices, hospital and social care</td>
</tr>
<tr>
<td>GP practice based nurse care manager</td>
<td>Castlefields Health Centre model, where former district nurse and social worker work with people identified at risk of hospitalisation within the practice population</td>
</tr>
<tr>
<td>Case finding team</td>
<td>London Older People’s Service Development Programme, where nurses identified older people at risk from A&amp;E and through other risk factors such as falls, working with multiple GP practices, hospitals, social care and voluntary services</td>
</tr>
<tr>
<td>Chronic disease management coaching model</td>
<td>Pfizer model of care, where nurse provides a telephone support service using a computer based decision support tool</td>
</tr>
<tr>
<td>District nurse care managers</td>
<td>District nurses based in social services teams to case manage people with complex health and social care needs. This related to care needs assessment and funding packages of care.</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>Nurses act as discharge planners and providers of intermediate care, to reduce unplanned hospital admissions and bed days</td>
</tr>
</tbody>
</table>

Lyon et al (2006) reported on a study referred to as a ‘comparative observational study’: this examined the Castlefields Health Centre model, where one of the authors (Dr Lyon) was a practising GP. It presented how a district nurse and a social worker for older people introduced an integrated case management approach for patients in one general practice. A district nurse worked for half time with a full time social worker to undertake joint assessments and set up joint packages of care for older people. They undertook in-reach to the hospital for early discharge planning. All social services referrals and a substantial number of district nursing referrals for the practice’s registered patients were rerouted to the new service. The study reported 97% of patients received a social work assessment the same day as referral whereas previously routine assessments took six weeks or more. Discharge planning was reported to commence within 2 days in ‘most cases’, although a comparison of previous outcomes was not made. The average length of stay and number of bed days amongst the practice population reduced, the reduction being statistically significant. GP consultations and home visits were reduced, and there was an anecdotal report that district nursing workload had fallen, as they had not been required to backfill the half time district nursing post. However due to a lack of clear reporting about the research design, namely sampling, specificity regarding comparison of intervention versus non-intervention, it could not be ascertained whether improvements were attributable to the intervention, or other factors were at play. As such the study was weak as a ‘comparative observational study’. The observation
aspect of the study was not evident in the report. As a practice development, it highlighted the potential for a different nursing and social care model for case management within primary care. Further information about the roles undertaken by each practitioner was needed to gain an understanding of how such roles worked in practice. However the report placed greater emphasis on the social work role, so the nature of the district nurse’s practice in case management could not be determined. This practice was presented in vignettes as an exemplar within the NHS and Social Care Model (DH, 2005e), emerging as the Castlefields Model, with increasing interest from SHAs and PCTs reported by Singh and Ham (2006) (as described in section 2.3). This raised questions about the evidence base used for the management of long term conditions policy and how its implementation could be evaluated.

Evans et al (2005) argued that literature to inform policy on the management of long term conditions had not considered the existing practice nurse workforce as case managers, rather than the development of new specialist nursing posts. Their study examined the extent to which practice nurses used the five cyclical elements of a case management approach (Iliffe and Drennan, 2000) when caring for people over 75 years old. Using a postal questionnaire with a combination of closed and open questions, a random sample of 500 practice nurses were asked the frequency of case management activity in relation to practice nursing. Findings showed marked variation in the use of a case management approach. Elements of case management most frequently used were assessment, care planning and care delivery, and referral to an external agency being the least common. Those with a district nursing qualification were significantly more likely to refer to a social services care manager. Those with district nursing or practice nursing qualifications showed an increased trend towards offering opportunistic medication reviews. However 52% reported time was the biggest barrier to incorporating case management elements to their work.

The research was well executed, as shown by the questionnaire design, sampling and analysis described in the study. It was limited though in considering case management within a narrow context, in the existing model of practice nursing where nurse consultations were held within a general practice. However the study highlighted the potential for the practice nurse role to contribute to the wider case management function, and also how some practice nurses’ experience and expertise makes them ideally placed to become community matrons. The question remained unanswered regarding how the community matron role would work with existing roles in nursing and how the background of a community matron would affect their practice.
2.4 Policy framework for the community matron

There were five key policy documents published by the Department of Health regarding the community matron role and its implementation; the policy documents and their key themes are listed in Table 4. The context of these policies was introduced in section 1.2.

Table 4: Policy documents pertaining to the implementation of the community matron role

<table>
<thead>
<tr>
<th>Policy document</th>
<th>Key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Improvement Plan (DH 2004a) (Chapter 3)</td>
<td>Policy</td>
</tr>
<tr>
<td></td>
<td>High quality, personalised care for people with long term conditions</td>
</tr>
<tr>
<td></td>
<td>Self management, disease management and case management</td>
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<tr>
<td></td>
<td>Care closer to home</td>
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<tr>
<td></td>
<td>Social care</td>
</tr>
<tr>
<td>Supporting People with Long Term Conditions: NHS and Social Care Model to support local innovation and integration (DH 2005e)</td>
<td>Policy</td>
</tr>
<tr>
<td></td>
<td>Shift from reactive and unplanned approach to planned, targeted intervention</td>
</tr>
<tr>
<td></td>
<td>Improving effectiveness, quality and use of resources</td>
</tr>
<tr>
<td></td>
<td>New models of care</td>
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<tr>
<td></td>
<td>Integration</td>
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<tr>
<td></td>
<td>Role development</td>
</tr>
<tr>
<td></td>
<td>Long term conditions pyramid and targeting care at each level: case management, disease specific management, self care</td>
</tr>
<tr>
<td></td>
<td>Community matron role and competences</td>
</tr>
<tr>
<td></td>
<td>Implementation</td>
</tr>
<tr>
<td>Supporting People with Long Term Conditions: Liberating the talents of nurses who care for people with long term conditions (DH 2005a)</td>
<td>Implementation guidance</td>
</tr>
<tr>
<td></td>
<td>Developing new roles for nurses</td>
</tr>
<tr>
<td></td>
<td>Nursing role at each level of the long term conditions pyramid</td>
</tr>
<tr>
<td></td>
<td>Implementing case management by community matrons</td>
</tr>
<tr>
<td></td>
<td>Redesign of wider workforce</td>
</tr>
<tr>
<td>Case management competences framework for the care of people with long term conditions (NHS Modernisation Agency and Skills for Health 2005)</td>
<td>Implementation guidance</td>
</tr>
<tr>
<td></td>
<td>Differentiation between community matron and case manager</td>
</tr>
<tr>
<td></td>
<td>Competency: 9 domains</td>
</tr>
<tr>
<td>Caring for People with Long Term Conditions: an education framework for community matrons and case managers (DH 2006)</td>
<td>Implementation guidance</td>
</tr>
<tr>
<td></td>
<td>Differentiation between community matron and case manager</td>
</tr>
<tr>
<td></td>
<td>Overview of competency domains</td>
</tr>
<tr>
<td></td>
<td>Education framework</td>
</tr>
</tbody>
</table>

As Table 4 shows, the policy intentions regarding the community matron were introduced broadly in the *NHS Improvement Plan* (DH 2004a) set in the context of redesigning health services to address the increasing numbers of individuals with long term conditions and complex needs, and shifting care from secondary to primary care. These themes then ran through the subsequent documents, becoming more focused and detailed, so that the policy
was building from these general concepts to tangible plans for implementation. Whilst there was repetition in subsequent documents about the model, this created consistency of the policy message through the documents.

The timing of publication of the documents created a drip feed effect, which, as discussed in section 1.2, generated speculation and uncertainty. It was unclear whether the publications were purposely staged as a strategy to stimulate large scale organisational change akin to the first stage of change implementation (Lewin, 1951). Lewin argued that for change to occur, there needs to be dissatisfaction to ‘unfreeze’ the status quo, followed by ‘moving’ where behaviours change, to ‘refreezing’ where the new behaviours, that is, the change, becomes the new status quo.

Alternatively the delay in publishing subsequent documents reflected a gap between the policy concepts and the formulation of implementation plans. The evaluations of pilot studies had not been completed when the implementation guidance were released, suggesting that the direction for implementation had been decided but was not supported by evidence.

Footnotes rather than full references were used to denote that the *NHS and Social Care model* (DH 2005e) was drawn from the Chronic Care Model (Wagner, 1998), the components of which were research based (Singh and Ham, 2006), and from the Kaiser pyramid of care, which identified patients with long term conditions in three distinct groups according to their need. The Kaiser model was also reported to be based on the Chronic Care Model (Wallace, 2005). So research evidence underpinned the concept of the policy, but this was not clear from the document.

There was also minimal reference to research evidence throughout all the policy documents; instead there were vignettes describing examples of the policy in practice. For example, the eligibility criteria for case management used by a nurse and social worker at Castlefields Health Centre, and those used by one of the Evercare pilots are presented, to support the plans for the identification of patients at risk of unplanned hospital admissions (DH, 2005e). The risk criteria for each of the examples presented differed, so patient access to case management would vary according to models adopted locally. So variation in implementation of the policy was being presented from the outset.

*The NHS and Social Care Model* (DH 2005e) claimed to address policy for health and social care by virtue of its title; however whilst throughout the policy it referred to ‘health and social
there were no references to the role of the social worker with regard to development, change of role or specific service redesign in social care. This suggested that whilst the policy advocated inter-professional working, it did not provide evidence of such working in producing a shared policy at Government level. So the policy did not reflect how inter-professional working would be implemented, but rather was left for local determination at organisational and individual level. Therefore it was unclear how inter-professional working would be implemented in practice.

The core functions of the community matron and competences required to fulfil these functions were first set out in the NHS and Social Care Model (DH, 2005e). These are outlined briefly in Tables 5 and 6. Again, these functions and competences were not supported by any referencing to indicate their origin or any underpinning research evidence.

Table 5: Core functions of the community matron (DH, 2005e)

- Collaborative working
- Assessment and planning of care, including preventative action
- Patient monitoring
- Initiate action, e.g. diagnostic tests, prescribing
- Maintain contact during hospital admissions to maintain continuity of care
- Updating records and sharing information
- Liaison with other agencies
- Teaching symptom awareness to promote earlier intervention
- Securing additional support required in the home

Table 6: Competences required of community matrons (DH, 2005e)

- Care coordination and case management (brokerage and provision)
- Physical examination and history taking, diagnosis and treatment planning
- Managing cognitive impairment
- Using population and individual information to support decision making
- Independent and supplementary prescribing and medicines management
- Interagency and partnership working
- Management of long term conditions (particularly the interplay between multiple diseases)
- Working in the home and community setting
- Supporting self managed care
- Managing care at the end of life
- Prevention and health promotion
- Advanced level professional practice, including self directed learning, managing risk, autonomous practice, higher level communication skills

There was inconsistency between the community matron role outlined in the NHS Improvement Plan (DH, 2004a) and functions described in the NHS and Social Care Model (DH, 2005e), as set out in Table 4. In the Plan the community matron role was described as a ‘new type of specialist clinician, often a nurse... who has particular expertise in responding to
patients’ complex problems’ (DH, 2004a, p.37) In the Model, however, the concept of advanced practice and clinical interventions such as physical assessment, diagnosis and prescribing were introduced. It was also stipulated that the community matron was a nursing role. This difference may be attributed to use of terminology, as the description of the original concept for the role was expanded in more detail; alternatively it may reflect an underdeveloped concept that was shifting during the policy setting phase. In either case, such mixed messages could cause confusion which would impact on the policy implementation.

Advanced professional practice was only referred to as a competence in the model (DH, 2005e) and was only defined further in the competences framework (NHS Modernisation Agency and Skills for Health, 2005) and the education framework (DH, 2006). However the competences cited were medically focused and did not resonate with definitions of advanced nursing practice recognised within the profession: for example Manley (1997) described advanced practice as incorporating roles of expert practitioner, educator, researcher and consultant. The remaining roles and competences could be open to interpretation with regard to the level of practice. So there was lack of clarity regarding how functions and competences matched nursing concepts of specialist and advanced practice, which could affect how the role was implemented. This is explored further in section 2.6.

A case manager role, distinct from the community matron role, was not defined in the original model, and the term was on occasion used interchangeably with community matron (DH 2005e, p.17; p.37; p.39). However the competences framework (NHS Modernisation Agency and Skills for Health, 2005) and the education framework, the purpose of which was to ensure that the roles developed in accordance with Department of Health guidance (DH 2006), addressed this confusion. Both frameworks clearly differentiated the roles: the community matron would provide advanced nursing care in addition to case management for people with very complex needs, in contrast to the case manager who would work with people with a dominant single condition that required help with care coordination. However organisations had been expected to expedite the implementation of the community matron role in order to meet targets for the management of long term conditions, prior to the frameworks being available. Therefore it was unknown whether community matron roles would, in practice, develop in line with national policy or local interpretation would generate variation in implementation.
2.4.1 Policy implementation issues

Hudson (2005, p.381) argued that the policy on long term conditions (DH 2005e) was “best located at the level of political rhetoric rather than daily reality”; he considered that, based on previous unsuccessful drives for seamless care between health and social services (Glendinning et al 2002; Hudson 2002), there was insufficient evidence that the proposed model could be achieved in practice. Policy implementation and the gap between what the policy intended and its actual outcomes have been the subject of analysis within health and social care (Hill and Hupe 2002). Policy implementation has been considered from ‘top-down’ and ‘bottom-up’ perspectives: The ‘top-down’ model assumes that decisions are made at the top tier of an organisation which then must be implemented by lower levels of the organisation (Palfrey, 2000). Top-down theorists (Pressman and Wildawsky, 1973; Van Meter and Van Horn, 1975; Hogwood and Gunn, 1984) identified variables or criteria affecting the success of policy implementation. Palfrey (2000) summarised these in three broad areas, namely:

- **Change**: whether the change required is clear and accepted by all interested and influential groups that would be affected
- **Control**: whether the policy makers control the resource required for implementation and direct all participating parties
- **Compliance**: whether the top level decision makers have complete confidence that those who are needed to enact the policy will do so without resistance.

Given the extent of debate and concern generated by the announcement of the policy to introduce community matrons, it was debatable whether these criteria could be met with regard to the NHS and Social Care Model (DH, 2005e).

The ‘bottom-up’ model has been described as ‘*a process of consultation and negotiation that takes place between those at the ‘top’ and those implementing policy... that might at times be the only means by which resistance and suspicion on the part of individuals and groups with entrenched interests might be overcome...*’ (Palfrey, 2000, p. 45). Lipsky (1980) is regarded as the key theorist for the bottom-up perspective of policy implementation (Hill and Hupe, 2002). He proposed in his theory of street level bureaucracy that public sector workers on the front line (street level bureaucrats) use discretion in delivering policy at street level. Only by doing this can they manage to cope with conflict and uncertainty created by the work demands placed on them with limited resources. This compromise may result in practices and routines emerging that are not in line with professional or service ideals, which become the
policies through custom and practice at service level. As such these would not reflect the intended policies of the organisation.

Matland (1995) considered how both top-down and bottom-up factors affect policy implementation, and argued that the higher the level of ambiguity in the policy goals, the greater potential for conflict and impact at the point of policy implementation.

Theories of implementation (Van Meter and Van Horn, 1975) and street level bureaucracy (Lipsky, 1980) were applied to policy implementation in community nursing by Bergen and While (2005) by re-examining data from a research project on community nurse case managers. The research explored the extent and nature of involvement of community nursing in case management (also described as care management) as set out in the community care policy, *Caring for People* (DH, 1989). Case management in this context referred to the function of care needs assessment, which had traditionally been undertaken in the main by social workers. Their multi stage methodology included a national telephone survey, followed by a more detailed questionnaire survey and a purposive sample of 13 case studies, across a variety of community nursing specialisms. A longitudinal follow up study with participants was conducted 5 years later. They later undertook a retrospective analysis of the data to consider the tensions between policy and practice. The analytic strategy was described as being based on pattern-matching logic, to compare the patterns from the study with a predicted one, from Yin (2003). Whilst the original study was a large scale qualitative study, there was insufficient detail regarding how the retrospective analysis was undertaken to determine its rigour. However examples of interview data were used to support reported findings.

They reported that there was some deviation from the intended policy by the organisations in terms of partial rather than full budgetary devolution to practitioners and that this may have been the profession’s way of coping with a policy that was at odds with professional values. The lack of direction from policy allowed local diversity which facilitated good interagency working. So the scope for variation in policy interpretation allowed community nurses to align their new roles to their own concept of nursing practice. Bergen and While (2005) also argued that such ambivalence in policy intentions would lend to variations in interpretations and implementation of the new community matron roles by the profession, local politics and practitioners. The findings of the retrospective analysis from this study cannot be assumed to be transferable to other contexts. However it does present inferences for future policy implementation in that the nature of policy implementation for the role of the community
matron may impact on the degree of variation seen in the role, the level of support within the profession and inter-professional working.

2.5 The community matron role
At the start of the study there was limited research about the implementation of the community matron role in England, with the exception of evaluation reports for the Evercare model based on nine pilot sites (UnitedHealth Europe, 2005). These, as discussed in section 2.3.1, focused on the outcome of the case management approach (Singh, 2005a). A small number of US studies had emerged specifically on the role of the Evercare nurse practitioner (called advanced primary nurse in the England pilot sites, and subsequently named community matrons in 2004). In light of the lack of research evidence about the community matron role in England, the US studies have been considered here.

2.5.1 Roles and activities of an advanced primary nurse
The Advanced Primary Nurse (APN) was called the Evercare Nurse Practitioner in the US. Six key roles of the Evercare Nurse Practitioner were identified in the Evercare case management approach (Abdallah et al 2005) which are set out in Table 7. Clear similarities can be seen between these roles and those of the community matron set out in Table 5.

Table 7: Roles of the Evercare Nurse Practitioner (Abdallah et al, 2005)

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Collaborator: clinical co-decision maker with the physician, collaboration regarding diagnosis and management of care</td>
</tr>
<tr>
<td>Clinician: care management, including patient assessment, including examination and diagnosis, and</td>
</tr>
<tr>
<td>Care manager/coordinator: co-ordinate care across care settings and care providers, including consideration of cost-effectiveness; liaison with other health professionals</td>
</tr>
<tr>
<td>Communicator/cheerleader: ensure information sharing with patients, family and health professionals. Promotion and enthusiasm about Evercare model of care to engage others in accepting model of care</td>
</tr>
<tr>
<td>Coach/educator: support patients, carers and other health professionals in developing self care and understanding condition</td>
</tr>
<tr>
<td>Counsellor: supporting patients and families in decisions about end of life care</td>
</tr>
</tbody>
</table>

The roles in Table 7 were research evidenced based, from a US study to develop and test an instrument to measure the frequency of activities by Evercare nurse practitioners (Abdallah et al, 2005). Activity categories for each role were generated from a sample of Evercare nurse practitioners through participant observation (5), interview (11) and focus groups (4), followed by questionnaire survey to 127 Evercare nurse practitioners from five sites. Rigour of the study was shown through clear sampling, inclusion and exclusion criteria, application of
method and statistical analysis. Tests for content validity and internal consistency reliability tests were undertaken on the instrument. The questionnaire survey results were reported in another paper in relation to the frequency that practitioners undertook activities supporting each role (Abdallah, 2005). Here it was reported that in three of the five sites, greater emphasis was placed on the collaborator role, which may reflect the different regulations and limitations on the practice of the nurse practitioners in different US states. Overall there was consistency reported in activities for each of the roles across the five sites, which was considered to reflect the central management of the programme and the systematic approach adopted to care. The study was limited as findings were based on self reporting by nurse practitioners; their retrospective judgement of time allocation to activities may not be accurate, and might be better determined through observation or real time recording. As the Evercare nurse practitioner in the US was based in nursing homes, results were not directly comparable to the role of community matron. However the study raised the question of the part played by uniformity in systems to deliver consistency in how a role is carried out. Given the different approaches to case management described in the NHS and Social Care Model (DH 2005e), it was unclear whether such variation would have implications in the implementation of the community matron role and the focus placed on different activities within the role.

2.5.2 The experience of practising as a community matron in England

Articles in the UK literature were predominantly narratives of the implementation of Evercare in some of the pilot sites (eg. Agnew, 2004b; Fraser et al. 2005; Bee and Clegg, 2006). However one small phenomenological study of the Advanced Primary Nurse (APN) was reported in three short papers (Adler, 2005a; 2005b; 2005c). The title of APN was used by the pilot site prior to the title community matron being introduced. Adler (2005a; 2005b; 2005c) interviewed five APNs about their experiences in this new role and their transition from their previous roles into being an APN. Very little detail is reported on the Heideggarian phenomenological approach used (Adler, 2005a) so it is not possible to determine the rigour of the study, for example there is no rationale for the choice of methodology or explanation of sampling. Whilst it states that the researcher was also an APN, reflexivity or the potential for researcher bias are not addressed. This may be a reflection on the style of the publication and its target audience, in being a practitioner journal rather than an academic publication. Therefore such omissions may not indicate a weakness in the study itself.

The study did not specifically examine the key functions of the APN, but stated that the role ‘proactively monitors and case manages 40-50 older adults with complex long term
conditions’ (Adler 2005a, p.16). It did not refer to the roles of the Evercare APN (see Table 7), on which the role in this study was predicated with the exception of championing older peoples’ issues and undertaking medical functions (Adler, 2005a), nor to the roles of the community matron published by the Department of Health (DH, 2005e) (see Table 5). Therefore it is not explicit whether the APN role is comparable to the community matron role. This restricts the applicability of findings to other roles.

The study identified key issues of role transition in the first 12-18 months, including anxiety and uncertainty, the development of new clinical skills, resistance, developing collaborative working and peer support. Individual relationships and communication appeared key in overcoming resistance to the new role. However these concepts in managing change were not developed further in the research paper. Participants stated they were well supported by nurse practitioners, GPs and nurse consultants (Adler, 2005a), but the nature of this support was not described.

Adler (2005b) identified five key themes pertaining to experiences of undertaking the new role, which were comparing district nursing with the new APN role; holistic practice; case managing across the whole system; championing older people’s issues, and caseload numbers.

Comparisons were made with the district nursing role, with the district nursing role being described by APNs as a more task oriented role. Participants felt that the APN role was more strategic and highly regarded than the district nursing role, which Adler (2005b) argued may have reflected the low morale and perceived value of district nurses. So the distinction was made about others’ recognition of the role and skills required, with specific differences between the role function of an APN and district nurse being less prominent.

The holistic nature of the new role was defined in terms of being able to work more intensively with patients on a one to one basis, and being able to provide a holistic approach to care by incorporating medical functions. The paper is unclear as to whether the role does focus holistically on the patient or if APNs just carry out medical tasks and the paper does not explore further the issues of whether the role is advanced or extended practice, which limits the interpretation of these findings.

Case management by the APN was described as a unique function because the role crossed boundaries across social care and secondary care, but the findings did not consider the
perspective of those working in these areas. Similarly the new role was seen as ideally placed ‘to champion older people’ (Adler, 2005b, p.17), without discussion of the relationship with those already working in this area. The final theme described experiences with caseload expectations. Participants highlighted the pressure to achieve the target number of 50 patients and questioned the evidence to support this. They expressed concern that it was difficult to maintain an effective case management function and that they reverted to a task oriented approach when under pressure, akin to how they practised when district nursing. So the numbers expected in caseloads as set out in the policy may be unrealistic in practice.

Participants referred to their training and development for the APN role when interviewed. They were offered initial training in history taking and physical examination, academic advanced practice modules (including independent prescribing), training from consultant physicians and support from nurse consultants. This programme was complemented by monthly mentorship sessions with a nurse practitioner. They also attended ward rounds and clinics for further teaching from consultants and registrars but some were reported as restricted due to time pressures on the APN. However, the nurses reported that they perceived that their individual learning needs had not been considered and they had difficulties with learning to undertake a new role at the same time as having caseload targets, ‘learning on the job’ (Adler, 2005c, p.20). So training and development for the role appeared to be dominated by medical aspects, but it was not clear whether the mentorship element contextualised this into its application in nursing.

The study was limited as a very small scale study; the themes identified were not discussed in any depth with only sparse extracts of data to substantiate the claims made in the findings. The study also presented the experience of the new role from the practitioner’s perspective only, so the views and experiences of colleagues working with the APN were unknown. This is particularly limiting when considering the findings about inter professional relationships.

So the study provided an indication of issues for practitioners taking on the new community matron role. However it did not provide further insight into the role, relationships and the process of policy implementation. Therefore issues regarding community matron role support, role priorities and dealing with external expectations have been explored only in a very limited way in the existing literature.
2.6 The community matron - advanced nurse practitioner, clinical nurse specialist or nurse practitioner?

Spilsbury and Meyer (2001) argued that traditional boundaries between professional groups were breaking down and new roles for nursing were emerging, in response to major changes in UK healthcare including changes to health care delivery and national policy. These parallel the context in which the community matron role was introduced. Read et al (1999) defined ‘new’ nursing roles as innovative and non-traditional, or taking responsibility for aspects of care previously undertaken by another group of health professionals; again, the proposed community matron role fitted this definition.

The community matron role was referred to as a specialist clinician in the *NHS Improvement Plan* (DH 2004a), but later the role was described as autonomous advanced practice in the NHS and Social Care Model (DH 2005e). This reflected an inconsistency in the use of titles and terminology relating to roles that have evolved in nursing, for example nurse practitioner, clinical nurse specialist, nurse consultant and advanced practice nurses (Ormond-Walshe and Newham, 2001; Roberts-Davis and Read, 2001; Horrocks et al, 2002; Carnwell and Daly, 2003).

Sibbald et al (2004) categorised changes to role in four ways to analyse job redesign in health care and its impact, namely enhancement, substitution, delegation and innovation. However this still presented challenges to interpretation: for example, where innovative roles may have been considered to include nurse practitioners, clinical nurse specialists and advanced practice nurses, they argued that these were enhancements of existing roles. Sibbald et al (2004) did not consider any examples of roles in the UK to be wholly innovative. Such classification does not address composite roles, where, as in the community matron role, it could be argued that it contains aspects that are enhancement, substitution and innovation. This may contribute to how confusions between roles arise.

Roberts-Davis and Read (2001) sought to establish the similarities and differences between nurse practitioners and clinical nurse specialists using the Delphi method. They found similarities with regard to core competences. Competences required primarily of the nurse practitioner included physical examination, diagnostic decision making, prescribing and care planning. Comparisons could be seen here with the functions of the community matron described earlier (Table 4) and those of the Evercare nurse practitioner (Table 5). It was unclear from the study whether respondents were from a cross section of practice or whether
there was a bias towards acute or community practitioners. This limits the application of the findings in the context of the community matron.

A further difference reported between the nurse practitioner and clinical nurse specialist was the focus of practice, with the nurse practitioner considered to be a generalist seeing undifferentiated patients, whilst the clinical nurse specialist would practise within a specific domain (Roberts-Davis and Read, 2001). The community matron role, however, did not comfortably fit this distinction, as it was not generalist in the sense of a nurse practitioner, but neither was it confined to a specialism, with long term conditions spanning a multitude of chronic diseases. Carnwell and Daly (2003) reported that the essence of an advanced nurse practitioner role combined the generalist knowledge of a nurse practitioner with the specialist knowledge of the clinical nurse specialist. In their qualitative study of advanced nurse practitioners in primary care, the nature and focus of advanced practice varied between disciplines of district nursing, health visiting and practice nursing. So the expertise of an advanced practitioner in practice nursing lay in advanced practical assessment and diagnosis of patients, with little opportunity for strategic development, placing the role at the extreme practice end of the practice-strategic continuum.

In contrast, the advanced practitioners in health visiting and district nursing operated at the other extreme of the spectrum, with further distinction between these in relation to another dimension, the individual-community continuum: the strategic involvement of the district nurse advanced practitioner focused on the patient care level, reflecting their roles with individual patients and carers, whilst the health visitor advanced nurse practitioners focused on strategic work at the community and population level. These findings were helpful in unpicking the complexities of advanced nursing practice, to better define such practice where roles have different origins, spheres of practice and purpose. The roles and competences outlined for the community matron role with regard to clinical assessment, diagnosis and intervention could be considered to align with the advanced practice seen in practice nursing, but the level of practice in the other competences remained unclear.

Advanced practitioners were argued to ‘act in a proxy capacity covering specific medical tasks as well as traditional nursing functions’ (Adams et al, 2000, p.543) but Manley’s perspective of advanced nursing practice contested this (Manley, 1997). She viewed such posts developing at the nursing medical interface to be specialist posts, rather than roles that encompassed expert nursing practice together with functions of educator, researcher and consultant. Her conceptual framework for advanced nursing practice was predicated on a
three year extensive action research project, and comprised three elements: the advanced practitioner, with four integrated subroles (expert practitioner, educator, researcher and consultant); the context of practice and the outcomes in practice in relation to developing practice, developing and empowering staff, and creating a transformational culture. It was unclear whether the original notion of the community matron role embraced this concept, but the roles and competency approach to its development suggested otherwise.

So it appeared that the community matron role presented within the NHS and Social Care Model (DH 2005e) did not marry with Manley’s concept of advanced practice (1997), nor fitted with descriptions of specialist and nurse practitioner roles. As such it was unknown if the difference in perspectives regarding the role’s level of practice would affect how the role would be interpreted, and whether different levels and types of practice could emerge under the same title.

2.7 Working across health and social care
The NHS and Social Care Model (DH 2005e), by the nature of its very title, presented itself as a collaborative initiative. However commentaries from the social care literature heavily criticised the dominance of health targets and the medical model within the policy to the virtual exclusion of the social care perspective (Hudson, 2005; Hunter, 2005). Given the potential effect of this in practice, the research literature regarding inter-professional working between health and social care was explored, to gain understanding of the context in which the community matron role was being implemented.

2.7.1 Inter-professional working
Cameron and Lart (2003) have criticised the lack of questioning about the benefits of partnership working or whether it makes a difference to outcomes: following a systematic literature review, they argued that there were very few studies which asked whether joint working was a ‘good thing’ and whether it made a difference. However their systematic review was limited: the 32 studies included in the review resulted from a restricted search of predominantly social care databases, and did not include CINAHL database, which may have resulted in some nursing research being excluded. Their views were corroborated, though, by other authors who report a lack of evidence to underpin the credence given to partnership in health and social care policy (El Ansari et al. 2001; Kharicha et al. 2004). Some studies have not been able to generate conclusive findings to support partnership working. For example Brown et al. (2003) undertook a non-randomised comparative study to investigate the outcomes for a user group served by a new integrated health and social care team, and those
for a group of patients served by more traditional uni-professional arrangements. The sample populations were clearly described in each group, with participants being over 64 years, registered at one practice and were referred for assessment for community care services. Standardised tools for outcome measures were used in relation to mental health and activities of daily living. Statistical analysis was described at length so that the findings were substantiated. The study found that integrated primary-care-based health and social care teams were no more clinically effective than traditional service provision (Brown et al, 2003).

2.7.2 Factors affecting partnership at practitioner level
Peck et al. (2001) report a mixed method research study, using qualitative techniques in the form of interviews and exploratory workshops, and quantitative methods including a postal survey. The report is limited in its description of its method and it does not explain its sampling rationale. Although it describes multiple methods, it is difficult to unpick the report to determine how results were interpreted or used to corroborate other findings: there is no discussion of method or data triangulation as proposed by Creswell (2007). Peck et al (2001) did report their findings of two opposing pulls for professionals, which affect how they value collaborative working. On the one hand fears were expressed about loss of organisational and professional identity when working in a different but perceived stronger culture. This was balanced though with the recognition of improved cooperation, team commitment and developed skills arising from working in partnership.

Hudson (2002) proposed in his discussion paper about inter-professional working, that the strength of feeling about professional identity, particularly in well established professions such as nursing and social work impacts directly on the enthusiasm for collaborative working, so that where a threat is felt from another profession, a practitioner’s resistance is likely to increase. This view was countered by North et al. (1999), who concluded from their study that practitioners place more value on informal partnerships formed through the interpersonal relationships with colleagues. For example, they found that GPs were receptive to collaborative working with social workers and nurses.

Interestingly, the non-randomised comparative study by Brown et al (2003), described earlier in section 2.7.1, eliciting service users’ views found that they considered the quality of relationships with service providers as most important, and that there was little interest in how or who provided services, but the fact that they provided the care they needed. This suggests that service users do not view partnership working as having an intrinsic value, but it is a means to an ends.
2.8 Role theory

There are many definitions of role theory but Biddle (1986) argued that role theorists were largely similar in their philosophical orientation. He articulated role theory as “...to concern itself with a triad of concepts: patterned and characteristic social behaviors, parts or identities that are assumed by social participants, and scripts or expectations for behavior that are understood by all and adhered to by performers” (Biddle, 1986, p. 68). So within role theory, Biddle (1986) identified three basic concepts:

- **Role**: characteristic behaviours
- **Social positions**: parts or identities assumed by individuals
- **Expectations**: the scripts for behaviour, which can be generated by norms, beliefs or preferences.

Role theories are classified into five main perspectives, namely functional, symbolic interactionist, structural, organisational and cognitive. Cognitive role theory and symbolic interactionist role theory focus on the individual, and include relationships among roles, role playing and role taking. Both have been criticised for not considering the contextual or structural constraints on individuals and behaviours in roles (Biddle, 1986). In contrast, the remaining three perspectives focus on the person as representative of a social position within a social system, with structural role theory primarily addressing the social environment rather than individual roles per se. As such structural role theory has been considered limited in its interpretation of behaviours and experience (Biddle, 1986). Functional role theory focuses on roles arising from expectations about functions within society, which then manifests itself in expected behaviours. It is criticised however for its premise that society is stable and that all roles are linked to social positions (Biddle, 1986). Similarly, organisational role theory implies that organisations are rational, stable entities. However the wider perspectives of both functional and organisational role theories consider the constraints and potentially conflicting norms exerted on individuals within multi-tiered systems. Organisational role theory in particular gives emphasis to problems within social systems such as role ambiguity and role conflict. Biddle (1986) defines these problems:

- **Role ambiguity**: where expectations are incomplete or insufficient to guide behaviour
- **Role mal-integration**: when roles do not fit well together
- **Role discontinuity**: when a person must perform a sequence of mal-integrated roles
- **Role overload**: when a person is faced with too many expectations
- **Lack of skill leading to difficulty performing the role**
• Incongruence between expectations and personal characteristics leading to difficulty performing the role

It is argued that any of these problems could arise in the implementation of the community matron role as it is being introduced into an existing social system. Role ambiguity may be generated as the community matron is a new role and therefore has no frame of reference in which to determine expectations in practice. Rather, individuals would be reliant on theoretical cues such as job descriptions, service outlines and reports from the examples of its application in the USA. Unlike the US model, the role of community matron was implemented into a system where there were existing roles with responsibility to support people with long term conditions, for example GPs, district nurses and social workers. As such there was a risk of mal-integration if the interface with other roles has not been considered. Level of skill for new roles in nursing have been subject to debate, particularly in relation to advanced or specialist practice and so this may be a potential issue for community matrons. As the role has been driven by factors external to the nursing profession, there was potential for incongruence between expectations and the individuals’ professional perception of what the role should be. So consideration of the theoretical concept of role in relation to the role of the community matron highlights issues that may arise during its implementation.

2.9 Methodological Summary

In light of the extremely limited quantity and quality of research about the role of the community matron, this review focused on material that existed at the start of this study alongside the policy documents and government directives pertinent to the implementation of the community matron role. In doing so, this review has synthesised all the extant knowledge in the field at the outset of the study, and revealed significant gaps between policy, practice and evidence. The research evidence was polarised at the extremes of the research spectrum: there was only one small superficially reported phenomenological study (Adler, 2005a,b,c), generated by a practitioner within the nursing profession, whilst the reviews of existing care provision (Singh, 2005a,b), generated outside of the nursing profession, were predominantly highly positivist and structured randomised controlled trials. So the extremely limited body of knowledge showed there was little understanding of the role of the community matron and its implementation in real practice contexts, in particular from a qualitative perspective. In addition the evidence does not include the perspectives of multiple stakeholders. Therefore the literature review has demonstrated there is an overwhelming need to undertake qualitative research that explores in depth the nature of the community matron role, in particular in the context of the practice of nursing.
2.10 Conclusion
The literature review has shown that the role of community matron was a recent addition to the vast array of roles in nursing. Whilst research and policy have focused on the field in which this new role operates, i.e. the management of long term conditions (Singh, 2005a,b), there has been almost no emphasis on the role itself or its relationship with existing health and social care roles.

As the role of the community matron was a new policy initiative at the start of this study, there was little research evidence on which to draw in order to consider and inform the study questions. This role, as with other examples in nursing, was driven by government policy due to external factors, for example service demand management and cost containment, rather than by the profession itself. That said, the benefits for patients described in the policy for the management of long term conditions (DH 2005e) would resound with professional values, such as those articulated by the RCN (2003). However it was unknown how these drivers would manifest in the way the role was to be implemented.

The debate about expanded, extended, specialist and advanced practice has continued to challenge the profession, affected again by issues of whether developments are internally or externally driven. This new role potentially opens up the debate again, as the description in the policy regarding the level of practice purports to be advanced practice, but the competency based approach did not necessarily match Manley’s concept of advanced practice (Manley 1997), in terms of capturing both the skills and the qualities required. The level and scope of practice of the community matron role, whilst described, had not been evaluated in the English NHS service model for the management of long term conditions.

There were a variety of service models for the management of long term conditions already in operation (Singh, 2005a). Therefore it is interesting that the policy for supporting people with long term conditions (DH 2005e) should focus on a role predicated on a US service structure and organisation (UnitedHealth Group, 2003; 2005). This raises questions as to the transferability of the role into a system where there are existing roles with responsibility for supporting people with long term conditions, and how the implementation of a new role affects those existing roles. Questions are also raised as to whether it was wise to attempt to transpose a model of care that had arisen out of a US context, and translate it into an English NHS context.
The NHS Health and Social Care Model (DH 2005e) claimed to promote inter-professional working. However previous research evidence surrounding inter-professional working in the community found issues of barriers, role boundary issues for nurses, GPs and social care workers. As a new policy it was unknown whether its implementation would face these issues, and if so whether they would be overcome.

Consideration of the concepts in role theory, in particular organisational role theory, highlighted potential problems that could occur with the implementation of the community matron role.

Therefore there was very little evidence to underpin the community matron initiative. The English evaluation studies into models of care for the management of long term conditions, such as Evercare, Pfizer and Kaiser, were still in progress when the policy was published, and the links between policy and research evidence cannot be clearly traced. As such the policy initiative did not fit with the rhetoric. Similarly, the policy was inconsistent about the nature of the nursing role within professional practice, and was disconnected from the body of research evidence within the nursing profession about levels and breadth of practice.

Therefore further exploration was warranted into how the policy for the new role of community matron was implemented in practice, and how community matrons worked with existing practitioners caring for people with long term conditions. Given the limited evidence available regarding the community matron role and the complexity of the context in which the role was being introduced, a qualitative case study was considered the best approach to explore the implementation of the community matron role. The methodology and the rationale for its application in this study are discussed in Chapter Three.
CHAPTER 3: METHODOLOGY

3.1 Introduction
This chapter presents the methodology used in this study. It was considered that a qualitative approach using case study would best suit the exploratory nature of the questions it sought to answer. The rationale for this choice is discussed, by presenting the research questions, an explanation of case study as applied here, and its underpinning epistemology. The application of case study methodology in this study is discussed in Chapter Four.

3.1.1 Research questions and aim of the study
Research up to the start of this study had not considered how the community matron role had been developed and implemented, particularly in the context of the changing organisational structures in the National Health Service. Further inquiry could reveal how a change in professional practice and role could be achieved and where barriers could occur, particularly outside the formal processes of organisations. Murphy (2001) argued that descriptive detail was needed to better understand the context in which policies are introduced; in this way policy makers and practitioners may understand how the practice setting impacts on policy implementation. Therefore the research questions were formulated from the gaps in the research literature and formed to generate description of the role of community matron in practice.

The research questions were:

- How does a community matron undertake this new role?
- How does the introduction of this new nursing role affect existing practitioners working in the management of long term conditions?
- How have community matrons negotiated their role boundaries and has this affected the boundaries of other community nursing roles?

Building on the research questions, the aim of the study was:

To develop insight and understanding of the role of community matron, and its implementation within three primary care trusts.
3.2 Selection of methodology

The research questions were exploratory in nature, to gain insight into experiences of community matrons in the context of their social systems, that is the organisation they worked in and their relationships with others in that system. It is considered that qualitative research provides the mechanisms by which to explore different dimensions of the social world by describing

“the understandings, experiences and imaginings of our research participants, the way that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate” (Mason, 2002, p.1).

Being in the interpretive paradigm, qualitative research facilitates the presentation of different views of events, which is essential in exploring different experiences of a phenomenon. In this study, the experience of role implementation would be considered from multiple stakeholders’ perspectives, such as those in the role, and those coming into contact with such individuals. Therefore a qualitative approach best supported the aim of the study.

The study aim required in depth analysis of the community matron role in context to understand its implementation in practice. Case study is becoming an increasingly popular nursing research methodology (Anthony and Jack, 2009). Examples can be seen in research about the implementation of policy driven nursing roles in the acute sector (McDonnell et al, 2000; Read et al, 2004); nurse education (Lyte, 2007) and nursing practice in palliative care (Walshe et al, 2005; Payne et al, 2007). It has been acknowledged as a useful approach to study the phenomena of nursing (Anthony and Jack, 2009) due to its strength in generating a richness of data (McDonnell et al, 2000; Spilsbury and Meyer, 2001), and accurately accounting for the realities of practice (Cowley et al. 2000a; Spilsbury and Meyer, 2001).

Recognised authorities on case study research, namely Stake, Creswell and Yin, agree that case study methodology is the best approach for describing, exploring and understanding a phenomenon in its real life context (Anthony and Jack, 2009). Therefore it was considered the methodology of choice for this study. Case study may draw on both quantitative and qualitative methodologies (Eisendhart, 2002). This is explored further in relation to epistemology.

3.2.1 Epistemology

Case study research can be quantitative or qualitative in nature (Stake, 1995, Yin, 2012), which appears to present conflict with regard to its underpinning epistemology. Yin’s positivist
stance is reflected in his case study terminology, i.e. hypothesis development, empirical data
collection, analysis and conclusions (Yin, 2003). Whilst this implies that Yin supports a
positivist paradigm, this is not necessarily fully reflective of his stance, as Yin argues that
case study research does not reside in either of these methodologies, but rather appears to
be based on its own separate method (Yin, 2012).

Stake (1995) argued that the distinction between quantitative or qualitative inquiry is made in
the nature of knowledge being sought from the research question. He proposes that case
study has an epistemological advantage over other inquiry methods “...because of the
universality and importance of experiential understanding, and because of their compatibility
with such understanding” (Stake, 2000 p. 24). Eisendhart (2002) endorsed this and showed
how case study methodology can be developed from the spectrum of concepts, citing, for
example, grounded theory (Glaser and Strauss, 1967), to strengthen the design.

There is a growing argument that case study research does not need to be determined by a
sole paradigm, and that the use of multiple paradigms can foster a more comprehensive
picture of complex phenomena (Hassard and Kelemen, 2010). However caution has been
raised in that where there are theoretical or empirical deficiencies in the multiple paradigm
positions adopted, analysis may in fact be poorer (Scherer and Steinmann, 1999). Therefore
to undertake a multiple paradigm perspective, these would need to be fully understood.

Given the epistemological debates regarding case study, it was important to discuss the
epistemological background to the case study in question.

Ontological realism is the belief in ‘the existence of an external and already determined world
and social reality, independent of any human knowledge, action or activity’ (Maréchal, 2010,
p.220). Positivism is founded on the tenet of an external reality that can be explained
objectively in a value free way (Sharma, 2010). This contrasts with relativism, where reality is
viewed as a social construct, that is, there are multiple realities made from different people’s
perspectives of the world, which are socially and experientially based (Guba, 1990).

This study sought to develop a holistic understanding of a phenomenon, in this instance the
role of the community matron. To do this, the multiple perspectives of the role were
recognised, from those in the role, working with the role as colleagues or receiving care. This
view is underpinned by the constructivist paradigm, as described by Denzin and Lincoln (2003, p.35) in that it

“assumes a relativist ontology (there are multiple realities), a subjectivist epistemology (knower and respondent cocreate understandings), and a naturalistic (in the natural world) set of methodological procedures”.

Schwandt (2003 p. 305) interpreted constructivism to mean

“…human beings do not find or discover knowledge so much as we construct or make it. We invent concepts, models, and schemes to make sense of experience, and we continually test and modify these constructions in light of new experience.”

So from a constructivist stance, reality is not a concept independent from human perception, so it cannot exist separately from human experiences and beliefs. Berger and Luckmann (1966) introduced the term ‘social construction’ where the repetition of individuals’ experiences creates patterns and routines, which are then negotiated with others to shape an agreed reality for that society. Language, discourse, and interpretive repertoires are the primary devices for construction of social reality. So the ‘social construction of reality’ occurs when knowledge and people’s conception of what reality is becomes embedded in the institutional fabric of society (Eidlin, 1992; 2010). Social life reflects the collective negotiation of multiple realities and their conflicting interpretations (Maréchal, 2010). Social processes, then, influence individual perceptions and beliefs about the world (subjective reality) that themselves play an important part in the (re)construction of institutions and persons (objective reality) (Berger and Luckmann, 1966). As constructivism focuses on human social processes and activities that serve to generate a socially agreed reality, it readily supports the use of case study when applied to the questions about how individuals create a new concept, that is, a new role, and to negotiate its acceptance into a new reality.

This underlies the approach to this case study research and in particular the epistemology that shaped the choice of methods and approach to analysis as described in Chapter Four.

3.2.2 Definition of case study research
A fundamental problem for case study is that there is not a common understanding of what it means; prior to its use in research the term ‘case study’ was applied to mean a practical example being used as a teaching tool, as seen in many settings including law, education and medicine (Gomm et al, 2000; Anthony and Jack, 2009). The term’s broad application has meant that its use in research has been open to confusion and the perceived lack of defining
parameters can be interpreted as a weakness (Grbich, 1999; Thomas, 2011). It is important, therefore, to define case study research and to describe in detail the case and its context (Tellis, 1997; Anthony and Jack, 2009).

Yin (2009) defined case study as:

“… an empirical enquiry about a contemporary phenomenon (e.g. a “case”), set within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident.” (Yin, 2009, p.18)

Yin’s reference to empirical enquiry again suggests his positivist perspective. Simons (2009), however, defined case study that reflects an interpretive perspective and highlights the complex nature of the topics of inquiry that case study can serve:

“Case study is an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a “real life” context.” (Simons, 2009, p.21)

Therefore Simons’ definition best reflects the interpretation of case study that has been adopted in this thesis. Both definitions concurred with Stake’s interpretation (2006) who also considered the case, or phenomenon, to be a definable, bounded entity. He differentiated this from a function or action, which would not be suitable as a case because they lack the specificity required to be useful to case study (Stake, 2005). So a case is defined as:

“a bounded entity (a person, organization, behavioural condition, event or other social phenomenon), but the boundary between the case and its contextual conditions... may be blurred.” (Yin, 2012, p.6)

Cases may have cases within the larger case, defined by Stake (2006) as mini cases or embedded cases, and called embedded units of analysis by Yin (2004). Confusion was generated between the case and unit of analysis as Yin also referred to sources of data as embedded units of analysis (Yin, 2012). Tellis (1997 p. 5) presented another interpretation, describing the case or unit of analysis as “typically a system of action rather than an individual or groups of individuals”.

Fletcher and Plakoyiannaki (2010) clarified the different views of Tellis and Yin, in describing the major entity under study as the unit of analysis, differentiating this from units of observation, that is, units from which the researcher collects data. So in this study, whilst there was more than one community matron in each case study site, the role rather than the
individual was the unit of analysis, and each community matron was a unit of observation. Similarly, other sources of data included district nurses, GPs and social workers: They were units of observation rather than sub-cases or embedded units of analysis, as these roles were not the subject of the study.

So for the purposes of this study, the case was defined as the role of the community matron, in the contextual setting of a primary care trust.

Case study has been classified to indicate research purpose and the number of cases in the study: Yin (2009) identified a holistic case study, based on a single unit of analysis, and an embedded case study, based on multiple units of analysis. Both types may comprise single or multiple cases so presenting four types of case study design. Yin (2009) also classified studies relating to the purposes of exploration, description or explanation. These distinctions are closely aligned to Yin’s positivist perspective; for example he viewed an exploratory study as a precursor to the main study to support the development of hypotheses, data collection choices and analytic methods rather than a study in its own right (Yin, 2009). This view is considered unnecessarily limiting to the value of exploratory case study (Rudden, 2006). Similarly Yin considers that descriptive and explanatory studies should be structured around the comparison of suppositions of theory prior to the study, with findings, to substantiate, contest or develop theory (Yin, 2009). However Flyvbjerg (2006) argued that concrete, context dependent knowledge was more valuable than seeking predictive theories and universals, so that focus on the specifics of the case was more meaningful. These opposing views highlight the different ontological stances underpinning the view of case study.

Stake, in contrast to Yin (2009), views the pursuit of knowledge from case study from an interpretive perspective akin to Flyvbjerg (2006) and Rudden (2006). This is reflected in Stake’s approach to classification in identifying three types of case study as intrinsic, instrumental and collective (Stake, 1998). These are described in detail in Table 8.

This study drew on the collective/ multiple case study design, within Stake’s classifications (Stake 1998 & 2006): it comprised three cases within three contextual settings, namely the role of the community matron in three primary care trusts. The study sought to understand a phenomenon wider than the case itself, namely the implementation of the role, and so it is an instrumental multiple case study. It is descriptive in nature, but unlike Yin (2009) this study did not begin with an established descriptive theory, as it followed an inductive approach. The
study did not aim to develop a hypothesis, as this was counter to the interpretive nature of the study.

Table 8: Classification of case studies (Stake, 1998)

<table>
<thead>
<tr>
<th>Classification</th>
<th>Characteristics</th>
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<tbody>
<tr>
<td>Intrinsic</td>
<td>To seek better understanding of a particular case, the case itself presenting the focus of interest. It is not intended to be representative of other cases or to illustrate particular traits.</td>
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<tr>
<td>Instrumental</td>
<td>Where the case is used to better understand an issue, that is, to help understanding of something wider than the case itself.</td>
</tr>
<tr>
<td>Collective</td>
<td>A number of cases, which may be similar or varied, studied jointly to further understand a phenomenon or general condition. Stake views this as an instrumental study extended over several cases. Stake (2006) subsequently referred to the collective case study as multiple case study, the term multiple is also used by other authors (eg Yin,2012).</td>
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So the nature of the case study was determined by the research question, the case under study and the epistemological position behind the question. As such this study was not directed by a single approach, for example Yin (2009) or Stake (1995), but drew on such guidance to inform the study development and design, in line with the study’s epistemological underpinning of social constructivism.

3.2.3 Rationale for choice of case study as a research methodology

Case study was selected over other methodologies whilst drawing on those within the interpretive paradigm. Quantitative methodologies using experimental design such as randomised controlled trials were discarded as their foundations in the positivist paradigm did not marry with the naturalistic nature of the research question being posed here. Also the literature shows that large national and international comparative studies looking at the ‘mechanics’ and performance outcomes of providing care in the management of long term conditions, are emerging (Singh, 2005a).

Creswell (2007) indicated that case study generates descriptive data, and whilst acknowledging that analysis can produce themes and assertions from case study, favours instead the use of grounded theory for the generation or development of theory. Grounded theory has been criticised because its application is rigidly structured, reflecting a positivist framework (Gerbich, 1999; Hall and Callery, 2001), which does not sit comfortably with the desired approach to this study. However the principles within grounded theory as an inductive approach support the process in this study.
Stake (1998, p. 89) suggests that the collective case study can lead to better understanding of a wider collection of cases, that is, make ‘generalisations’ to cases outside of the study, and potentially aid ‘better theorizing’. Stake (1995) interprets such wider understanding as ‘naturalistic generalisation’, based on the process by which people generalise themselves in day to day life, using their experiences to interpret new information to inform their understanding. This is in keeping with Schwandt’s interpretation of constructivism set out in the previous section 3.2.1.

Others have demonstrated that the case study approach can be used to build theory (Cowley et al., 2000a; Eisenhardt, 2002; Yin, 2003). Such approaches are underpinned by how generalisations can be made from case studies. Yin (2003, p.10) explained:

“… that case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes… and in doing a case study, your goal will be to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)”

Yin (2003) took this further to propose that theoretical propositions should be developed in the design to provide direction for the study, data collection and analysis. In contrast, Stake (1998) warned that over commitment to generalise or create theory can jeopardise the study by distracting focus from the case itself. This study did not aim to build theory, but to generate description that would build insight and understanding regarding the community matron role. The development of theoretical propositions also is counter to the inductive approach adopted for this study. Instead the study design would aim to facilitate ‘naturalistic generalisation’ as described by Stake (1995).

3.3 Methodology conclusion

Case study methodology is considered the best approach for describing, exploring and understanding a phenomenon in its real life context (Anthony and Jack, 2009). Therefore it was selected to address the exploratory questions posed in this study. Case study may use quantitative or qualitative methodologies: for this study it is defined as a descriptive qualitative study underpinned by social constructivism. This study drew on the collective/ multiple case study design, within Stake’s classifications (Stake 1998; 2006). The application of the case study methodology is discussed in Chapter Four.
CHAPTER FOUR: APPLICATION OF CASE STUDY METHODOLOGY TO THIS STUDY

4.1 Introduction

This chapter presents the application of case study methodology in this study. Thomas (2011) argued that there was little guidance for researchers in terms of the organisational structure of undertaking a case study. However there were similarities in the overarching approach described by Yin (2003), Stake (2006) and Gray (1998). Yin (2003) identified three stages, namely defining and designing the case study (including the selection of cases), preparation and data collection (including recruitment, access and within case analysis), and analysis and conclusions (including cross case analysis and report preparation). Stake (2006) added the understanding of context of the case study in the first stage, however in this study the context was considered throughout the stages of the study and presented with the findings. Gray (1998) described key stages to conduct case studies as: orientation, sampling, data collection and tools for data analysis, framework for analysis and interpretation of data, and preparing and disseminating the case report. This approach was successfully applied by Lyte (2007) and has been adopted for this study. The stages are discussed in more detail below.

The stages cannot, however, be viewed as exclusive steps; elements of each stage overlap and run concurrently in order to inform and complement each other. Gillham (2000) described this as the need to have interaction between the literature review, getting to know the cases, deciding broad aims of the study and focussing the research questions.

A timeline of the study from 2005 to 2012 can be seen in Table 9 on page 61. This shows the first literature review was undertaken in 2005, finishing at the outset of data collection in the case study sites. The literature was revisited five years later to inform the analysis phase. Data collection in the first case study site was undertaken in 2006, followed by data collection in case study sites two and three in 2007 through to the beginning of 2008. There was a one year interruption to the study from 2008 to 2009 which meant the initial analysis needed to be revisited in 2009. Writing up of the study was undertaken in 2011, in conjunction with consideration of relevant research about the role of the community matron that had been published during the period of the study.
Table 9: Timeline of study

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<th>Year</th>
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<td>Document review</td>
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<td>Observations</td>
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<tr>
<td>Access approval**</td>
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<tr>
<td>Document review</td>
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<tr>
<td>Observations</td>
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<tr>
<td>Interviews</td>
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</tr>
<tr>
<td>In case analysis</td>
<td></td>
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<tr>
<td><strong>Case Study Site Three</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access approval**</td>
<td></td>
<td></td>
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<tr>
<td>Document review</td>
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<tr>
<td>Observations</td>
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<tr>
<td>Interviews</td>
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<td></td>
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<tr>
<td>In case analysis</td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>02 04</td>
<td>06 08</td>
<td>10 12</td>
<td></td>
</tr>
<tr>
<td>2nd Literature review</td>
<td></td>
<td></td>
<td></td>
<td>Registration for study October 2004: research modules undertaken up to January 2005</td>
</tr>
<tr>
<td>Cross case analysis</td>
<td></td>
<td></td>
<td></td>
<td>* Interruption to study from April 2008 – March 2009</td>
</tr>
<tr>
<td>Write up</td>
<td></td>
<td></td>
<td></td>
<td>** Access approval included recruitment of participants and introductory site visit</td>
</tr>
<tr>
<td>Submission</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2 Orientation

Orientation comprises the background and preparation to undertake the study, including a search of the literature (discussed in Chapter Two). This literature review and the exploration of case study methodology helped to refine the research questions and aim, informed the selection of data collection methods, and the development of data collection tools, which is discussed in more detail below.

4.2.1 Identification of the case

It was important to define the case under study, as highlighted earlier in section 3.2. Both Yin (2009) and Stake (2006) regarded this as the most important facet in the case study design. If the definition of the case is unspecific, choices regarding the case content are impaired, weakening the study (Grbich, 1999).

For this study the case is defined as the role of the community matron. The contextual setting of the case is the primary care trust (PCT). The term ‘community matron’ has been used to mean the new role that has been introduced in the NHS as a case manager providing advanced clinical care to improve services for people with long term conditions (DH 2005e).

4.2.2 Type of case study

As discussed earlier in section 3.2.3, a qualitative descriptive case study based on multiple case study design (Stake, 1998; 2006) was considered to best address the research questions. Creswell (2007) suggested that typically no more than four cases are selected, as the study risks dilution of the overall analysis as the number of cases increases. Therefore it was considered that using three cases generates rich description from in depth study of individual cases, with the selection of cases facilitating comparison and contrast of findings from which to better understand the phenomenon. Limiting the number of cases to three also ensured the study could be undertaken within resource and time constraints.

4.2.3 Selection of case study sites

‘Case study site’ has been used to define the contextual setting in which each case is located, that is, each PCT where the role of the community matron is practised. Selection of case study sites marks the beginning of the sampling stage of the research study but it also forms part of the orientation stage. Selection is, however, restricted in this stage to the selection of case study sites only and not the participants within the case study site. Sampling within each case study site is described in section 4.3.
As case study site selection is identified as a potentially lengthy process (Yin, 2012), it was necessary to initiate selection of case study sites during the orientation stage in order to ensure sufficient time for the ethical and access approval processes within organisations.

Selection of cases in case study research differs from the traditional interpretation of ‘sampling’; the main criterion is that case study sites will maximise learning (Stake, 1995). Stake (2006) identified three main criteria for selecting cases in multiple case studies, namely relevance, diversity across contexts, and opportunity to learn about complexity and contexts. Yin, however, asserted that selection should be premised on the researcher’s belief that similar results will be found, described as ‘replication logic’ (Yin, 1993). Both Yin and Stake highlighted that selection should not attempt to be representative of a population, described by Yin as ‘sampling logic’, nor should it use sampling of common attributes or data points as a key factor. The distinction is made because case study does not claim to be generalisable to a population, but rather to modify and refine existing understandings (Stake, 1995) or to offer the potential to generalise to a theory (Yin, 1993). Yin’s approach serves to support analytical generalisation, as discussed in section 3.2.3. The difference between Stake seeking diversity and Yin seeking similarity reflect their ideological stances underpinning case study, as discussed in section 3.2.1.

Selection criteria for case study sites are, therefore, more aligned to sampling associated with qualitative research, in this instance purposive sampling. Silverman (2001, p.250) argued that purposive sampling

“allows us to choose a case because it illustrates some feature or process in which we are interested.... demands we think critically about the parameters of the population we are interested in and choose our sample carefully on this basis”.

Therefore, Stake (2008) argued, purposive sampling is used to generate variety and select cases where there is greatest opportunity for study. In this study the selection factors considered to generate the maximum opportunity for learning, were as follows:

- At least one community matron was in post in the PCT for a minimum of three months prior to the start of the study, to ensure the availability of rich, relevant data.
- Geographical diversity was sought by selecting case study sites from inner city, urban and suburban/rural locations
• Organisations were within one strategic health authority at the start of the study so that organisations were subject to similar local as well as national policy and strategic drivers
• Feasibility of the case site (for example anticipated ease of access into the primary care trust, travelling distances for the researcher) was taken into consideration.

4.2.4 Ethical approval
Ethical approval was sought in the early stages of the development of the study. Approval for all case study sites was given by one Local Research Ethics Committee, as the case study sites were within one strategic health authority (COREC, 2004), as seen in appendix 1. Approval letters have been anonymised with regard to the case study site locations. As the study was undertaken as part of an academic award, the proposal was also submitted to and approved by the University Senate Ethics Committee (see appendix 2). Ethical issues are discussed in detail later in section 4.6.

4.2.5 Recruitment of case study sites to the study
The Director of Nursing was identified as a key point of contact to secure access to each potential case study site. There was an overall willingness from the directors for their respective organisations to participate in the study on the completion of ethics and access approval processes.

The primary factor that affected selection of case study sites was the length of time community matrons had been in post, which varied from posts already in operation to plans for recruitment to be initiated within six months. Primary Care Trusts were approached within one Strategic Health Authority, from which three case study sites were identified where community matrons were already in post.

4.2.6 Access approval
The PCTs within the strategic health authority operated a collaborative for formal approval of research proposals. This process was aligned with the NHS procedures for research ethical approval (COREC, 2004). Once ethical approval from the Local Research Ethics Committee was given the application for PCT approval was submitted. Approval was given from all proposed case study sites (see appendix 3).
4.2.7 Choice of data collection methods

Good case studies benefit from multiple sources of data (Yin, 2012). For this study, qualitative data were collected guided by the sources of evidence proposed by Yin (2003) and Stake (2006). Table 10 outlines the sources of data selected. The rationale for these choices, their strengths and limitations are detailed below.

Table 10: Sources of evidence and data collection

<table>
<thead>
<tr>
<th>Source of evidence</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents</td>
<td>Community matron job description and person specification</td>
</tr>
<tr>
<td></td>
<td>Local development plan/ business cases for community matron posts</td>
</tr>
<tr>
<td></td>
<td>Agendas, minutes of meetings and reports about or referring to the implementation of community matrons</td>
</tr>
<tr>
<td></td>
<td>Agendas, minutes of meetings attended by and reports by the community matron</td>
</tr>
<tr>
<td></td>
<td>Organisational strategies and workforce development plans</td>
</tr>
<tr>
<td></td>
<td>Performance reports to strategic health authority and PCT Board</td>
</tr>
<tr>
<td></td>
<td>Protocols, policies and procedures related to the role of the community matron</td>
</tr>
<tr>
<td>Informal documents</td>
<td>Reflective diaries kept by community matrons for period of study</td>
</tr>
<tr>
<td></td>
<td>Diary and notes of researcher</td>
</tr>
<tr>
<td>Archival records</td>
<td>Organisational and communication charts</td>
</tr>
<tr>
<td></td>
<td>Statistics of community matrons: number and length of time in post; caseload figures and profiles</td>
</tr>
<tr>
<td>Observation</td>
<td>Informal two hour visit to case site to shadow community matron and see work environment, using field notes</td>
</tr>
<tr>
<td>Interviews</td>
<td>Tape recorded semi structured interviews using a brief topic guide with community matron, manager, patients and key contacts, e.g. GP, consultant, practice nurse, physiotherapist, as identified by community matron and documentary evidence.</td>
</tr>
<tr>
<td></td>
<td>Meetings with groups associated with the community matron role, e.g. district nurses, social care workers, specialist nurses</td>
</tr>
</tbody>
</table>

4.2.7.1 Documents and archival records

Material such as records provides a source of data that can show differing and interacting interpretations of a phenomenon, (Hodder, 2000) and provide further context (Stan, 2010). However, it is recognised that records may be subject to bias, or be incomplete (Raptis, 2010; Yin, 2012). Documents have been classified as formal, informal and archival records:

- **Formal documents**: these provide information about the formal perspectives on the role of community matron, such as the organisational view of the role. Such documents are generally readily accessible in the public domain.
- **Informal documents**: these were sought to provide insight into the day to day reality of the role (i.e. the lived experience) and to explore whether this matched or varied from the formal perspective. Informal documents have an advantage that they are more likely to reflect personal attitudes and ideas about their work, than formal documents (Hallett, 1997). However this is dependent on the writer’s views about the intended readership and
potential use of the informal documents. It was important, therefore, to be explicit about the way in which reflective diaries kept by the community matrons, would be used. The diaries were also able to generate personal perspectives from the community matrons over a longer period of time than could be captured through observation and interview alone.

- **Archival records**: these would not generally be in the public domain. Such documents may be limited in terms of providing quantitative data, but would be used to corroborate or provide further explanation of information collected through observation and interview.

### 4.2.7.2 Observation

Yin (2012) and Stake (2006) considered observation to be one of the most distinctive and meaningful data collection methods in case study. Adler and Adler (1998) described qualitative observation as fundamentally naturalistic in essence, and so it was suited to the approach of this study. Participant observation was used to gather impressions about the context in which the community matron worked and it provided a mechanism to verify data from other sources, in doing so enhancing the rigour of the different sources of data (Adler and Adler 1998).

The approach was similar to the role of ‘observer-as-participant’ (Gold 1958), but as interpreted by Adler and Adler (1998): the purpose of observation was made explicit and was over a short period of time (approximately 2 hours per community matron). It incorporated interaction with the community matron during the period of observation in keeping with the naturalistic approach in this study. This also helped to establish trust in the researcher; Adler and Adler (1998) described this trust as vital to enable observation and interaction closely enough to form a view of the participants’ work as they experience it.

It was agreed with participants that handwritten notes would be taken during observation sessions, as this would minimise the loss of data (Hammersley and Atkinson, 1995). The exception was during patient contact when note taking was deferred until after observation, so as not to distract the patient from their interaction with the community matron. Grbich (1999) proposed that no note should be made on site so that observation is unobtrusive, which was considered important to minimise the impact of observation on patient care. The researcher reflected on all notes after each session.

Limitations of participant observation may be that behaviour is altered by virtue of being observed; however Gillham (2000) argued that being open about the researcher’s presence
does not bias the participants and that this is only affected if the researcher tells participants what results are expected. The potential for bias in observations was mitigated by multiple data sources.

Observations were used to see the activities undertaken by the community matron, in order to better understand the role function and how the role was undertaken in practice. Observation also gave the opportunity to observe relationships with colleagues and other agencies. The selection of activity to be observed was led by the community matrons, to indicate their typical working practices. Observations varied in length, depending on the activity being observed. Table 11 depicts the range of observations and what was observed during each activity.

Table 11: Range of Observations

<table>
<thead>
<tr>
<th>Nature of Observation</th>
<th>Range of times of observations</th>
<th>Activity observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient home visits</td>
<td>0.5 – 1 hour</td>
<td>Interaction with patient; communication; direct patient care including physical assessment, medication reviews, advice</td>
</tr>
<tr>
<td>Office work</td>
<td>1 hour</td>
<td>Telephone discussions with patients; indirect patient care, including referrals, discussions with colleagues, updating electronic records; report preparation; discussions with colleagues (CMs and ACMs)</td>
</tr>
<tr>
<td>Hospital visit</td>
<td>2 hours</td>
<td>Case finding from hospital records; ward visits; interactions with hospital staff</td>
</tr>
<tr>
<td>Team meeting</td>
<td>2 hours</td>
<td>Interaction within the team; caseload reviews; discussions about practical issues; discussions about organisational priorities; discussions about management; shared learning</td>
</tr>
<tr>
<td>Liaison activities</td>
<td>0.5 hour</td>
<td>Visits to and by colleagues including GPs, practice manager, district nurses, social workers, to discuss patient care, update on current status of patients</td>
</tr>
<tr>
<td>Presentations/teaching</td>
<td>1.5 hours</td>
<td>Presentations about service to social workers, GPs; teaching session to residential care home staff about rare medical condition affecting a patient</td>
</tr>
<tr>
<td>Care coordination meeting</td>
<td>1 hour</td>
<td>Interaction with colleagues and carers; presentation of clinical assessment; shared care plan development</td>
</tr>
</tbody>
</table>

4.2.7.3 Interviews

Gillham (2000) described semi structured interviews as the most important form of interviewing in case study, as it can be the richest single source of data. This was reflected in this study where interview data were found to be the single most used type of data. Gillham (2000) also stated that interview data can provide consistency, as the framework of questions focuses the interview on the key topics, whilst the responses provide individual and unique
accounts. The interview guide (appendix 4) was developed from themes in the literature review. The guide was used for all participant groups to ensure similar themes were explored from the different groups’ perspectives. Rubin and Rubin (1995) highlighted qualitative interviewing as a way of exploring people’s experiences and allowing them to reconstruct events so as to better understand their world. This supports the constructivist ideology underpinning the study.

A limitation of interviews is that the findings are reliant on the candour of the participant, and responses may not necessarily reflect what they actually do in everyday life (Hodder, 2000). However the participants’ construction of reality can provide important insights into the case study (Yin, 2012). In addition the application of multiple data collection methods can be used to corroborate data from different sources (Fontana and Frey, 2005).

Interviews were conducted with community matrons, colleagues and patients. All except one interview were audio-taped with the participant’s permission and later transcribed verbatim by the researcher. Notes were taken during the unrecorded interview, with the participant’s consent. It is acknowledged however, that the process of transcribing does select data through choices of the degree of detail recorded (Riessman, 2002), for example the tone and rhythm of the voice may depict emotions that are not conveyed in recording words alone. The audio tapes were kept to check for such cues as necessary during the analysis.

4.2.7.4 Focus groups
Focus groups are said to be particularly useful where little is known about the phenomenon of interest (Stewart and Shamdasani, 1990) and to gain insight in complex areas (Krueger and Casey, 2009). Focus groups also have the advantage of facilitating discussion between group members which can generate ideas or uncover perspectives that would not have emerged from individual interaction (Stewart and Shamdasani, 1990). Groups also enable larger numbers of participants to contribute. Potential limitations of focus groups include group members being reluctant to talk due to conflicts in the group or sensitivity of the topic (Krueger and Casey, 2009). However Jackson (1998) found, in her experience, that participants did not show any reluctance to challenge views expressed by others. This disadvantage was minimised as participants could choose to participate in focus groups or individual interviews. Participants were fully briefed on the nature of discussion prior to the focus group. However the researcher can also address this risk by ensuring all participants have the opportunity to contribute to discussions (Jackson, 1998; Krueger and Casey, 2009). Facilitator bias was also minimised by using the same topic guide as used for the semi-
structured interviews, so as to provide consistency across the two methods (Lane et al, 2001).

Focus groups were offered for participants who preferred to meet with peers rather than individually. One focus group was undertaken with active case managers in case study site two. The discussion was audio-taped with the group’s permission and transcribed verbatim.

4.2.8 Numbers of interviews, observations and focus groups
A total of 30 interviews were undertaken. The interviewees are detailed in Table 12, which shows the numbers of interviews undertaken in each case study site. Seven active case managers attended a focus group in case study site two. Interviews and the focus group lasted between half hours to one and a half hours in length.

A total of 33 observations were undertaken. The nature of the observation and numbers undertaken in each case study site are depicted in Table 12. The length of observations ranged from half an hour to two hours, depending on the activity. The range of observations is detailed earlier in Table 11.

Table 12: Numbers of interviews, observations and focus group per case study site

<table>
<thead>
<tr>
<th>Type of data collection</th>
<th>Case study site 1</th>
<th>Case study site 2</th>
<th>Case study site 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interviews</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community matron</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Active case manager</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>District nurse</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>GP</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Senior manager</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Patient</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>10</strong></td>
<td><strong>10</strong></td>
<td><strong>30</strong></td>
</tr>
<tr>
<td><strong>Focus group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active case managers</td>
<td>-</td>
<td>1</td>
<td>(7 attended)</td>
<td>1</td>
</tr>
<tr>
<td><strong>Observations</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient home visits</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Office work</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Hospital visit</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Team meeting</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Liaison</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Presentations/teaching</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Care coordination meeting</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>10</strong></td>
<td><strong>13</strong></td>
<td><strong>10</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>
4.3 Sampling

Sampling is the next stage of the case study method, although some aspects began in the orientation stage as described in section 4.2.3. This section refers specifically to the involvement of participants in each case study site.

4.3.1 Purposive sampling

As stated in the selection of case study sites (section 4.2.3), selection of participants in case study research also differs from the traditional interpretation of ‘sampling’; the main criterion is reiterated here in that selection of participants is made in order to maximise what can be learned (Stake, 1995). Selection or ‘sampling’ is not founded on seeking a representative sample of the population.

Table 13: Framework for purposive sampling

<table>
<thead>
<tr>
<th>Participant group</th>
<th>Data collection method</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
</table>
| Service users                          | Observation, Interview | - is currently receiving care from a community matron or is a carer/significant person to someone receiving care from a community matron within a participating PCT  
  - is able to give consent            | - is not on a caseload of a community matron from a participating PCT  
  - is unable to give consent          |
| Community matron                       | Observation, Interview, Documents and records | - has been employed as a community matron for at least 3 months from the start of data collection in the PCT  
  - is employed by a PCT identified as a case study site | - is not employed as a community matron  
  - is not employed by a participating PCT  
  - has been employed as a community matron for less than 3 months at the start of data collection in the PCT |
| Staff colleagues of community matron   | Interview and/or focus groups, Documents and records | - has working links with the role of community matron, or  
  - is involved in the care of a service user who is on a caseload of a community matron or  
  - is involved in supporting service users in managing long term conditions | - has no working links with the role of community matron, or  
  - is not involved in the care of a service user who is on a caseload of a community matron, or  
  - is not involved in supporting service users in managing long term conditions |
Purposive sampling was adopted, which is non probabilistic, that is, there is no element of chance in determining who will be selected (Grbich, 1999; Draucker et al, 2007). Participants selected would be key informants, for example the community matrons, other health and social care professionals working with people with long term conditions, and patients themselves. Table 13 describes the characteristics used for the selection of participants to maximise learning.

In developing purposive sampling frameworks, the terms inclusion and exclusion criteria are not generally used. However they have been used here in the practical application of purposive sampling, in order to be pragmatic in providing consistency in terminology used by the Local Research Ethics Committees and application forms. Therefore the positive characteristics (inclusion criteria) and those that may limit the contribution of an individual (exclusion criteria) were identified. Inclusion criteria facilitated involvement from anyone who identified their link with the role of the community matron and who wished to participate.

4.3.2 Recruitment of participants

Information sheets and consent forms were tailored for different participants, namely community matrons, colleagues and service users, as seen in appendices 5 to 10. Community matrons were identified by their employing PCT, following PCT agreement for the organisation to participate in the study. The researcher met with community matrons in each case study site to discuss the study details and commitment anticipated so that the community matron could make an informed decision whether to participate.

Service users were identified by community matrons, from their caseloads, who sought consent on behalf of the researcher. Where service users may become participants by virtue of observation of the community matron, the community matron sought consent at least 48 hours prior to their visit, and consent was reaffirmed immediately prior to the visit.

Colleagues were also identified by community matrons, who sought consent on behalf of the researcher. It was recognised that recruitment of colleagues and service users via community matrons was a limitation of the study, as the community matrons may select those who would favourably reflect the community matron role.

Numbers and details of participants can be found in section 5.1.
4.4 Data analysis

Ritchie and Spencer (1994, p.176) state that “qualitative data analysis is essentially about detection, and the tasks of defining, categorizing, theorizing, explaining, exploring and mapping are fundamental to the analysts role”. The Framework approach to data analysis (Ritchie and Spencer, 1994; Ritchie et al, 2003) was adopted in this study, as described in section 4.4.2. Data analysis forms two stages, data handling and data analysis (Ritchie et al, 2003), which are discussed below.

4.4.1 Data handling

There are differing views regarding the appropriateness of computer-assisted qualitative data analysis software (CAQDAS) within the literature. Bryman (2001) highlighted this debate: he states that some argue, for example, that computerised code and retrieve processes result in fragmentation of the texts which lose the narrative flow and potential loss of important events, or decontextualises data. Others, Bryman (2001) suggested, argue that such programmes enhance the transparency of analysis and may force researchers to be more reflective about the analytical process. The crucial factor in ensuring that CAQDAS is used appropriately and effectively is the researcher, as the software cannot replace the researcher’s role in the analytical process (Coffey and Atkinson, 1996). As such, data analysis remains dependent on the rigour, clarity and creativity of the researcher’s conceptual thinking (Ritchie et al, 2003). Advantages of software include reduced time in data preparation, management and retrieval; easy access to data which keeps the researcher close to the data; and supporting reflexivity (Jemmott, 2006).

The software package for data analysis should be considered in relation to how it remains grounded in the data, how it facilitates and displays ordering of data, and how it facilitates thematic associations within cases and across cases (Spencer et al, 2003). NVivo is versatile in facilitating different data sources including audio and text documents; it captures the characteristics of participants by coding of attributes and facilitates indexing. It is also suited to case study as its search and retrieval tools enable in case and cross case analysis (Bazeley and Richards, 2000; Bassett, 2010). In light of these considerations and the benefits of using CAQDAS, the software package NVivo 7 was adopted to support data management.

4.4.2 Framework approach to data analysis

The process of analysis needs to be systematic and transparent to increase the dependability of the study (discussed in section 4.7.3) whilst being flexible to multiple methods: the framework approach (Ritchie and Spencer, 1994; Ritchie et al, 2003) was used, as it is
Figure 3: The stages of Framework analysis and an example of its application in this study (adapted from Swallow, Newton and Marshall 2003)

1. Familiarisation
   - Immersion in data
   - Listening to and transcribing taped interviews
   - Uploading data to NVivo

2. Identifying thematic framework
   - Listing initial ideas and themes from data
   - Drawing on themes from literature review
   - Compiling nodes for initial themes in NVivo based on data (further nodes added during indexing process)

3. Indexing
   - Extract from nodes for indexing data (see appendix 11)
   - Role function
     - Case finding
     - Boundaries
     - Communication
     - Medication
     - Issues
       - Attitude
       - Delegation
       - Lack of clarity
     - Assessment
     - Level of practice
     - Referrals
     - Variance
     - Care coordinator
   - Extracts from Transcript (CM12)
     - "I’m still utilising my nursing skills in the assessment of the physical, psychological, social perspective, and drawing up the management plan as to what I’m going to be doing with the patient, in agreement with the patient, but I’m mixing it now with medical bit, which I didn’t do as a district nurse because I didn’t have the skill."
     - "My aim is not just to sort of examine somebody’s chest or to have a chat with them, my job is to pull the services together so as well as providing that sort of physical examination for those patients at a higher level."
     - "I’m actually coordinating their care and trying to pull all services together."

4. Charting

5. Mapping and interpretation
   - Within case and cross case: comparing accounts/data in relation to themes
   - Reconsidering themes and connections to realign nodes to relevant themes
   - Exploring associations between themes and possible explanations from theoretical concepts

<table>
<thead>
<tr>
<th>Site 3 Data</th>
<th>Theme: Role function</th>
<th>Care coord</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM11</td>
<td>Assessment you just sort of know really from observing somebody whether they’re ill enough to go into hospital or whether they just need a bit of TLC</td>
<td></td>
<td>If they want us to be following the medical model then I can’t see how we can do the job without it [prescribing], I really can’t.</td>
</tr>
<tr>
<td>CM12</td>
<td>Assessment of the physical, psychological, social perspective, and drawing up the management plan</td>
<td></td>
<td>I’m actually coordinating their care and trying to pull all services together</td>
</tr>
<tr>
<td>OBS IC/CM 12</td>
<td>Report on physical assessment: CVS, CNS, resp systems</td>
<td>CM coordinating inputs to meeting and action plan</td>
<td>CM arranging for respite care</td>
</tr>
</tbody>
</table>
particularly applicable to case study in facilitating comparison within and between cases (Ritchie and Spencer, 1994). The framework involves five stages (Ritchie and Spencer, 1994 Ritchie et al, 2003), namely familiarisation, identification of a thematic framework, indexing, charting, and mapping and interpretation. The application of these stages is depicted in Figure 3 and is described further below. Two worked examples of the Framework Approach can also be seen in appendices 12 and 13. These show extracts of data and the categories against which the data were indexed, the emerging themes from charting, and the subsequent mapping and interpretation.

**Familiarisation:** The first stage of familiarisation was done by reading documentary material, observation notes and diaries; listening to interview tapes, transcribing and making notes of interviews. This was reinforced while inputting data to NVivo 7. Initial ideas about themes were noted whilst re-listening to interviews and re-reading transcripts, notes and documentary material. Initial themes included effectiveness and outcomes, role function, service model and relationships. Familiarisation started shortly after data had been collected in each case study site.

**Identification of a thematic framework:** Key themes were identified to build up a thematic framework to which data can be examined and sorted. The researcher determines the meaning, relevance and importance of issues and connections between ideas (Ritchie and Spencer, 1994). Key themes for the thematic framework were identified from the research questions and literature review, these themes being role function, relationships and service model. These themes were also emerging from the data, as described in the familiarisation stage. The emerging themes were used to set up the indexing framework on NVivo prior to the indexing stage.

**Indexing:** the thematic framework was systematically applied by indexing the data. This was facilitated in NVivo by setting up categories or subjects called ‘nodes’: each piece of data was examined line by line and was indexed under these ‘nodes’. NVivo allows for categories to be stand alone (called ‘free nodes’) or linked to other categories (‘tree nodes’). Tree nodes were mainly used so links to the initial themes were made during this process. Themes and categories used in indexing can be seen in appendix 11. Categories were added throughout the process of indexing where a new or sub category was identified. This gave flexibility to data analysis so that emerging ideas not previously identified could be captured (Bringer et al, 2006). An excerpt of indexed data can be seen in Figure 3, where a part of an interview
transcript is indexed against categories relating to role function. Further examples of indexing applied to raw data can be seen in appendices 12 and 13.

**Charting:** a picture of the data as a whole is developed by considering the data outside its original context and reconsidered for thematic reference. This generates abstraction and synthesis of the data. First, the content and source of data within each node, and the frequency each category had been used in indexing was examined. This was done by creating tables where all the data indexed for each category could be viewed. An excerpt of charting can be seen in Figure 3. From these charts the categories were re-examined to consider the importance and relevance of these within each case study site. The charts also enabled the data to be explored for emerging themes. For example, data that had been indexed in relation to improving patient lives and avoiding admissions presented emerging themes of competing priorities. This can be seen further in appendix 13.

**Mapping and interpretation:** Mapping pulls together the key characteristics of the data. Contexts are defined using the original objectives, mapping phenomena and creating typologies. Concepts and phenomena are explored in more depth to find associations and where appropriate, ‘explanations’ (Ritchie et al, 2003). The charts from the previous stage were used to identify connections between themes. For example, when considering role function, themes of identity and the changing nursing role, that is, its fluidity, were emerging, together with the theme of shifting boundaries. This can be seen in appendix 12. Within the theme of relationships, the theme of shifting boundaries also emerged from the issues of the interface between professional roles and conflict between roles. So, connections between themes were explored at this stage. Through these interrelated themes the concept of ‘making sense’ was seen, for example making sense of the role, and making sense of values, again shown in appendix 13. As such this shows how the raw data underpinned the interpretation of findings and the emergence of final themes and concepts.

At this stage the initial thematic framework was also reconsidered; indexing of categories in relation to preparation and learning was also linked to other themes such as role function, role effectiveness and relationships. Therefore the categories within this theme were realigned, so that the final themes emerging from the data were service model, role function, relationships, and role effectiveness and outcomes. This can be seen in Table 14.
**Table 14: Research questions and alignment of emerging themes**

<table>
<thead>
<tr>
<th>Research question</th>
<th>Initial themes</th>
<th>Emerging themes</th>
<th>Realignment of themes to research questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does a community matron undertake this new role?</td>
<td>Role function</td>
<td>Service model</td>
<td>Service model</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preparation and learning</td>
<td>Role function</td>
</tr>
<tr>
<td>How does the introduction of this new nursing role affect existing practitioners in the management of long term conditions?</td>
<td>Relationships</td>
<td>Effectiveness and outcomes</td>
<td>Relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Preparation and learning</td>
<td>Effectiveness and outcomes</td>
</tr>
<tr>
<td>How have community matrons negotiated their role boundaries and has this affected the boundaries of other community nursing roles?</td>
<td>Service model</td>
<td>Relationships</td>
<td>Service model</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Role function</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Relationships</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effectiveness and outcomes</td>
</tr>
</tbody>
</table>

Each case was analysed separately (‘within-case analysis’) and then the results from each case was compared with the results with the other cases (‘cross-case analysis’) (Cowley et al. 2000b). Cross case analysis was undertaken by examining each of these themes in relation to the three case study sites, so that similarities and differences could be explored. It is this cross case analysis that is presented in this thesis.

The outcome of the final stage of the Framework Approach to analysis, interpretation, is presented in the discussion chapter (Chapter Ten).

**4.5 Ethical Issues**

The key ethical considerations for this study are underpinned by the principles of respect for autonomy, namely consent, confidentiality and truthfulness (Beauchamp and Childress, 2001). These are discussed in detail below in sections 4.5.1 to 4.5.3.

**4.5.1 Consent**

The components of giving informed consent (Beauchamp and Childress, 2001) were fulfilled as follows:

*Having competence to understand and decide:* Patients were identified by community matrons so that ability to consent for health care was used as a measure for competence to consent to participate in this study. Competence was assumed for all community matrons and colleagues.
Having sufficient information on which to make a decision: Informed consent was obtained from all participants, using information sheets and letters designed specifically for patients, colleagues and the community matrons, and written consent forms (Appendices 5 to 10).

Understanding information on which to make a decision: All potential participants were given the opportunity to ask questions arising from the written information. For patients this was offered via the community matron. There were no requests for further clarification.

Being able to act voluntarily, without being under the control of another influence: it was important that community matrons did not feel obligated to participate by their employer. It was emphasised that the study was not dependent on all community matrons within the organisation agreeing to participate. This was not an issue as all community matrons approached wanted to participate. Patients did not have direct contact with the researcher until they had given consent to prevent undue pressure to participate. It was emphasised in the written information for patients that their decision whether to participate or not would not affect their care in any way (Appendices 7 and 8).

Giving consent: written consent was used so that consent had to be actively given. In one instance verbal consent only could be obtained for an observation of a patient visit. This occurred in specific circumstances in which the researcher needed to immediately assess whether pursuit of written consent was in the best interest of the patient. The literacy capability of the patient could not be ascertained and it was considered that asking for the patient to sign may generate concern which could impact on the community matron’s future relationship with the patient. Therefore verbal consent was sought prior to entering the patient’s home and reaffirmed with the patient before any observation of the visit was made. The patient demonstrated understanding of giving consent which was witnessed by the patient’s son. As such it was considered that the principles of informed consent had been adhered to.

4.5.2 Confidentiality
The researcher did not have access to any patient details until consent had been obtained through the community matron. Participants were allocated codes which were known only to the researcher in order to protect their confidentiality.

All personal data, for example personal contact details and consent forms were stored securely. Any identifiable data stored electronically was password protected and accessible to
the researcher only. Each participant was allocated codes to be used on tapes and transcripts; codes were stored separately from personal data and consent forms. This ensured data was stored in accordance with the Data Protection Act.

Although participants were anonymised, there was a potential risk of individuals being identified by virtue of their being the sole or one of a few post holders and the content of their interviews (Christians, 2005). The consent form included consent for data to be used by the researcher for the purposes of this study. The risk of identification has also been mitigated by the extent of organisational change since data collection: services have subsequently transferred to different employing organisations, which has rendered individual participants as virtually unidentifiable and untraceable from data presented in this thesis.

4.5.3 Truthfulness
Issues of truthfulness are reflected in three key aspects within the study: honesty of the researcher; openness with participants; and the authenticity of findings.

There is a risk of misleading participants about their relationship with the researcher if the aims of the study and the researcher’s role and actions within the study, namely data collection and interpretation, are not made explicit. This is particularly pertinent as participants were aware of the researcher’s nursing background and so this could lead to misinterpretation of the role by either colleague or care giver. Therefore the researcher needed to maintain honesty with participants and also be true to herself with regard to how her interaction with participants affected the research findings; a reflective research journal was used to facilitate this (Jasper, 2005; Koch, 2006), as discussed in section 4.6.5.

There is an assumption that those in health professional roles have an obligation of beneficience to patients (Beauchamp and Childress, 2001). In research, the obligation of beneficience is to the wider population through the pursuit of new knowledge, which in health care will benefit all patients. Therefore the benefits of research do not necessarily directly benefit the individual participants. Therefore it is essential that the study was explicit about the benefits of participation. It was acknowledged that there may not be any immediate or direct benefit to service users or staff in the written information (Appendices 5, 7 and 9). However participants have the opportunity to express their views and experience of clinical practice that directly affects them. Opportunities for participants to use their contribution to benefit themselves were exploited, for example community matrons were able to use copies
of reflective diaries for their own portfolios: some commented that being interviewed gave them the opportunity to reflect on their practice.

Authenticity is addressed through measures of rigour to achieve credibility, as discussed in section 4.6.1 and requires research findings to be true to the perspectives expressed by those who participated.

4.6 Rigour of the study

There is no single or accepted guideline to assist researchers in determining the rigour of qualitative studies (Armour et al, 2009). Researchers using a positivist approach to case study have evaluated the rigour of research with the application of validity and reliability measures used for quantitative research (Paré, 2002; Yin, 2009). It has been contested that criteria for quantitative research do not serve to determine rigour in qualitative research due to the differences in ontology and epistemology (Patton, 2002). There is debate, however, as to whether criteria for rigour should be paradigm specific or whether general criteria may apply to qualitative research (Armour et al, 2009). Creswell (2007) identified eight mechanisms to assess the quality of a study, including 'persistent observation', triangulation, member checking, thick description and external audit, and argued that some were more appropriate to certain paradigms than others.

Guba and Lincoln (1994) proposed that the question of rigour should focus on the unique challenges of qualitative research, in particular naturalistic inquiry, namely multiple value structures, social pluralism, social conflict and accountability. They have maintained that the criteria by which the rigour of quantitative research is assessed, namely internal and external validity, reliability and objectivity, originate in positivism and therefore are not appropriate for qualitative research (Lincoln and Guba, 1985; Guba and Lincoln, 1989; 1994; 2005; Lincoln, Lynham and Guba, 2011).

Instead, alternative criteria were identified by which to evaluate the trustworthiness and authenticity of qualitative research, namely credibility, transferability/fittingness, dependability and confirmability (Lincoln and Guba, 1985; Guba and Lincoln, 1989; 1994; 2005). Whilst the criteria were still criticised for being aligned to the positivist paradigm (Whittemore et al 2001), Koch (2006) argued that Lincoln and Guba’s approach best reflected the constructivist paradigm of qualitative research. Therefore the criteria of credibility, transferability/fittingness, dependability and confirmability were applied to this study, as discussed below. In addition, reflexivity was considered to be a mechanism to support the trustworthiness of the study, by
considering how the researcher affected the study as themselves (Lincoln and Guba, 2003), and so has been included in this study.

4.6.1 Credibility
Credibility is dependent on faithful descriptions of the research (Guba and Lincoln, 1989) and is enhanced by description and interpretation of the research experience by the researcher (Koch, 2006). A research diary, as proposed by Koch (2006), was adopted by the researcher in this study to reflect on the research process and note aspects of interactions with participants. This enabled the researcher to consider how the relationship with participants and personal views could affect choices within the research process, including selection of data, sampling and interpretation of findings. Guba and Lincoln (2005) describe this reflective process as ‘reflexivity’, which is discussed in more detail in section 4.6.5.

Triangulation involves gaining multiple perspectives on a specific topic from different sources (Armour et al. 2009) in order to check whether there is congruence in the findings. There are mixed views on the appropriateness of triangulation for qualitative research, for example Barbour (2001) argued that data from different sources would not necessarily concur, where different perspectives are being considered; this was counter to an interpretive approach. In contrast, Lincoln and Guba (1985), Tobin and Begley (2004), Armour et al (2009) and Stake (2008) advocated its application in qualitative research. Stake (2008) argued that triangulation would reduce the likelihood of misinterpretation; using multiple perceptions can clarify meaning by identifying different ways in which the case can be seen, and in doing so helps to identify different realities. Stake’s perspective fits with constructivism. The use of multiple data sources in this study, therefore, strengthened its credibility.

Member checking is where participants are asked to check the data of the study for accuracy and interpretation. Whilst advocated by Lincoln and Guba (1985), Koch (2006) and Creswell (2007) to enhance the credibility of a study, member checking has been challenged as counter to interpretative based research (McConnell-Henry et al, 2011). Also concerns have been raised that such checking will compromise credibility due to the unreliability of recall, respondents’ own biases and the influence of social constraints (Sandelowski, 1993; Barbour, 2001). As the disadvantages were considered to outweigh the advantages, member checking was not used in this study.
4.6.2 Transferability/fittingness

Case study provides ‘thick description’ which enables judgements to be made on transferability of findings to other contexts (Lincoln and Guba 1985). This research study did not intend to be generalisable to other settings, as discussed in section 3.2.2, but its findings could be used by readers to compare with their knowledge and experience of the implementation of the community matron role in other organisations. Such judgements are reliant on adequate contextual descriptions so that the reader can assess its transferability (Koch, 2006). In this study the use of documentary material, as described in section 4.2.7.1, enabled a detailed description of the context of the case in presenting the findings of the research, as described in Chapter Five.

4.6.3 Dependability

Sandelowski (1993) argued that the concept of replicability of findings is not applicable to research within the naturalistic or interpretive paradigm. Rather, dependability is the preferred criterion, as a judgement of the likelihood that another researcher would arrive at comparable interpretations by following the same decision trail in the study (Sandelowski, 1986). This is reflected in the level of explicitness of the research process; Guba and Lincoln (1985) use auditability (the term used by Koch, 2006) of the research process as a measure of rigour, a mechanism that is supported by Koch (2006). The audit trail considers how decisions were made; in this research the explicit, in depth description of research methods and process, analysis and interpretation demonstrates how dependability has been achieved.

4.6.4 Confirmability

Confirmability requires a study to demonstrate the way in which interpretations of findings have been arrived at (Koch, 2006). So whereas dependability considered the process of the research study, confirmability is concerned with its outcome, namely its findings. Guba and Lincoln (1989) considered confirmability had been established when credibility, transferability and dependability had been achieved. Again, the auditability of the decision making process with regard to analysis serves to attest whether confirmability is achieved. In this study, the use of the Framework approach to data analysis (Ritchie and Spencer, 1994; Ritchie et al, 2003), as discussed in section 4.4.2, facilitated the account of the decision making process. This demonstrated the connections between the raw data and interpretations, evidenced through indexing and theme development. Through this the confirmability of the study is met.
4.6.5 Reflexivity

Research that is founded on a positivist perspective attempts to remove the effect of external influences, including the researcher, in the pursuit of ‘value free’ objective findings. However research within the constructivist paradigm, as in this study, is undertaken on the premise that values, interactions and perceptions are integral to the findings (Hammersley and Atkinson, 1995). As such, ‘researchers both influence and are influenced by the process of research’ (Northway, 2000, p.392). Therefore the potential impact of the researcher on the study needs to be considered (Neil, 2006). Reflexivity is described as:

“...an awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process.”

(Robson, 2002, p.22)

Guba and Lincoln (2005) argued that without such self awareness the credibility of the study can be undermined, as discussed in section 4.6.1 in relation to credibility and rigour. In embarking on this study the researcher’s most recent experience in senior management in the NHS was acknowledged as an influence on how service delivery was perceived by the researcher. As a senior manager and commissioner of health services the researcher was familiar with interpreting data and evaluation reports about services in the context of standards of care and value for money. Also, the researcher considered that her perceptions of clinical practice would be affected by her own clinical experience but that this was influenced by historical recollection of practice given the length of time since being directly involved in providing patient care.

Therefore it was important for the researcher to consider how current and previous experience affected decisions about what was recorded, for example in making field notes of observations, what and how questions were asked in interviews and how documents were reviewed. Ways used to assist reflexivity that were adopted included:

- keeping a reflective diary to enhance self awareness of personal perspectives on events as they were unfolding, particularly on things that came up in the interviews and observations, as advocated in qualitative research methodology literature (eg Erlandson et al, 1993; Koch, 2006);
- using field notes to note perceptions of researcher impact on observations (Allen, 2004);
- giving voice to participants by quoting large amounts of raw data (Leonard and McAdam, 2001), as seen in Chapters Six to Nine, and
• being guided by a framework analysis approach which enabled a systematic approach to the data (Pope et al, 2000).

In relation to analysis the researcher considered the impact of current experience as a senior manager on what would appear to be significant. Hart (2000) argued that to see connections or interpretations that may not be readily visible we need to move out of our frame of reference and view situations as if looking through another’s eyes. It was important to return to the raw data throughout analysis so that the participants’ voices and experiences presented the picture or story from their perspectives (Leonard and McAdam, 2001). The use of Framework Analysis facilitated this immersion in the data, as discussed in section 4.4.2.

The researcher’s experience and interest in policy were drawn upon during analysis to consider the contextual factors such as organisational change in which the study was undertaken. This was reflected in the interpretation of the findings, although emphasis was checked by revisiting the raw data throughout the mapping and interpretation stage of Framework Analysis, to ensure that the experience and views of the participants were fully represented.

Grbich (1999) also noted that reflexivity is needed to address differences in power, culture and class relations between researcher and participants. Walt et al (2009, p. 314) described this as the ‘positionality’ of the researcher and argued that this affected access to data, the researcher’s focus and research questions asked. This included consideration of whether the researcher was viewed as an ‘insider’ as a fellow nurse, or an ‘outsider’ as a researcher and manager (Walt et al, 2009).

Advantages of being accepted as a colleague, that is, an ‘insider’, have been reported as improving access to research settings, being readily accepted, understanding culture and lessening the impact of the researcher on the usual activity in the clinical setting (Leslie and McAllister, 2002; Allen, 2004). Disadvantages have been reported with regard to over familiarity with participants and the research setting impairs the researcher’s ability to analyse (Adler and Adler, 1987). In this study the researcher shared a commonality with participants of a community nursing background, but this did not extend to being a complete ‘insider’ as the researcher was not engaged in clinical practice at the time of the study. This reduced the potential for blurred boundaries and misperception of the researcher as ‘one of the team’, as experienced by practitioner researchers (eg Burns et al 2012). However in one instance the team in one of the case study sites extended a personal invitation to a social event. This was
reflected in the researcher’s diary as to whether an over familiarity had developed but was considered rather to be an indication of acceptance. As such the researcher was able to balance outsider ‘strangerness’ with insider ‘relationality’ (Burns et al 2012).

So, in approaching participants with clinical roles it was important to be transparent about the researcher’s nursing background and role in senior management in a different organisation, at the same time emphasising the role as researcher whilst in their organisation. This was described in the participant information leaflets (appendices 5, 7 and 9). Prior to interviews or observations, the researcher met with participants to discuss the research study, seeking to establish a balanced relationship between the researcher and participant. At the meeting the researcher’s role in senior management was described but emphasis was placed on the researcher role and interest was expressed in participants’ practice and experience. The researcher also highlighted that she had not practised in the management of long term conditions, and in doing so placed emphasis on the participants as the experts in the field under study. This also helped to counter the potential imbalance in the relationship by nature of the researcher’s senior management role.

Personal experience in community practice was used as examples in conversation with participants before the start of data collection and during visits to case study sites between observations and interviews. This helped to build an empathetic understanding with participants so there was a shared experience to relate to. Wenger (2002) argued that such self disclosure aided in building a rapport, reducing the distance and potential imbalance between researcher and interviewee. All participants appeared relaxed in the presence of the researcher, for example, it was noted in field notes that at the end of an observation of a team meeting, one participant commented that they had forgotten that the interviewer was present. All participants appeared open about all areas of practice during observations and interviews. There were no occasions where it felt that the participants were trying to only show practice favourably and readily shared both good experiences and aspects of concern or frustration. In this respect the researcher felt accepted and treated as a fellow nursing colleague interested in their work.

Similarly with participants who were patients, the researcher’s background was explained in the information leaflet (appendix 7) and prior to starting interviews. Again previous nursing practice of the researcher was described to promote confidence, but with emphasis that the researcher could not answer specific questions about their care or conditions. In one instance a patient asked about their care and described symptoms, which, with the patient’s consent,
were reported back to the community matron immediately after the interview was completed. This ensured that appropriate and prompt care was initiated for the patient.

Dadds (2008, p.287) considered the impact of empathy in practitioner research, and commented:

"... we are entering into others’ emotional worlds when we invite them into our research to share information about their experiences..."

The researcher also used the reflective diary at the end of a day’s data collection to consider the whether researcher’s approach as a nursing colleague had been sensitive to the feelings and reactions of the participants that the questions may have raised. In one instance the interview led a participant to reflect on the level of support they received in their role. After the interview had finished, the researcher talked with the participant about ways of seeking support, as this was a way of sharing the researcher’s personal nursing experience to help the practitioner, in response to the participant’s help to the researcher. Northway (2000) referred to this as reciprocity, where the researcher shares personal information which makes explicit their personal values that influence their perceptions and decisions.

In this section, reflexivity has been discussed in relation to the researcher’s position as a nurse and a senior manager, and how these roles may have impacted on how participants may have responded to the researcher. In addition, it reflects on how the researcher’s own background may have affected the researcher’s approach in conducting the study and interpretation of findings. This highlights the strength of Framework as a tool for analysis, as it makes interpretation explicit, and enables the researcher to ensure that themes are grounded in the data, so making the research an inductive process.

4.7 Summary
This chapter has discussed the application of case study methodology, using a multiple case study design. The case is defined as the role of the community matron in the contextual setting of the primary care trust (PCT). Three case study sites and participants were selected using purposive sampling. Participants were community matrons, patients, active case managers, district nurses, social workers, a GP, and manager. Data sources were documentary material, participant observation, interviews and focus groups. NVivo 7 was used to facilitate data analysis, using the framework approach. Ethical issues relating to consent, confidentiality and truthfulness were explored to demonstrate how these had been addressed in the study design. Similarly issues of trustworthiness were considered using
Guba and Lincoln’s criteria for quality (1994) to show how the study had met criteria for credibility, transferability, dependability, confirmability and reflexivity.

The next chapters present the outcomes of the study: Chapter Five describes the participants and the context of each case study site. The presentation of findings and the annotation to identify data sources is described to demonstrate how findings are founded on raw data sources. Chapters Six to Nine then present the findings.
CHAPTER 5: CONTEXT OF THE CASE STUDY AND THE APPROACH TO PRESENTATION OF FINDINGS

This chapter introduces the findings of the study. It begins by describing the participants of the study. The context of the case study is then discussed. The key themes that emerged from analysis were the service model, the role function of the community matron, key relationships, and role effectiveness of the community matron. These themes are presented in Chapters Six to Nine.

This chapter concludes by describing how data sources are presented in the findings, including the codes used to annotate the data cited throughout the findings. This serves to demonstrate how findings are founded on raw data sources.

5.1 Participants

Table 15 presents the number of all participants with direct involvement in the study. The different numbers of community matrons and active case managers in each case study site reflects the different team structures as described later in Chapter 7 and Figure 4 on page 94. The code denotes the annotation used to identify participants in the presentation of findings, which is explained further in section 5.6.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Code</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community matron</td>
<td>CM</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Active case manager</td>
<td>ACM</td>
<td>-</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Patient</td>
<td>P</td>
<td>2</td>
<td>8</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>District nurse/ team lead</td>
<td>DN</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Social worker</td>
<td>SW</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>GP</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Senior manager</td>
<td>SM</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>12</td>
<td>21</td>
<td>16</td>
<td>49</td>
</tr>
</tbody>
</table>

Of all the community matrons, only one was male. There were two male active case managers, one in case study site two and one in case study site three. In reporting findings all community matrons and active case managers have been referred to as ‘she’ in order to protect the anonymity of participants. One community matron and two active case managers were from black and minority ethnic populations, as was one of the other health and social
care professionals. Table 16 presents further details about the background of the community matrons. Eight of the 12 community matrons had previous experience in district nursing. Four were independent non medical prescribers; three of these had qualified as advanced practitioners.

Table 16: Backgrounds of community matrons

<table>
<thead>
<tr>
<th>Community matron code</th>
<th>Case study site</th>
<th>Previous experience</th>
<th>Advanced practitioner</th>
<th>Non medical prescriber</th>
<th>Base</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM01</td>
<td>1</td>
<td>District nursing; continuing health care</td>
<td>In training</td>
<td>No</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM02</td>
<td>1</td>
<td>Practice nursing; strategy and policy</td>
<td>In training</td>
<td>No</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM03</td>
<td>1</td>
<td>District nursing</td>
<td>No</td>
<td>Independent</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM04</td>
<td>1</td>
<td>Health visiting; care of older people; acute medical care</td>
<td>In training</td>
<td>No</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM05</td>
<td>1</td>
<td>District nursing</td>
<td>No</td>
<td>Supplementary</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM06</td>
<td>1</td>
<td>District nursing</td>
<td>In training</td>
<td>No</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM07</td>
<td>1</td>
<td>Intermediate care; practice nursing; health visiting</td>
<td>In training</td>
<td>Supplementary</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM08</td>
<td>1</td>
<td>Rehabilitation; COPD case management</td>
<td>No</td>
<td>No</td>
<td>CM team office</td>
</tr>
<tr>
<td>CM09</td>
<td>2</td>
<td>District nursing</td>
<td>Yes</td>
<td>Independent</td>
<td>District nursing team</td>
</tr>
<tr>
<td>CM10</td>
<td>2</td>
<td>District nursing</td>
<td>Yes</td>
<td>Independent</td>
<td>District nursing team</td>
</tr>
<tr>
<td>CM11</td>
<td>3</td>
<td>District nursing; case management</td>
<td>In training</td>
<td>No</td>
<td>Health centre</td>
</tr>
<tr>
<td>CM12</td>
<td>3</td>
<td>District nursing</td>
<td>Yes</td>
<td>Independent</td>
<td>Health centre</td>
</tr>
</tbody>
</table>

Of the patients, six were female and ten were male. Two patients were from black and minority ethnic populations; one in case study site two and one in case study site three. All patients were over 65 years old. Twelve of the patients lived alone. Of those who had recent hospital admission, only one was already a patient of the community matron. Table 17 provides further details of the patients and their health conditions. All had multiple health needs: nine had chronic obstructive pulmonary disease (COPD) or a chest condition, seven had diabetes and five had cardiac problems.
<table>
<thead>
<tr>
<th>Patient code</th>
<th>Case study site</th>
<th>Male/ female</th>
<th>Conditions</th>
<th>Recent hospital discharge</th>
<th>Previous admissions/ GP calls</th>
<th>Lives with</th>
<th>1st visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>P01</td>
<td>1</td>
<td>M</td>
<td>Falls, osteoarthritis, cardiac problems, mobility problems</td>
<td>Yes</td>
<td>No</td>
<td>Alone</td>
<td>Yes</td>
</tr>
<tr>
<td>P02</td>
<td>1</td>
<td>M</td>
<td>COPD, breathlessness, long term indwelling urinary catheter, cataracts</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P03</td>
<td>2</td>
<td>M</td>
<td>COPD requiring CPAP, non insulin dependent diabetes, cellulitis, anxiety</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P04</td>
<td>2</td>
<td>F</td>
<td>Parkinson’s disease, falls, postural hypotension, weight loss</td>
<td>No</td>
<td>No</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P05</td>
<td>2</td>
<td>F</td>
<td>Neurovasculitis, post chemotherapy, anxiety</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P06</td>
<td>2</td>
<td>M</td>
<td>Diabetes, sleep apnoea, nutrition problems</td>
<td>No</td>
<td>Not known</td>
<td>Wife</td>
<td>No</td>
</tr>
<tr>
<td>P07</td>
<td>3</td>
<td>M</td>
<td>Chest infection, alcohol dependency, nutrition problems</td>
<td>Yes</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P08</td>
<td>3</td>
<td>M</td>
<td>COPD, arthritis, anxiety</td>
<td>No</td>
<td>Not known</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P09</td>
<td>3</td>
<td>F</td>
<td>Falls, cardiac problems</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P10</td>
<td>3</td>
<td>M</td>
<td>Diabetes, cataracts, neuropathy, nutrition and weight problems, depression</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P11</td>
<td>3</td>
<td>F</td>
<td>Diabetes, neuropathic pain</td>
<td>No</td>
<td>Not known</td>
<td>Daughter</td>
<td>Yes</td>
</tr>
<tr>
<td>P12</td>
<td>3</td>
<td>F</td>
<td>Diabetes, breathlessness, fluid retention</td>
<td>No</td>
<td>Not known</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P13</td>
<td>2</td>
<td>M</td>
<td>COPD, heart failure, chest infection</td>
<td>Yes</td>
<td>No</td>
<td>Alone</td>
<td>Yes</td>
</tr>
<tr>
<td>P14</td>
<td>2</td>
<td>M</td>
<td>Cardiac and chest problems</td>
<td>No</td>
<td>Not known</td>
<td>Wife</td>
<td>No</td>
</tr>
<tr>
<td>P15</td>
<td>2</td>
<td>F</td>
<td>Diabetes, breathlessness, anxiety</td>
<td>No</td>
<td>Yes</td>
<td>Alone</td>
<td>No</td>
</tr>
<tr>
<td>P16</td>
<td>2</td>
<td>M</td>
<td>Diabetes, COPD</td>
<td>No</td>
<td>Not known</td>
<td>Wife</td>
<td>No</td>
</tr>
</tbody>
</table>

5.2 Context of the case study sites

Each case study site was a primary care trust (PCT) located within one strategic health authority in the north of England. Data collection for the study was conducted between 2006 and 2008, a time of significant organisational change in the NHS in England, as discussed in section 1.4. This included a reduction in the number of strategic health authorities (DH
There was also a change in function, with many responsibilities previously held by the strategic health authorities being devolved to PCTs. During the period of the study the strategic health authority in which the case study sites were located was dissolved and a significantly larger strategic health authority came into effect.

PCTs were also reduced in numbers and reconfigured (DH, 2005c). This directly affected case study sites two and three, where both organisations were being amalgamated with other PCTs. Therefore in these two case study sites there was uncertainty and subsequent changes for senior management and directors of each organisation. This disrupted the line management of the community matrons and case management services. In addition, all PCTs were required to separate their commissioner and provider functions. Again, there were changes in senior management and director accountabilities in all case study sites which affected the services’ line management. Each case study site was exploring its strategic approach to the possibility that provider services could become independent organisations in the long term, with the potential to be in competition with other service providers to maintain their service contracts in the future. Practitioners, then, were working in a time of uncertainty, great disruption and a feeling of increasing scrutiny of their practice which had not been experienced before.

Local general practitioners were increasing involvement and control of commissioning decisions of the PCTs, as described in section 1.4. As a consequence, the nature of relationships between senior managers of the PCTs and general practitioners were changing, as were the relationships between practitioners such as community matrons and general practitioners. Such changes were impacting on all three case study sites at the time of data collection.

At the time of the study the strategic health authority was developing an advanced practitioner and assistant practitioner programme in partnership with local higher education institutions as part of its workforce development strategy, as seen in its evaluation documents (DOC EVAL/SHA; see Table 19 for details of coding).

The programme was applicable to acute, community and specialist services, and across nursing and allied health professions, as described in the course handbook (DOC AP/HEI). With the advent of community matrons, this programme was used to develop practitioners in these roles across the health authority, and was used in all three case study sites. The attributes of the three case study sites are summarised in Table 18 and are described below.
The data sources were census data, the General Household Survey and mortality data from the Office for National Statistics (ONS), the English Indices of Deprivation 2004 from the Office of the Deputy Prime Minister (ODPM) (2007), Quality and Outcomes Framework (QOF) data (2005/06) from the NHS Information Centre for Health and Social Care, Local Authorities Classifications from the Department for Environment, Food and Rural Affairs (DEFRA) (RERC, 2005) and PCT annual reports (2005/2006), as indicated on Table 18. In some instances the data source has not been fully referenced in order to preserve the anonymity of the case study sites.

Table 18: Attributes of case study sites

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Case Study Site One</th>
<th>Case Study Site Two</th>
<th>Case Study Site Three</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (PCT annual reports 2005/6)</td>
<td>215,000-220,000</td>
<td>115,000-120,000</td>
<td>160,000</td>
<td>-</td>
</tr>
<tr>
<td>Area</td>
<td>Urban &amp; rural</td>
<td>Outer city</td>
<td>Inner city</td>
<td>-</td>
</tr>
<tr>
<td>Black and minority ethnic population (PCT annual reports 2005/6; 2001 census)</td>
<td>17.7%</td>
<td>14.1%</td>
<td>22% (over 50% in 2 wards)</td>
<td>8%</td>
</tr>
<tr>
<td>Ranked within 50 most deprived areas of England in 2004 (ODPM 2007)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>-</td>
</tr>
<tr>
<td>No. of Super Output Areas (SOAs)</td>
<td>143</td>
<td>68</td>
<td>65</td>
<td>-</td>
</tr>
<tr>
<td>% of SOAs in PCT in 20% most deprived SOAs of England in 2004 (ODPM 2007)</td>
<td>36%</td>
<td>87.2%</td>
<td>72.2%</td>
<td>-</td>
</tr>
<tr>
<td>Standardised mortality ratios: all ages all causes in relation to national average (ONS 2005)</td>
<td>18% higher</td>
<td>30% higher</td>
<td>24% higher</td>
<td>-</td>
</tr>
<tr>
<td>Disease prevalence</td>
<td>Hypertension</td>
<td>Coronary heart disease</td>
<td>Stroke</td>
<td>COPD</td>
</tr>
<tr>
<td>(QOF data, 2006)</td>
<td>11.2%</td>
<td>3.8%</td>
<td>1.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td></td>
<td>10.5%</td>
<td>4.0%</td>
<td>1.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td></td>
<td>8.5%</td>
<td>2.5%</td>
<td>1.0%</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td>12.0%</td>
<td>3.6%</td>
<td>1.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td>People describing themselves as living with limiting long term illness</td>
<td>20.3%</td>
<td>25.3%</td>
<td>19.1%</td>
<td>19%</td>
</tr>
<tr>
<td>People describing their health as not good (Census 2001)</td>
<td>11%</td>
<td>15.1%</td>
<td>11.1%</td>
<td>14%</td>
</tr>
<tr>
<td>General practices</td>
<td>47</td>
<td>35</td>
<td>41</td>
<td>-</td>
</tr>
<tr>
<td>Of which Single handed (PCT annual reports 2005/6)</td>
<td>18</td>
<td>4</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>PCT Budget (millions)</td>
<td>302</td>
<td>260</td>
<td>282</td>
<td>-</td>
</tr>
<tr>
<td>Hospital services</td>
<td>157</td>
<td>171</td>
<td>182</td>
<td>-</td>
</tr>
<tr>
<td>Primary and community care (PCT annual reports 2005/6)</td>
<td>68</td>
<td>57</td>
<td>58</td>
<td>-</td>
</tr>
</tbody>
</table>
5.3 Case study site one

Case study site one was located in an urban area but also incorporated some of the surrounding rural populations, with 8.4% of the total population located in a rural area (Rural Evidence Research Centre (RERC) 2005). This site was larger than case study sites two and three, serving a population of 215,000-220,000, which was continuing to grow (PCT Annual Report, 2005/6). The age groups that were increasing in both size and proportion were those aged 25 to 34 years and over 50 years. The numbers of those aged 10 to 24 years and 35 to 49 years were decreasing in proportion. Compared to the national average, the area had proportionately more people aged 15 and under and proportionately fewer people aged 65 years and over (2001 census, ONS).

Around 17-18% of the population were from black and minority ethnic populations compared with a British average of 8% (2001 census, ONS). The largest proportions of the black and minority ethnic populations were Pakistani and Bangladeshi, both groups being a higher proportion than the national average (2001 census, ONS). The black and minority ethnic population was increasing in size, particularly in the under fifteen year old age group.

Overall the area was ranked within the fifty most deprived areas in England in relation to the Index of Multiple Deprivation (ODPM 2007), as were case study sites two and three. The index draws on seven domains of deprivation, which include deprivation in relation to income, employment, education and skills, health and disability, living environment, barriers to housing and services, and crime. These are measured for ‘Super Output Areas’ (SOA), which are small geographical areas of approximately equal population size (the mean SOA population was 1500 for the 2001 census, but population numbers were higher in case study sites two and three). However this severe level of deprivation was not spread across the whole case study site; of the 143 SOAs within case study site one, 36% were ranked within the 20% most deprived SOAs in England in 2004 (ODPM 2007). This differed from case study sites two and three where the level of deprivation was much more widespread.

The population had high mortality rates with the standardised mortality ratio being 18% higher than the national average (ONS, 2005), although this was lower than in case study sites two and three. The most prevalent long term conditions affecting the population were chronic heart disease (with around 11% of practice populations also having hypertension), respiratory disease including asthma and chronic obstructive pulmonary disease (COPD), and diabetes (QOF data, 2006). The prevalence of all long term conditions listed was equal to or higher than the national average. The General Household Survey 2001 (ONS 2002) showed that
20.3% of the population considered themselves to have a limiting long term illness, compared to 19% nationally. In case study site one the percentage who considered themselves to have a limiting long term illness was lower than case study site two but higher than case study site three.

As the largest of the three case study sites, site one had the largest budget for health care, at around £300 million (PCT Annual Report, 2005/6). Of this budget, around 60% was allocated to hospital and specialist services, slightly less than case study sites two and three. Around 22% was spent on primary and community health services, which was similar to case study site two and slightly more than case study site three. The population was served by a local general hospital but also accessed specialist services out of the area. The PCT provided a range of community health care, which included district nursing, active case management, transfer of care, continence services, health visiting, school nursing, community paediatrics, child protection, adult and children’s learning disabilities, speech and language therapy, occupational therapy, podiatry, audiology, and community dental services (PCT Annual Report 2005/6). There were 47 general practices within the area; eighteen of these were single handed practices (PCT Annual Report 2005/6) which were a much higher proportion than in case study sites two and three.

The active case management team comprised a team of eight community matrons who were based together in one office within a health centre. The team was supported by one part time administrative post. The team structure is depicted in Figure 4. Five of the eight community matrons were undertaking the advanced practitioner course at a local university. One community matron qualified as an independent non medical prescriber towards the end of data collection in the case study site, but was not undertaking the advanced practitioner programme. Two community matrons who were undertaking the advanced practitioner course indicated that they were supplementary prescribers from their previous roles as a district nurse and health visitor. Of the community matrons, four had district nursing qualifications, two had been health visitors, but working with older people. One had a background in practice nursing and one in rehabilitation. The service had been operating for less than six months at the start of the study, following a pilot the previous year.

5.4 Case study site two
Case study site two was within a city, serving a population of 115,000 – 120,000 (2001 census, ONS) across part of the inner city and mainly the outer areas of the city. This was slightly smaller than case study site three and was the smallest of the three sites. The area
had proportionately more people aged 15 and under and proportionately fewer people aged 65 years and over, compared to the national average (2001 census, ONS), as seen in case study site one.

Figure 4: Clinical structures of community matron teams

Around 14-15% of the population were from black and minority ethnic populations (2001 census, ONS), which was less than in case study sites one and three. The Pakistani population was the largest black and minority ethnic group, and the proportion of people from this group was much higher than the national and regional average (2001 census, ONS). Like case study sites one and three, the black and minority ethnic populations were increasing.
As seen in case study site one, the area was ranked within the 50 most deprived areas of England in 2004 (ODPM 2007). However unlike case study site one, deprivation was more widespread throughout case study site two, with 87.2% of its SOAs being ranked in the 20% of the most deprived areas in England (ODPM 2007). Deprivation was also distributed over more SOAs in this site than in case study site three.

The population experienced the highest mortality rates of the three case study sites, its standardised mortality ratio being 30% above the national average in 2005 (ONS, 2005). As in case study site one, the most prevalent long term conditions affecting the population were chronic heart disease (with around 10% of practice populations also having hypertension), respiratory disease including asthma and chronic obstructive pulmonary disease (COPD), and diabetes (QOF data, 2006). However the prevalence of COPD at 2.3% was much higher in this population than the other two case study sites, and the national average of 1.4% (QOF data 2006). The 2001 census showed that 25.3% of the population considered themselves to have a limiting long term illness, compared to 19% nationally. Case study site two had the highest proportion of people with a limiting long term condition when compared across the three case study sites. Also case study site two had the highest percentage of people who described their health as not good, which was higher than the national average. In case study sites one and three the percentage was lower than the national average.

As the smallest of the three case study sites, site two had the smallest budget for health care, at around £250-260 million (PCT Annual Report 2005/6). Of this, nearly 70% was allocated to hospital and specialist services, the highest percentage of the three case study sites. The population was served by a local hospital and also accessed services from a large hospital in the inner city which provided specialist services regionally. Around 22% of the PCT allocations were spent on primary and community health services. As in case study sites one and three, the PCT provided a similar range of community health services (PCT Annual Report 2005/6). There were 35 general practices, of which only four were single handed practices (PCT Annual Report 2005/6). This was a significantly lower proportion of single handed practices than seen in the other two case study sites.

The active case management team comprised two community matrons and seven active case managers, supported by a case finder and administrative support. The team structure is depicted in Figure 4. The service had been operating for two years. Both community matrons had recently qualified as advanced practitioners and were independent non medical prescribers. Both community matrons were from a district nursing background. The active
case managers had previous experience in district nursing and general nursing. Members of the team were located in different health centres and clinics across the case study site, in order to be located with district nursing teams and GPs with whom they worked.

5.5 Case study site three
Case study site three was located in an inner city, with a population of around 160,000 (PCT Annual Report 2005/6). The greatest proportion of the population was people of working age, which was higher than the national average, unlike case study sites one and two. The proportion of retired age people was 12.5%, which was much lower than the other two case study sites (2001 census, ONS) and the national average of 18.3%.

Around 22% of the total case study site’s population were from black and minority ethnic populations (PCT Public Health Annual Report 2006), which was greater than the other two case study sites. In two of the wards over 50% of the population were from these groups. Whilst people from Pakistani heritage were the largest section of the black and minority ethnic populations, other groups were more diverse than seen in the other two case study sites, incorporating larger proportions of people from Caribbean, African and Irish populations (2001 census, ONS).

As in all the case study sites, the area was ranked within the 50 most deprived areas of England in 2004 (ODPM 2007). Deprivation was widespread throughout case study site three with 72.2% of its SOAs being ranked in the 20% of the most deprived areas in England (ODPM 2007), which was much greater than in case study site one but less than in case study site two.

Mortality rates in case study site three were higher than case study site one but less than case study site two; in 2005 the standardised mortality ratios were around 24% higher than the national average (ONS, 2005). The prevalence of long term conditions affecting the population showed a different pattern to case study sites one and two; there were fewer people with chronic heart disease (and the prevalence of hypertension also being lower at 8.5%) and COPD. However asthma and diabetes were at similar levels to case study sites one and two (QOF data 2006). Here there were the least number of people reporting that they had a limiting long term illness, at around 19%, matching the national average (Census 2001). Around 11% of people described their health as not good, which matched case study site one and was less than the national average (2001 census).
The PCT had a budget for health care of around £280 million (PCT Annual Report 2005/6), of which around 65% was spent on hospital and specialist services. This proportion of spend was midway between the allocation in case study sites one and two. The population’s local hospital was also a regional centre for many specialities and so treated patients from a wider geographical area. The PCT spent around 21% of its budget on primary and community health services (PCT Annual Report 2005/6), slightly less than the other two case study sites. It provided a range of local primary care and community health services including district nursing, health visiting, physiotherapy, and podiatry. The PCT also provided some services for its population and for neighbouring populations, which included audiology, orthoptics, speech and language therapy, children’s services, dental services, sexual health services, learning disabilities services and link worker services. There were 41 general practices, of which eight were single handed (PCT Annual Report 2005/6).

The population was served by four active case management teams each comprising a community matron, two active case managers, and an assistant practitioner. Each team received administrative support. The team structure is depicted in Figure 4. The service had been operating for over two years. Two teams participated in the study; one of the community matrons had recently started the advanced practitioner course having been in post for less than six months. The active case managers in this team had also been in post less than a year. In contrast, the second community matron had been in the role for over two years since the inception of the service. This individual had qualified and had been practising as an advanced practitioner for at least six months. The active case managers working with this community matron had also been in post for over two years. Case study site three was the only site where one of the participating active case managers came from an allied health profession rather than nursing. The three active case managers who were nurses had all previously been working in hospitals with experience in respiratory care, renal nursing and rehabilitation respectively. Both community matrons had been district nurses. Both teams were located in health centres; the first had recently transferred to a new building and was co-located with colleagues such as district nurses.

5.6 Approach to presentation of findings

Findings are drawn from multiple sources, consistent with case study methodology (Yin, 2003). Data sources were documentary material, observation, interviews, participant diaries, discussions and a focus group. Types of data sources have been coded to identify the source of data. The list of coding for data sources can be seen in Table 19. These notations have
been used in the presentation of findings in Chapters Six to Nine, and explained further below.

Table 19: Data sources and coding

<table>
<thead>
<tr>
<th>Data source</th>
<th>Data</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
<td>Meeting</td>
<td>OBS MT</td>
</tr>
<tr>
<td></td>
<td>Patient visit</td>
<td>OBS PV</td>
</tr>
<tr>
<td></td>
<td>Case finding in hospital</td>
<td>OBS CF</td>
</tr>
<tr>
<td></td>
<td>Indirect care</td>
<td>OBS IC</td>
</tr>
<tr>
<td>Interview</td>
<td>Community matron</td>
<td>CM</td>
</tr>
<tr>
<td></td>
<td>Active case manager</td>
<td>ACM</td>
</tr>
<tr>
<td></td>
<td>Patient</td>
<td>P</td>
</tr>
<tr>
<td></td>
<td>District nurse</td>
<td>DN</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
<td>SW</td>
</tr>
<tr>
<td></td>
<td>GP</td>
<td>GP</td>
</tr>
<tr>
<td></td>
<td>Senior manager</td>
<td>SM</td>
</tr>
<tr>
<td>Focus group</td>
<td>Active case managers</td>
<td>FG ACM</td>
</tr>
<tr>
<td>Formal</td>
<td>PCT Annual report</td>
<td>DOC AR</td>
</tr>
<tr>
<td>documents</td>
<td>Evaluation report on the implementation and impact of Advanced practitioners in the SHA 2006</td>
<td>DOC EVAL/SHA</td>
</tr>
<tr>
<td></td>
<td>MSc Advanced practice programme handbook (Higher Education Institute)</td>
<td>DOC AP/HEI</td>
</tr>
<tr>
<td></td>
<td>PCT strategy/project plan/development paper for long term conditions</td>
<td>DOC STRAT</td>
</tr>
<tr>
<td></td>
<td>PCT operational policy/protocols/governance frameworks</td>
<td>DOC POL</td>
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<tr>
<td></td>
<td>Minutes of meetings</td>
<td>DOC MIN</td>
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<tr>
<td></td>
<td>Progress reports/updates</td>
<td>DOC UP</td>
</tr>
<tr>
<td></td>
<td>Performance reports</td>
<td>DOC PR</td>
</tr>
<tr>
<td></td>
<td>Information pack</td>
<td>DOC INFO</td>
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<tr>
<td></td>
<td>Presentations</td>
<td>DOC PRES</td>
</tr>
<tr>
<td></td>
<td>Job description</td>
<td>DOC JD</td>
</tr>
<tr>
<td>Informal</td>
<td>Reflective diaries of community matrons</td>
<td>DIA CM</td>
</tr>
<tr>
<td>documents</td>
<td>Press articles and statements</td>
<td>DIA PR</td>
</tr>
<tr>
<td>Archival</td>
<td>Unique Care Calculator</td>
<td>ARC UCC</td>
</tr>
<tr>
<td>records</td>
<td>Referral proforma</td>
<td>ARC FORM</td>
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<tr>
<td></td>
<td>Questionnaire</td>
<td>ARC Q</td>
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<td></td>
<td>Performance data</td>
<td>ARC PD</td>
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<tr>
<td></td>
<td>Clinical audit</td>
<td>ARC AUD</td>
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<tr>
<td></td>
<td>Anonymised patient lists</td>
<td>ARC PL</td>
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<tr>
<td></td>
<td>Performance Indicators</td>
<td>ARC KPI</td>
</tr>
<tr>
<td></td>
<td>Caseloads and patient dependency categories</td>
<td>ARC CL</td>
</tr>
</tbody>
</table>

Findings are reported by denoting the data source and the case study site, for example CM11/site 3 would denote data taken from an interview with the community matron referenced as CM11 in case study site three. In some instances the data source is from the strategic health authority (SHA) or a Higher Education Institution (HEI), and this is denoted using the respective initials. Care has been taken to use illustrative quotes from participants.
across the three case study sites; however some participants expressed views more clearly, or expressed more on a particular topic.

Organisational documents such as annual reports have been used in particular to support the context of the study; however, whilst the type of data has been stated, in some instances the data source has not been fully referenced within the findings in order to preserve the anonymity of the case study sites.

During analysis interview data emerged as the richest data source, particularly in relation to interpersonal themes such as relationships, which is shown in the predominance of interview data presented in this theme.

5.7 Summary
This chapter described the context of the case study. Community matrons across all case study sites were female, with the exception of one. Eight of the twelve community matrons were from a district nursing background. Of the three case study sites, case study site one served a larger population, in an urban and rural area. Case study site two was located in an outer city and case study site three was an inner city area. In all case study sites the black and minority ethnic population was larger than the national average, in particular in case study site three. Whilst all case study sites were within the 50 most deprived areas of England (ODPM 2007), case study sites two and three were particularly affected by high levels of deprivation. The population of case study site two experienced higher than the national average mortality ratios and higher prevalence of long term conditions.

Case study site one was characterised by a much higher proportion of single handed GP practices. The community matron teams differed in each case study site too; in case study site one the team comprised eight community matrons, with administrative support, whereas case study site two was served by two community matrons with a team of seven active case managers, a case finder and administrative support. Case study site three also had community matrons and active case managers, but they were configured into four teams, each team led by one community matron with two or three active case managers, supported by an assistant practitioner and administrative support. Case study site one had been operating for the shortest amount of time at under six months at the start of data collection, whilst case study site three had been established for over two years.
The findings of the study are presented in the following chapters, six to nine. Data has been annotated to indicate its source, and the findings are presented in four key themes that emerged from the data, namely the service model, role function, key relationships, and the effectiveness and outcomes of the community matron role.
CHAPTER 6: SERVICE MODEL

This chapter is the first of the findings chapters presenting the first of four key themes that emerged from the data, that of the service model. Key data sources informing the findings in this chapter were organisational documents, interviews and observations.

The last chapter highlighted the different service structures in the case study sites; this is explored further here, by looking at the local service models that have developed in comparison with the national policy. Despite the national model in England for the management of long term conditions (DH 2005e), findings in this study showed marked variance in its application to local models in each case study site. The chapter then presents findings about how the different organisational approaches to service structure, eligibility criteria and case loads was reported to have impacted on professional practice of community matrons.

The findings showed that organisational approaches raised questions amongst community matrons and active case managers about exercising individual decision making in practice. This chapter presents data that indicates that community matrons flexed organisational policy to fit their professional agenda.

Themes about local service models were also linked to role function, which is explored further in Chapter Seven.

6.1 Influence of national policy on local service models

Despite the significant promotion of the Evercare model nationally, as discussed in section 2.3.1, it was not referred to by participants or in organisational documents in any of the case study sites, in relation to local service models. Reference was made by participants to Unique Care as a service model, but this was restricted to case study site one. For example, one community matron said of the local model "...it was all linked to Unique Care" (CM04/site 1).

The Unique Care model had been promoted by the strategic health authority, as seen in its progress notes for the long term conditions work programme (DOC MIN 1/SHA). In case study site one the organisation’s strategy for long term conditions (DOC STRAT 1/site 1) described the development of the community matron role within the Unique Care Model.

Two community matrons (CM01/CM07/site 1) in case study site one were observed making reference to Unique Care when explaining the service to social workers (OBS MT1/site 1) and
to GPs (OBS MT2/site 1). During a presentation CM01/site 1 described how Unique Care had been developed from the Evercare model, adapting it to the British health care system. Both community matrons used the reference to introduce the Unique Care calculator (ARC UCC/site 1) which was an assessment tool to determine the patient's level of risk of hospitalisation, as the way in which the service identified patients with complex needs. However both indicated that the calculator was used for reference only and that professional judgement would take precedence, CM01/site 1 referring to "common sense" and CM07/site 1 using the term "gut feeling". So whilst the community matrons recognised and referred to the Unique Care model, it did not appear to have directed their professional practice; rather they had fitted the aspects of the model around their practice.

In case study sites two and thee, community matrons and active case managers referred to the Castlefield Project (which developed the Unique Care model) in relation to the assessment tool used (ARC UCC/site 2). They too indicated its limitations in that the score would not necessarily reflect a patient’s needs and complexity of their condition (CM09/site 2; ACM09/site 3; ACM10/site 3). For example:

"... we do use the Castlefield but its also done on clinical judgement as well... You can have a Castlefield score of 10 but be seriously ill and have lots of problems, and you could have a Castlefield score of 22 but be absolutely great, but then you need to go and meet the patients as well... With Castlefield it’s supposed to be anyone with 20 and above are supposed to be at risk of rehospitalisation, a high risk user, but doesn't always ring true..." (ACM09/site 3)

So in all case study sites, community matrons and active case managers knew about the Unique Care tool but did not have confidence in its accuracy (CM01/site 1; CM07/site 1; CM09/site 2; ACM09/site 3; ACM10/site 3). In case study site thee an organisational audit of the active case management patient records found that only 17% had recorded the score from the Castlefield questionnaire (DOC PR1/site 3), which suggested that the tool was not as widely used in practice. Instead they had overridden the results from the tool to use their professional judgement in determining patient need (CM09/site 2; ACM09/site 3; ACM10/site 3). This suggests they felt bound to use the tool despite not seeing it as trustworthy on which to base professional decisions.

The Evercare model was not referred to by most of the community matrons across all case study sites, although aspects of the community matron role was aligned with the role functions of the Evercare nurse, as described in section 2.5.1. Evercare was mentioned by one community matron (CM08/site 1) in relation to how the community matron role differs from Evercare in fitting into the existing health care model:
“...in America, with the Evercare model, basically there weren’t really any real roles like that, within the community, so they’ve brought it in and it was wonderful, but we’ve been kind of put in the middle, and I’m sure this has happened in other trusts... there’s already lots and lots of people doing these roles, and it’s almost like, just put another one in the middle...” (CM08/site 1)

The issues of boundaries are discussed further in Chapter Seven about role function and Chapter Eight about relationships.

So reference to the underpinning models of Evercare and Unique Care focused on their use as assessment tools to access the service, rather than the service model and its ethos per se. As such there was a disconnection between the national service models and the local development and interpretation in practice. Whilst the national models were acknowledged, by some, individual practitioners determined their own approach to practice (CM01/site 1; CM07/site 1; CM09/site 2; ACM09/site 3; ACM10/site 3). This was more evident in the issues arising about professional judgement about people’s eligibility to receive the service. This is explored further in sections 6.3, 6.4 and 6.5 about eligibility criteria, ‘active and inactive’ terminology, and visiting schedules.

6.2 Local organisational structures and service delivery
The service structure in each case study site was different, implementing different skill mixes of staff. In case study site one, where the service structure comprised eight community matrons and a part time administrator, all community matrons had their own caseloads. Within each caseload, patients varied in their level of clinical need and dependency. This presented a very flat structure, unlike case study sites two and three where the teams, led by the community matron, had active case managers and an assistant practitioner. Case study site two also had a case finder to support the team. The structures are depicted in Figure 4 on page 94.

The community matron team in case study site one was set up when the national policy in England and organisational targets for community matrons were first announced in 2005, as evidenced in the PCT’s strategy for long term conditions (DOC STRAT 1/site 1). There was reference to the introduction of an assistant practitioner role, but not identified in relation to the community matron (DOC STRAT 1/site 1). The assistant practitioner role was not in place at the time of data collection in case study site one. However data collection in case study sites two and three started later in 2006 to 2007, after the initial policy was amended to allow organisations to include case managers as part of meeting their targets (DH 2004a; DOC
The introduction of case managers was reflected in the structures of the services in case study sites two and three.

There were no indications in organisational documents in case study site one (DOC STRAT/site 1) that there would be a change to the service structure once those community matrons undertaking the advanced practitioner course had qualified. Here all community matrons would continue to manage a caseload spanning highly dependency to low complexity needs of patients, although there were expectations that the assistant practitioner role would be introduced (CM04/site 1; CM08/site 1). However one of the community matrons in case study site one described how her expectations had been more akin to the structures used in case study sites two and three. This had not been realised within her team and she described the problems this brought in managing caseloads:

"... I read around a lot about it, and the community matrons, the idea came from the government was that they would manage the level 3 of the tier, so they were really small, I think it was 3 or 5 per cent of the population with the complex needs and then there would be a cascading effect where they would be passed down to whatever you call them... case managers... as they become more stable and things, erm, and I presumed that would be how we would run...... when we actually set up the team...I did kind of voice my concerns really, after working in case management, and seeing how dependent these patients can be, that to actually go out to all those patients, we could be really inundated with, as that’s almost I’d say up to 70% of the over 65s are like that… so… it has kind of turned out like that, we kind of realised that …" (CM08/site 1)

So in case study site one, the community matrons anticipated problems of demand management being generated by their service structure. In relation to this, the team identified the difficulty in not having any step down arrangements or delegation because of their current service structure. For example:

"...the problem is that a lot of the issues are around capacity really, and as our caseloads increase, we don’t have that outlet yet to pass them on to other people really, to maintain them so we’re trying to do everything at the moment. So of the issues that are brought, it’s difficult to do anything about them really.” (CM01/site 1)

Whilst the team in case study site one was not anticipating a move to the structures seen in case study site two or three, there were plans to introduce the role of the assistant practitioner into the team albeit not in the immediate future. This was reflected in the organisation’s strategy document for long term conditions (DOC STRAT1/site 1) and reflected in comments by the community matrons. For example:

“So they only see us, and I will go back and do blood pressure checks, whereas if we had a trainee assistant practitioner they could go... which we are going to do eventually, so I don’t feel its not part of our job, at the moment we need to do it, we need to do these things because we’re monitoring that patient.” (CM04/site 1)
So community matrons in case study site one appeared to be practising in a transitional phase, anticipating working in a different way which they believed would be more effective and utilise their skills. However they were yet to experience working in the new structure. Community matrons and active case managers in case study sites two and three had been working in a structure that facilitated delegation. The benefit of having an assistant practitioner was described by an active case manager in case study site three:

“Our assistant practitioner works very well, ours has a caseload already, of low patients that just can’t be inactivated easily and she’ll help me with some of my patients that don’t speak English so I can go just once a month.” (ACM08/site 3)

In all case study sites the teams highlighted the importance of administrative support one day a week which included maintaining the database, letters, orders, and processing new referrals (OBS MT5/site 3).

Case study site two had a distinct post of case finder; this post was a support role that reviewed hospital discharge summaries and GP records using a case finding tool in order to identify potential candidates for the community matron service. It was introduced to reduce the administrative work of clinical team members (DOC STRAT 3/site 2). In case study site one the case finding function had been undertaken by the community matrons, and by the community matrons and active case managers in case study site three (as described in Chapter Eight).

So there were different service structures in each of the case study sites, from a flat structure in case study site one comprising community matrons working with similar cohorts of patients on their caseloads, case study site two with two community matrons overseeing a team of active case managers supported by a case finder, to case study site three where four community matrons were each supported by two or three active case managers and an assistant practitioner. This resulted in different problems and issues in each case study site. In case study site one there were concerns about demand management, which is discussed further in relation to eligibility criteria. In case study sites two and three, concerns focused on patient flow in a tiered structure, and the impact of this on individual clinical competence: this is discussed in Chapter Seven in relation to role function.

All case study sites had been practising in a transitional phase towards the final service model; case study site three was closest to this being realised. Practitioners remained unsure of how the structure would impact on how they practised, so the structure was affecting their role. This is explored further in Chapter Seven.
6.3 Eligibility criteria

Each case study site had set criteria that would determine whether a patient was eligible to receive the community matron service (DOC INFO1/site 1; DOC STRAT2/site 2; DOC POL1/site 3). Such eligibility criteria emerged as one of the key themes in relation to the service model, as it affected how the service would develop and also how demand could be managed. As services were being established, it was an important theme for many participants in all case study sites.

Criteria were presented either as those used for case finding or for referral to a community matron and included long term conditions, age, hospital admissions, as cited in service information or operational policies (DOC INFO1/site 1; DOC STRAT2/site 2; DOC POL1/site 3). These are outlined in Table 20. The criteria listed for case study sites one and three were minimum requirements whilst in case study site two individuals would be over 65 years and present with a selection from the criteria listed.

Table 20: Eligibility criteria for the community matron service

<table>
<thead>
<tr>
<th>Case Study Site One</th>
<th>Case Study Site Two</th>
<th>Case Study Site Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 65 years old</td>
<td>Over 65 years old</td>
<td>Over 50 years old</td>
</tr>
<tr>
<td>One long term condition</td>
<td>2 or more long term conditions</td>
<td>2 or more emergency admissions in past 12 months</td>
</tr>
<tr>
<td>Have had or at risk of an acute medical hospital admission</td>
<td>2 or more non elective admissions in past 12 months</td>
<td>Registered with GP within site</td>
</tr>
<tr>
<td></td>
<td>4 or more medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 3 home visits in last 3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In top 3% of frequent visitors to GP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>More than 2 out-patient appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Carers in crisis or no formal carer</td>
<td></td>
</tr>
</tbody>
</table>

As can be seen, the thresholds for criteria varied between case study sites; case study site one had a lower threshold in relation to hospital admissions and long term conditions, whilst case study site three had a much lower age threshold. The age threshold in case study site three reflected the different demographic proportions of the population, as it had a lower
proportion of residents in the over 65 year old age group in comparison to the other two case study sites.

Only case study site three specified registration with a GP in the area, however it was implicit in documents for case study sites one and two (DOC INFO1/site 1; DOC STRAT2/site 2; DOC POL1/site 3). The specification in case study site three may reflect its location in an inner city and the hospitals in case study site three that provided health care to individuals from outside the area.

Case study site three also had a prioritisation list supporting the criteria, which was based on high usage of services. These indicators were similar types of measures as used by case study site two in relation to hospital and GP attendance, but were quantified differently and with higher thresholds. For example, prioritisation in case study site three included two or more accident and emergency attendances in the past year, ten or more GP visits or practice appointments in the past year, hospital stays totalling to more than four weeks in a year, four or more active long term conditions, and requiring more than 15 hours of home care a week (DOC POL1/site 3).

Variance between case study sites suggests that the setting of criteria has been pragmatic and formed on local experience, rather than being directed by clear guidance or policy. During interviews and observations, the issues relating to eligibility criteria and ways in which they were applied in practice emerged. This is explored in section 6.3.1, in relation to selected criteria.

6.3.1 Reducing thresholds to access - age criterion
In general, the age criterion that had been set was applied in all case study sites but was being questioned as the service developed. For example, in case study site one the community matrons had begun the debate whether the age criterion should be reduced and were in some instances waiving it:

“... the role’s evolving…you know the community matron didn’t just go in and say, right, these are our strict criteria, this is strictly how we’re going to work, and we’re not going to deviate from this path at all...what we’ve always said is our criteria is over 65, long term conditions, send us anybody and we’ll work out whether they’re appropriate, and if they’re not appropriate we’ll signpost them to the appropriate person, so it very, erm, it was a huge criteria really, and that criteria remains, because, you know, even now we get younger people, late 50s early 60s, people say I know this isn’t for you but where do I go?...and that’s something we want to look at in the future…” (CM02/site 1)
In case study site one it emerged from two of the community matrons (CM02/CM03/site 1) that the age threshold was also linked to funding sources, which did not appear to be the case in the other case study sites. One community matron stated:

“We’re asking to see younger people and it is off, as we have to say no at the moment, because the funding came from the NSF for older people so we have to be guided by that... we were just given the criteria when we came into post, that we would see over 65s with long term conditions, a lot of the work we were told from the NSF and that’s what we’ve been geared up to do really.” (CM 03/site 1)

So in this instance the age criterion stemmed from economic rationale rather than identification of need in the population. In case study site one there was variance in the way individuals presented the age criterion to potential referrers, which was not seen in case study sites two and three. For example, relaxation of the criterion was used when introducing the service to colleagues and as a way to increase referrals, as observed when a community matron (CM07/site 1) was presenting to a GP practice meeting (OBS MT2/site 1). During the presentation one of the GPs reminded the community matron that she had mentioned people over 65 years, to which she replied that they should ignore the 65 and over threshold, if someone has a long term condition because ‘it’s not right’.

However at a presentation to social workers, another community matron (CM01/site 1) was observed explaining referral criteria as people over 65 years old, due to caseloads and capacity (OBS MT1/site 1). A social worker asked about a proposal for working with people under 65 years as they knew of a pilot that was underway to work with people under 65 years. The community matron discussed the value of working with people under 65 years old and indicated that it was their vision for future due to its importance for prevention. The responses of the community matrons suggest that they found fixed criteria restrictive and counter to a more familiar needs assessment approach.

Such variance may reflect the short length of time the service had been in operation, as it was in its first six months in case study site one whereas it had been operating much longer in case study sites two and three. Also the latter case study sites were operating to lower age thresholds; in case study site three the threshold of 50 years and over was observed being applied by the community matron (CM11/site 3) during a case finding visit to the hospital (OBS CF2/site 3) and was also confirmed by an active case manager (ACM09/site 3):

“My job role is to look after people over 50 with chronic diseases, people with lots of long term health issues that may be have had multiple admissions to hospital, high service users with GPs, lots of medications...” (ACM09/site 3)
These applications matched the criteria set out in the organisational operational policy (DOC POL1 /site 3). Since the start of the service, case study site two had extended the age criterion from over 65 years to include any adult (18 and over), as reported by the active case managers during a focus group (FG ACM/site 2). This was also explained by one of the community matrons:

“... at one time it was said that we were only going to have over 65 years of age, and now that is not the case, now it is any adult with chronic diseases. Because when we did that, we eliminated a lot of younger people who were chronically disabled due to diabetes or Parkinsonism, or epileptic fits... so if you used the criteria of 65 you wouldn’t be picking those up...”  

(CM10/site 2)

Determining criteria after the service started was also reflected in case study site three by a district nurse:

“... It did come later, they developed a tool for how appropriate a patient was, it had to meet certain needs, and I think when it was first set up, that didn’t happen. So now obviously they’re going out and they have to fit the criteria before. And some patients really just don’t fit the criteria....”  

(DN04/site 3)

So in general age criterion was being applied but was being adapted in case study sites one and two to meet the local population need, which also reflected the lower age criterion set in case study site three from the outset. In case study site one the criterion was being waived informally by the community matrons but in case study site two the criterion had been changed formally through the organisation.

This suggests that where community matrons could not change criteria they worked around them. Where the community matrons had influence to change criteria in response to patient need and demand they were able to adapt the service to patient need.

6.3.2 Varying the thresholds – hospital admissions and number of long term conditions

Although community matrons wanted to reduce the threshold in relation to age there were concerns about the thresholds created by other criteria being too low. Case study site one had wider criteria than case study sites two and three in relation to number of hospital admissions and the number of long term conditions. As the service had developed and caseloads were increasing, several community matrons in case study site one identified difficulties in the criteria set, and that they were meaningless as a threshold (CM05/site 1; CM08/site 1). One stated:

“Our criteria is very broad, because we only have one long term condition and one hospital admission whereas other areas are going on multiple hospital admissions,
Community matrons in case study site one recognised the problems in trying to narrow the criteria in relation to hospital admissions once the service was in operation. One community matron stated:

"...one or more long term condition, and one or more acute medical admission to hospital in the past year, or, erm, at risk of going into hospital, but I think we’ve now said, at the last awayday we tweaked it... we said two or more acute medical admissions to hospital in the past year, but that’s very difficult to say, we started off running the way we are... Its very difficult to back down then, you’re better to start in a small way and open yourself up wider, but we’ve started off in a very wide way."

(CM08/site 1)

In a discussion about the community matron’s links with the medical assessment unit at the hospital (OBS MT/site 1), one of the community matrons (CM05/site 1) also expressed concern that one hospital admission was no longer appropriate or practical. Despite the criteria set, the community matron was using her own clinical judgement to prioritise referrals, which usually included two admissions, so narrowing the criteria. This community matron in case study site one, was informally applying prioritisation akin to the formal prioritisation list described in organisational policy in case study site three (DOC POL1/site 3), as described earlier.

Concerns about demand were specific to case study site one, as in case study sites two and three the community matrons and active case managers were applying their professional judgement to override the criteria, to effectively widen access rather than restrict it. This was reflected in observed visits to patients, where two community matrons from different case study sites did not consider that the patient they were visiting would meet the existing criteria; one (CM10/site 2) noted that the patient’s physical condition alone would not warrant community matron intervention but their anxiety levels increased their likelihood of hospital admission (OBS PV13/site 2). The second (CM11/site 3) anticipated that the patient would develop further needs in the future and felt there was opportunity to undertake a preventative role (OBS PV10/site 3).

This practice was explained by one of the community matrons, who indicated that the criteria were not applied in practice:

"...there’s no criteria, even though we’ve got this risk assessment tool, there is no actual criteria for the patients that we take... but we don’t use that, it’s just a general scoring system, it doesn’t really translate in practice that well...”

(CM11/site 3)
None of the community matrons portrayed their actions as ‘against the rules’ or suggested there would be any repercussions for working outside the criteria. Instead, part of rationale given for widening access was to meet government targets for caseload numbers. The community matron went on to say:

“At the moment to be honest we will just take pretty much anybody, we’re happy to have any referrals, because obviously we have targets which is totally fair, a lot of money has been invested in it and it’s hard to find patients. So we would get somebody and maybe take them on, and think so we will have them on the books, because they are obviously going to be ill at some point in the future and maybe we can do something with them now, health promotion or something like that.” (CM11/site 3)

This seemed to be contrary to the organisation’s guidance for building caseloads, which specified the three main criteria, and the prioritisation list based on high usage of services (DOC POL1/site 3), suggesting that numbers took precedent over true clinical need. However this could be more a reflection of the shorter period of time the community matron had been in post.

Eligibility criteria remained subject to further development as the service evolved, which would widen access further. However this was driven locally by patient need and learning about how the role of the community matron could be applied, rather than adhering to the initial guidelines set nationally. As with the age criterion, case study site two appeared to have taken a systematic approach to reviewing and developing the criteria. For example one of the community matrons said:

“... we are also looking at readmission to hospital rates but that is eliminating us from having referrals from GPs and other colleagues, so we added more to it [criteria]; ...It was only going through the process of it, even though we had this directive from central government and the papers saying we would look at poly-pharmacy, we would look young people, at this and that, ...we looked at it and we would decide which to choose to look at for criteria to take forward, ... now we’re going for cause of falls, stroke as well... and now we’re getting referrals from all quarters. In fact we are inundated with referrals at the moment....” (CM10/site 2)

So eligibility criteria were seen both as barriers for some of the population that would benefit from the service, but also as a way of containing demand. In all case study sites age was seen as an unfair arbiter for service access, maybe because age is not subject to interpretation in the way that a clinical condition can be. As such the practitioner was able to use professional judgement to interpret the remaining criteria in relation to clinical need and in doing so be flexible about access to the service. In case study site one, the community matrons were looking at increasing the threshold for criteria for hospital admissions and long
term conditions to manage demand for the service, whereas in case study sites two and three
the teams were widening the criteria to increase access. The drivers for this across all case
study sites appeared to be national targets for the numbers of patients being seen by
community matrons, and identification of need in the local population. However the impact on
demand was beginning to be seen in case study site two. Any changes in case study site
one appeared to be instigated within the team either informally or without organisational
challenge, with the exception of financial constraints. This contrasted with case study sites
two and three, where changes seemed to be organisationally driven or in partnership with the
community matrons but still within organisational frameworks.

6.4 New terminology in determining patient need: interpreting ‘active’ and ‘inactive’
caseloads
Participants across all case study sites referred to patients on the caseloads being ‘active’,
meaning those who are currently being seen by the service, and ‘inactive’ for those patients
who are on the caseload but not requiring intervention at that time. This appeared to be new
terminology that had been introduced into service models across all three case study sites, as
it was not found previously in the literature review or national policy documents (Singh and
Ham, 2006; DH, 2004a; DH, 2005e).

The distinction between ‘active’ and ‘inactive’ in itself posed difficulties for community
matrons: issues of interpreting and applying ‘active’ and ‘inactive’ to patients on the
caseloads was a common theme across all three case study sites, and related to how
caseloads were managed to meet targets and manage demand.

In all case study sites there was an expectation that caseloads would comprise active and
inactive cases. In case study site three it was specified that ‘active’ and ‘inactive’ should be
equal proportion of the caseload, and had been formally incorporated into the key
performance indicators for the service (DOC POL1/site 3). The target of 50 cases per
practitioner was consistent across the case study sites and was in line with the revised
English national policy which was reduced from between 50 and 80 (DH, 2005e) to 50
(Beasley, 2005). One active case manager described how caseloads were counted and how
the definition of active and inactive was linked to the visiting schedule:

“...we’ve got to get 50 patients on our caseload. Going along with that, we’ve got to
make half of those what we call inactive, which is patients that you’ve seen, we’re
suppose to see people, we take them on, we have 12 weeks to sort them out, to sort out
all the problems, their health needs. After 12 weeks we’re suppose to make them
inactive, where we then follow them up at 6 weeks, 3 months, 6 months, where they can
have a phone call or you can go round and make sure they are okay. That is extremely
difficult to do with long term patients. Trying to meet the targets of 50 onto your
caseload, trying to make them inactive as well, is extremely difficult... I’ve got 40 at the
moment... 16 of those are inactive, it’s getting a struggle, managing that amount of
patients...” (ACM09/site 3)

Variance emerged in what may be considered ‘active’ and ‘inactive’ in relation to the level of
intervention required. This was seen in case study site one in particular. This reflects the
flexibility given to individual community matrons in this case study site to determine their
visiting patterns, as different patterns were described by three of the community matrons in
case study site one:

“... because some of my actives I’ll phone once a month at the moment to see if
everything is okay and if they’re doing okay with their tablets or different things, so…
some other actives I see once a week at the moment... it depends how active your
actives are... you see somebody once a week for 4 weeks and then it can go to
telephone calls but then some of my telephone calls, they’re still active…” (CM04/site 1)

“...They’re not really inactive, we call them inactive, but they’re not really inactive... But,
but if you’re talking active that means daily or weekly contact, very regular contact...”
(CM02/site 1)

“But of the 20 active, I’d say that at least 14 or more are really active, I’d say I’m seeing,
and these are like hour visits a day, you know when you go, and there’s a lot of ongoing
work as well” (CM08/site 1)

So community matrons were identifying different levels of complexity and need within the
‘active’ group which was not captured by using the definitions ‘active’ and ‘inactive’ alone.
‘Inactive’ patients still required a level of intervention which added to the confusion about
differentiating between ‘active’ and ‘inactive’ patients, as highlighted predominantly by four
community matrons in case study site one, and one from case study site two (CM02; CM04;
CM06; CM08/site 1; CM10/site 2). The higher number in case study site one may reflect the
greater flexibility accorded to community matrons. Also the service in case study site one had
been operating for a shorter period of time at the time of the study, so community matrons
were still developing the systems and processes, and were encountering a rhetoric/ reality
mismatch. This extract from a community matron exemplifies how ‘inactive’ is implemented,
and the fact that the term is a misnomer:

“...what we say is inactive is somebody who we have done our maximum work with,
they are stable, maintaining a steady life, but we will probably give them a ring or they
will give us a ring, and then, we said we will try to give them a ring every 2 months, even
though they are inactive, a telephone call to see how things are, have things changed
e tcetera, have they continued with what they were supposed to be doing... its not just a
phone call... its an assessment process over the phone...” (CM10/site 2)
One community matron highlighted how the specific long term condition affects how the active/inactive status could be applied, and also suggested that the approach was influenced by the community matron’s previous experience. These factors were not specifically highlighted by other community matrons:

“... there seems to be common theme that the people who come from district nursing backgrounds tend to visit more and tend to be more actively involved in the patients whereas other people from different backgrounds are managing their patients in a different way... I tend to have more COPD patients than heart failure patients, and they're quite unwell patients really and they've got used regular contact, they will activate when they are not feeling very well. Other people tend to do more telephone contacts and making their patients inactive when they've sorted the problem out, whereas mine, I don't feel I can do that at the moment, some of them because they are quite poorly as so they activate and I'm visiting them a lot more when we've looked across the team.” (CM06/site 1)

Concern about professional responsibility to the ‘inactive’ caseload was also expressed by a community matron (CM08/site 1) and an active case manager (ACM11/site 3):

“Sometimes I feel really guilty because some of those patients I’m not really contacting over 2 or 3 weeks, even a phone call. I think, they are on my caseload, I should be finding out where they are, what they are doing, what's happening with them, and if they're stable... you feel responsible for them don’t you. And not everybody is going to have the confidence to pick the phone up to you straight away. I always say to some of them ‘why didn't you ring me?’ Something small, it can turn into something quite major in a couple of days, start with a chesty cough....” (ACM11/site 3)

So community matrons and active case managers from all case study sites were not comfortable with the categorisation as they did not feel it matched the reality of the patients’ needs. As such they continued to rely on their own professional judgement but felt conflict with the system with which they were expected to operate.

The concept of ‘active’ and ‘inactive’ cases was still being formed, as factors such as frequency and nature of intervention were being explored. This was more dominant in case study site one, where the infancy of the service would generate such debates. Also those practitioners who had been in post for a shorter period, such as those in case study site one and one of the community matrons in case study site three, might still have been developing their own understanding of their practice. However as an issue in all case study sites, the visiting schedule may have been the precipitating factor to bring the active/inactive debate to the fore, as discussed next in section 6.5.
6.5 Visiting schedules

The way in which community matrons organised care delivery through their visiting schedules was important to them as it reflected how they balanced individual patients’ needs with managing a caseload and meeting organisational expectations. As such it emerged as a key theme across all case study sites in relation to the service model.

The quotes above show how community matrons and active case managers linked the difficulties in adhering to a twelve week visiting schedule with the issues of how and when a patient could be considered ‘active’ and ‘inactive’. Further issues pertaining to the visiting schedule included the dependency of patients, predetermined visiting patterns and how patients could be discharged from the service.

The visiting schedules in all case study sites reflect a pattern of intensive visiting initially that decreases over time. This pattern was described by a patient in case study site two:

“So then I was in a month, and then I came out and then they sent somebody. They sent some lady...and that's when [active case manager] came on the scene... She was coming every week to see me, and I was having chemotherapy at the hospital. I was going once a week for chemotherapy, and then they put it to once a fortnight, and she’s still there, still coming... Yeah, but it has eased off a little bit now, but I still ring her if I need her. I still ring her...'ring me if you need me’... At the moment I think she’s due to come this month, but she’s been twice in between....” (P05/site 2)

In case study site one the visiting schedule was determined by the community matron for each patient depending on the needs they had, as described in earlier quotes in relation to the ‘active/inactive’ debate. This differed in case study sites two and three where community matrons were expected to manage their intervention within a twelve week plan in order to minimise dependency of patients on the service (SM01/site 2; ARC KPI 2/site 3).

The visiting schedule was developed with the community matrons in case study site two, as stated by the senior manager:

“...we also worked on things like what period of time, we tried to work it out from complicated cases they had been seeing, what is a good time you could realistically sort out a lot of these complex problems, and we worked on something around six to ten weeks you could probably get a lot of what you needed to do with patients and then you could slowly inactivate them, but we knew you couldn’t just do it suddenly, because we’d got that experience from district nursing.... so it was more of a step down of visits.” (SM01/site 2)

In case study site three the visiting schedule had been formalised into a twelve week plan in a PCT document (DOC POL1/site 3), where community matrons were required to report where
the twelve week management plan had not been achieved, as ‘exception reporting’. The exceptions were classified as hospital admission, exacerbation of long term condition, change or deterioration in social circumstances or cognitive problems affecting the patient’s ability to develop self care. Achievement of the twelve week management plan was also incorporated into the key performance indicators (ARC KPI 2/site 3).

The twelve week plan was working in some circumstances as described by an active case manager in case study site three:

"...but there are other patients where you’ve put everything in place and they are managing really well. We have an example of a fantastic 95 year old, she is 95 and she is looking after her 70 year old daughter who’s had a stroke. We’ve only had to put in 12 weeks of management with her and now all her needs are being met.... She knows she can pick up the phone to feel supported, she feels she can manage her long term condition and look after her daughter, both in their own home... it was a very short input with her. She only has 2 conditions so she is not really complex and at 95 she’s still quite mobile and independent... so it works for some people..."  (ACM11/site 3)

However there was dissatisfaction about the visiting schedule being imposed by the organisation in case study site three. Here concern about the twelve week schedule was expressed by all the active case managers and one of the community matrons. This was not evident in the other two case study sites. One active case manager felt that the twelve week schedule limited their individual autonomy and influence on the service development:

"We do have a say because in our job description on which they employed us it says you’ll be responsible for shaping the service... but actual policies are all management led... I wouldn’t say it’s a conflict I’d say I just have different idea as to what case management should be regarding long term conditions management.... certainly it wasn’t put at the job interview that we had 12 weeks to turnaround, everything was going to be rosy and they could all be inactive, but there’s none of that, it was you could shape the service and all that but it doesn’t seem to have happened that much.”  (ACM09/site 3)

However in more instances active case managers expressed practical difficulties in implementing the twelve week plan and questioned its appropriateness due to the nature of long term conditions. It was also seen as a change from policy, as originally the model of care was predicated on being on the caseload of a community matron for life (DH, 2005e), and that this change was seen as an organisational edict. This view typifies the responses of all the active case managers in case study site three:

"We’re getting more and more referrals and I feel the expectation to take patients off the caseload is unrealistic. They say you should be inactivating after 12 weeks, if they’ve become stable and you’ve put in all the input you can. But some patients you know you can’t, because they just go from one crisis to another crisis. They might be stable for 2 or 3 weeks but things soon slip back again... they might not be taking their medication appropriately, get confused... there is a bit of an expectation, why has this
patient, fill out an exception report, why has this patient been on the books for 18 months now. But she’s been on the books for 18 months and has only had one hospital admission; she has been really well and kept her in her own home with relatively small care package, so they’re not looking at the wider picture. At the outset it was management till the end of life, but now because of the numbers…” (ACM11/site 3)

The difficulty of applying the twelve week plan to patients with long term conditions was also expressed by the community matron (CM11/site 3) and was observed when she telephoned a patient (P12/site 3), who was going to become ‘inactive’ but during the telephone call she found the patient had a problem with swollen feet and pain (OBS IC4/site 3), and on a follow up visit further needs were identified so that the patient remained ‘active’ (OBS PV10/site 3).

So visiting schedules were used in all case study sites and were based on a ten to twelve week intensive visiting programme that reduced incrementally over the twelve week period. The approach and length of visiting schedules in case study site one were determined by individual community matrons who varied visiting from patient to patient according to identified and anticipated need. This differed from case study sites two and three, where the twelve week programme was more prescriptive. In case study site three in particular there was resistance to this approach and a view that it was imposed by management rather than driven by patient need or professional opinion. This may be indicative of a clash between professional autonomy and organisational targets.

6.6 Creating dependency
The expectations raised with patients at the inception of the service were considered to affect whether a patient would accept an ‘inactive’ status. It was felt that a dependency had been created, which affected the ability to increase caseloads. This was seen when an active case manager (ACM01/site 2) was visiting a patient (P05/site 2) that she felt should be ‘inactive’ but the patient responded to visits and the active case manager, where the patient had refused to see a counsellor for their psychological needs (OBS PV/P05/site 2). Another active case manager described the impact of trying to change the patients’ expectations from a life long service, as promoted in the original national policy (DH 2005e), to one of a needs responsive approach:

“... because at the start they only had about 5 patients, I think there was an awful lot done for those particular patients and its actually those particular patients that need you now all the time from two years ago still, will need you to go round at least once a week, and are very needy with you. It’s almost a demand... I think [they] were probably told it was a life long service, and they become very dependent. And I have got at least two or three patients that are extremely dependent on you going round every week even though you don’t need to.......” (ACM08/site 3)
The senior manager in case study site two described how they were trying to address this:

“...And also encouraging staff to say at the initial assessment to patients, we’ll be doing some intensive work with you for the next few months and then we will slowly remove ourselves but you will always be able to contact us... so preparing the patients that they wouldn’t get intensive visiting and assessments for ever, and that certainly helped with that...” (SM01/site 2)

Developing dependency rather than increasing self care was identified by two community matrons, one in case study site two (CM10/site 2) and one in case study site three (CM11/site 3), an active case manager in case study site three (ACM10/site 3) and by a district nurse in case study site two (DN/site 2). However this was seen in the context of preventing hospital admissions and as such retained a positive outcome for the service:

“... there was one patient that my colleague was very effective in reducing hospital admissions, prior to that he was on the revolving door every three weeks back into A&E, and with the interventions and intensive support, as in calling in, having a cup of tea, saying no you don’t need to go, you’re absolutely fine, quite intensive support, that was reduced to over a six month period of one hospital admission. So it was a significant impact but it was a very intense relationship to get it to there, and somewhat draining for my colleague at the time, as this person then shifted his dependency totally from the hospital to my colleague, and that’s not easy to cope with... but it did stop him going in hospital.” (DN02/site 2)

So it was considered that the service had generated a dependency by patients at the beginning by offering a life long service that could not be sustained due to increasing demand. Once generated it was difficult to reduce this expectation. In some instances though, the shift of dependency was seen positively in that it prevented hospital admissions, which supported the organisational outcomes.

6.7 Summary of themes relating to the service model

Whilst national policy in England set out the service model for the management of long term conditions (DH, 2005e), its interpretation varied in each of the case study sites when applied in practice. This was particularly different in case study site one, where the service model was based on a single level of practitioner, unlike case study sites two and three where there was skill mix and consequently variation in approach to caseloads and patient dependency needs.

The development of the service model appeared to be influenced by organisational drivers and existing service arrangements, such as the organisational perspective on the future development of the district nursing services, for example case study site two. Aspects of the Unique Care model were evident in the service delivery in all three case study sites, as seen with the assessment tool. However, neither Evercare nor Unique Care models were evident
in the service structures of the case study sites. Whilst such models were referenced by community matrons, they did not appear to exert much influence over practice. This brings into question the transferability of models from different health care systems and also highlights the importance of the practitioners' beliefs and interpretation of the model as to its implementation.

The eligibility criteria, caseload management and visiting schedules appeared to be organisationally driven to address service demand management. Some practitioners reported the organisational approach to be challenging their view of the service and their decision making within their practice. Community matrons in case study site one appeared to have more freedom over the service development in relation to eligibility criteria and visiting schedules, than in case study sites two and three. The degree to which the pre determined service model was upheld by the organisation or its fluidity to change determined the level of constraint on practitioners.

So, community matrons appeared to flex the service model to fit their ways of practice and professional decision making, although this may not have been conscious behaviour. The approach and views of practitioners reflected the impact of working in transition. The lived experience for practitioners working in the service model was important in influencing and shaping the role, making changes so that the service developed in line with the belief of its purpose and desired outcomes.

Themes surrounding the role and functions are expanded in Chapter Seven.
CHAPTER 7: ROLE FUNCTION

This chapter describes the key functions of the community matron. Issues raised by participants in relation to role function are described, including how the service structure, as described in Chapter Six, affected the community matron role. Key data sources informing the findings in this chapter were observations and interviews, supported by organisational documents and to a lesser degree by diaries.

This chapter begins by describing the activities most commonly cited by community matrons, namely assessment, coordination, advising and promoting self care. Medication reviews and prescribing were also cited, albeit to a lesser degree, as functions that were integral to the role. Case finding was viewed differently in each case study site as to whether it was the role of the community matron, and was linked with the developmental stages of the service, as identified in chapters five and six. The chapter then describes the dilemmas for practitioners in adjusting to role change and what they considered their functions should be. Themes related to this were the advanced practitioner role, treatment and care, and aligning roles with patient dependency. A further theme related to role function was boundaries with other roles; this is explored further in Chapter Eight in relation to relationships.

7.1 Assessment

Fourteen home visits were observed across the three case study sites; ten by five community matrons (CM06/site 1; CM09/CM10/site 2; CM11/CM12/site 3) and four by an active case manager (ACM01/site 2). Assessment was central to all the interactions with patients that were observed. This ranged from a formal systematic process to informal discussion during visits or telephone contacts, depending on whether it was an initial visit, follow up or assessment determined by the needs presented by the patient during the visit. For example, on all initial visits with the exception of one visit, the community matrons undertook a full assessment with a physical examination including listening for chest sounds. Where the full assessment had not been done, the community matron did a preliminary assessment to determine the overall condition of the patient and explained in discussion with the patient that she would complete further assessment incrementally over subsequent visits (OBS PV/P11/CM11/site 3).

The assessments observed in all interactions were based on a holistic approach, incorporating physical, psychological and social aspects and considering the activities of daily living, as would be typical in a nursing assessment. A conversational style was adopted by all
practitioners, so they were able to ascertain information about the patient’s condition, symptoms and social circumstances in a discussion that was led by the patient. In all visits the community matron or active case manager used prompts to steer the conversation to cover aspects that had not been raised directly by the patient so they could fully assess the patient’s current needs and condition. This demonstrated a high level of expertise in assessment and communication skills.

For example, a visit by one of the community matrons (CM06/site 1) typified the interventions observed when undertaking an assessment visit for a gentleman recently discharged from hospital who had a history of a fall, cardiac and respiratory problems, mobility problems and osteoarthritis (OBS PV/P01/site 1). The community matron engaged the patient in a general chat, including about the local shops and streets that the patient used. When the patient digressed the community matron steered the conversation onto a topic to give further information, for example the hospital experience, coping and help at home and preparing meals. This led to more detailed discussion about the patient’s treatment for his knees. At this point the community matron asked to examine the gentleman and checked his legs and skin condition, and was able to observe whether the patient put on support stockings correctly. The patient highlighted that he had lost a lot of weight, and the community matron asked questions about this and fluid retention, and made links to the amount of fluid loss he had experienced.

During the visit the patient needed the toilet, and the community matron used the opportunity to assess the patient’s breathlessness when walking, and to ask the patient about access to the toilet and his diuretics. This opened the conversation to all the patient’s medications, which the community matron checked and listed, and found duplications which could have resulted in overdosing but reassured the patient about his and advised on his medication regime. Following this the community matron completed the physical assessment which included a chest examination and blood pressure, and she explained that by doing this she would know what was normal for the patient, for future comparison, particularly in relation to chest sounds.

The community matron explained how she would liaise with the GP, future visits and the role of the community matron team, before leaving the patient with contact details should he have any concerns before the next visit.
The level of expertise required to undertake this level of assessment was acknowledged by several community matrons from all case study sites and an active case manager in case study site two, although in some instances they found it difficult to articulate what this level of expertise looked like:

“So having that knowledge and skill, and about how you... make your conversation, about how you ask questions... how you observe and how you interpret replies and things like that... being aware of what's out there for families, support and things, or how you refer, who you would refer to, how you make the referral in the best interest of the patient, because there are ways to do things that smooth it out and there are ways that can obstruct as well, make it worse, so knowing the protocols, knowing the guidelines as well, because they, all the NICE guidelines, keeping up to date with those, so...its hard to describe, it is hard to put it into words.” (CM07/site 1)

One community matron in case study site three explained how she utilised her experience and skills developed over her years of clinical practice that were now at an intuitive level (akin to expert practice described by Benner et al. (1996)) even though she did not recognise these as advanced assessment skills:

“I think when you’ve been in this job a long time you kind of, it’s like a sixth sense, it’s ridiculous, you just sort of know really from observing somebody whether they’re ill enough to go into hospital or whether they just need a bit of TLC, and that’s all he needed, somebody to feed him up, look after him and just get him back on his feet. He didn’t need any IV antibiotics or IV fluids; he needed a good wash and some food. A few weeks later he’s in rehab, back home, haircut, walking round everywhere.... but thinking back if I had been a district nurse, I might have just sent him into hospital, I wouldn’t have had the cost effectiveness, it’s the only sort of option you would think of really whereas we think of different things.” (CM11/site 3)

The three community matrons who had qualified as advanced practitioners (CM9,CM10/site 2; CM12/site 3) described how they used diagnostic models and recognised how they used the physical examination and the approach from the medical model to enhance their assessment and had incorporated these skills into their practice, rather than replacing the ‘nursing’ assessment:

“I’m still utilising my nursing skills in the assessment of the physical, psychological, social perspective, and drawing up the management plan as to what I’m going to be doing with the patient, in agreement with the patient, but I’m mixing it now with medical bit, which I didn’t do as a district nurse because I didn’t have the skill. And the only reason why I can do it now is because I’ve got the advanced clinical skill, passed my clinical skills assessment, at level 2 initially and level 3 and 4, which is like an autonomous practitioner... or as an expert practitioner who uses research and all that in evidence based practice, that kind of thing, but I couldn’t have done that, even at the beginning of the course.” (CM12/site 3)

This contrasted with the experience of a community matron in case study site one who was learning these assessment skills on the advanced practitioner course and remained uncertain
of the level to which she would be competent to practise once qualified, making comparisons with the level of practice of a doctor rather than enhancing nursing expertise:

“I see it as to know all the normal properly and just to pick up the red flags and know who to refer to, and I don’t see it as I’ll be diagnosing and such because I don’t think I’m going to have the confidence to do that… I’ll know this wheeze doesn’t sound right or that sounds right, and know what it could be, and then refer on, I think. I don’t know, It would be nice to be that confident in the end… I could probably diagnose an infection and if I could prescribe antibiotics, that part, but if there was anything else I think I’d refer on, I know I don’t see it as a fully fledged doctor’s role.” (CM04/site 1)

The assessments observed of the active case manager (ACM01/site 2) in case study site two were with patients already known to the service and were follow up visits. Therefore assessments were tailored to the specific needs of the patient on the visit. For example, during a visit to one patient with chronic obstructive pulmonary disease (OBS PV/P03/site 2) the active case manager measured the patient’s oxygen saturation, and blood pressure in addition to checking recent blood glucose measurements. Again the active case manager used conversational style to assess the patient’s symptoms and condition and used opportunities to make recommendations about diet and exercise, to which the patient was receptive which demonstrated trust within the relationship. As such the same levels of expertise in relation to assessment and communication skills were being demonstrated, with the exception of the diagnostic and physical examinations being undertaken by the community matrons.

In general the development of advanced assessment and diagnostic skills was accepted by participants as part of the community matron role. Those who had qualified as advanced practitioners had incorporated this into the function of the community matron role. The use of advanced skills to undertake comprehensive and patient focused assessments was explicitly stated in the community matron job description (DOC JD/site 2). One active case manager in case study site two expressed concern about the emphasis being placed on examination and assessment skills as advanced practice, and considered other elements of coordination and communication of equal if not greater importance:

“...when I look at my role as case management, I’ve been nursing for 20 years ... and I feel I have so many skills, from a communication point of view, and coordination point of view... which when I first started this role, that was the highlight of what this job was about... but sometimes I think people think that that’s not that important, because the most important thing is about the development of advanced practitioner skills regarding examining, prescribing, all these other things...but then I think I feel that the skills of communicator and the skills of coordinator role is of more importance than the other side of it....” (ACM02/site 2)
So the assessment was an integral part of the intervention by the community matron and active case manager with patients. This was also corroborated by an organisational audit of the active case management service in case study site three, where 94% showed evidence of a contact assessment being undertaken (ARC AUD 1/site 3).

The assessment was undertaken from a holistic perspective, with those who had qualified as advanced practitioners incorporating a full physical examination. This utilised medical skills to complement rather than replace a nursing assessment. Those who were still in training to be advanced practitioners were also undertaking physical examinations but these were not embedded in the assessment to the same degree as those who had qualified. All practitioners were demonstrating expertise in their practice, particularly communication skills (e.g. OBS PV/P01/CM06/site 1; OBS IC/CM05/site 1; OBS PV/P13/CM09/site 2; OBS PV/P16/CM10/site 2; OBS PV/P07/CM12/site 3). However the level of skill was not always recognised by practitioners themselves. The introduction of a medical style examination for diagnostic purposes as advanced skills in nursing practice appeared part of the community matron role. There were some concerns expressed as to whether this was advancing nursing practice, and that expertise in communication and coordination were under valued.

7.2 Coordination
Coordination of care was a key function of community matrons and active case managers across all case study sites. Again coordination was explicitly described as a function in job descriptions (DOC JD/site 2; DOC JD/site 3). The prominence of this function in everyday practice was widely expressed (nine of the community matrons across all case study sites, four active case managers across case study sites two and three, and by a social worker in case study site three). This was described by one of the community matrons:

“My aim is not just to sort of examine somebody’s chest or to have a chat with them, my job is to pull the services together so as well as providing that sort of physical examination for those patients at a higher level, I’m actually coordinating their care and trying to pull all services together so we’re all singing from the same hymn sheet and the patient knows exactly what’s going on. But without that it wouldn’t work, so you have to get all these people together.” (CM12/site 3)

Such activity was seen during observations of interactions with patients (OBS PV/P01/site 1; OBS PV/P02/site 1; OBS PV/P03/site 2, OBS PV/P04/site 2, OBS PV/P13/site 2; OBS PV/P07/site 3, OBS PV/P08/site 3, OBS PV/P11/site 3, OBS PV/P12/site 3) where the community matron or active case manager discussed involvement of one or more other health care professionals or social care agencies with the patient. This indicated how the
community matron had previously coordinated care based on their assessment of the patient’s needs.

For example, one of the active case managers (ACM01/site 2) visited an elderly woman who had Parkinson’s disease and lived alone (OBS PV/P04/site 2). The patient had refused referral to the falls team previously but had agreed to a referral to the Parkinson’s disease nurse specialist. During the visit the active case manager asked about the visit from the nurse specialist, which had led to acceptance of a referral to the specialist physiotherapist. The active case manager also monitored the patient’s weight and blood pressure due to the patient’s recent weight loss and hypotension, for which she was liaising with the nurse specialist and the GP. In conversation the active case manager ascertained that the patient was yet to see the practice nurse for ear syringing, and the patient expressed concerns about going for an appointment with the practice nurse. The active case manager discussed the patient’s concerns who agreed that the active case manager could follow this up on her behalf. After the visit the active case manager went to see the practice manager where it came to light that the practice nurse did not perform ear syringing and so the active case manager arranged for an outpatient appointment.

The coordination role was supported by a patient’s comments who described how the active case manager had coordinated care to meet her needs:

“I slipped and fell down the stairs, that's why they put another rail up. They were going to put a little chair up but my stairs are very narrow, so I couldn't. They said well try, and I said I'd rather not, so they said we'll have another rail up. I don't know if it was [ACM10] that got it all organised for me. She was very good with me, she was really was... asks ‘are you alright, is there anything you need?’ and she’d look around and say we’ll get you this, make your life easier... She's very good... she wants the carers every time to ring in so she knows they've been, which is good isn’t it... “ (P09/site 3)

In addition the coordinating role was evident in activity that was not direct patient contact, as seen when observing telephone calls to and from other agencies such as social services (OBS IC/CM03/site 1; OBS IC/CM05/site 1) and case finding (OBS IC/CM11/site 3).

A further example of the coordinating role was observed at a case conference attended by the community matron (OBS IC/CM12/site 3), the active case manager (ACM 11/site 3), the social worker, district nursing sister and staff nurse, care services for sheltered housing and the patient’s son. Discussion focused on the community matron’s report of her assessment and physical examination of the patient, and her recommendations for future care. The community matron ensured all contributed to the discussion, for example by asking the
patient’s son whether her findings reflected how he found his mother’s condition, by asking the carers about their role and what they could undertake within their role in relation to medication and seeking the district nurses’ opinions about the patient’s nursing needs. The members of the group appeared to endorse her role as coordinator. This included the social worker, who would also have a coordinator function, but who acknowledged the community matron’s experience and expertise with the patient.

The range of agencies that community matrons and active case managers involved with patients varied according to individual need, but included district nursing; GPs; social workers; mental health services; physiotherapists; occupational therapists; medical consultants and secondary care for example in relation to heart failure, kidney failure, coronary care; specialist nurses such as rheumatology and respiratory; palliative care team; rapid response team and also council departments and in one instance the police. In case study site two, where the age criterion for patients was widened to include all adults, an active case manager described how this widened the network of agencies they now worked with to coordinate care:

“... school nurses... because we link with the patient I’ve been involved with, the lady has Huntington’s disease, she has a young child, she is a single mother, and when I do case manage I don’t just manage the patient, I do family nursing, because the family dynamics are very important... I met with the school, I met with school nurse, I’ve gone to young carers, and children’s social services. I had a meeting at the school with the teacher as well, to explain what the situation was at home, because they weren’t aware of the very difficult circumstances that he was in, the circumstances of his non-attendance. That sort of network is growing... From there I have another patient who has bronchial diseases, she has two children, and I’ve done similar for them, links with school liaison, and the school counsellor. It’s very important to look beyond just the patient as we do with family nursing.”

(ACM07/site 2)

One community matron aptly described what coordinating care was like:

“...it is about pulling the threads together. I had a friend who had a job once and she always felt like a big spider in a web pulling it all together, erm, and I can see exactly what she means because that’s exactly what you feel like some days, you are pulling those together and making those links and connections for the benefit of the patient.”

(CM02/site 1)

The level of skill required to coordinate complex care packages was not widely acknowledged, although one active case manager did highlight this:

“I’ve never had to try so hard to integrate other services together. And I think that’s what’s so good about it, and also people that have always been involved with a particular client group, they feel very challenged when you’re trying to work with them because they’ve always done it that way. And you’re bringing about change, by saying, hey why can’t we work together to see if we can do it a different way, and that is very, very complex. People don’t see that.”

(ACM02/site 2)
Therefore coordination was recognised as fundamental function for the role and was seen in day to day practice. This required liaison and joint working with a wide range of health and social care professionals and other agencies. Extending the age criterion for the service expanded the number and type of agencies with whom the community matrons and active case managers worked. However the complexities of undertaking the coordinating role and level of skill required were not generally acknowledged.

7.3 Advice and promotion of self care

Providing advice and promoting self care was evident as a key function of community matrons across all case study sites. In case study site two this was stated in the job description as ‘to champion the principles of self-care and patient empowerment’ (DOC JD/site 2). It was a feature of observed patient visits, and took a prominent part of the visit in at least six of those observed (OBS PV/P02/site 1; OBS PV/P06/site 2, OBS PV/P15/site 2; OBS PV/P07/site 3, OBS PV/P08/site 3, OBS PV/P12/site 3). For example, a community matron (CM10/site 2) visited a patient with diabetes (OBS PV/P15/site 2), whose anxiety and breathlessness was preventing her from being fully self caring. The community matron worked with the patient on relaxation methods, which had been taught at a previous visit. The community matron explained after the visit that the patient had been a frequent caller to the GP but this had now reduced significantly, and also possibly prevented a hospital admission.

There was consensus amongst community matrons and active case managers across all case study sites about the importance of this function in the role, as shown by this example:

“I also think we do a lot of teaching. I came from a respiratory background so I spend a lot of time doing inhaler techniques, it’s extremely poor with nearly everybody I come into contact with, so I spend a lot of time going through inhalers, making sure they are on the right inhalers, and then actually doing proper teaching, and adding inhaler aids and things like that if they’re not able to use their inhaler. So that’s also what I think is important, obviously in the area we work most people have got smoking related disease...” (ACM08/site 3)

A few community matrons mentioned that not all patients wanted to accept their advice (for example CM09/site 2), although this was not commonly reported. There was only one observed visit where the patient was not overtly receptive to the community matron’s advice and where the patient did not acknowledge their own responsibilities in self care (OBS PV/P07/site 3). The patient had recently been discharged from hospital and was already known to the community matron (CM12/site 3). The community matron asked how the patient had been since discharge, about his levels of smoking and drinking and explained their effect
on breathing and appetite suppression. The patient did not accept this, stating that he had always smoked, and asked why his chest was bad. The patient said that the doctors and nurses should have the answers and should make him better. The community matron had to negotiate with the patient to not light another cigarette whilst she undertook a chest examination and blood pressure reading. Again the community matron used the opportunity to explain the patient’s chest condition and its link with smoking but the patient did not accept this. The community matron broached what she could offer him if he did not listen to or want advice and emphasised his own responsibility to improve his health. The observation demonstrated the skill of the community matron in presenting the facts to the patient in different ways to seek the patient’s understanding and also her willingness to enter into an open conversation with the patient about the usefulness of her visits if the patient was not prepared to listen to her advice. Later the community matron acknowledged that the visit was challenging, and whether she should continue to offer the service if the patient was not responding. This also indicated how the community matron was assessing how and where she should invest herself as a resource, whilst considering the impact of withdrawing the service from those who were unreceptive. The observation also demonstrated that some individuals will not ‘fit’ the model to support self care, which impacts on how the community matron can undertake this function.

Mostly, though, support and advice about managing a long term condition was valued by patients during visits across all case study sites and confirmed by interviews with patients. As exemplified here, patients welcomed the relationship with the community matrons and active case managers, where they would be honest with patients about the expectations of their long term conditions whilst helping them to address the challenges it brings to daily life:

“I mean there’s been many, many times I’ve got up in the morning and been really poorly, you know and she’ll say to me, ‘in what way are you poorly? Do you want me to come?’ and I’ll say come, and she’ll come, and I’ll sit and she’ll say ‘it’s all part of the illness, [patient’s name], you’ve got to learn to live with this’ you know, ‘but tell me’... and she’ll listen to you, and by the time she’s gone you’ll feel great, you know because she’s put my mind at ease... because I think am I going to collapse again in the street, like I did on the ward, and she got me all the things I needed, she got me the walking thing for going out, she got me everything, there wasn’t anything I needed.. it was ‘right, I’ll get you that’...” (P05/site 2)

Patients clearly recognised the role that community matrons and active case managers undertake to promote self care. Another patient volunteered examples of ways in which an active case manager had provided advice and introduced systems to enable them to be able and more confident to self care:
"... see that list there, [early warning chart about what the patient is feeling, when and who to ring with telephone numbers] that’s from her... she put that up, it’s good isn’t it? It’s her name on it and everything... and she’s done that...... I did [use the chart] twice... I make an effort to get up the stairs after they put a second rail up... she advised those drinks, you know, 2 a day. I was on 4 a day to start with... I lost a stone... used to get the scales out every time she came, I was eating but I was losing it other ways.... I wear a pendant, a pendant alarm... [ACM name] sent the doctor over to see me and all the rest of it. So I’m like that, I never go without it... I feel very secure, yeah, because when I couldn’t get used to the stairs at one time, the more I was not well, I was frightened to death of the stairs, they are that steep, it made me confident as I’ve got this and I wear it going to bed, I always have it on me, for that reason. She [ACM] says, don’t think it’s just for ornament! I can see her now telling me. She said you must wear it all the time. I said I do take it off to get washed. I made her laugh. She’s a nice person...”

(P09/site 3)

One active case manager in case study site three identified the potential problem of transferring dependency from the hospital to the community matron or active case manager, in the process of developing confidence and understanding of self care with patients, although this was not raised by others as an issue. Their experience also highlighted how progress can be thwarted where other professionals are not approaching the problem in the same way, as described here:

"Just teaching people to recognise early deterioration in their symptoms so that, rather than waiting till the last minute, encouraging them to, getting them to recognise things are going wrong, to ring the GP. It does have its negatives, because some do become almost dependent on you, which is something you want to try and prevent happening because you're trying to develop their own resources, but the very fact they've actually started to ring you rather than ring an ambulance when things are going wrong is a major improvement. They see that hospital isn't necessarily the most ideal place for them to be. So even if they do start off developing a dependency on us, it's a step. Then it's a case of moving them onto ring the GP but then the issues are whether or not they can get a GP, or, as some patients have said, they've just been advised to ring for an ambulance, so it becomes almost circular.”

(ACM10/site 3)

So, in summary, providing advice and supporting self care was central to the community matron and active case managers’ roles and seen as a fundamental function utilising teaching and communication skills. This was recognised and valued by patients, with a few exceptions which posed challenges to the community matrons with regard to developing and maintaining relationships with people who were not receptive to their advice. One active case manager considered developing an individual’s self sufficiency in itself could potentially create a shift of dependency from other health services such as hospital, to the community matron service, but this was a stage in the process of developing patient's self confidence.

7.4 Medication reviews

Medication reviews were described within the study as a distinct function from prescribing. Prescribing is discussed in a later section of this chapter. Medication reviews were
undertaken as a way to review and improve compliance with medication, and as such was part of the role in promoting self care in managing a long term condition. There was unanimous recognition of the community matron’s role in medicines management for patients with long term conditions across all case study sites. This function was specifically stated in job descriptions (DOC JD/site 2; DOC JD/site 3) and was reflected in practice described by practitioners. For example one community matron in case study site one described her approach with patients to determine their actual medication regime:

“I'm in the house, and when I go a lot of it is non compliance to medication as well, a lot, yeah. So once you find, you say to them, erm, you don't just ask them what they're taking or to see the boxes that they've got there, you say to them where do you keep your medication and you go to that cupboard and it's full sometimes of medication that they've not been taking…” (CM04/site 1)

So the way of undertaking medication reviews went beyond checking the prescriptions to using observation combined with patient comments to ascertain compliance. This was also reflected in the observed visits to patients in all case study sites (OBS PV/P01/site 1; OBS PV/P04/site 2; OBS PV/P13/site 2; OBS PV/P11/site 3). An example was described earlier under advice and promoting self care, where the community matron identified duplications which could have resulted in overdosing (CM06/P01/site 1). Medication reviews were also undertaken by active case managers, as seen when an active case manager checked a patient’s medication with them to ensure compliance, as the patient was being treated for hypotension which had been diagnosed following a fall (OBS PV/P04/site 2). The active case managers in case study site two stated that medication reviews were a large part of their role as it was important to assess whether medication had been prescribed appropriately in order to prevent hospital admissions (FG ACM/site 2). This view was supported by active case managers in case study site three (ACM08/ACM09/site 3).

The GP from case study site three cited medication reviews as one of the functions of the community matron in that it provided extra help to patients and helped with compliance (GP1/site 3). Patients also recognised this function as important; for example one stated that the active case manager goes through the medication with them and helps in getting further prescriptions from the doctor:

“She, er, gets me different things for me, I can't get from the doctors... medication... for me breathing, for me heart, for me legs, yeah... she helps me along. I know she's there and I'm quite happy.” (P03/site 2)
Another reported how the active case manager had shown them how to fill their medication box, which they could now do themselves, so aiding compliance and increasing their capacity to self care:

“...she showed me how to fill the thing [medication box]... and I do that every Sunday morning now.” (P05/site 2)

So across all case study sites medication reviews was a key role of both community matrons and active case managers, who used similar approaches to the reviews. This was recognised as a key function by the GP and by patients. Medication reviews were integral to providing advice and promoting self care in relation to compliance and supported the community matron’s aim to reduce hospital admissions.

7.5 Treatment and care

Interestingly, the provision of ‘hands on care’ that could be considered traditional nursing functions, particularly those undertaken by district nurses such as tissue viability and continence assessments, were generally not considered to be part of the community matron’s role. This was also reflected in the job description, where it talks of ‘instigating therapeutic treatments’ and ensuring involvement of appropriate professionals to provide care (DOC JD/site 2). Reasons cited for this included avoidance of duplication, and also time capacity, as described by one of the active case managers:

“Part of our role is care coordination and to actually access the right services for that patient; I normally get in touch with the person, the specialist in that job, who can give that input... if there are any district nursing needs I will get the district nurses involved... and when cancer becomes the overriding pathology, I get the palliative care team in and district nurses are involved, as they become more end of life, and my long term condition management is stopping. So I get the other services involved, I’m not doing anybody else’s job. We need speech and language therapy, we need physios, we get the right services. Our role is very specific to physiological monitoring, chronic disease management and looking at the health and social care aspects. You haven’t got time to do any of the others if you’re doing that properly... I do refer ... unless it’s a real emergency... whereas I’m trying to look at the diabetes, the medication, antibiotics... all the other aspects...” (ACM11/site 3)

However one active case manager in case study site three considered the role did encompass nursing functions associated with monitoring of a patient’s condition and activities of daily living, but linked this with a small degree of medical knowledge:

“It is a very broad role. We do some traditional nursing roles, so we will do blood pressures, temperatures, basic nursing roles looking at activities of daily living, bowel care, nutrition, that kind of thing. We do then have a lot of a bit of a medical slant as well, with the advanced practitioners, so we go to a lot of medicines management. So we kind if have a bit more, if I say sort of a bit more medical knowledge as well as nursing knowledge... it gives us a little bit more insight as to what is going on with
We do have an increasing number of medical aspects. We're not like the community matrons, the community matrons do the advanced practitioner so I think they're pitched at house officer or SHO level once they qualify.” (ACM09/site 3)

So those functions described could be considered to be moving away from ‘hands on’ physical nursing care and more involved with developing nursing assessment and advice by introducing more medical knowledge. This was reflected in the observations of all interactions with patients across all case study sites, where community matrons and active case managers did not undertake any functions such as wound care or full continence assessments.

One active case manager expressed some concern about not undertaking fundamental nursing care, when it was felt to be in the patient’s best interest, and described how a colleague had been directed by a manager not to provide such care:

“There doesn’t seem to be clear vision of what our remit is, what our limits are, you just might be told at some point that's not your remit, that's going beyond your boundaries... I’m thinking of a colleague... who had carried out some hands on procedures which at the time she felt needed doing, and as a consequence she was told... she found it quite upsetting, as it was quite serious, that it was beyond her remit, even though a trained nurse; things that involved catheterisation for a patient who was going into retention. The options would have been to call a district nurse which could have taken hours, or send somebody into A&E. So she took the decision to do an emergency procedure for which she had been trained, and had her wrists slapped for doing that. I can see that from a trust perspective, because that’s widening our role in a big way ..., but it just seems to feel it comes down to a lack of clarity... in that particular case, you could keep the patient out of hospital, if you had the skills to do it, and you’ve got the equipment available to do it, then I think I’d do it. It’s probably just second nature, you want to intervene...” (ACM10/site 3)

Some, particularly from a district nursing background, found it difficult to ‘let go’ of providing such care, for example one community matron, who when asked about the key elements of the role, described how she felt:

“Mainly support I would think, which again I found really hard, for me, because I’m a practical nurse and will always be a practical nurse... Say for instance if I’ve identified that they've got a pressure area problem, for me to pass that on to somebody is not in my nature at all. I find I really want to keep these people for me; I want to do it where I'm having to get rid of that and pass them on. That is a big thing for me. ... as a district nurse, those patients were always supposedly mine, it was my caseload if you like... if it was a pressure area problem you may see that patient three times a week, where now I have to get the district nurses involved. And I know they're going to care, that's not the issue, the issue is that I want to do it. I want to see them 3 times week, as opposed to seeing them maybe once a fortnight... I miss that tremendously. I'm not 100% sure yet that I'm not going to go back to that.” (CM03/site 1)
However in general it was still felt that clinical expertise was needed to underpin the role, as expressed by a community matron in case study site three:

“...we wouldn’t do any nursing procedures, but I’m still utilising my nursing skills in the assessment of the physical, psychological, social perspective, and drawing up the management plan.” (CM12/site 3)

Therefore traditional nursing functions related to ‘hands on care’ were not seen as part of the community matron or active case manager role, as this was considered to be duplication of existing roles. Even though it was recognised that community matrons and active case managers had the skills to provide such care it was expressed that there was not enough capacity within the role to do this. It was felt that nursing knowledge and skills were being applied to the role and used in conjunction with new skills such as prescribing.

7.6 Prescribing
One aspect of treatment and care that was evident was prescribing. Whilst only four community matrons were independent prescribers (at least one in each case study site), several others were nurse prescribers from their previous practice as a district nurse or health visitor. Seven community matrons from across all case study sites specifically stated that they felt that prescribing was needed and was part of the role, with one stating that it was “imperative for the job” (CM10/site 2). The need for prescribing was presented in terms of reducing delay in starting treatment by removing the need to refer to the GP. The same scenario was described by two community matrons from different case study sites, for example:

“... say ... I go out to see somebody with a UTI, and I’ve identified there’s a UTI, then yes, if I’m happy and I know that patient inside out back to front, then I would prescribe the relevant antibiotic for that... ... I would only prescribe for something I was really secure in. It would be where, I don't think I'm replacing a doctor then, I'm actually saving that patient time from diagnosis that they have got a true UTI to waiting for another 24 hours to get another prescription from the GP to waiting another 24 hours for the chemist to deliver... many of our patients are quite elderly and infirm, you can’t just get hold of somebody and say the prescription’s ready for you, its everything that goes with that in that process, so that would make that a lot quicker and I can get my patients treated a lot quicker.” (CM03/site 1)

Prescribing was considered essential to be able to fully use advanced practitioner skills by at least four community matrons across all case study sites, and in doing so comparisons were made with the role of doctors. One community matron in case study site one, when presenting to a group of social workers, referred to the advanced practitioner as akin to a junior doctor role, by undertaking diagnostic and prescribing functions (CM01/site 1). The connection between using advanced practitioner skills, doctor’s roles and the problems of not
be able to prescribe was demonstrated in comments by another community matron in case study site three in her diary (DIA CM11/site 3) and in interview:

“Nurse prescribing isn't included in the [advanced practitioner] course so we've got this knowledge, what do we do with it, we've got to go back to the doctor to prescribe based on what we're saying, that's putting them at risk as well. So how useful those skills are in practical terms are, I don't know... I think we'll need prescribing for the role, if they want us to be following the medical model then I can't see how we can do the job without it [prescribing], I really can't. Because we're not autonomous at all, we're just doing a bit of listening to someone's chest, I can hear this or I can hear that, and the GP then has got to go on your word and prescribe something...” (CM11/site 3)

There were differences in advanced practitioner programmes (DOC AP/HEI), in that one did not include prescribing, as quoted here, whilst others in case study site two did undertake prescribing as part of their advanced practitioner course (CM09/site 2). Two of the active case managers in case study site three saw prescribing as part of the advanced practitioner role rather than their own (ACM09, ACM11/site 3). However one community matron in case study site one did not fully concur with this; whilst recognising prescribing could be part of an advanced practitioner role, she felt it was required more as a community matron rather than an advanced practitioner. In doing so she made a distinction between these roles:

“... prescribing should be part of the advanced practitioner course, it's just not been tied together yet... but I don't think you need to, I think you need to have prescribing as a community matron, but not necessarily advanced practitioner” (CM02/site 1)

Interestingly the manager in case study site two did not feel that prescribing was essential to the role, as other mechanisms could be put in place to address this need. This was dependent on good relationships with other professionals such as consultants, GPs and medicines management personnel. When asked whether prescribing was required she stated:

“Not necessarily, because the medicines management and the pharmacy, they do the reviews, as long as they had a good system in place which, with the GPs, and some of them have things like a plan, which would, say for instance there was one particular COPD patient who'd had about 24 admissions for COPD a month, and what they did, the case manager met with the chest physician at the hospital and they did a management plan, and what they did was have some steroids and antibiotics, everything that they needed like a package in the patient's home, so should an emergency arose [sic] they knew what to do step by step. It doesn't sound rocket science but the GPs were quite reluctant to have medication sat at patient's homes without them being used... but otherwise patients were going in just to get that...” (SM01/site 2)

Prescribing, then, was seen as essential by the majority of community matrons and was closely associated with being an advanced practitioner and undertaking functions that were traditionally medical roles. However there was a view expressed that the role could be
effective without prescribing, but this was dependent on effective working relationships with other professionals. Given that issues had been raised about such relationships (as discussed in chapter 9), being able to prescribe could circumnavigate these issues and as such be seen as necessary for the role.

7.7 Case finding

Case finding is seeking out individuals who have long term conditions and are at risk of hospital admissions or require a high level of health service intervention, within the parameters of the eligibility criteria, as discussed earlier in chapter six. It was described as a function of the community matron in all case study sites but the way in which this was done differed between case study sites, particularly in case study site two where the job description indicated that the community matron was responsible for case finding, but did not state that they would undertake the task themselves (DOC JD/site 2). The approach to case finding had also changed over time in all case study sites. In case study site one the community matrons took turns to attend the hospital each morning in order to identify cases from admissions, which was not mirrored in case study sites two and three. Case finding in this way was observed when the community matron visited the bed bureau to examine the admissions data on the computer (OBS CF1/site 1), and she identified nine patients over sixty five years old who were discharged, although the community matron commented that they would expect more on days later in the week (CM04/site 1). After spending over one and a half hours at the hospital, the community matron stated that she felt like she was ‘starting work now’ (CM04/site1). A further two community matrons (CM03, CM06/site 1) commented that this was not a good use of their time, as they felt that someone else could collect the data, and also they were not able to follow up patients identified this way due to capacity. This view was shared by the team as they discussed the issue at their team meeting and subsequently changed their approach (OBS MT3/site 1). The frustrations and changes were articulated by one of the team:

“Going to bed bureau is not very good really. I felt that a lot of the time I was sat there printing things off the computer that somebody else maybe could do, that I didn’t need to be doing, but we’re not doing that any more... We’d go to bed bureau every morning and pick up everything, and that was nearly an hour and a half of your day. I used to sit there thinking, mm..... So what’s happening now is instead of going every morning and printing all the discharges and admissions off, they’re faxing it through to us who’s been admitted and who’s been discharged.” (CM06/site 1)

In case study site one case finding by visiting wards and attending ward rounds continued, as evidenced when a community matron visited a patient at home after initial contact on a ward round (OBS PV/P01/site1). This was also the approach used in case study site three,
although the limitations of case finding by visiting wards outside of ward rounds was recognized. Here the community matron (CM11/site 3) and active case manager (ACM09/site 3) were observed visiting a medical ward and the medical assessment unit, which was undertaken twice a week (OBS CF2/site 3). Once they had introduced themselves to the staff they went through the patients’ notes for possible candidates for referral and then asked ward staff to refer the patients using the hospital system, as an electronic referral process had been set up on the ward workstation. The community matron also asked ward staff directly about any patients that would be suitable for the case management service but were not able to accept some of those identified as the patients were outside the community matron’s area. The community matron indicated after the visit that they used to collect information from the wards on such patients and shared with teams from other PCTs, but stopped as it was not reciprocated. This suggested a lack of shared working across boundaries and may reflect different ways of working, as seen in case site two discussed below. This may also have affected the level of engagement by ward staff.

The community matron stated that it had been a good visit as they had identified five to ten possible patients, as sometimes less would be found in this way. She reported that most referrals had been from occupational therapists and physiotherapists rather than nurses. They had tried working with District Nurse liaison but were not getting referrals via this route. Despite feeling it had been a productive visit at the time, the community matron later indicated that this approach to case finding was not sustainable, and they were looking to develop new ways of working using a predictive tool called PARR (Predicting At Risk of Re-hospitalisation) (King’s Fund, 2006):

“All the ones we found that day, we got two, and I think there were about nine, but we only got two back..... The ones they don’t refer, we go back and get the details... it’s a waste of time, and its... when you think how many there are there and we’re just getting a few of them just by looking in their notes... there’s got to be a better way of doing it, there really has. That’s got to come by us going in there, going to their meetings, get our faces known. They wouldn’t think twice about referring to a district nurse, and that’s the kind of thing we need to be aiming at... this whole case finding thing doesn’t seem to move forward. Maybe that will change with the PARR tool.” (CM11/site 3)

The other community matron in case study site three did not undertake visits to wards to review notes, but did attend multi disciplinary team meetings and had links with consultants.

In contrast, case study site two had focused case finding in general practice using hospital admissions data together with the GP records, rather than attending the hospital to case find.
The community matrons and active case managers had done this when the service was in its infancy, which helped to increase their profile with GPs, as described here:

“Most of the referrals are from GPs now. All of us are known, attached to a GP practice. It was more by going in and talking to them [GPs], and doing case finding, they got to know more of us, they actually felt the benefit for the patients, they found the intensity of our involvement for these patients, and now, that has prompted them, they do refer patients they think have a high risk, we’re getting those which is good.” (CM10/site 2)

However a designated post for case finding at a lower grade (Agenda for Change band four) had been introduced so that the community matrons and active case managers no longer undertook case finding which increased their capacity to see patients. This was seen as an improvement by the active case managers (FG ACM/site 2) and by one of the community matrons:

“When we first came into the role we used to have to go into the GPs and case find. We used to get the hospital admission data which was anonymised until we went into the GP surgery and we matched it up with the data there and the NHS number to identify the patients. And we used to spend two hours for each patient trying to identify them, pull all the information off about how many admissions, what they were for, the medication, and long term condition. We’d spend so much time, and I think the role has improved because we’ve now got a case finder in post... that probably came a year that we’d been doing it, so that used to impact a lot on our time... so just having one case finder to be able to do that has alleviated a lot of our time.” (CM09/site 2)

So in summary, case finding was seen as a function of the community matron and active case managers in all case study sites at the outset of the service being established, which may be linked to the need to achieve target numbers of patients seen by community matrons (this is discussed in chapter nine). In case study sites one and three case finding focused on hospital admissions as the main source whereas case study site two used general practice, which had the added benefit of helping to develop relationships with GPs. In all case study sites case finding was recognised as time consuming and questionable as to whether the community matron was appropriately used in this way. Case study site two had addressed this by introducing a role to case find for the community matron and active case managers. However in case study sites one and three whilst the community matrons had tried to improve the processes of case finding they still retained this function.

7.8 Functions in relation to the national description and Evercare nurse practitioner role

Table 21 shows a comparison of the role functions emerging from the findings, as discussed in sections 7.1 to 7.7, with the Department of Health’s core functions (DH 2005e) and those of the Evercare nurse practitioner (Abdallah 2005; Fraser et al 2005). Activities reflected some
of the core functions of the community matron as described in the NHS and Social Care Model (DH 2005e), and also those in the Evercare model (Abdallah 2005), which were discussed in sections 2.4 and 2.5.1.

Table 21: Comparison of role functions with DH role description (DH,2005a) and Evercare roles (Abdallah, 2005)

<table>
<thead>
<tr>
<th>Role functions from findings</th>
<th>DH</th>
<th>Evercare Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Assessment and planning of care</td>
<td>Clinician</td>
</tr>
<tr>
<td></td>
<td>Initiate action</td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td>Collaborative working</td>
<td>Care orchestrator</td>
</tr>
<tr>
<td></td>
<td>Liaison with agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintain contact during hospital admissions to maintain continuity of care</td>
<td></td>
</tr>
<tr>
<td>Advice and promotion of self care</td>
<td>Teaching symptom awareness to promote earlier intervention</td>
<td>Coach</td>
</tr>
<tr>
<td>Medication reviews</td>
<td>Patient monitoring</td>
<td>Clinician</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Initiate action</td>
<td>Not explicitly stated</td>
</tr>
<tr>
<td>Case finding</td>
<td>Not explicitly stated</td>
<td>Not explicitly stated</td>
</tr>
<tr>
<td>Coordination</td>
<td>Updating records and sharing information</td>
<td>Communicator</td>
</tr>
<tr>
<td>Coordination</td>
<td>Securing additional support required in the home</td>
<td>Champion</td>
</tr>
</tbody>
</table>

So it can be seen that the functions identified from the findings are akin to those described by the national role description (DH 2005e) and that of an Evercare nurse practitioner (Abdallah, 2005). Case finding, whilst had been undertaken by community matrons at some stage in all case study sites in this study, had not been considered to be appropriate use of community matrons’ time (CM03/CM06/site 1; CM09/CM10/site 2; CM11/site 3): in the national description (DH, 2005a) case finding was acknowledged as important but was not a specific role identified for the community matron.

The role of champion, as described in the Evercare model, was not one articulated by community matrons in the study. However, they did promote improving care for people with long term conditions throughout their work, specifically observed in teaching in residential homes (OBS IC/CM12/site 3). Promotion was also referenced in diaries in relation to increasing awareness with other colleagues (DIA CM07/site 1; DIA CM10/site 2; DIA CM12/site 3) and teaching (DIA CM04/site 1; DIA CM12/site 3). So whilst community matrons were undertaking activity that could be considered as a ‘champion’ function, they did not
appear to acknowledge it as such. This may be due in part to their reflections being focused on their relationships with others, as discussed in Chapter Eight.

7.9 Advanced practice and the community matron role

Advanced practice was described by participants as part of the role of the community matron, in particular in relation to advanced assessment skills as described in section 7.1, and prescribing in section 7.8. Very skilled communication and complex coordination functions were observed, as described in sections 7.1, 7.2 and 7.3, but these were not generally acknowledged as advanced practice by participants. Levels of practice were being delineated between the community matron and active case manager in case study sites two and three; this is described further in section 7.9 in relation to aligning roles with patient dependency.

One community matron commented in her diary that she had been able to use her advanced clinical skills whilst spending time in an urgent care centre, focusing on more acute conditions such as tonsillitis (DIA CM11/site 3). She contrasted this with her main role as chronic disease management, suggesting that she did not feel that she utilised these specific clinical skills in her community matron role.

However, one community matron described the differentiation between roles in relation to the advanced practitioner, in terms of their expertise and experience, rather than specific functions, which reflects Manley’s interpretation of advanced practice (Manley 1997):

The differentiation between the community matron and the case manager is in terms of the intensity and complexity that the community matron or the advanced practitioner is going to deal with; that may not be at the same level of responsibility and autonomy that the case manager has. I’m not saying that they may not have experience; some of these colleagues have come up from district nursing and other areas where they ... are very competent, they feel they can do the job equally as me... I’m here to deal with whatever complexities and to support them [case managers] beyond that... to lead the process of case management, to ensure that case management is being based on evidence based practice (CM10/site 2)

There was variance between all case study sites with regard to the organisational approach to adopting the advanced practitioner role: in case study site one, five of the community matrons were undertaking the advanced practitioner course, but the team did not anticipate that all community matrons would be advanced practitioners, when discussed at a team meeting (OBS MT3/site 1). The organisation’s strategy for managing long term conditions described the advanced practitioners ‘will work alongside the community matrons to develop robust services’ and that there would be a minimum of eight advanced practitioners (DOC STRAT 1/site 1), which equalled the number of community matrons at the time of the study.
There was no indication in the organisational strategy that there would be a tiered model in the future (DOC STRAT 1/site 1). However the strategy implied there would be distinct roles for community matrons and advanced practitioners. The impact of those qualifying on roles across the team had been considered by one of the community matrons (CM05/site 1):

“...I’m sort of a bit torn really, personally I’m not sure if I want to do it or not... But professionally I sort of worried that if I don’t do it [advanced practitioner course] I’ll be left behind basically. That these guys will all be examining chests, diagnosing, prescribing, and I can’t do that.... I had to get a GP to come out and visit somebody, because there was no point in me going out to a chest because I don’t know what I’m doing, it would be dangerous, so I asked if a GP would go out and visit... one of my colleagues whose doing the advanced practitioner, probably would have gone out, listened to the chest and made a decision on that basis, whereas I’m not able to do that. Yes, there are disadvantages really. But then I feel I’ve got other skills in other areas.”

(CM05/site1)

In case study sites two and three however, the advanced practitioner qualification was a requirement for the post of community matron, as stipulated in job descriptions and service descriptions in each organisation (DOC JD2/site 2; DOC JD1/site 3). As the advanced practitioner role was new to the area, those appointed were required to undertake the course. In case study site two, there were two community matrons and both were just qualifying as advanced practitioners. In case study site three only one had qualified and the others were at different stages on the advanced practitioner course. All three services in all three case study sites were, then, at different stages of development with regard to advanced practitioner roles at the time of the study, and it remained unclear whether the advanced practitioner role was that of a community matron, or whether it was a separate function. This was also linked to different approaches to role alignment to patient dependency, as described in section 7.10.

7.10 Linking roles with level of patient need: community matrons, active case managers and assistant practitioners

In case study sites two and three it was expected that as the community matrons qualified as advanced practitioners, they would manage more clinically unstable patients on a high dependency caseload (DOC JD/site 2; DOC POL 4/site 3). There, community matrons as advanced practitioners would provide support and guidance to the active case managers who would manage a medium complexity caseload. Lower dependency would be managed by the active case manager with ongoing support by the assistant practitioner (ARC CL1/site 3). The striation of dependency needs mirrored the pyramid of dependency levels set out in the national strategy for the management of long term conditions (DH, 2005) as described in section 2.3. The dependency levels had been interpreted locally and were described in a guidance document for the team in case study site three (DOC POL1/site 3). This guidance
listed factors for those considered being of high dependency, which included requiring an advanced practitioner assessment, and their health condition would be unstable or unpredictable. Medium dependency included factors such as recurrent infection or exacerbation of health conditions but some achievement of self management, and care coordination was still needed. Low dependency included those whose long term conditions were stable but still required monitoring, and where health promotion was still required to achieve self management. The community matron who had qualified as an advanced practitioner described how this worked:

“I work in a team approach, we do have patients with high, medium and low dependency. So when the person moves up to high, I intervene and do the full physical, but if they have a problem with their patients they will call on me to see theirs.” (CM12/site 3)

Patient allocation according to dependency was observed at a team meeting in case study site three only, where patients were reviewed by the team, and ranked according to dependency into high, medium and low bands. The community matron explained during the meeting that they did this using their clinical judgement (OBS MT5/site 3).

Experiencing this way of working played a part in its acceptance; active case managers working with this community matron supported this approach although differentiation between the roles was still being established, as described here:

“... I think there should be a difference, because if the leads have been trained with advanced clinical skills, assessment skills, then I think that’s where their skills should be used...what I think should happen is that the leads should maybe be, having people coming on and off their caseloads, as and when they deteriorate, so they wouldn’t have a fixed caseload. The active case managers will be filtering patients to them as their own patients deteriorated, went into hospital, due for discharges... it’s the whole idea, the way it was set up was on a pyramid scheme; you’d have the very low level ones monitored by the health care assistant, medium level being looked after by the active case managers and high level ones by the leads [community matron]. But no definitions as to what is low, medium or high have ever been established, so it comes down to at what point do we decide somebody would be high?” (ACM10/site 3)

Active case managers working with a community matron still undertaking the advanced practitioner course were also anticipating the tiered approach to caseload management. However a few active case managers had reservations about adopting this and about how it would affect their practice (ACM02/site 2; ACM08/site 3). The active case manager in case study site three who expressed concern about being deskilled also considered the effect on the relationship with GPs:

“...so there’s nothing different really to what we do as active case managers, probably not until maybe they get on a little bit and they start doing more of the physical
examinations and things like that and then I think it changes... So you’re probably not going to have your own patients then, so you won't have own GP practices, like we do at the moment... It will be a big shift for the GPs as well... instead of having one port of call they might have 3 or 4... I don’t know whether they might not be quite so keen on that, or they might embrace it ... In the future they’ll be advanced practitioners, so, it’s difficult as at the moment I’m managing high, medium and low patients. But then...it seems to me that high patients will be taken off me and I’ll be with the medium patients. I’m not sure whether that deskills you or not...” (ACM08/site 3)

Such changes were reflected in discussions amongst the team in case study site two also. Here the community matrons and active case managers each had their own caseloads but as community matrons were just qualifying as advanced practitioners, this was changing:

“....about the top percent, they should be managed by a community matron, well, we had a discussion about that, saying, really, if you feel competent in managing patients it doesn’t matter what level they’re at, if you as the case manager feel competent to manage that patient, why would you have to pass it on to the community matron because it says that that’s the top percent that you have to manage, because they will only be passing it back to you...” (ACM02/site 2)

So there were issues of maintaining personal professional competence for the active case managers and the level of constraints the tiered dependency model would impose on individuals. These concerns were recognised by the senior manager who had proposed how the community matron would be involved when dependency increased:

“... we tried to work it that they [ACMs] would have their own caseloads but if there were problems with complications, like maybe a COPD patient who might need to auscultate the chest to prevent an admission, they’d step that up to a community matron, but once that acute episode had resolved bring them down, and they felt quite happy with that... as it meant they could keep their skills but once it got a little bit tricky they could ask the community matron for some support. They could either do that by asking them to come and see them and they keep the patient or hand it up so there was like a flow of patients. Initially that didn’t happen the way I thought it would, I did think there would be a lot more flow of patients... I think it’s happening more like that now, and I think that’s more to do with community matrons having completed the course.” (SM01/site 2)

The approach being developed in case study sites two and three presented similar service models where patients were matched according to level of dependency and complexity with the community matron who had advanced clinical skills, the active case manager or the assistant practitioner. In case study site one the team recognised the benefits of a skill mix in roles but were yet to experience this; in case study sites two and three the change towards this was met with a degree of resistance by the active case managers who were yet to adopt the revised caseload allocation, whilst there was support from active case managers in case study site three where the tiered model of service delivery had been introduced. Dependency levels resulting from the complexity of health need were linked to the level of professional
intervention and skill mix within the service, as discussed in section 6.5, in relation to visiting schedules.

7.11 Summary of themes relating to role function
Key activities most commonly cited by community matrons were assessment, coordination, advising and promoting self care. In addition the importance of medication reviews and prescribing were recognised. These activities reflected some of the core functions of the community matron as described in the NHS and Social Care Model (DH 2005e), and also those in the Evercare model (Abdallah 2005). So in this respect the observed and reported practice of community matrons reflected expectation from the national policy. Case finding was recognised as important but was not considered to be appropriate use of the community matrons’ time; this had been addressed in case study site two with the appointment of a designated case finder.

Functions described within the community matron role could be considered to be moving away from ‘hands on’ physical nursing care and more involved with developing nursing assessment and advice by introducing more medical knowledge, and also traditional medical functions such as prescribing and medicines reviews. This brings into debate what is valued in nursing and recognised as expertise in nursing skills. It questions whether traditionally medical tasks are perceived to justify or give value to the nursing role or whether it is simply medical delegation. This presents a further example in the role extension and expansion debate as discussed in section 2.6.

In introducing a new role to the nursing landscape, there was ambiguity for those learning the new role and those working alongside it. This presented challenges to individuals’ professional identity, which over time and through personal learning with experience, would undo and reconstruct professional identity. This was influenced by external factors, such as organisational drivers, education programmes and other professionals such as doctors acting as mentors to community matrons on the advanced practitioner course (e.g. CM08/site 1; CM10/site 2; CM12/site 3). Such factors also brought the potential for conflicting ideologies.

This ambiguity was exacerbated by introducing the role of the community matron and the advanced practitioner simultaneously, without clarity of function and the interrelation between the two roles, or even whether they were the same role, where the advanced practitioner function reflected the skills and expertise required to fulfil the community matron function. This concept appeared to shift in time as the roles developed, from one of being the same
role to one of separate functions within the service model. This was highlighted by the different approaches to the two roles in the three case study sites.

Themes relating to function and role also affected boundaries with other roles. This is explored in Chapter Eight with regard to relationships.
CHAPTER 8: RELATIONSHIPS

This chapter describes the key relationships with the community matrons, where relationships have been positive, negative and the reasons proposed by participants for this. The predominant data source in the findings about relationships was interview data, supported by observations and diaries.

The chapter begins by looking at participants’ perceptions of internal relationships with the team dynamics, as these were strikingly different across the three case study sites, reflecting the differences in team structures described earlier in Chapter Six. Then the chapter turns to out-facing relationships where the findings showed significant tensions with district nurses, arguably the closest nursing role to community matrons. Relationships with hospital staff were described differently by participants, possibly reflecting different expectations and different levels of understanding of other professionals’ roles. Findings also showed how the nurse doctor relationship was reported differently by individual practitioners. In contrast, the relationships with social workers, a more distinct professional group, were portrayed consistently as more positive. As such these relationships have been presented here as key aspects of how relationships were reported to have developed, affected by previous experiences and expectations, professional behaviours and perceived threats to their own roles.

8.1 Team dynamics

Internal relationships within the teams were different in each case study site. In case study site one the community matrons were unanimous about the openness and supportive nature of the team which they described in interviews (CM01; CM02; CM04; CM05; CM06; CM07; CM08/site 1) and were observed in casual conversations and in a team meeting (OBS MT3/site 1). This strength meant they were able to raise difficult issues with each other, such as perceptions of differences in ways of working. For example, at the team meeting they discussed ‘team rules’ for annual leave during which the impact of the time out by those on the advanced practitioner course on the workload of the remainder of the team was openly acknowledged (OBS MT3/site 1). It was also seen as important to deal with issues to prevent those becoming larger problems, as described by one of the community matrons:

“We did have quite an open discussion on Friday, which needed to happen because people were getting quite stressed about the workload and people going home feeling tired and upset. So we talked about that, it was quite difficult in being open...there were a few tears, but we had to discuss what we were talking about and it was confidential and we wouldn't make any of it personal to any individual. But people were quite open
because we got to the point where we had to be for things to move on. It was good for
everybody because there were certain people in the team that hadn’t noticed that
anybody was upset and hadn’t noticed the pressure that was on other people, they were
quite surprised... it wasn’t a comfortable feeling...but you have to go through that...”
(CM06/site 1)

In this way the team was self managing, which reflected the flat structure of the team, as
discussed in Chapter Seven. Even though one of the team was designated team leader, this
was not seen as hierarchical but as a coordinating function, which may be because it was
intended that the team leader function would rotate within the team every six months. The
community matron operating as team leader at the time stated:

“...they’re such a good team and manage themselves, and if an issue comes up, they
usually try and deal with it. So really from my point of view it’s just been that connection
with our line manager that’s been the main bit. Apart from when everyone’s disagreeing
about something and I have to say, right, we’ve got to make a decision here. That’s
probably happened a couple of times.”   (CM01/site 1)

One of the team did highlight the potential problems in operating this model of self
management when reflecting on her personal experiences in a previous role:

“I had to… to completely distance myself really to an extent, because the team I worked
for there were a lot of issues ongoing and there were things I had to deal with as a
manager... and that’s why it’s quite difficult in a team like this I think... you need
somebody that is completely separate... that’s just my view but I think you do...”
(CM08/site 1)

The majority of the team highlighted effective working relationships through how they would
recognise individuals’ areas of experience and different backgrounds, so they could all benefit
from the wide range of expertise this brought to the team. For example:

“...we do work together really well because last week I had a gentleman who was quite
bad with COPD, and I was a bit unsure, and I asked [name] to come with me to visit
him, and it got quite late that day because we were in a meeting, and we came out and
she said do you still want me to come and I said, yeah if you don’t mind...and I needed
her really, she knew a lot more clinically, even though she’s not doing the advanced
practitioner she knew a lot more clinically than I did...and it was really good and she
taught me which was good...”   (CM04/site 1)

There appeared to be a sense of togetherness from the team in case study site one,
demonstrated in all observations in how the team interacted with each other and in how they
described experiences working with each other (OBS MT3/site 1). One community matron
reflected how the team had supported her after dealing with a clinically challenging
experience (DIA CM04/site 1). Support went beyond working practice to friendship, and was
summed up as follows:
“I just feel its erm, its having a belonging... somehow.... But say something like, say, like last night we all went out, well I never had that because I didn’t really belong with anybody really, even though I worked with everybody, it was too big. And I really missed that, not being able to speak to somebody, that relationship, and the support, and the learning from each other; phenomenal really, we all share what we know...”
(CM07/site 1)

The degree of team cohesiveness seen in case study site one was not replicated in case study sites two and three. Here there was a sense of hierarchy in that the community matron was seen as a team leader of active case managers. In case study site two the relationship between community matrons and active case managers was developing and role differentiation still unclear. This was linked to the stage at which the community matrons were on the advanced practitioner course, as they were just qualifying as advanced practitioners. This was, in turn, changing the interaction between the community matrons and the active case managers. Although aspects of role changes in relation to applying the case management model were discussed by community matrons and some active case managers, its impact on the team dynamics was not openly discussed, with the exception of one of the active case managers:

“It’s not even people...its a feeling... nobody overtly says anything, but whenever we have our meetings, say, there’s always a divide between ...and its not even a talked about divide...its a divide as in community matron and case management. But where that’s come from I haven’t got a clue, but I don’t know whether that’s the culture being devised by management, or ... I think that is talked about but nobody actually says it out loud, but I think there is an understanding that there’s more emphasis placed on the community matron, and whatever goes on with them will influence us, rather than us influencing what happens in general...”
(ACM02/site 2)

However the community matrons in case study site two did not see themselves as team leaders in the managerial sense but as a professional support, which may have affected the feelings of implicit rather than explicit influence of the community matron in leading the team.

“It’s not delegation; skill mix is what we have with, like assistant practitioners, that is totally different. These are not, we’re talking about very experienced, skilled colleagues... you have to deal with them at a common level, and also as a community matron I don’t have a hierarchical thing with them. Because I’m not their clinical lead, we have a general manager who is their lead, but what I hear is that I’ve been given the lead, I’m the first line manager in terms of that ... Our job is to help them with collegial support, to empowering them into being more independent and autonomous in their practice, to encourage them to continue with their personal development in clinical practice”
(CM10/site 2)

The distinction between community matrons and active case managers was not seen when observing a clinical review meeting at which active case managers, community matrons and a manager was present (OBS MT4/site 2). Here an active case manager presented a case and
the team discussed issues that had arisen, with the community matrons and active case managers advising on aspects of care. One of the community matrons also presented a case in the same manner, and the approach was peer to peer rather than any acknowledgement of differentiation between either levels or expertise in the team.

In case study site three the team dynamics differed again as each community matron led a smaller team of two or three active case managers and one assistant practitioner. There was greater differentiation of the community matron as the team leader in relation to managerial responsibility, as supported in operational documents for the management of sick leave and annual leave (DOC POL2/site 3). The difference was highlighted by one of the active case managers in case study site three when commenting about support, but the limitations of this were acknowledged whilst the community matrons were on the advanced practitioner course, and it did not reflect the nature of openness expressed in case study site one:

“We do get some support from the leads [CMs] but they have to manage a team and do the advanced practice... that’s the advanced practitioners in training... We do have team meetings and there is support there but it’s not to degree that you actually say its productive support, its not somebody you can call on to say, I’ve got this problem, Monday to Friday, there’s not that much degree of support. But then I wouldn’t say that was down to individuals, I would say that was down to the make up of our teams, about the case management process as a whole, and how we all work together.” (ACM09/site 3)

However it was only with the community matron who had qualified as an advanced practitioner where the role was distinct as the clinical and managerial lead in the team. This was evident when the team was observed in a team meeting (OBS MT5/site 3), where the community matron led the discussion about the team’s activity, seeking feedback from active case managers about their patients, providing clinical advice and making decisions on patient allocation based on dependencies. There still remained openness within the team to enable discussion about future ways of working and the best ways in which to use the skills of the community matron and the active case managers, as observed at the team meeting (OBS MT5/site 3).

One of the active case managers (ACM10/site 3) referred to how the community matrons undertook joint visits with the active case managers which provided training and support. Also the manner in which the community matron talked about her role it was clear that she directed other areas of work within the team, for example:

“They will do presentations if they’re asked, [ACM name] is not happy, s/he’s not one of these who, they’re all different skill mix and all different personalities. And because we’re a good team, I don’t sort of put pressure on people to do things they don’t like
“doing, there’s nothing worse than that. But [ACM name], s/he’s not a lead, s/he likes to just do patient care...” (CM12/site 3)

Overall, the team dynamics were different in each case study site, reflecting the different skill mix and size of teams, and also the stage at which community matrons were on the advanced practitioner course in case study sites two and three. In case study site one the team leader was one amongst equals, in a purely coordinating function, whilst in case study sites two and three there was increasing delineation between the community matron as a clinical and managerial leader and the active case managers. This was affecting the team dynamics, and was in a transitional stage in case study site two. Here there appeared to be less openness between team members to that experienced in case study site one. In case study site three, the transition of the community role into team leader was more progressed and there was openness of discussions amongst team members, albeit not to the extent of case study site one but greater than case study site two. In particular the leadership role was established by the community matron who had qualified as an advanced practitioner in case study site three, as acknowledged by her colleague in another team (CM11/site 3). However, it is not clear whether this would have been irrespective of the advanced practitioner qualification, in that the community matron would have adopted such responsibility for the team.

8.2 Relationships with district nurses

The relationship between the community matron and the district nurse role was described differently in each of the case study sites within policy documents and job descriptions of community matrons (eg DOC STRAT1/site 1; DOC JD2/site 2; DOC POL1/site 3). Only in case study site three, was the district nurse formally identified as a member of the ‘virtual team’ alongside, for example, dieticians and mental health services (DOC POL2/site 3). Here, the GP and pharmacist were seen as other clinicians with whom the community matrons would work, but not as ‘team member’ status (DOC POL2/site 3). This differed in case study site one where the strategy for the management of long term conditions focused more on the relationship with general practice rather than existing nursing teams (DOC STRAT1/site 1). Within the job description for the community matron in case study site two, the district nurse was not identified explicitly whilst the GP was (DOC JD2/site 2). Similarly in case study site three, the job description made generic reference to other clinical practitioners, rather than nursing specifically (DOC JD1/site 3). As such it seemed that there was an assumption that the role of community matron would work with existing nursing roles, such as district nurses, and had not been considered in detail within the developments on each case study site by the respective organisations.
However the experience of working with district nurses was difficult initially for community matrons and active case managers, notably in case study sites one and two, and to a lesser extent in case study site three. Two community matrons in particular noted how they found district nurses intimidating, for example:

“I find it quite hard going to the district nurses ... but I think that's more my problem than theirs. They can be quite hostile some of the district nurses really... because their role feels threatened I think.” (CM06/site 1)

This was also reflected in diaries of three community matrons in case study site one. For example, one community matron commented about her attendance at a district nursing meeting:

“At times I felt that they were not making it easy for me. They are a large team and can be intimidating”  (DIA CM05/site 1):

One diary entry indicated how resistance had permeated into patient care:

“Joint meeting with family, social worker and myself arranged. Social worker informed district nurses re meeting who in turn cancelled the meeting I had arranged and said they had a lot of involvement with patient and didn’t think it was appropriate for me to get involved. Initial thoughts were at no time did either patient/wife inform me that district nurses had made any significant impact on patient’s care or helping family. Two separate people had asked me to visit but had I not thought deeply enough about who would be the best people to deal with [the] situation? ...Reasoned in the end that I would still visit the patient as he needed care and nursing politics are low on my priorities”  (DIA CM08/site 1)

This reflection suggests that the community matron did not consider the district nurses’ response to be based on clinical issues but on role demarcation. Here the response was not made direct to the community matron but rather appeared to be an attempt to block her access to the patient. This type of indirect reaction had not been noted in other findings.

In case study site two the active case managers reported specific antagonistic behaviour towards them. During the focus group with active case managers, one reported that they had felt bullied by a district nurse, to the extent that they nearly went to Human Resources. Another described the unhelpful attitude towards them on the telephone (FG ACM/site 2). A further example described the behaviour a district nurse towards the active case managers:

“I came up a few times to speak to the sisters, the team to say, and this particular sister completely ignored me and slammed things down, and all that carry on, you know, and I thought, mm, I don’t know how to handle this. But I thought, just let it go.”  (ACM02/site 2)
The tensions were affecting how the active case managers went about their work, as indicated here:

“I’ve avoided going into the office, as having to deal with other professionals over the phone, because people are listening to your conversations ... it affects your confidence levels as well.” (ACM07/site 2)

The perceptions of antagonism and tensions were not restricted to the community matrons and active case managers, as in case study site three it was one of the district nurses who described how an active case manager had been treated by a group of district nurses, even though the community matrons and active case managers had made less reference to it than in case study sites one and two:

“I remember a lot of antagonism... I know a colleague who we worked with for quite a long time went to be one of the case managers... I know she was met with a lot of, I wouldn't say aggression but people didn't want to listen, people were very concerned, very concerned... Presumably that was an attempt to put people's minds at ease... but there was still that concern after the meeting, and somebody said she was given, she got a hard time.” (DN03/site 3)

Participants interpreted the poor reception as a reaction to a perceived threat of the role to district nursing. The threat was described in terms of a fear that district nursing would be replaced by active case management and community matrons, the district nurse would be managed by community matrons and that the role was being devalued and not recognised.

Six community matrons across all case study sites made specific reference to it, for example:

“I think initially there was a lot of trepidation about the district nursing role, where the job’s going to go, same as social workers... community matrons were going to change the world, we were going to get rid of all district nursing and social workers, because they wouldn’t be needed because there’d be community matrons going to do that…” (CM02/site 1)

This was echoed by the active case managers in case study site two:

“... one time to be a district nursing sister, one time that was something, and the when the role of case management came in, it really shattered the foundations of community nursing because there was this complete divide about who did they think they are, and what’s it all about... there became another tier in the structure, and even now there’s district nurses sometimes feel that it’s devalued their role.” (ACM02/site 2)

The professional threat was also acknowledged by three of the four district nurses interviewed, as illustrated by this observation by the district nurse of another’s reaction to a case manager:

“... there was a patient who the case manager was seeing, and the case manager rang her [district nurse] and said ‘the dressing has come off, shall I renew her dressing for you?’ And she was ‘no, no, no, I'll come and do it’. She didn’t want her to do that... it was wanting to hang on to her job.” (DN03/site 3)
The concern for the district nursing role was also being discussed in higher education with those on and applying for the district nursing course, so those embarking on district nursing as a career path were being confronted with confusion and concerns even before qualifying:

“The role was being introduced when I started my district nursing training in October 2005. The concern from tutors was that part of district nurse role might be eroded as result of the introduction of community matrons. I think there was a lot of crossed wires and grey areas that people didn't understand where the roles divided, where they slightly overlapped. District nurses are aware that their role is often misunderstood, and this seemed to be a pretty well defined role, that district nurses were losing out on... There was a lot of concern at the time.” (DN03/site 3)

Two district nurses in case study site three articulated the threat in the context of the low morale within district nursing and feeling devalued as a professional group that was already happening at the time the community matron role was introduced. The reaction amongst district nursing to the national policy about community matrons (DH, 2005a), almost a sense of being let down by the chief nursing officer, then impacted on how the roles could work together:

“What came out from the Department of Health was very unclear in many respects, not helpful at all, and you can understand why people felt the way they did, when the chief nurse talked about the opportunities and all this sort of thing, and district nurses, I think there was one mention, this might be suitable for a district nurse, the role of a community matron. And yet it was sort of it was going to be different from district nurse, and I suppose in a way it devalued what district nurses did, almost, that was the effect.” (DN03/site 3)

“It’s felt as if their role has been eroded a bit in some areas. It’s okay if you can work together and can look at what you are doing, but if there isn’t that team working between the case managers and the district nurses then it can be a problem.... you wouldn't want the district nursing role to be eroded really and I think at the present climate, staff morale is quite low, and to have more of your role taken away, you feel undervalued.... [this role] has exacerbated it” (DN04/site 3)

These fears may have been reinforced by the lack of clarity about the relationship between the roles within each of the case study sites, as described earlier in relation to organisational strategy and policy (DOC STRAT 1/site 1; DOC POL 1/site 3).

Participants across all case study sites reported that relationships improved over time and with one to one working the perceived threat dissipated. This was described as a normal process in dealing with change as articulated by a district nurse:

“There were lots of rumblings when case management came in, clashes between team leaders and case managers about who's doing what, but that all seems to be settling, and I think its just quite naturally the roles are defining... because I'm not hearing the
niggles any more, because they'd say 'what are they getting involved for, they said I should have done this, and that seems to be calming... But again its very subjective... it's just the gossip and the chat we have... It's the classic model of storming, forming and norming isn't it, and agreeing to live harmoniously....” (DN02/site 2)

This in turn developed into positive relationships with district nurses and other colleagues, particularly in case study site three where the good relationships were specifically described by two of the active case managers and one of the community matrons, for example:

“Actually everybody has come on board with us. Even if they haven’t known a lot about our service, when we’ve actually spoke to them, once they’ve listened to what we have to say, they’re quite happy to come on board, they’ve not been negative about it, do you know what I mean, ‘oh that sounds wonderful, that’s going to work’, so its been quite positive about it. Erm, so if you’d asked me that question maybe eighteen months ago, I might have district nurses, but I can’t say that now because it’s moved on. So that everybody that I deal with [researcher’s name] is positive about the role and they do like the role”. (CM12/site 3)

In summary the relationship between community matrons, active case managers and district nurses in all case study sites was initially one of confrontation and explicit antagonism from some district nurses due to a perception of threat which was reported to have impacted on how the community matrons and active case managers have felt able to practise and develop the role. Over time relationships were reported to have developed through one to one working to be a positive relationship, with an understanding of how the roles can work together effectively.

8.3 Relationships with general practitioners
There were mixed reports about relationships with GPs. A limited degree of antagonism from GPs was reported by a few community matrons in case study site one. However this was not the extent or nature experienced with the district nurses, nor was this seen in the other case study sites. Unlike district nurses, the negative reaction of GPs did not tend to be associated with the perception of a threat to the GP role. However this was mentioned by one community matron in case study site one, who also suggested that advanced practitioners could be used where there were GP shortages:

“...that’s the other question we keep getting, how are you different therefore from a GP? ...I did have a confrontation with a GP the other day who said that my role was exactly the same as his... I think advanced practitioners, a lot of it has come along because of the shortage of doctors...and there is some, erm, antagonism from some GP practices, but in actual fact the ones we’ve come across who are antagonistic are the very good practices in the area who can easily therefore attract doctors, and don’t have a problem with staffing.” (CM02/site 1)
In all case study sites the difficulties reported in relationships with GPs were more related to a lack of recognition and understanding of the role or acknowledgement of the need, but in case study sites two and three these difficulties were countered with reports of positive working relationships where GPs had embraced the role and identified the benefits for themselves, for example:

“... Some GPs have taken on the service with great gusto, probably for them they see it as taking workload off them, helping them to meet their QOF targets by getting data they wouldn’t get themselves. I think for many GPs possibly there’s a lack of knowledge on what we do and can help them. So I don’t think really we’ve got those close networking relationships developed yet that enable us to sort of ... to be honest it feels like, I personally feel like we’re always on the outside, still struggling, fighting to get in... whether or not many GPs feel it’s unnecessary... I have heard, a colleague... her GP... he expressed that he thought case management was a waste of time and didn’t really see point - maybe lack of education again, maybe that stems down to a fundamental definition of what case management is about, it seems to be a bit woolly...

(ACM10/site 3)

A GP (GP01/site 3) referred to some resistance to the role because GPs did not want any interference in their work, even though they themselves saw the benefits. In one instance in case study site one a community matron reported that the relationship was good but the GP was protective of existing ways of working and roles:

“I’ve got a really good relationship with that practice, but the GPs are very old style GPs, really, and I go to a meeting where possible on a weekly basis, you see, it’s their MDT meeting which is very good, but they still have this ... even though I’m working with the patients, the practice nurse will still go out... and I’ve tried to address it, but the GP is oh no, no, no, my practice nurse that he’s had for years, they’ll go, don’t worry, they’ll take the bloods, ...it’s got better, I think I’ve had to get used to the practice and they’ve had to get used to me... they don’t know me, they don’t know my standards of care...”

(CM08/site 1)

Positive relationships were specifically reported by seven community matrons across all case study sites and also by the majority of active case managers (in a focus group in case study site 2 and in individual interviews), which tended to be predicated on previously established relationships of individuals with GPs rather than their new role in active case management. One community matron in case study site three reported a positive relationship with the GP mentor whilst on the advanced practitioner course (CM12/site 3).

Where there had not been a previous working relationship it was harder for community matrons and active case managers to be accepted. For example, one community matron in case study site one described how her experience had been different from her colleagues:

“I didn’t have a problem at all in seeing any of the GPs. None of the GPs said no we’re fine thanks; we don’t need your service, where some members of the team have had that. ... they don’t use them and it’s a case of, we’re alright. And even with the GPs that I
knew I made appointments to go and see them to say this is what we're doing, this is what we can offer. Although the rest of the team did that, some GPs said, I think we're alright and we don’t see a need for you, we have a good relationship with the DN, for instance, so it's been quite hard for some. But its only because I've been here and people know me.” (CM03/site 1)

The degree of acceptance of the role and how GPs would utilise it was interpreted as the level of trust the GP had developed in the individual and the degree of confidence they had in their practice, particularly for the active case managers in case study sites two and three. One active case manager made light of this in recognising when a GP was testing clinical knowledge:

“They still test me... one of them rang me up and asked me which blood bottle, it was something about one of the blood tests wasn't done, and he gave me a quick test on which blood bottle I was supposed to use, and I got it right and he went oh, yeah that's right – I just thought that was funny actually but I did feel like I was still being tested about things...” (ACM08/site 3)

In case study site two the active case managers highlighted experience where GPs would not accept their advice. This had two facets: a lack of confidence in their skills and also a reflection of how the GPs traditionally related to nurses, as described by one of the active case managers in the focus group in case study site two:

“... you have some GPs don't want to listen to what you say as well, you can phone and say this person, I don't think they should be on this and give them the reason why argue till you're blue in the face, they still won't take them off a drug or put them on a drug until they decide, no matter what evidence you've got to say they shouldn't or... They don't like it, even though it is just advice, they don't like you advising them...” (FG ACM/site 2)

One district nurse countered this in reporting feedback from a GP which showed concern about clinical interventions by individuals in this new role where they had yet to develop trust in the individuals. This suggests there were communication problems and working relationships and role boundaries had not been determined before working in an environment where the GP had traditionally led patient care and always had complete responsibility for prescribing:

“I suppose the other thing that worries me a little bit is that they are able to change medication. Just one example I've seen, and this is only one person... I know a GP who got quite cross when somebody changed the medication of one of his patients, and I remember him saying 'I've known patient for 30 years, I know what this person can have and can't have, and it's been changed without my consent or discussion', and I think that's worrying...” (DN01/site 2)

Although not explicit across all participants, there were references to how beliefs and perceptions of GPs about the doctor-nurse relationship were being played out, from two community matrons in case study sites one and three, and from active case managers in
case study sites two and three. The frustrations of this were expressed by one community matron who perceived an imbalance in the relationship, with GPs adopting a superior position (CM05/site 1). This was also reinforced by ways of working where the community matron had to wait outside GP rooms giving the GP control of the relationship. Such frustration was also expressed by active case managers in site two because of the time wasted waiting for GPs. The community matron said:

“I think the frustration element of working with people who don’t understand what I do or who have issues of their own knowledge base shall we say, people such as GPs, who perhaps have not been used to speaking to nurses as a colleague, erm, and who believe they’re right, so it’s been quite frustrating... you’re still having to wait outside doctors’ rooms, which annoys me a bit, really, I mean obviously if they’re in a consultation I wouldn’t want to interrupt, but it’s kind of the way it’s all set up, isn’t it, you have to go to them, you have to sit behind their desk, and they’re in control, aren’t they, while you ask. I keep giving my mobile number for them to ring me back when they finish seeing patients, some do and some don’t. Again, that’s to do with the fact that they don’t want to discuss what they’ve decided with a nurse, I think. Because they don’t need to, unless they want me to do something.” (CM05/site 1)

This was not endorsed by the GP in case study site three, who stated that the GP was always available for the community matron and that the relationship was formed on discussion and not direction from the GP.

The active case managers in case study site two expressed frustration with GPs telling them what to do, even though it was not their role and how they would say no:

“We go to the surgery over and over, and tell the GP that this isn’t the kind of patient we take and they will still... ‘well I want you to do it’, well no, that’s not our role...”

(FG ACM/site 2)

However, the community matron expressing frustration with GPs had reflected on how she had been able to challenge a GP, implying this was not something she had been comfortable doing in the past:

“Was able to use my new skills to challenge a GP about his attitude towards a patient. I felt this went well and that the GP was aware that perhaps he needed to look at all the info before making a decision...” (DIA CM05/site 1)

She commented further on how to use the relationship for her advantage, describing ‘rules of engagement’ and the complexities of making this work when dealing with a large number of different GPs:

“Yes [laughs] ... you’ve got to be a little bit clever, don’t you because if you say, you do this for me, and I’ll do this for you, and it is a little bit of a... you have to play a game with them, and you have to know how to play it, play each one, and that’s what’s difficult for me, if I’ve got ten different GPs, different practices... “ (CM05/site 1)
Therefore relationships with GPs had been mixed, with positive relationships being underpinned by previous working experiences with individuals rather than from acceptance of the role. Community matrons and active case managers were trying to practise in an environment where role boundaries and relationships with GPs had not been developed which evoked challenges. Difficulties seemed to be accepted rather than challenged, with working practice circumnavigating the problem to achieve what the community matrons and active case managers needed to achieve. In general, despite some of the problems, the relationships with GPs were seen to be positive, albeit on the GP’s terms.

8.4 Relationships with hospital staff

Whilst participants referred to their relationships with hospital staff, this was to a much lesser extent than their significant relationships with district nurses, social workers and GPs. Relationships with hospital staff were referred to mainly by participants in case study sites one and three. There appeared to be less interaction with hospital staff by community matrons and active case managers in case study site two, as reflected in discussions and in observations. In case study sites one and three community matrons had undertaken regular visits to the hospital for case finding (OBS CF/CM04/site1; OBS CF/CM11/site 3) and multidisciplinary team meetings (CM12/site 3) whereas in case study site two hospital visits and attendance at multidisciplinary meetings tended to be patient specific, such as once a patient had been admitted (ACM10/site 2). Case finding in case study site two had been undertaken through general practices rather than at the hospital (CM09/CM10/SM01/site 2).

The discussions by participants about hospital staff tended to fall into two groups; the consultants and the nursing and therapy staff. Relationships with consultants were reported positively across all case study sites (CM02/CM04/site 1; SM01/site 2; ACM08/CM11/site 3), and were mostly predicated on knowing the consultant previously, either by working with them in the hospital environment, for example two active case managers in case study site three had each worked with the consultant for renal disease or the consultant for respiratory disease. This was demonstrated indirectly when the active case manager visited a renal patient on the hospital ward, where the conversation between the active case manager and the patient reflected this positive relationship (OBS PV/ACM08/site 3). Other positive relationships had developed where the consultant had been personal mentors to community matrons whilst doing the advanced practitioner course, as reported by community matrons in all case study sites (CM04/CM07/site1; CM10/site 2; CM12/site 3).
One active case manager in case study site three who did not have a prior working relationship reported very positive relationships with consultants that had developed through joint contact with the patient. This enabled the relationship to develop so that the consultants knew the individual practitioner and recognised the active case management role:

“Some consultants are very much involved and are happy to be emailed to ask them questions, which is really good, makes life a lot easier, and we can get patients seen a bit quicker if they need seeing quicker, or they’ll recommend something to you, or it’s just to check that you’re doing the right thing sometimes as well, so that’s something I think is quite beneficial really... I think because they see you with the patient, you go to their appointments which we have time to do, then they actually see you and are quite happy to help. I have email addresses and we can then discuss the patients and make sure everything is going quite well, which I think is extremely helpful... I’d never met any of these people before... there are certain consultants, I guess our patients are more elderly so there are certain consultants that you see quite a lot with different patients so they get to know your face, get to know what you do, and I think because they’re happier that they’re monitored a little bit closer at home as well, because most of them, the disease is quite difficult for them to manage, so having somebody there that is monitoring them is important. I think they see the benefit of us catching things early rather than them ending up in hospital...they are happy to offer advice.” (ACM08/site 3)

In case study site one the majority of community matrons reported positive relationships with hospital staff whereas in case study sites two and three the community matrons appeared to face more challenges in developing relationships with general ward staff and therapists. This was demonstrated when observing a community matron visiting the hospital wards in case study site one (OBS CF/CM04/site 1), where they were immediately recognised by ward staff and engaged in general conversation as well as discussion about specific patients to be referred to the community matrons. As another community matron in case study site one stated:

“And now the ward staff are good and started faxing to us even when we don’t know the patient, or even better when there are a known one they refer back to us. It’s beginning to work and they’re just really positive and they say it’s good to know there’s somebody out there, so they don’t worry about [patient name] going home, and there’s nobody, she lives alone, and she gets mixed up with her tablets, so there’s somebody out there just to oversee it really.” (CM05/site 1)

However when observing a community matron and active case manager visiting wards in case study site three, they were not recognised and needed to introduce themselves and the role on each ward (OBS CF/CM11/ACM08/site 3). The ward staff did not actively engage with them but gave them access to patients’ records. There was one exception where a nurse was dynamic in using the opportunity to share information about care of specific patients and potential candidates for the case management service. The community matron commented at the time that they had limited success in developing relationships with the wards, despite sharing information, posters and contact details with the wards, and therefore were looking at
other ways of developing relationships, for example by attending multidisciplinary team meetings. Another community matron in case study site three (CM12/site 3) had reported separately that such links had been developed by attending weekly multidisciplinary team meetings and were targeting specific wards where patients were more likely to be admitted (for example medical wards caring for people with respiratory conditions).

When describing the difficulties in developing relationships with ward staff, one active case manager and a community matron in case study site three highlighted this was affected by the changes of staff on shifts and how busy the ward staff were. One expressed concern about how other active case managers had interpreted the lack of engagement:

“... we had a discussion... within the wider social team; I was the lone person sticking up for the hospital worker. I find it really hard to listen to people saying that they’re lazy, and don’t do this and they don’t do that, and I think, no, they’re not, they work so hard... but its frustration that they’re not getting the referrals they’re supposed to. Because I know that they [hospital staff] know who their regular attenders are, in the hospital, I know they do, but they don’t have time to talk about it...someone else coming along and asking for ten minutes of your time, physio... OTs... discharge person... the consultants asking for it, that’s probably an hour and half in the end of someone just wanting 10 minutes of your time. But I think I’m the only person that sees it... it’s completely different in community to working in the hospital, even though it’s stressful, the job is.... nobody else sees it, because they haven’t seen it for such a long time... it’s a different world.” (ACM08/site 3)

This frustration was expressed by another active case manager in case study site three:

“... a lot of time they, when nursing staff and hospital doctors don’t really want to spend the time to listen, I might say I only want to take a few minutes of your time; my interest is to want to make it easier for you to understand what the patient is like before they came in...” (ACM11/site 3)

In light of such difficulties some active case managers had changed their approach and chose to communicate through the patients’ records, with two (one from case study site two and one from case study site three) commenting on the improvement, for example:

“You don’t actually work with hospital staff because the communication isn’t always that great. We go into the hospital a lot, talk, very often what we’re trying to do now is, because sometimes when you go in the hospital, there’s that much change over of staff, when you do speak to the staff, they go, ‘well I wasn’t on yesterday, I don’t know what happened, and oh well, I was only on for the morning’; so you never get any good continuity with care. So very often what I try and do now is plan it so the time I know there’s going to be a doctor’s ward round, something like that and specifically go and those times, so I can get a lot of knowledge... on occasions I’ve felt I’m not getting any success here, not getting any communication, so what I’ve started to do, and this again is only with experience, I write in the doctor’s notes now, from a community perspective, we feel we need these issues addressing, and I write down what I feel the issues are. And I’ve had good success with that.” (ACM02/site 2)
Relationships with therapists were acknowledged by participants across all case study sites but they were not depicted as a key relationship nor had any specific issues. Only one active case manager in site three indicated that they would communicate more with therapists than nurses and doctors:

“... its usually OT, physio, rehab staff, if you’re going to have contact with anybody about patients in the hospital, generally speaking it’s going to be them, very rarely doctor, and nursing staff again very rarely. Half the time they barely seem to know much about what’s happening with the patients.” (ACM10/site 3)

Interestingly participants, whilst recognising the importance of good relationships with hospital staff, such relationships did not share the same prominence as those of social workers, district nurses and GPs. Relationships with consultants were very positive, the majority being established on existing relationships or through mentoring arrangements, similar to the reports of positive relationships with GPs, and were developed through joint contact with patients. Relationships with ward staff were more patchy and difficult to develop in case study sites two and three, whereas in site one the relationships between community matrons and ward staff had been successfully developed.

8.5 Relationships with social workers

Relationships with social workers were the most frequently reported as being positive, with nine community matrons from across all case study sites and active case managers from case study site three in particular reporting good working relationships. Active case managers in case study site two reported that the relationships were developing but were also positive. For example:

“we’ve got a good relationship now, with all the social workers involved, we’re really close, it brought us, you know, professionally really, we understand each others roles, because we were doing joint visits, case finding people who weren’t known to health and social care... I’ve had a very good response from all social workers that I’ve rung up, very positive.” (CM05/site 1)

The social workers from each case study site consistently reported good relationships, going beyond one to one relationships to describing shared working practices and an excellent rapport between themselves and community matrons, as shown here:

“As the service has developed, as they’re experts in their field, it’s been a very much joint working relationship... they’ve introduced us and in turn we’ve knocked on things we would not have known about, through the health incentives... it was really good... and also this shared meeting... we’ve lots of changes coming within the next few months in adult social care services, and I think it’s important as they’re going out and seeing patients in the community that they have some understanding of the changes.... and we share the venues, as well which is rather nice, we’re going through to the local health centre for a meeting, we have a bit of a joke about who provides the biscuits... or
they might come here to our conference room... its lovely, you know, really good.”
(SW02/site 2)

The good relationships were associated with shared goals of the social care and active case management services. The community matrons in case study site one were at an earlier stage of the relationship than sites two and three, and the commonalities and positivity were being seen at the outset as shown in this report from a community matron:

“... it’s far more proactive …now they’ve only just come on board in the last couple of weeks, so to me, you know, it looks like they’re trying to prevent people becoming a critical problem for social services, just as we are trying to prevent people becoming a critical problem for the NHS. So I see health and social, for this group of people, goes very much hand in hand, I would see a very close, hopefully a very close working relationship there.” (CM02/site 1)

The shared goals remained apparent in case study sites two and three where there had been shared working for a longer period of time. For example, the social worker in case study site two related their day to day working with their service objectives:

“They’ve been really, really good in helping when we’ve needed them. When we’ve been out, we’ve seen someone with concerns, time and time again, they’ve said, ‘look, okay, I’ll pop in, or I’ll go there tomorrow morning, or I’ll support you with this’, its really good... it’s all about making the person more independent and looking after their general well being... I think they’ve learned from us and we’ve learned from them... they’re very clear about their overall thing, and that goes with us as well, preventing hospital admissions, because ours is around prevention, the same ambitions really, the same sort of targets, that we’re all about preventative services, that’s health or social care, so it’s about pulling together on that... to prevent people going into crisis.” (SW02/site 2)

This common objective translated into a symbiotic relationship, so that community matrons, active case managers and social workers across all sites were describing shared working in terms of joint visits and the benefits that brought. The mutual respect between the two professions was observed at a multi disciplinary team meeting to discuss the future care of a shared client (OBS IC CM12/site 3). Here the social worker who was chairing the meeting acknowledged the expertise of the community matron and the importance of the information that was being presented with regard to health needs.

All three social workers valued this working relationship and recognised it was distinct from other relationships with health professionals. For example, the social worker from case study site three described how it worked:

“It works because they understand that there’s a wide gamut of social components that we can respond to, and there’s a whole range of medical issues that they address, and often they intertwine or need an intervention from both sides to work most effectively, in terms of we help to manage the care package and if the ACM feels something needs to go onto the care package they have to engage with us to get the care plan changed.
Conversely if we need supporting information for a particular type of hoist or pad or something they can quickly access that, and they can make justifications why it’s needed using medical terminology a lot better than we can... It’s a mutual interest to work together... It lends itself to the informality, to talk very plainly and clearly about what we need from each other... the difference is with the ACM it is community based, and it’s holistic, it’s based on a wide range of people’s needs.” (SW03/ site 3)

An exception to this was experienced by a community matron and an active case manager in case study site three, who reported that the social worker would be assigned to a case for six weeks, and if the case was closed at that point, there would need to be a new referral made where a different social worker could be assigned, which was affecting how they could work effectively together:

“... and what this client needs, and what they say to you on a day to day basis, and the social worker can go round and get a snapshot of an hour, go away with something completely different, and it gets hard, we have a lot of heated debate with social services, just about... they have their own agenda so they take a case on, they look at a case and then they shut the case, so its like putting something in there, then they shut it, and if you want, say they put a care package in, if you want that care package reviewing two months down the line, it won’t be the same social worker... which doesn’t fit with the case management ethos.” (ACM09/site 3)

However this was not raised by other participants and the community matron did indicate that the relationships were improving:

“... the fact they don’t keep their patients very long... we get the same ones [key workers] over and over, because we work in the same geographical area, so you know their voices, you get to meet them every once in a while, and we are developing quite a good relationship...” (CM11/site 3)

Resistance was only mentioned by one active case manager in case study site three. This related to a perceived concern from social services that involvement of active case managers and community matrons would increase demand and therefore pressure on social care budgets. This was related to a lack of understanding of the role and developing trust in another professional:

“I did get resistance from ... social services because they think you’re going to ask them to spend lots of money on their patients, that we’d ask for residential care straight away, a bit of respite... they don’t understand you’re trying to empower the patient, you can only ask for things that are appropriate. You don’t want to send someone into residential care unless they’re really meet the criteria and they feel they can’t manage at home.” (ACM11/site 3)

Whilst in case study site one the role of the community matron and active case manager was raised as a perceived threat to the social worker role by three community matrons and the social worker, this was not antagonistic or personal, as experienced with district nurses. The
social worker was very positive about the role of community matrons but described the threat in terms of fear about the future of one’s own role, which went beyond social care:

“I think... its like a fear factor that’s around maybe sometimes, because the pathway we’re moving is to work very, very closely together, health and social care, but you do have this fear, I think, that one sort of area could be subsumed by the other, if we’re honest about it... I think there’s a fear factor... and whose role is going to be eroded?” (SW01/site 1)

Again the fear subsided as individuals developed working relationships, as described by one of the community matrons in the same case study site:

“I think when I first met up with the social worker at the beginning she didn’t know anything about my role...And I think they know more and we’ve been out to talk to more people about our role, we’ve been to the social services and...and I think they were a bit threatened at first, thinking we were taking their jobs over... They contact us now, and ask us to go and see people, or can we do a joint visit, which is good, so we are working now...” (CM04/site 1)

Perceived threat was not an issue raised in case study sites two and three, with the exception of one active case manager in case study site two who indicated that the mental health social worker specifically felt that the active case manager was challenging her practice, so in this circumstance it was personal:

“I’ve had an incidence just recently where I was asked to visit a lady who was late forties, who had heart failure and COPD, but she had learning difficulties and mental health problems, and when I went to see her she had like twenty dosset packs not opened and she was involved with a social worker, a mental health social worker, and I contacted the social worker whose known her for seventeen years, and she really couldn’t understand, what’s it got to do with me, why I wanted to meet the social worker, why I wanted to interact with her, and she felt she’s the only one that’s ever been involved with her for seventeen years, and I think she felt very threatened, that I was challenging what she was doing.” (ACM02/site 2)

Where social workers had been able to work with active case managers and community matrons over a period of time, a clear level of trust and mutual understanding was evident across all case study sites, as illustrated by the social worker in case study site three:

“Well you can’t put a value on this really, if you work in a particular locality, you know the active case manager well, you can always say, I’ve got one of Dr W’s patients, do you know her? And this is the phrase I always remember, ’no, should we?’ and that's the value, because they trust you enough, even though you're not medical, even though we work in different spheres, they trust you enough to say if you think we should know her, tell me more. That's so useful because you know you've got a way in.” (SW03/site 3)

Therefore relationships with social workers were portrayed as very positive by community matrons, active case managers and social workers. Whilst there had been a perceived threat by some social workers with regard to the introduction of the community matron role, this did
not appear to hinder the development of effective working practices. In fact the relationship with social workers was portrayed as the strongest relationship by the majority of community matrons and active case managers, which was reciprocated by social workers, and appeared to reflect the alignment of service goals in relation to promoting independence and avoiding crisis for service users.

8.6 Developing the relationships

Promoting awareness of the role through presentations was reported by community matrons as the main vehicle to start to build relationships, as described community matrons in all case study sites and the active case managers in case study site two. Such presentations were observed, for example to GPs at practices (OBS MT2/CM04/site 1) and social workers (OBS MT1/CM1/CM2/site 1). Further presentations were reported to have been given to the Local Medical Committee, Practice Managers’ Forum. In case study site one a community matron described presenting to the Area Committee which had been a particularly challenging and difficult experience (CM08/site 1). Of the presentations seen in case study site one, social workers were responsive and engaged in discussion about working together. However whilst the presentation for a GP practice generated responses which questioned the need for the role, GPs raised concern about its impact on traditional roles of district nursing and practice nursing and also challenges about potential increase in call outs for GPs. However the majority of community matrons across all case study sites still felt such presentations were important to begin to establish relationships and needed to be reinforced. For example:

“I think it’s because I’ve tried to promote the service and I’ve not given up on it. I’ve actually kept presenting every now and again to the same people. I’ve had regular GP meetings, erm, I’ve involved people in the MDT meetings, we’ve pulled everything together and I think that’s why it’s worked effectively. Without doing it that way you’d probably still be in the same position you were before.” (CM12/site 3)

One to one meetings and regular contact were methods described by community matrons and active case managers in each case study site to develop effective working together, for example:

“I made appointments to see most of the GPs to let them know I was here. As time has gone on I’ve had more to do with them because I’ve gone along with problems for patients. Some GPs are better than others, so just by meeting the GPs...” (CM06/site 1)

Visits to GP surgeries and contacts were seen whilst observing active case managers (OBS/ACM01/site 2) and community matrons (OBS/CM06/site 1; OBS/CM09/site 2; OBS/CM11/site 3; OBS/CM12/site 3). Whilst visiting a practice, one active case manager explained how it was helping to build the relationship with the doctors, as they had not liked
others seeing their patients (ACM01/site 2). In all case study sites the community matrons and active case managers were GP attached. The importance of this in building regular contact with practices was described by a community matron:

“Now all of us are attached to GP practices... It was more by going in and talking to them, doing case finding to get to know more of us, they actually felt the benefit... the patients, they [GPs] found the intensive involvement of community matrons with patients, and that has now prompted them, that now they do refer, and the patients coming to us are high risk patients which is good...” (CM10/site 2)

There were still frustrations expressed about relationships not developing despite efforts made to engage with GPs and district nurses, as demonstrated by the active case managers in case study site two:

“I’ve got to say though, we work with three district nursing teams where we are, and even now they still come to us and ask what is case management, what is your role about... and the GPs very much the same, even though lots of presentations were given to the GPs... we’re still getting inappropriate referrals. When we started... [we] went to all our GPs, discussed it with them and the managers. Some took it on board straightaway, some we still don’t hear from, and some we just get such inappropriate referrals from them, they’ve got everything there written down in front of them, they’re just not reading them... or you just don’t get referrals, because they’re not quite sure who to refer.” (FG ACM/site 2)

The approach to building relationships differed slightly between that adopted with the GPs to that with district nurses, where for district nurses the style was predominantly negotiation:

“I think at the moment its up for...its just a negotiation, well you’re going in more than me, it would seem more appropriate if you carry this caseload, and if you have any problems come back to me... you, from a community matron point of view, you step back, and use me as a signposting service, which is part of the roles, but not the whole part of it, so you know, come back to me if you need some help, if you think I can help you...rather than taking over...” (CM02/site 1)

This was also cited from the district nurses’ perspective:

“For my patients, I’ve said to the community matrons I’d like to have you there as a valuable resource, as a specialist that I can dip into and dip out of as I identify problems, like I do with tissue viability, when I’ve got a certain area I identify as problematic. Say I had a gentleman with heart failure which I can deal with but say there was something with his medications I wasn’t quite sure of, I’d like to be able to access the community matron, their specialist knowledge who deal with that regularly, but not for them to take overall... I want to remain that because of the other needs... they [community matrons] seem quite relieved, ‘thank goodness for that, another person we don’t need to see’. They seem to be quite busy from what I can make out, so not a problem...” (DN02/site 2)

Negotiation with GPs was described by one active case manager:

“The practice I went to, to start off with had had 3 or 4 case managers in about 18 months, so the first thing was ‘are you going to stay or are you going like everybody
else?’ Once they got used to somebody, someone else came in and did it differently, and then they got used to them, and someone else came and did it differently... I think I’ve been the longest there... one example would be the first person would go to every single practice meeting and do a very detailed handover, they didn’t like that. It’s just small things like that. So we came to an agreement that I would only go once a month, and I would just speak on the phone if I needed any assistance, or write them letters if I needed something doing, because they felt that before was far too much... I was actually relieved... I would have to have pulled out of going every week... so that was mutually beneficial.” (ACM08/site 3)

However tactics used to build relationships with GPs were more focused on demonstrating how the role would benefit the GPs, either through helping them to meet their targets or reducing workload, which was seen across all case study sites. For example:

“... by doing something for them and hoping that would be enough brownie points. It’s very difficult... I think this GP was quite happy that she’d seen this patient at home, and now has taken her under her wing, this lady.... I think, hopefully she [GP] realised all she needed was some steroids and antibiotics at home which I’ve now organised anyway, that are there in the house just in case, and we’ve got a loose plan for this lady, in case it does happen again. It’s just chipping away at things with them like that, softly, softly... so hopefully it’s now got into this doctor’s mind that yes, perhaps we did avoid an admission there and now I’m not going to have the PCT breathing down my neck and maybe I can at least say to them I saw someone at home and prevented an admission.” (CM11/site 3)

So community matrons and active case managers used presentations to raise awareness of their roles with the groups they had identified as their key working relationships, such as GPs, district nurses and social workers. The majority of this work was undertaken by the community matrons themselves although some had been undertaken by senior managers in all case study sites as the service was being set up. This was seen as an important way of introducing themselves but they recognised that it needed to be reinforced and that effective relationships only developed through one to one working. The one to one approach was tailored to the individual, with negotiation being the reported tactic with district nurses, and potential benefits being the carrot offered with GPs. Such tactics were less explicit when working with social workers. Even with one to one working, it was sometimes challenging and frustrating in trying to develop relationships where the efforts were not reciprocated.

8.7 Summary of themes relating to relationships

Internal relationships with the team dynamics were strikingly different across the three case study sites, as reported by community matrons and observed in team meetings (OBS MT/site 1; OBS MT/site 2; OBS MT/site 3) which reflected the differences in team structures described earlier in Chapter 6. Where there was a flat structure in case study site one, there appeared to be more interpersonal support reflecting the development of friendships between
colleagues and a level of personal trust, whereas the introduction of skill mix in case study sites two and three presented more formal relationships reflecting a managerial type relationship. As such organisational structure appeared to influence the nature of relationship building and behaviours between new colleagues and the team dynamics.

There were significant tensions reported with district nurses, arguably the closest nursing role to community matrons. This may reflect the level of perceived threat to an existing role, as articulated by some community matrons. Behaviours of district nurses, reported by community matrons and active case managers, showed how groups within nursing ‘closed ranks’ to protect themselves. Also, whilst dealing with individual and isolating behaviours towards them, community matrons and active case managers empathised and justified the reactions and behaviours of some district nurses. To some degree individuals would still identify themselves as part of this group of nursing, due to previous roles and relationships, which then presented dilemmas as to why another member of this group could treat them as an outsider. This highlights how differences between disciplines in nursing may be used to form their professional identity, which can then create a dichotomy with the concept of a whole family of nursing. Relationships with hospital staff were described differently, reflecting different expectations and different levels of understanding of other professionals’ roles.

Findings also showed how the nurse doctor relationship was reported differently by individual practitioners. This reflected how individuals had developed strategies to circumnavigate or confront others, that is, use personal power to address the use of professional power, which tended to reinforce an imbalance of power between the two professions. In contrast, the relationships with social workers, a more distinct professional group, were portrayed very differently. These appeared to be symbiotic relationships where the behaviours reflected a mutual respect.

Findings about relationships suggested that the new community matron role affected existing practitioners and its impact affected different professional groups in different ways. Community matrons negotiated their role boundaries through their relationships to enable them to operate in their new role function. This has impacted on how they reported how they can be effective in their role, which is explored further in the next chapter.
CHAPTER 9: EFFECTIVENESS AND OUTCOMES OF THE COMMUNITY MATRON ROLE

This chapter presents selected findings regarding the effectiveness and outcomes of the community matron role, predominantly from interviews and organisational documents. Themes relating to effectiveness and outcomes were linked to the service model, as discussed in Chapter Six. Effectiveness and outcomes had not been identified as a theme prior to data collection, as the study did not endeavour to critically assess or evaluate the effectiveness of the role or its performance against targets and objectives. This was reflected in the study questions described in section 3.1. However effectiveness and outcomes emerged from the data as important to participants and was also reflected within organisational documents, for example strategic documents and performance reports. Thus, the findings represent the emphasis placed on different types of outcomes by the community matrons and where the organisational and individual priorities appeared to be aligned or were seen to be polarised. Numerical outcomes that had been prescribed nationally and by PCTs, such as activity and reducing medical intervention, were not reported to be as important to community matrons and active case managers. Rather, they reported qualitative and patient focused outcomes such as improving quality of life and patient choice to be of greater importance. To that end, some organisational outcomes in relation to medical intervention appeared to be reinterpreted in the context of improved patient experience. These are presented in sections 9.1 to 9.5.

9.1 Activity targets

In all case study sites, participants referred to target numbers for activity of community matrons and active case managers (CM01/CM02/site1; ACM02/CM10/SM01/site 2; ACM08/ACM10/CM11/CM12/site 3). Target caseload numbers cited were 50 and 80, which reflected the target numbers cited in national policy (DH 2005e) but the interpretation of this was affected by the categorisation of caseloads into active and inactive, as described in Chapter Six.

Some also recognised organisational targets and the reporting requirements of organisations externally, such as the strategic health authority (CM02/site 1; ACM08/site 3; CM11/site 3). For example:

“There are targets; I think we were supposed to reach 50 in April... because managers need us to reach our targets, don’t they, because the government need them to reach their targets, so I think we’re all very aware of the fact we do have to reach them... Case load numbers and inactive/active patients are quite a biggy I think, and the target
of three months and then they should be inactivate; that’s a biggy as well, which is a very hard one to achieve. I haven’t achieved it that many times really.” (ACM08/site 3)

The external accountability of organisations to achieve nationally driven targets was seen whilst observing one of the community matrons in case study site one who was acting as ‘matron of the day’ and received a telephone request for statistics about caseload numbers for a report to the strategic health authority (OBS IC/CM02/site 1).

In case study site two, the senior manager reflected that there was pressure to increase caseload numbers and considered their target of 80 to be unrealistic, and that 50 was more appropriate for the type of patients being seen by the service.

“I felt that the target was totally unrealistic, I still believe it is, the caseload of 80, totally unrealistic for the type of patients being seen. I went out with a community matron and I did that quite regularly, so I could see what type of patients and what they were faced with really... the assessments themselves were very long, the amount of referrals and everything else you needed to do, it just took so long, and if they kept going on this 80 caseload, I think its just going to dilute so much of what was really good about case management in the first place.... The target hasn’t shifted at all, still 80... But I think the number came before the work really... 50 was more realistic, but I would say that would take, you would need to be in post at least 18 months before you could really realistically hit that... there’s still pressure around the caseloads...” (SM01/site 2)

The pressure to increase the number of patients was also reported by two community matrons, one in case study site one (CM08/site 1) and one in case study site three (CM12/site 3). As with the senior manager in case study site two, there was concern about the impact of continuing to expand caseloads on the quality and effectiveness of care, for example:

“I think sometimes having unrealistic targets can be a bit of a barrier, but saying that we’ve agreed on targets, but we’ve had to do that over period of like the last twelve months, we kept saying that we’re pressurised to build up the patients, and I feel, talking personally now, not for anybody else, is that, yes everybody needs to have targets but if the goal is to provide quality of care for the patient, getting too many patients onto a caseload and trying to do everything for them, often you’re not doing the job properly in that respect, so if you have less, you feel you can do a lot more with patients and things don’t get missed. So we renegotiated the targets, to be realistic.” (CM12/site 3)

There was further concern in case study site one that targets could not be achieved as the targets did not take into account that five of the eight community matrons were taken out of the clinical service for two days per week each due to undertaking the advanced practitioner course:

“...there were real issues they were pulled apart about targets and things like that. Now, I want it to be made known that I’d like to do that first hand, that basically they may have set targets for this team, but when those targets were set, finance was set and
everything, did they realise taking 5 people of the team is a massive chunk of time out…” (CM08/site 1)

However in case study site three the target numbers for caseloads had been adjusted from 50 to 18 for those on the course, so that it was proportioned to the days in clinical practice (CM11/site 3):

“I think it's 50 for the full time, 25 active and 25 inactive, but then again that's all changing at the moment. And we're on like a whole time equivalent, so 18 each for the ones doing the course... we're all a bit under and we're all struggling really. I don't like targets but I think there needs to be in this job, there really does, because you do have to show, and it's very difficult to show its value for money. For every admission we prevent, it probably pays our wages for the year, but you do need to have these things…” (CM11/site 3)

In all case study sites, the target caseload numbers had not been reached; for example the active case managers in case study site two reported caseloads of 35 to 40 each, whilst in case study site three a community matron reported a shared caseload of 100 between the community matron, and two active case managers.

In addition to caseload numbers, all case study sites measured activity by number of contacts (CM02, CM08/site 1; ACM02, SM01/site 2; CM11, CM12, ACM08/site 3), which was also reflected on data activity sheets (ARC PD 2/site 3), caseload operational policy (DOC POL 3/site 3) and performance indicators (ARC KPI 1/site 2). Whilst the need to measure the service activity was recognised, there was concern about the focus on numbers rather than quality outcomes, as expressed previously above, and articulated by an active case manager in case study site three:

“My feelings are it comes down to bean counting, and on that basis alone if we're going to be judged I can't see how it can succeed, and that would be a shame. ... It's quality of life versus bean counting, and my personal feeling is bean counting wins out full stop.” (ACM10/site 3)

So it was recognised by participants that the service was being measured by the organisation and externally by activity and caseload targets, but these appeared to be of little value to community matrons in determining the effectiveness of the service or role of community matron, and that quality outcome measures were of more importance.

9.2 Reducing medical intervention
Reducing hospital admissions was the most prominent outcome discussed by participants, reflecting their knowledge of national targets relating to the role of the community matron and local organisational targets. It was cited by all the community matrons and the majority of
active case managers across all case study sites. It was also reflected in discussions with patients (P03/site 2; P09/site 3), social workers (SW01/site 1; SW02/site 2) and district nurses (DN04/site 1; DN01/site 2; DN02/site 2; DN03/site 3).

Reducing GP intervention was described as an outcome to a much lesser degree by community matrons (CM06, CM07/site 1; CM09, CM10/site 2; CM12/site 3). Whilst it was recognised across all case study sites, reducing GP intervention was referred to alongside reducing hospital admissions so that medical intervention was seen in this wider context in case study sites two and three. This was reflected in the organisational data used to assess the effectiveness of the community matron service, where in case study sites two and three data on GP visits prior and post community matron involvement were recorded alongside hospital admissions (DOC STRAT 3/site 2; ARC PD 2/site 3), as discussed in section 9.3. However there were mixed views about reducing hospital admissions as an outcome and the effectiveness of the role of the community matron in achieving this, as discussed below.

The majority of community matrons and active case managers across all case study sites felt that they were reducing hospital admissions and reported this as a key outcome of their role, for example:

“...this job is trying to reduce hospital admissions ...so therefore if the person goes in we need to get in there quick. So that’s been the biggest change for myself. I think for the organisation, because the aim is to prevent inappropriate hospital admissions, and reduce the amount of bed days, but also from the other side to reduce the amount of GP visits as well.” (CM12/site 3)

Of those community matrons, four also referred to reducing GP intervention (CM07/site1; CM09, CM10/site2; CM12/site 3), as did the majority of active case managers in case study sites two and three.

Comments highlighted that there were specific targets placed on the role from the outset which focused on organisational and strategic objectives to reduce hospital admissions and shift care provision to a community setting rather than focusing on the outcomes for individual patients. For example, a community matron in case study site one said:

“...when we were first in post it was avoid five hundred inappropriate admissions before April.” (CM05/site 1)

The focus of the role and activity on the avoidance and reduction of hospital admissions was observed in team meetings. For example community matrons in case study site one
discussed the admissions avoidance database (ARC PD1/site 1) which showed the highest ranking conditions that had been reported as avoided admissions and the estimated cost savings in the previous four months (OBS MT3/site 1). In case study site three, the community matron (CM12/site 3) attended weekly multidisciplinary meetings to review hospital admissions and consider where they could have been avoided.

Many community matrons and active case managers across all case study sites gave examples of patients where they considered a hospital admission had been avoided, such as a patient with COPD who did not want the doctor to be informed about their condition as the patient thought the doctor would send them to hospital (CM03/site 1). The community matron (CM03/site 1) was able to get agreement from the patient to have a blood transfusion as a day case rather than be admitted and consent to inform the GP of the patient's condition. The community matron felt that without their involvement the patient's haemoglobin levels would have dropped and that the GP would not have arranged the transfusion as a day case, therefore the patient would probably have ended up in hospital as their condition would have deteriorated further. In this example the interventions used by the community matron to prevent hospital admission included communication with the patient and coordination of care with the GP and the hospital, which required knowledge about services and how to navigate the system. Further examples from community matrons also highlighted similar types of interventions (CM04/site 1; CM07/site 1), as typified here:

“...one lady rang me up … a daughter of one of my patients, she was just about to ring an ambulance, and I said what for? And she said she feels that she needs an ambulance and I said I’ll come out now. Now that, is a bit of an acute really… because….I knew this lady so I knew, she didn’t have chest pain or anything, I asked that over the phone, but she was going to phone an ambulance because she had a buzzing in her ear or something, so I thought, I avoided an admission then...” (CM04/site 1)

Anecdotal feedback from a hospital ward about the role preventing admissions was also described by one active case manager in case study site three:

“I had a patient that used to go to hospital about once every 2 weeks for many, many years, and after I took him on he went into hospital about 6 months after with quite serious problems, so he had to go into hospital, and the nurse on the ward was talking to me about him and said “we thought he’d died as we hadn't seen him for so long. I’d checked to see whether he’d died...” And he’d just been out because he’d had really good support at home, so anecdotally it’s really good but doesn’t measure anything, does it. But that’s kind of… but I thought what a wonderful sort of advertisement for the job and how well you do, that you’ve kept them out for so long and so well, but that’s the only other measure I’ve ever had.” (ACM08/site 3)
These accounts were supported in the observations, for example one community matron (CM06/site 1) explained after visiting one patient (P02/site 1) how the patient had previously had regular hospital admissions, particularly breathing difficulties at night, and would call ambulance. Since the community matron had been visiting eight admissions were reported to have been avoided.

It was also reflected in patients’ comments. For example, one gentleman (P03/site 2) who suffered from chronic obstructive pulmonary disease (COPD), type 2 diabetes, anxiety and required oxygen using CPAP (continuous positive airway pressure) reported that he had not been in hospital for over a year. When asked what the active case manager did for him, the patient responded:

“She won’t let me go back into the hospital... Yes, if there’s anything, I ring her up, she’ll come out, she’s very good, very good at being there.” (P03/site 2)

He compared this with what happened prior to the role of the active case manager and community matron had been introduced:

“I’d send for the doctor, he wouldn’t come out so he’d send me in...Before [active case manager’s name] came along, that happened three or four times a year.” (P03/site 2)

The importance of this for the gentleman was depicted in his description of his previous experiences:

“Its awful. I’ve never liked hospitals, me. A dreadful experience, although they were very good to me...” (P03/site 2)

As seen above, the patient identified how he would contact the active case manager rather than the GP which he attributed to the reduction of hospital admissions. Another patient in case study site three, when asked what they would have done before the active case manager visited, responded in virtually the same way:

“... the doctor, in the end instead of me going over there, because it's only at the corner... he used to send somebody over to me... it was awful trying to get over there, I was frightened to death... I ended up in [hospital name]... and I thought goodness, look where I’ve ended up...” (P09/site 3).

However the focus on hospital admission avoidance appeared to place pressure on individuals with regard to their clinical decision making: one community matron reflected in her diary that she questioned herself in admitting a patient with exacerbation of COPD, despite exhausting all options to keep the patient at home, and reaching her decision in consultation with the GP that the patient needed hospital care (DIA CM04/site 1).
Compared to examples of hospital admission avoidance, there were fewer descriptions of where GP intervention had been reduced or prevented, although it was commented on by community matrons whilst observing visits. For example, prior to visiting a patient with diabetes, anxiety and breathlessness (OBS PV/P15/site 2) the community matron (CM10/site 2) commented that the patient’s anxiety levels prevented her from being self caring. The patient was reported to have been a frequent caller for the GP to visit, but since the community matron had been involved the calls had reduced. During the visit the community matron worked with the patient to practise relaxation methods.

One community matron (CM06/site 1) referred to reducing GP visits in the context of personal skill and knowledge development rather than specifically in relation to outcome measures.

So community matrons and active case managers clearly articulated hospital admissions avoidance as a key purpose of their role, and that this contributed to organisational objectives. All were able to give examples of patients where hospital admissions had been avoided, which were also reflected by hospital staff and patients. The reduction of GP intervention as an outcome was also recognised but to a lesser degree, as were the examples cited.

However issues were raised about how hospital admissions avoidance was used as an outcome measure, as discussed in the next section.

9.3 Collecting data about hospital admission avoidance

Whilst hospital admission avoidance was recognised as an outcome measure, there did not appear to be an agreed definition for what was an avoided admission. This was raised as an issue in case study sites one and two in particular by community matrons and active case managers. For example, one community matron in case study site one described the subjectivity in interpreting an avoided admission when basing this on the intervention with a patient, which could range from information sharing to intensive visiting:

"... what is the criteria for an avoided admission, its really difficult. so if I’ve phoned somebody up and given some advice, they don’t want to see me, but I’ve given them some advice over the telephone and I’ve given them our contact telephone number... we’ve not seen them, at all, ... is that an avoided admission? ... Now I’m quite sure that you, like I would say, no, that’s not it, but over Christmas, we have two phone calls from two patients where exactly that had happened to…and they said, I don’t know who else to ring, I don’t want to ring the emergency doctor, I don’t want to go to A&E- can you help me? And both of them were exacerbation of COPD, both of them, we managed them with again antibiotics, steroids, stuff like that, and kept them at home. So, it’s really, really difficult. I mean there’s the very, very obvious ones, but then you think, I’ve
given a telephone number, no, that's not avoided admission, but sometimes it does.”
(CM02/site 1)

This was echoed by an active case manager in case study site two, who raised the difficulty in then being able to evidence how an intervention had led to a preventative outcome:

“how do you know how many you've avoided...you see I've had this conversation with many people, and sometimes you feel you’ve done so much work for that person, and you know it can be as simple as making sure they’re having their tablets every day, and its not mega complexity that’s done, but it can be a very simple task, yet you’ve avoided that person going into hospital but how do you prove that, you know...”(ACM02/site 2)

One community matron in case study site one (CM03/site 1) did suggest a tool that was used to assess the risk of a patient of hospital admission as a measure against which the likelihood of admissions (ARC UCC1/site 1) could be compared with actual admissions; however this was not used for measuring outcomes in this way:

“If you go off the Unique Care calculator, that gives you the percentage so you could do it off that, and most of the patients will have whatever percentage they come out, so you could you that for facts and figures if you wanted, so you could say if this person, because they’re suffering from a,b,c and d complaints, their probability of a hospital admission would be 55%, well it gives you three categories, so you could use that.... but its not how they're collecting the figures. We would always give them a percentage but nobody particularly asks us for that figure. It’s not collected anywhere I don't think. .... We physically write it on a piece of paper, what we've done to avoid it...”(CM03/site 1)

In each case study site there was reference to the statistics that were collected in relation to avoided hospital admissions, and in case study sites one and three a community matron specifically referred to data that showed a reduction in hospital admissions. For example CM02/site 1 stated:

“the clinical activity goes with the clinical activity data sheets, they go back to PCT so we know we’ve seen somebody, we’ve had a telephone call, we’ve referred them for this, that and the other, so all that sort of thing goes back as part of clinical services, but as well as that we record for each GP we’re in with, how many ... active cases, how many we’ve got on the register for that practice, ... erm, it’s a running 12 months, how many bed days they’ve had in the last 12 months for patients, and how many patients have actually been admitted to hospital...so we can actually look back then, and see we are reducing the figures, admissions, …and therefore reducing the admissions for length of stay as well...”(CM02/site 1)

In case study site three the data collection sheet showed some similar categories, including the number of new patients, the number of active patients and inactive patients, number of contacts and hospital admissions (ARC PD2/site 3). Data was also available regarding the number of patients per general practice who were being case managed which was used to compare the number of hospital admissions for case managed patients nine months prior and nine months after case management, which was presented in the PCT’s active case
management key performance indicators report (DOC PR1/site 3). The community matron in case study site three articulated how the statistics were revealing how they were achieving this outcome:

“We've ... had some figures in the last eight months and it's coming down, for GPs and certainly the hospital. So the amount of attendances, and the amount of length of stay, the bed days, has come down as well, since we've been doing the job.” (CM12/site 3)

The reports from case study site three supported this comment, where nearly 40% reduction in emergency hospital admissions amongst case managed patients was stated, with a decrease in the number of bed days for these patients by nearly 36% (DOC PR1/site 3).

However, there were differences in the interpretation of the targets for reducing hospital admissions which would affect whether the role would be considered effective. This stemmed from whether the distinction was made between all emergency admissions and emergency admissions of patients with long term conditions or the cohort of patients on the caseload of community matron or active case manager. This was specifically raised in case study site one, although the subjectivity of defining hospital admission avoidance was an issue in all case study sites. A community matron in case study site one gave an example of how a different interpretation of the target impacted on the measures and parameters by which the effectiveness of the role was assessed by the organisation. This was particularly stark when translated into financial benefits and highlighted the importance of the community matrons being able to understand and challenge statistics:

“... we did a report, and we had the discussion with the Director of Finance,[he said] 'well my figures are different', but his figures will be different because he’s looking at all emergency admissions – medical, surgical, 0 to 100, we’re looking at just medical, over 65s, so ours is only a small wedge of that, and we know the figures’ going up nationally anyway, so its really comforting to actually pull out our figures and say actually our figures have dropped 9% since September...I did an exercise the other week of just picking out the patients of avoided admissions we had seen... and looked at an acute admission charge for those patients, ...I think I looked at 80 patients, and for those 80 patients there was £250,000 saved.

And that ...was only a 4 month period, ...its very difficult to say well, I definitely saved that admission, so therefore I’ve definitely saved over two and a half thousand pounds, today. Its not as, you know, yes, we went out, saw that person, got the steroids in, got the antibiotics in, got them on the oxygen, we saw them everyday ...yes we feel we kept them out of hospital. Would they have really have gone into hospital? Who knows?” (CM02/site 1)

So the different interpretation and subsequent expectation of the role would affect the external judgement on the role’s effectiveness. Where such differences in interpretation have not been explicitly articulated, the use of hospital admissions as a measure of the role’s
effectiveness would lose the impact of the role on those patients being seen by the community matron service, as it becomes a drop in the ocean against the overall volume of hospital admissions. One community matron in case study site one described a medical director’s perspective:

“...the medical director for the acute trust; I was with him last week and the hospital had 47 medical outliers, and he had to cancel all elective surgery... he was saying ‘I know all these initiatives like rapid response and community matrons but there’s always someone to fill a bed’, so if I say I’ve avoided a hospital admission, somebody else is just going into that bed. It’s very hard to say, to prove your worth really... it might be that you’ve avoided an admission of an over 65 but there’s more people going in under 65. I don’t know. I find it hard to quantify, I find it hard... I feel like I’m doing a good job and I feel like I’m making a difference but whether that’s, figures, that’s not my thing really.” (CM06/site 1)

Another dimension raised specifically in case study sites one and three was the feasibility of determining the effectiveness of the community matron role based on hospital admission avoidance (CM05/site 1; SW01/site 3; ACM10/site 3). It was proposed that it was not possible for the role to make an impact on hospital admissions with the level of investment made in the community matron service:

“...we know we’re supposed to prevent hospital admissions, particularly over past few months with bed crises happening at the [hospital name], there’s been these complaints that active case managers are not there, when in fact they are there and people don’t take any notice; there’s not a great deal we can do if the hospital don’t refer patients to us. But what they don’t also see is the people we do see at home and do actually keep out of hospital, they never get there, so they’re not going to see the patients where we’ve prevented hospital admissions. But on the basis of what they want us to achieve and the beds they want us to cut, I just don’t think it’s possible, it’s not realistic. When I first took this job on they were cutting 50 rehab beds, and part of the basis of that, supporting that was that case management was going to prevent hospital admissions... a team of 15 nurses trying to prevent in effect... 50 beds, that’s 18,000 bed days a year, it’s just not physically possible.” (ACM10/site 3)

This was also recognised outside of the community matron teams by one of the social workers:

“... at a bed pressures meeting maybe, particularly at this hospital, it’s “well we’ve got a community matron so that’s the answer to our prayers”, and it doesn’t work like that... it’s probably unrealistic because what resource will people have with the role to carry on and make any significant difference initially.” (SW01/site 1).

Scepticism about the impact on reducing hospital admissions was countered with the importance community matrons and active case managers placed on improving quality of life for patients. This was articulated both in all case study sites, for example:

“I think it’s naive to think we’ll make a difference to figures but we do make a difference to individuals’ lives.” (CM05/site 1)
... in terms of the hospital I think it will fail dramatically, because I don’t think we can achieve what the hospital want us to... but so many of those patients are from outside [case site name], so if they’re coming in to [hospital name] beds, we have no impact on those, so we’re on a hiding for nothing in trying to stop admissions. But if we are going to be assessed and evaluated on patient outcomes then I think case management would be a resounding success.” (ACM10/site 3)

One community matron expressed reducing hospital admissions in the context of improving patients’ lives, so the target was about the individual rather than the organisational outcomes:

“I do think its not actually doing the work yourself but coordinating it with other people...the right people are in there and then its all sort of brought together. Keeping people at home is just amazing, it’s where they want to be...” (CM07/site 1)

So the use of avoided hospital admissions as an outcome measure was viewed as positive where it was specifically measuring admissions amongst patients of the community matron service, but could be problematic where there were different interpretations of what was or should be used as the measure. There was also concern that it was not an appropriate measure due to the size and complexity of hospital admissions in that it could only play a minor role in addressing increasing demand, and that the level of investment in the community matron service did not match the expected level of change from hospital to community based health care.

9.4 Improving quality of life as a desired outcome
Whilst recognising reduced medical intervention was an organisational objective, many community matrons and active case managers described this outcome in terms of the improvement of the quality of life for the patient, that is, as an individual outcome. This appeared to enable community matrons and active case managers to relate the outcome to the aspects of their role they felt to be of value. Community matrons and active case managers across all case study sites commonly cited the most important outcome of their role was their impact on people’s lives and whilst the avoidance of hospital admissions as an outcome was acknowledged it was not viewed as the dominant factor. For example, when asked whether their role had affected hospital admissions, these community matrons replied:

“Yes, but that’s not my main focus really... but I hope to do that in my job but if I don’t do that, and improve their quality of life then I think I’m doing a good job.” (CM06/site 1)

“The main thing is that you’re giving them patients a quality of life, because there are times when some of the patients you work with might be in level 3, tier 3, the really complex needs, but, they still have to go into hospital, and you won’t prevent that with some of them, but the times when they’re not in hospital, they’ve got a better quality of life maybe... so its not all about preventing hospital admissions...” (CM08/site 1)
This suggested that the practitioners were making the organisational outcomes fit with their individual belief system about the value of outcomes, to make acceptable to them the measures by which they would be evaluated. This viewpoint can then accommodate their approach to practise individualised care and to respect the patient’s choice. However in some instances it was expressed explicitly that the organisational outcome was not appropriate, where community matrons and active case managers expressed that reducing hospital admissions was not necessarily the desired outcome for all patients:

“...job has become too focused on one aspect, the idea of keeping patients out of hospital for the benefit of the hospital rather than the benefit of the patient. If benefit for the patient means you need to keep going in, then that’s not recognised. The target for hospital admission becomes the driver rather than improving the life longevity for the patient. ...confidence, whether or not they’re feeling supported, that maybe they’re able to, basically to feel more confident in managing themselves at home, and so that they feel less alone. So if a patient feels that those changes have taken place, then I feel we’ve had a success.” (ACM10/site 3)

The importance of giving people control over their lives and conditions was expressed explicitly by community matrons in all case study sites, so that self confidence and skills to manage their long term conditions was seen as a desired quality outcome by community matrons, active case managers and by colleagues, namely a district nurse and a social worker (CM05, CM06, CM07/site 1; ACM02, CM09, CM10, DN02, SW02/site 2; ACM10, CM11, CM12/site 3). This fits with the proposed outcomes of the health and social care model for managing long term conditions (DH 2005e) and also with the focus on the role function as a coordinator and supporting self care, as discussed in Chapter 7. In expressing the importance of the patient gaining control of their health and choice of care, participants aligned themselves with the ethos of the expert patient, in contrast to the medical model which was dominant in the patients’ experience of hospital care and seen in the dependency on hospital care that had been created. For example:

“People who’s felt that they hadn’t had control over their lives or their illness erm, I’ve managed to ... give them that control, erm, give them choices really as well. Erm, I’m thinking of a lady who was dying and I was able to give her a reasonable comfortable death. She was in the place she wanted to die...” (CM05/ site 1)

One patient in case study site two expressed the value of staying at home, having experienced multiple hospital admissions in the previous year, and being able to go outside, which they attributed to the input of the active case manager:

“It means an awful lot... I can go out on the machine there [electric wheelchair], I can go and get some fresh air...You’re not stuck at home looking at four walls, and I don’t like to languish here.” (P03/ site 2)
Patient choice with regard to the type and location of care was raised across all case study sites, but more so by community matrons in case study site one (CM05, CM06, CM08/site 1). Here they highlighted that it could not be assumed that all patients want to be kept out of hospital and that they associate the hospital with a place of safety and security, being in ‘safe hands’. For some it was felt this would always be the patient’s preferred choice, but they recognised that the patient’s dependence on the hospital had developed where they felt they had no other choice and that this would not change until the patient had developed trust over time in the community matron, for example:

“...so its about some patients straight away... they’ll say thank god you’re here, you know, I didn’t want to go into hospital, you know, I’m sick of going in every month whatever...but there are others who aren’t like that, and that’s the ones where eventually you might get to a stage where those patients, even then, even after you’ve worked with them, you’re not going to stop them, they still want to go into hospital...

...Obviously it depends on the individual patients, to start with, particularly patients with heart problems or breathing problems, going into hospital was their lifeline, so actually for you to go in and say we’re going to stop you going into hospital, they don’t want it...but as you start working with them and they build confidence up in you, they realise there is another side to life…” (CM08/site 1)

The community matrons and active case managers across all case study sites recognised that the establishment of a relationship with the patient underpinned their effectiveness in achieving outcomes, whether it was to reduce medical intervention or to enable the patient to make their own choice about services, as reflected by this comment:

“... giving people the knowledge as well, to look after their own illness really, so, and be confident about it, about reaching the right service at the right time, so ringing the doctor when they start feeling that tightness in the chest rather than wait until they get in a state so they need to be admitted to hospital, and that takes a lot of doing, because you need to build that trust relationship up. You quite often find you visit somebody, do a little bit of work with them, but they end up in hospital quite soon afterwards, and that is because they didn’t have that trust to ring your number and say, it’s me, can you come out and see me, whereas it’s such a nice feeling when someone does that, because you’ve broken it then, and they ring you up, and say I don’t feel well, will you come and have a look. And it maybe that they need to be in hospital, which is fine, or if they need a GP visit, which is fine, but it maybe that they’re not taking their tablets right, or they need to increase something…” (CM05/site 1)

The increase of patient control as an outcome was also expressed in terms of reducing dependency on services and health professionals by some community matrons and active case managers in case study sites two and three, again by using the development of rapport and trust with patients (CM10, ACM02, FG ACM/site 2; ACM10/site 3). This also reduced hospital admissions. For example:

“The nature of their dependency is always based on some type of need, they need something from someone. It could be the hospital, it could be the GP. Once you start to
explore that need you see the dependency get less and less. We had a gentleman who I think he actually went to the A&E about 50 times, basically with anxiety, there was always something wrong. Once we got to know him, initially his dependency level was high, but now my colleague supports him, it was all he needed, he has not made any call for an ambulance for months”. (CM10/site 2)

A further outcome that was described by active case managers in case study site two related to the acceptability and use of the service by those previously not accessing health services, although this impact did not appear to be formally measured through statistical reporting. This hidden impact alludes to the role meeting an unknown demand rather than impacting on existing service users. It also reflected the value active case managers placed on reaching people for whom services were difficult to reach. For example, when asked what the most important outcome of their role, active case managers responded:

“Patient satisfaction. The patients have somebody, a point of contact; that they don't feel guilty about picking the phone up, or bothering the GP. When they acknowledge how much you’ve done for them, you’ve done these referrals, you’ve turned their life around, and you’ve made a difference. You go and see them and they say it’s fantastic, you’re doing this, it’s amazing. They can’t thank you enough. ...

I think it’s looking at a group of patients that were slipping through the net that we’ve been able to give something they’ve never had before... I’ve had a few patients saying they’d never had this attention before, they’ve been struggling along, not realising what services they could have had...

The thing is, once they feel safer, they don’t bother going to the hospital all the time. A lot of it is they feel so vulnerable that they take themselves off to A&E or they sit in GPs surgery day after day, as they don’t feel they’re being listened to... Some patients don’t want to involve services, I’ve found, because they’ve been left alone for so long, and all this attention, to do this and do that, they’re like, I don’t know, they need motivation and encouragement to get on with services, to be involved in things...” (FG ACM/site 2)

Whilst most community matrons and active case managers across all case study sites described improving quality of life of driving importance to them as an outcome, one active case manager in case study site three expressed how this individual priority seemed at odds with the organisational priority for outcomes:

“I think we’re trying to juggle too many things really. What is the priority of case management? Patient welfare, hospital admissions? ... You could see hundreds of patients if you pick really easy patients with minor problems but whether or not you’re doing a great deal for their quality of life is debatable. Are you supporting people who live alone, elderly, chronic disease, anxiety, very little family support. For those people, the feedback seems to be they think the service is fantastic, because they no longer feel alone, they feel someone is listening to them, taking notice of them, whereas before they literally were alone. So I’m finding it difficult tying in what maybe managers want - high throughput, numbers, with what I was led to believe case management was primarily about, was in supporting patients in their quality of life... The focus seems to have become beds, which is depressing really.” (ACM10/site 3)
So some community matrons and active case managers considered improved quality of life to be the most important outcome. This may also reduce medical intervention but this was not their driver. They recognised the importance of building confidence of patients to use services effectively but still felt a dissonance with the organisational priorities.

9.5 Summary of themes relating to effectiveness and outcomes of the community matron role

The role of the community matron was subject to outcome measures that were set externally by the Department of Health (England) and monitored by the strategic health authority. Such outcomes focused on numerical measures, for example the number of patients on the caseload of the community matron. Additionally in each case study site the organisations set numerical measures such as the number of contacts made with patients. The numerical outcomes were acknowledged by community matrons and active case managers but they were not fully supportive of such measures, for example one (ACM10/site 3) felt that the role was being judged by ‘bean counting’ rather than the quality of the patients’ lives. This reflected the community matrons’ perception of what their nursing role should be and how they valued individual patient care above organisational priorities.

This was seen in the outcomes to reduce medical interventions, in particular avoidance of hospital admissions. This was recognised as an important outcome of the role by community matrons, patients, social workers and district nurses across the case study sites. The numeric outcome, that is, the number of avoided hospital admissions, though, was seen as an organisational priority, whilst the practitioner and patients’ focus was qualitative, that is, how avoiding hospital admission improved the quality of life.

The community matrons, then, appeared to be working in a culture which they perceived as conflicting with their own professional values. However such dissonance had not been expressed explicitly to the researcher. Rather, they redefined numeric outcomes in terms of patient outcomes so that they could align them with their professional values. It was also shown in resistance to how hospital admission avoidance was being measured.

There was concern amongst community matrons that there was a naivety about the level of impact the role of the community matron could make in that it was being heralded as the panacea for all the problems of increasing hospital admissions, as articulated by CM5/site 1. This again reflected the dissonance between the organisational outcome measures and the community matrons’ focus on making a difference to individual patients’ lives.
The reality versus the rhetoric of the role, that is the lived experience of community matrons versus what was set out in national policy was also seen where they reported that the numeric outcomes set nationally in relation to the size of caseloads were not achievable in practice. This appeared to be due to the developmental time needed to establish a new service and that the service cannot be fully operational whilst practitioners are learning new skills and expertise to fulfil the new role. This was reported as being dealt with differently in the case study sites, where in case study site three the community matrons had successfully renegotiated target service numbers, whilst this was not achieved in case study site one and two. Again the numeric outcome for caseload numbers challenged the community matrons’ values about providing high quality individualised care as they saw they could only reach the caseload targets by reducing the level of service they provided to existing patients. This brought into question whether there had been a common understanding of the concept of the service between the practitioners and organisation at the outset, or whether the view of what the service should be and achieve had changed during its development, either from the perspective of practitioners, patients, the organisation, nationally or all parties.
CHAPTER 10: DISCUSSION

10.1 Introduction
This study aimed to develop insight and understanding of the role of community matron, within three primary care trusts. At the start of the study the following questions were unanswered by the literature:

- How does a community matron undertake this new role?
- How does the introduction of this new nursing role affect existing practitioners working in the management of long term conditions?
- How have community matrons negotiated their role boundaries and has this affected the boundaries of other community nursing roles?

The research questions focus on the experience of the community matrons and so the implementation of the policy under study is examined through the lens of the community matron. However consideration has also been given to their perception of policy implementation at an organisational (meso) and national (macro) level. It is acknowledged that these interpretations of meso and macro levels of policy implementation are formed from limited data within this study due to the small numbers of other health professionals and managers who participated. As such these latter interpretations have been treated with caution, as indicated in the discussion.

This chapter will consider whether the study has addressed these questions through consideration of the findings in relation to theory and evidence. The discussion will refer to new studies that have been published since the initial literature review: in light of the limited research literature that was available at the start of the study, a second literature search was undertaken based on the themes emerging from the findings. This research evidence and theoretical concepts have been included in this chapter to inform the discussion.

The chapter discusses four key themes emerging from the findings: first, a theme developed around identity within a changing nursing role, drawing from findings in relation to role function and levels of practice. Second, a theme of shifting boundaries emerged from findings in relation to role function and relationships. A third theme a theme about conflict between organisational and professional values developed from findings about outcomes and effectiveness. Finally, the theme of ambiguity emerged from findings relating to service model and role function. Concepts of change and implementation ran through all these four themes.
In revisiting the literature, the concept of organisational change and social theories were explored. The concept of sensemaking (Weick, 1995) had been used in studies as a concept to help understand the process of change in health services (Apker, 2004; Checkland et al, 2009). Thurlow (2010) argued that in the process of sensemaking, individuals draw on social psychological properties to help them make sense of the experiences they encounter in organisations and society. This then creates meaning and guides their future actions (Weick 1995). As sensemaking is a social construction process (Weick,1995; Maitlis, 2005), it fits appropriately with the epistemology underpinning this study. The concept of sensemaking was considered by the researcher and there appeared to be parallels between this concept and the findings, so this concept was selected to support the interpretation of the findings. Critical sensemaking is described more fully in section 10.2.

Whilst the discussion will show that themes from the findings can be largely explained by sensemaking (Weick, 1995; Weick, 2001), other theories also show parallels, for example social structuration theory (Giddens, 1986; Bourdieu, 1991), negotiated order theory (Strauss 1978) and concepts of power (Lukes 2005) which have been reflected in the discussion.

Critical sensemaking can be used as an analytical tool (Helms Mills, Thurlow and Mills, 2010). When used in this way, it is used from the outset of the study as a framework for study design and analysis. However this was not the case in this study as themes were not predetermined; rather, themes have been derived through an inductive process from data. Critical sensemaking, then, has emerged in this study as an overarching theoretical perspective to provide a heuristic guide; it acts as a mechanism that guides and facilitates analytical thinking in order to support the understanding of the findings.

This chapter begins by describing the concept of critical sensemaking, which is then applied in the discussion of the findings. The chapter concludes by considering whether this study has addressed the research questions.

10.2 The concept of sensemaking and critical sensemaking as a heuristic guide
Sensemaking is described as a process of social construction in which individuals attempt to interpret and explain sets of cues from their environment (Weick, 1995; Maitlis, 2005). Discrepant cues, generated by crisis or change, interrupt an individual’s usual activity so that they reinterpret their environment to create meaning for, or discard such cues, in order to guide their future actions. Weick (1995) presented seven properties that influence how
individuals made sense of their surroundings. These properties are described in Table 22, taken from descriptions by Weick (1995) and Helms Mills et al (2010).

**Table 22: Properties of sensemaking (Weick, 1995; Helms Mills et al, 2010)**

<table>
<thead>
<tr>
<th>Property</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grounded in identity construction</td>
<td>Identity is continually redefined by life experiences and contact with others, eg parenting, school, jobs, employer which influences how we see the world</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Past experiences are used as comparators to make sense of the present</td>
</tr>
<tr>
<td>Focused on and by extracted cues</td>
<td>Certain cues are selected and others discarded in order to interpret an event or different experience. Previous experience, rules, regulations affect the selection of clues, so interpretation may be made to fit with existing beliefs</td>
</tr>
<tr>
<td>Driven by plausibility rather than accuracy</td>
<td>Selection of cues that make sensemaking plausible to the individual means that 'accurate cues' may be discarded, so perception is not necessarily accurate. This may contribute to inconsistency of sensemaking between individuals</td>
</tr>
<tr>
<td>Enactive of the environment</td>
<td>Sensemaking is constrained or created by the environment, which has been created by the sensemaking process; the environment created reinforces one’s sense of credibility</td>
</tr>
<tr>
<td>Social</td>
<td>Sensemaking is contingent on interactions with others, and is affected by societal and organisational rules, regulations, routines, symbols and language</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Sensemaking is a continual process through the influence of the above properties.</td>
</tr>
</tbody>
</table>

Thurlow (2010) proposed that sensemaking is not a linear process, so individuals’ analyses of their environment are not necessarily sequential by nature. Also these properties are not all equally visible and one or more of the properties may play a more significant role in influencing sensemaking at one time (Weick, Sutcliffe and Obstfeld 2005). Initially the properties were considered to be of equal importance, but identity construction has since been proposed as pivotal to sensemaking (Thurlow 2010) with plausibility having much greater importance than some of the other properties (Helms Mills et al 2010). Interestingly, Weick et al (2005) argued that the idea that sensemaking is driven by plausibility rather than accuracy conflicts with managerial practices and theories that assume that the accuracy of managers’ perceptions determine the effectiveness of outcomes.

In organisational change, organisational sensemaking is a social process which, by interpreting their environment in and through interactions with each other, organisation members construct consensus accounts that allow them to act collectively (Maitlis, 2005). A critical factor in organisational sensemaking during strategic change is ‘sensegiving’, described as ‘the process of attempting to influence the sensemaking and meaning construction of others toward a preferred redefinition of organizational reality’ (Gioia and Chittipeddi, 1991 p.442). Sensegiving and sensemaking processes occur between individuals.
in a sequential and reciprocal manner, creating a cycle that has periods dominated by understanding (sensemaking) and influence (sensegiving) (Gioia and Chittipeddi 1991). Sensegiving was found to be a fundamental activity for leaders during strategic change (e.g. Gioia and Chittipeddi 1991; Maitlis and Lawrence, 2007) and the degree to which leaders and stakeholders engaged in sensegiving affected how organisational sensemaking was played out, seen in four distinct forms: guided, fragmented, restricted, and minimal. These forms displayed distinct process characteristics which in turn resulted in particular ways in which accounts were made and actions generated (Maitlis, 2005). The four forms are depicted in Figure 5.

Weick’s framework has been criticised that it does not sufficiently consider issues of power, structure and past relationships (Helms Mills et al 2010). Helms Mills et al (2010) addressed this by building on Weick’s framework to develop the concept of ‘critical sensemaking’. Helms Mills et al (2010) introduced the broader context of organisational power and social experience: in doing so they incorporated consideration of ‘very complex variables including social psychological properties, discourse, organizational rules, and the formative context in which organizations exist’ (Helms Mills et al 2010, p.190). ‘Formative contexts’ are ‘the institutional and social practices that shape a society’s routines...they represent a restrictive influence on organizational rules and individual enactment of meaning through the privileging of these dominant assumptions’ (Thurlow, 2010 p. 258).

Helms Mills et al (2010 p.189) argued that the critical sensemaking framework ‘creates space for discussion of how the macro-level context in which individuals operate affects the cues they extract, the plausibility of various text and narratives, and the nature of enactment’.

Sensemaking has recently been used as a theoretical framework in health care research to explore and explain organisational change (Apker, 2004; Checkland et al, 2009; Manojlovich, 2010). For example Apker (2004) used sensemaking in her case study to explore how nurses made sense of the changes to care with the introduction of the managed care model of health care in a large US hospital. Exploration of the nurses’ sensemaking indicated that ambiguities of identity extended beyond any initial uncertainty brought about by the managed care change.
Checkland et al (2009) also applied sensemaking to their case study, which explored the issues raised as ‘barriers’ to the development of practice based commissioning within three PCTs in England. It is not clear from their reports whether sensemaking had been identified prior to data collection as an analytic tool, or whether it had been applied as an aide to explore the data. Both studies considered Weick’s ‘organisational sensemaking’ (1995) to be a useful framework within which to explore the problems encountered when implementing policy. In both instances, though, there was not a clear representation of a framework. Rather, sensemaking was used as a concept to explore reasons for behaviours behind the findings. However Checkland et al (2009) did show how the concept was useful to explore change in health care settings and health care policy, particularly in relation to the role
individuals play in these processes. These applications did not include the broader contexts incorporated in Helms Mills et al’s ‘critical sensemaking’ (2010), although they did reveal some issues of organisational control.

The critical sensemaking perspective has been used in this study as a heuristic guide to consider the findings and assist understanding of processes at work in the implementation of the community matron role from the perspective of the community matrons at micro (individual and team) level. It has also been considered at meso (organisational) and macro (national) levels but these interpretations at meso and macro level are drawn from limited data within this study.

10.3 Fluidity of the nursing role- a changing or constant identity?
The introduction of the community matron as a new role in the nursing landscape appeared to create ambiguity for those learning the new role and for those working alongside it. This seemed to challenge individuals’ professional identity, which, over time and through personal learning experience, could undo and reconstruct individuals’ professional identity. So the importance of identity construction as a key influence in sensemaking, and therefore how organisational change would ensue, was reflected in the themes raised about role identity in the findings of all the case study sites.

10.3.1 Reconstructing role identity
It could be argued that the drivers for the introduction of the community matron were external to the profession, in the form of the national policy through to the organisations (DH, 2004a; DH 2005e). If so, this could have a dominant influence on role identity (Maitlis and Lawrence, 2007). External factors described by community matrons included organisational drivers, education programmes and other professionals such as doctors acting as mentors (CM08/site1; CM10/site 2; CM12/site 3), as described in Chapter 7. Whilst role function developed in line with expectations of national policy, there was variation in how community matrons fulfilled these functions in practice where they had different nursing backgrounds. This suggests that their identity was embedded further within their previous roles as health visitors or district nurses. For instance, those with a district nursing background were perceived by colleagues to be undertaking more ‘hands on’ approach while those with a health visiting background adopted a more advisory function (eg CM05/site 1). This suggests a strong influence from within individual’s own view of nursing so that the community matron’s professional frame of reference served as a constant.
This was also found in the study of the management of long term conditions in ten PCTs by Reilly et al (2011). They reported that, of staff groups acting as case managers, “district nurses undertook a disproportionate amount of hands on or direct care” (p.226). Therefore in reconstructing their identity in their new role, community matrons may use their previous experiences as their cues to frame their identity, creating the opportunity for variance.

Alternatively, whilst individuals still were attempting to make sense of their role, they themselves were under pressure to present and promote the role to other stakeholders such as GPs and social workers. This was interpreted from observations of presentations given by community matrons (eg OBS MT1/site 1). So community matrons were simultaneously being the sensegiver whilst sensemaking, in order to gain acceptance and cooperation from others. This suggests that at times they felt other pressures whilst they were doing the job in providing patient care. In such circumstances individuals may revert to practising in the mode that was almost instinctive, i.e. their specific discipline of nursing. In this sense the findings may reflect a transient period of individual identity construction portrayed in practice and role development.

It could be argued that the process of reconstructing one’s role identity is not a linear one: rather it appeared to be ‘two steps forward one step back’ as different properties of sensemaking exert greater or lesser influence. For example, in case study site one the community matrons themselves were instrumental in setting up the organisational ‘rules’ for the role. They made changes to the referral criteria (CM05/site 1) and so created the environment within which they worked, progressing their meaning of the role. This was then influenced by social properties such as their interactions with other professionals on a one to one basis (eg with a district nurse, DIA CM08/site 1) or groups (eg presentation to social workers OBS MT1/site 1).

These influences would ebb and flow over time and cause individuals to reconsider their practice (CM05/site 1), in effect taking a step back. In case study sites two and three the community matrons appeared more bound by organisational ‘rules’, underpinned by the team structures, management involvement and reporting mechanisms (DOC POL3/site 3) but the social influence of other stakeholders such as GPs was still evident in community matrons’ reflection and articulation of their role (CM12/site 3). The property of role identity appeared to provide the most direction to individuals throughout the transition. This supported Thurlow’s proposition that identity construction is pivotal to sensemaking (Thurlow, 2010).
The possible difference between the level of organisational influence and professional influence between each of the case study sites may also reflect the stage of organisational sensemaking that had been reached at the time of data collection. Case study site one was at an earlier stage of implementation than case study site two, and three being at a further stage still. Adler (2005a) argued that the first 12 to 18 months were crucial in the development of a new role, based on findings from her small qualitative study, discussed in section 2.5.2. It could be argued that over time individual sensemaking will converge, so that the more collective view seen in case study sites two and three were depicting later stages of organisational sensemaking. It could be argued that the degree and time over which this would occur is dependent on the level of influence and power exerted by the organisation and to what extent this had been aligned with professional influences.

10.3.2 Competing or converging identities- community matron and advanced practitioner

The complexity of developing the new collective role identity for the community matron was overlain by the introduction of the role simultaneously with that of the advanced practitioner, as discussed in section 7.9. This complexity appeared to confuse the purpose of the role as there was not consistency as to whether a community matron needed to be an advanced practitioner to deliver the role effectively. This was particularly evident in case study site one, where some community matrons were training to be advanced practitioners and some were not. These two groups were developing distinct role identities whilst retaining the same job function. Unlike case study sites two and three, the advanced practitioner function was not explicitly articulated in the service structure and skill mix. Instead there was speculation about how the two roles would operate in the future (CM05/site 1), whether as separate roles or as a requirement of the community matron. This appeared to fuel the ambiguity about the role in the absence of any reported strong organisational influence. In addition, the role being experienced by patients and observed by others, such as district nurses and GPs, could differ according to whether the practitioner was able to utilise advanced practice skills (however data was limited due to the sample size of district nurses and GPs).

The advanced practitioner course used in the three case study sites was medically oriented, as seen in the course curricula and workbooks (DOC AP/HEI). It could be considered that this influence was generating functions in the role that were simply taking on traditionally medical functions to extend the nursing role such as diagnosis, prescribing and medication reviews, rather than the role evolving into advanced nursing practice (Adams et al, 2000). However, even at an early stage of the role development, community matrons were identifying such
developments within the language of nursing, so they were taking the functions and making them their own (eg CM12/site 3).

A further influence that may have been creating a disparate effect on the two diverging groups in case study site one was that of the mentor for community matrons on the advanced practitioner course in case study site one. Here, all mentors were hospital consultants; for those community matrons, they may have been subject to different organisational forces and cultures in the hospital environment that was not being experienced by those not on the advanced practitioner course. Organisation and structure in hospitals are predicated on the medical model which serves to perpetuate a medical superiority within its social processes (McIntosh and Dingwall, 1978). These community matrons were learning within the medical system of teaching and learning and therefore it could be said that they may conform to expected behaviours of doctors in that system as part of their identity construction. Alternatively they may consciously conform to be accepted into that role, even though they would not consider such behaviours to be part of their nursing identity. In either scenario, the mentoring process and the organisational influence in the hospital environment could play a significant part in the community matron’s sensemaking about the role of the advanced practitioner.

In contrast, those not undertaking the advanced practitioner course were making sense of their different experiences; they felt they were taking on more work while others were on the course, they did not see the same investment in themselves for role development, or the future opportunity to do so (eg CM05/site 1). This was paralleled by seeing a medically oriented nursing role being promoted as important and as the future of the community matron. As such they may have been building a self image that was not as valued by the organisation and an identity that did not match their perception of what the community matron role was or would become.

This presents a discourse for the community matrons about their identity, and potential fracture within the role dependent on the degree of influence given up to a medical model and control.

10.3.3 Role identity and sensemaking
It is argued that there was fragmented organisational sensemaking in case study site one during this period, as the community matrons addressed these issues themselves informally within the team (OBS MT3/site 1), dealing with relationships within the team and practical
issues of managing caseloads fairly, where minimal intervention or control by management was reported by community matrons. Similarly, Miller et al (2000) found that nurses relied on peers for information, to make sense of role ambiguity. In a study of sensemaking by hospital nurses during the introduction of a managed care model, Apker (2004) also found that where the organisational information and rules were not available as resources for sensemaking, nurses relied in interactions with others such as co-workers, managers and patients to understand the change being experienced.

So in case study site one it was still unknown as to whether the roles of community matron and advanced practitioner were to be the same role, or whether two distinct but complementary roles would emerge. As all those undertaking the advanced practitioner course within case study site one were yet to qualify, it was unknown what the advanced practitioner role would emerge. However, if the outcomes followed the pattern predicted where there is fragmented organisational sensemaking one would expect inconsistencies in the role to continue.

In case study sites two and three there had been role clarification about community matron and advanced practitioner roles. In both instances advanced practitioner skills were a requirement of the community matron role. The structure of the service included case managers and assistant practitioners which were led by the community matron. This brought a further dimension of team leader to the role, as described by community matrons and active case managers in case study sites two and three. This aligned an identity of authority with the community matron which organisational members could recognise. So its credibility appeared to be founded on status as well as clinical expertise. However, in case study site two the community matrons did not identify themselves with a leadership role in a managerial sense, but as an advisor; again this may be indicative of a point of transition as they were just completing the advanced practitioner course, and were adjusting to how this was impacting on their practice and that of their case managers. To do this they appeared to be embarking on a process of sensegiving with the case managers and so presenting their evolving role in a way that would be plausible for the case managers (Weick et al, 2005), and elicit change in their practice also within the service model.

In case study sites two and three, community matrons undertaking the advanced practitioner course were mentored predominantly by GPs rather than hospital consultants. The culture of medical practice by GPs would appear to be very different to that of their hospital colleagues; GPs operate as independent contractors as partners or leaders within their organisation
which is a much smaller scale. So whilst the GP may exercise a medical superiority within the practice, the approach to medical practice and relationship with patients and colleagues is very different. Also teaching in this environment would be characterised by a one to one relationship rather than as part of a junior doctor teaching session, as experienced by community matrons in case study site one (eg CM04/site 1). Therefore the community matrons’ exposure to the medical environment may present different influences and cues for their role development. Even so, there was consistency in the functions that were being adopted in the advanced practitioner role across the three case study sites, suggesting that these potentially different influences were not as evident as may have been expected. This may reflect the stronger professional influences that had been internalised in the individual nurses’ identity, even though strong professional leadership regarding the community matron role, for example from nursing organisations such as the RCN, was not reflected in the community matrons’ accounts.

The developmental stage of the community matron role may have affected the degree of clarity about role function; where the community matrons were still undertaking the advanced practitioner course, individuals (both community matrons and case managers) reported finding it difficult to delineate between the two functions (eg ACM02/site 2). It was only in case study site three, where a community matron had been practising as a qualified advanced practitioner, that the demarcation of roles and responsibilities were becoming evident. However during the transitional period in case study sites two and three the service structure and organisational involvement had provided the template into which the roles would develop and also be contained. So here a process of guided sensemaking to control the organisational change was more evident.

Overall, the functions within the role could be considered to be moving away from the traditional hands on nursing role to the introduction of more medically oriented functions of diagnosis, prescribing and medicines reviews, as seen across all case study sites (Chapter 8). This raises the debate as to whether the community matron role is simply medical delegation, or expanding and developing the nursing role; this argument is well rehearsed in the nursing literature (Adams et al, 2000; Sibbald et al, 2004). However, the focus in this study was the way in which practitioners identify themselves in the role. Whilst it was recognised that functions community matrons performed were traditionally medical, they strongly identified themselves as nurses (for example, one expressed that she was not a ‘mini-doctor’ (CM04/site 1)). This powerful self image as a nurse was also seen in Reay et al’s study (2006) of the introduction of nurse practitioners in Alberta, Canada. Their four year
A longitudinal study included 33 interviews with nurse practitioners and middle managers, observation and archival documents, to explore how role change occurred at an individual level and how such individuals contributed to the legitimisation of the nurse practitioner role within the province. In their study nurse practitioners also emphasised that they were nurses, not mini doctors, and ensured it was classified as a nursing role, clearly aligned to existing nursing functions.

So in this study the community matrons appeared, over time, to be redefining themselves in the new role, and working with each other in developing a collective identity. This was more self-driven in case study site one, where the flat structure and limited senior management involvement, appeared to minimise the external influence. However, there were differing internal identities in two key groups, one where the community matron was an advanced practitioner, and one where the role was not. In contrast, in case study sites two and three, whilst the community matrons did have a strong self-identity, the organisational influence was more evident in the community matrons’ accounts and documentary material. Organisational sensemaking here could be considered to be more guided in shaping the collective identity and action. In case study site three where one of the community matrons had been qualified the longest as an advanced practitioner, that community matron had a very articulate description of the role and their identity; they also appeared to have influence within the organisation and with other agencies, such as social services. Alternatively, these differences may again reflect the different stages of maturation of the role in each of the case study sites, due to the time of data collection.

10.4 Shifting Boundaries – sensegiving and sensemaking in action

The role of community matron was introduced into an existing health system, within which individuals with different roles were already providing care for the management of long term conditions (Sargent et al., 2007). In this study different responses and behaviours were seen within the immediate team dynamics and from different groups of professionals, from resistance experienced by community matrons and active case managers from district nurses and GPs (e.g., CM06/site 1; ACM02/site 2; FG ACM/site 2) to the role being embraced by social workers (e.g., SW02/site 2; SW03/site 3).

Collaboration, resistance, and coping/managing strategies emerged as the three key behaviours in relation to shifting boundaries, as described in Chapter 8. These behaviours are discussed below.
10.4.1 Collaboration

Where there had been positive working relationships and outcomes between community matrons and GPs and district nurses, there had generally been a pre-existing or previous working relationship between the practitioners, which both parties appeared to draw on in negotiating the professional boundary developing in the new relationship (eg CM03/site 1). Here the personal dynamic appeared to be important, in that trust had already been established, So, when the community matron presented the new role it was in effect underwritten with personal credibility and mutual respect. This was also found by Adler (2005a), who noted collaborative work in particular with district nursing and doctors. Similarly North et al (1999) found that practitioners placed more value on those partnerships formed through interpersonal relationships with colleagues. Personality and mutual respect were key elements in Jones' model of collaborative potential (Jones, 2007) to break down barriers and enable sharing of control and territory between roles.

In terms of sensemaking, then, the community matron and GP or district nurse had already engaged in cycles of sensegiving and sensemaking in understanding each other’s roles. Therefore, previous colleagues of community matrons appeared to have had a head start in renegotiating the working relationships with the role of the community matron, as the community matron as a sensegiver would already be influencing the perception of their identity due to their personal credibility. D’Amour et al (2008) argued that professionals need to know each other both professionally and personally to have a sufficiently high level of confidence in each other for openness and sharing of knowledge. Whilst it could not be determined from the data in this study, it is possible that the colleague of the community matron does not change their perception of the community matron’s identity. If so, they may acknowledge their new role, but accept the negotiated role boundaries based on who they are and not the role that they do. If this is the case, the element of mutual personal respect and trust would appear to go deeper than the renegotiation of functions or activities seen in a sensemaking process, even considering the level of influence of the retrospective property and personal experiences.

In this study positive collaboration with social workers within all three case study sites was reported by community matrons and social workers, which was not predicated on existing working relationships. Here, community matrons promoted the role with social workers through meetings, so initiating the sensegiving process. Given that the policy for the implementation of community matrons was called ‘An NHS and Social Care Model’ (DH, 2005e) it would be expected that social workers would have examined the policy with regard
to implications for their role. Indeed, this was seen in the professional literature for social care, including some concern about the role (Hudson, 2005; Hunter, 2005). Others had found little evidence to show the benefits of collaborative working between health and social care (El Ansari et al, 2001, Brown et al, 2003; Cameron and Lart, 2003; Kharicha et al, 2004). As such social workers would have started their own sensemaking process influenced by their own professional experiences and position taken by their employers. Anticipation of threat to the social worker role or role loss did not manifest in the reports of social workers in this study. This can be considered to be as an outcome of different influences during the sensemaking process; however this does not seem to fully account for such different meaning placed on the role.

The factors affecting collaborative working were more visible where it was not working. This will be discussed in relation to resistance.

10.4.2 Resistance

In terms of starting the sensemaking process, the introduction of the community matron role would immediately create ambiguity for stakeholders and destabilise role identities. Unlike Adler (2005a) who reported that nurse consultants, nurse practitioners and GPs were supportive of the new role, reports from community matrons and active case managers in the case study sites revealed different reactions of resistance from some stakeholders when the role was first introduced, most markedly from district nurses and GPs. As a consequence resistant behaviours reported were defensive, characteristic of response to threat (Piderit, 2000). For example, active case managers in case study site two in particular reported how district nursing teams had ignored them and isolated them in the office (ACM02/site 2).

Resistance was also seen from some GPs, some overtly, as experienced by the community matron presenting the role to a GP meeting (OBS MT2/site 1). It was also presented as issues of clinical practice, for example mixed feedback regarding the prescribing role of the community matron. In case study site three there was support from a GP for the community matron prescribing role (GP01/site 3) whereas in case study site two, some GPs were reported to be unhappy about a community matron prescribing for their patients (DN01/site 2). This differed to Chapman et al’s findings (2009) where GPs were supportive, particularly in relation to prescribing. Piderit (2000) argued that resistance may be generated from positive intentions, so in this study the GP’s resistance to nurse prescribing could be founded on clinical concern, rather than resistance to another practitioners’ role per se. However this could not be verified from the data. Where there is uncertainty, professionals will endeavour
to protect their areas of responsibility (D’Amour et al, 2008). So the reported resistance of GPs in this study could be where they have yet to develop a relationship of trust with community matrons.

The most significant tensions described were those between community matrons and district nurses, arguably the closest nursing role to community matrons. Chapman et al (2009), using focus group discussions involving 31 health and social care professionals, also found that a partial lack of consensus on professional boundaries was particularly noticeable between district nurses and community matrons. This reflected the level of perceived threat to an existing role. That said, Chapman et al (2009) also reported that district nurses expressed they had positive outcomes from working with community matrons and that the roles were complementary.

Reactions of resistance similar to this study’s findings were also reported by Cubby and Bowler (2010) in their qualitative study to evaluate the role of the community matron. They sought views of nine community matrons from three PCTs in the North East of England who had been in post between one and four years, using semi structured interviews. Whilst they reported positive outcomes for patients and in career development for nursing, they also reported that an unclear definition with the role had led to some resentment from other groups of staff. They reported a perception from others that the community matron role had taken some of their remit away, experiencing a range of reactions including lack of recognition, acceptance and cooperation.

The lack of role clarity, as discussed in relation to role ambiguity and the implementation of national policy, appears to also be a factor in role resistance (Thomas and Davies, 2005). This may be related to the level of perceived threat, which would be difficult to assess for the individual feeling threatened, and consequently the unknown would be likely to heighten anxiety. It also creates a sense of anticipated loss, as aspects of their own role are seen as being taken away. This is corroborated by Peck et al (2001) who reported that professionals in their study feared loss of organisational and professional identity when working in a different but perceived stronger culture.

Where the role is considered closest to the role of the community matron, such as the district nurse, the concern of loss would be greater. This concurs with Hudson (2002) who argued that the strength of feeling about professional identity directly impacts on enthusiasm for collaborative working, so where a threat is felt resistance is likely to increase. In terms of
sensemaking, the district nurses may be selecting cues that support their belief that the community matron role will take part of the district nurse role, leaving them with a lesser role. This may be driven by plausibility rather than accuracy as their assumption has not been articulated by the organisations but rather is influenced by their previous experiences where they perceived their own role to be undermined or undervalued. This would in part be influenced by the organisation promoting the role of the community matron. Had such promotion been undertaken in terms of the role’s relationship with existing roles, the importance of each role and the ways in which they would interact could have been emphasised so as to counter any sense of loss. Instead it appeared that district nurses created meaning in terms of losing their role that would then be played out in their actions, seen in their defensive behaviours described by the community matrons. Again this would suggest minimal organisational sensemaking as described by Maitlis (2005).

The community matrons expressed empathy with district nurses’ behaviours, showing an ability to understand the sensemaking of others. This may be due in part to some community matrons still identifying themselves as part of that group, as a result of their previous roles and relationships, even though they were subject to behaviours that treated them as outsiders. This separation by district nurses appeared to be reinforcing the differences between disciplines within nursing rather than identifying with the commonality of being part of the nursing profession. So whilst the community matrons were embracing their role as one embedded in nursing practice, the reported behaviours of district nurses appeared to be pushing this identity away from what they considered to be fundamental nursing practice. This could be underpinned by opposing stances; either a belief that the community matron role was no longer nursing, or that it was so close to the district nursing role it was duplicating, or more concerning, threatening to replace it. This can be related to the sensemaking process where different meanings are being generated by individuals and groups as they draw on different cues; here the influence of plausibility over accuracy appears to accentuate the different identity developments. However, social structuration theory (Giddens, 1986; Bourdieu, 1991) is more useful than sensemaking concepts in understanding these resisting behaviours. Bourdieu’s theory has been succinctly described by Lingard et al (2004, p. R407):

“... professions ... are conceptualized as social systems, in which each professional’s role is determined by its position in relation to others and by its access to certain commodities [capital]... Structuration theory is especially useful because it recognizes that individuals both within a profession ... and between professions ... are in a constant process of attempting to distinguish themselves and their profession and thus acquire more ‘capital’ so as to promote their ability to act (agency).”
Here, Bourdieu’s commodities (capital) relate to material resources, access to levels of information and access to social connections and acknowledged forms of expertise. So when applied to the reported behaviours of the district nurses, they could be considered to be protecting their ‘capital’ by attempting to block community matrons’ access to what they consider to be their domain of practice. In contrast, the community matrons were attempting to establish themselves in an area of care that was already ‘owned’ by other professionals, such as district nurses, GPs and social workers, and so had to contest that space using their initial ‘capital’ such as advanced practice. This capital was still low in value whilst individuals were developing these skills and also was not available to those not becoming advanced practitioners or active case managers. Therefore individuals would need to draw on their existing professional experience and professional relationships as capital (Bourdieu, 1991). As such degree of the success in establishing the role would be dependent on their individual skills in using their personal ‘capital’. This is explored further in the discussion about managing strategies in the next section.

10.4.3 Managing strategies

Negotiating boundaries between professions and within nursing is not new and is well reported in the research literature (e.g. Reeves et al 2009, McNamara et al 2010; Fisher, 2010). As such, the emergence of issues about shifting boundaries reflects those seen in the introduction of other nursing roles. For example, Faithfull and Hunt (2005) reported findings from a pilot study of a nurse led service to support men undergoing radiotherapy, which introduced a new advanced nursing role. They found that the politics of negotiating boundaries with other roles and frictions between professions were a source of discomfort and a barrier to making the role work, but argued that initial advice and guidance in establishing a new practice role was ‘lacking’ (Faithfull and Hunt 2005 p. 448).

Similarly there did not appear to be any debate in the case study sites about how the community matron role would impact on boundaries with existing roles, and how individuals could manage this. The strategy adopted by community matrons to negotiate boundaries appeared to be to promote the new role’s benefits, for example promoting a reduction in workload to GPs (OBS MT2/site 1). However the responses from the existing stakeholders in providing care for long term conditions, albeit limited in this study, suggests they did not see the benefits in the same way. Some had expressed concern that the new role would mean they would lose parts of their existing roles (e.g. DN03/site 3). In the absence of any existing strategy reported to manage this, it was for the community matrons to make sense of this
response and to negotiate the shifting boundaries with other stakeholders, in doing so filling the void created by minimal organisational sensemaking.

So it appeared that community matrons used their previous experience and understanding of other professionals’ behaviours to develop their strategies to gain acceptance of their role and in doing so negotiate role boundaries; that is, they would use their understanding to inform their next stage of sensegiving.

So at the same time the community matrons were making sense of their new role, they had to act as sensegivers in influencing others to accept and work collaboratively with the role. Throughout this period they were also evolving their practice as they built expertise as advanced practitioners. This appeared to show an ability to translate the concept of the role and present it in concrete terms that had meaning for colleagues. This meant the new role could be understood and adopted, whilst still sensemaking themselves. Such ability was recognised as essential in effecting organisational change successfully (Rouleau and Balogun, 2011). As seen in Rouleau and Balogun’s study of middle managers’ sensemaking (discussed in section 10.3.3), community matrons effectively engaged in discussions with others by using language and placing the discussion in the context that was familiar to those they were trying to influence.

In all case study sites stakeholder sensegiving and sensemaking appeared to be driven by the community matrons; but in all instances there had been initial awareness and role promotion undertaken by strategic leads, that is, they had started the scene setting prior to the introduction of the community matron role. In case study site one the media was also used to present new role, using ‘a day in the life’ stories and patient experiences (DIA PR1/site 1), which historically has not been used in the introduction of a new service in the NHS. So whilst the strategic leads initiated the sensemaking cycles with other stakeholders, it was the community matrons in all case study sites who maintained this both with groups and on a one to one basis in their daily work. Similarly, Reay et al (2006) identified how practitioners adopted strategies of achieving small wins with colleagues to influence change and seek acceptance of a new nursing role, in this instance a nurse practitioner.

Reay et al’s findings showed that individual practitioners used different strategies to negotiate boundaries with different professionals (Reay et al, 2006). Similarly in this study, the approach with social workers showed symbiotic relationships with behaviours reflecting a mutual respect (SW03/site 3). With nursing colleagues, the approach appealed to a sense of
a shared identity (CM02/site 1). With GPs however, the approach in some instances appeared to be reminiscent of Stein’s nurse-doctor relationship ‘games’ (Stein 1967), as seen in examples discussed in section 8.3. Stein et al (1990) proposed that nurses no longer played this game, instead being assertive in their interactions with doctors in the interest of patient care. The examples in this study, albeit small in number, suggest some gaming may still occur, although this may not necessarily indicate an acceptance of a subordinate position of nursing to medicine as proposed by Stein (1967).

The approach also involved community matrons presenting their role as a benefit to GPs in order to gain support and generate joint working. Speed and Luker (2006) examined the way in which district nurses and GPs interacted and affected each others work within primary care services. From participant observation and interviews with 33 district nurses, they found that district nurses operated as gatekeepers so reducing workload for GPs. In return they would gain access to GPs when they needed. Speed and Luker (2006) also reported that where a district nurse had gone outside the ‘rules of engagement’ or challenged a GP, the district nurse would suffer reprisals and access to the GP would be impaired in future. This was seen to a lesser degree in this study, where active case managers reported how GPs did not respond to overt challenge or accept advice in relation to a patient (FG ACM /site 2).

In terms of sensemaking, both professional groups may be strongly influenced by the social and historical context of their clinical practice, which affected how the roles in the relationship were played out (Helms Mills et al, 2010). In sensegiving the community matrons were presenting themselves as having authority to undertake care that was traditionally medically dominated. However this authority may not be recognised in GPs’ sensemaking as they themselves had not appeared to have relinquished the authority, from the limited data from GP and district nurses’ responses. This relates to structuration theory, in that the GPs have not released their ‘capital’ in terms of authority over medical functions (Bourdieu, 1991). The influence of the GP’s reaction on the community matrons’ sensemaking was strong in some cases in that community matrons reported that they reverted to learned behaviours to attempt to make their new role fit with the existing relationships.

Whilst this does reflect the impact of power as determined in critical sensemaking, it does not fully support understanding of behaviours in this interaction between professions. Instead, negotiated order theory (Strauss, 1978) provides some insight into the relationship between community matrons and GPs. Strauss (1978) proposed that individual interactions and negotiations shaped formal organisational rules and structures, and so these underpin the
development and maintenance of social order within an organisation. Previous research has found limited negotiation between doctors and other professions; for example Reeves et al (2009) undertook an ethnographic study of interprofessional interactions within two general and internal medicine wards in Canada. They observed interactions to be unidirectional where the doctor would ask for specific clinical information but other professionals were not invited or volunteering other professional perspectives on patient care. Reeves et al (2009) determined that there was a non-negotiated order between doctors and other professions.

So the interactions between GPs and community matrons in this study appeared to be GP led, with GPs maintaining control over when such interactions could happen. This would suggest that a non-negotiated order was in operation here. However it may be that as the community matrons develop confidence and competence in their role that they then increasingly challenge this order.

Speed and Luker (2006) observed some counter challenge by district nurses in relation to end of life care. They proposed that this may be ‘interplay of competing levels of knowledge where the nurses’ knowledge of end-of-life care is enough to challenge medical authority of the doctor.’ (Speed and Luker, 2006, p.894). This could be compared to the community matrons becoming expert in the management of long term conditions so they feel able to challenge. In addition some community matrons may have been developing in confidence to challenge the medical view as their skills in traditional medical functions of assessment and diagnosis increase, but their ‘expertise’ was not yet acknowledged by GPs. So this may suggest that community matrons were starting to use opportunities to open negotiation with GPs, shifting away from traditional role playing to a new relationship, that is, a new negotiated order. In this sense, the managing strategies undertaken by community matrons could be viewed as beginning to change the interprofessional relationships and generate acceptance of the role.

10.5 Making sense of values
This study’s findings presented two perspectives on the desired outcomes of the community matron role. From one perspective, the Department of Health for England prescribed specific numeric outcomes for the role of the community matron, such as the number of community matrons in post, activity levels and the reduction of emergency hospital admissions (DH, 2004b). In contrast community matrons and active case managers placed greater importance on qualitative and patient focused outcomes. To that end, some organisational outcomes in
relation to medical intervention appeared to be reinterpreted by community matrons in the context of improved patient experience.

### 10.5.1 Competing value systems

Part of the rationale underpinning the national policy for the introduction of community matrons was the need to control the demand for hospital services due to capacity and cost pressures (Gillam, 2001). This fundamentally was a resource issue, which, if unresolved, would have a detrimental impact on the quality of care. Doyal and Cameron (2000) argued that new nurse led developments in UK health care has been driven by resource issues, such as cancer waiting times, costs and reduction in medical staffing. In this study the national and organisational outcome measures reflected the need to demonstrate productivity and effectiveness, to provide a service for the greatest number of people with the resource available. As such the outcomes appeared to be founded on the importance placed on managing resources differently to provide better management of care for the population, in this case those with long term conditions. In doing so, there was less emphasis on the outcome for the individual patient.

In contrast, the community matrons and active case managers in this study emphasised the importance of the quality of life and improved care for the individual patient. These values were more aligned to those expressed by patients, for example one patient described the importance of being able to go out of their own home due to the interventions of the community matron (P03/site 2). Whilst they recognised the organisational outcome measures, the community matrons and active case managers considered such numeric outcomes to be less important. Rather, they valued what they viewed as desired outcomes for patient care. For example in case study site one, community matrons stated that it could not be assumed that all patients want to be kept out of hospital as for some it was felt this would always be the patient’s preferred choice (CM05, CM06, CM08/site 1). So the values being reflected in priorities of the community matrons and active case managers were akin to their professional values and belief in their duty of care to the individual, as reflected in The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC, 2008). Similarly Dick and Frasier (2006) reported how nurse practitioners articulated their role in terms of improving quality of life for patients.

The conflict between professional nursing values and organisational values is not new; Tuck et al (2000) examined the nursing philosophies of ten hospitals and health centres in the US to find values centred on humanism and individualism. They found that collectivism was not
highly valued by healthcare professionals but that it was the increasing value within the health care system. As such they argued that nurses were having to wrestle with a shifting value paradigm from individualism to collectivism, that is nursing practice would need to focus on the collective good while valuing individual worth. With the increasing focus on cost effectiveness in the NHS (DH, 2011) it is likely that such value shifts will impact on nursing in the UK.

Similarly other studies into values of nursing have found professional values that focus on individuals are of greater importance to nurses (Rassin, 2008; Shih et al, 2008). Rassin (2008) asked 323 Israeli nurses to rank professional values according their importance and found that human dignity (respecting the patient’s values and beliefs) and equality amongst patients (a patient has a right to be treated without discrimination) were rated as showing the most importance. Shih et al (2008) explored nurses’ values with 300 registered nurses in Taiwan, using 22 focus groups, and found that 75% cited caring for patients and their significant others with a humanistic spirit as the most important value, followed by the importance of providing competent and holistic care cited by 70% of nurses in their study.

Parallels can be seen between this study’s findings and Burhans and Alligood’s phenomenological study (2010) into the meaning of quality nursing care, in which they interviewed twelve nurses within acute care hospitals in the US. Six themes about what constituted the essence of quality nursing care were identified; responsibility, caring intentionality, empathy, respect and advocacy. Again these relate to professional values that focus on the individual patients’ needs rather than the organisation’s focus on resource management. So in this study it appeared that such professional values and organisational values were conflicting, creating a dissonance in which the community matrons were trying to establish and identify with their new role.

10.5.2 Managing dissonance – part of sensemaking?
The findings from this study showed how the community matrons reinterpreted the organisational outcomes in terms of individual patient outcomes. This suggests that the community matrons went through the process of sensemaking so as to give meaning to the outcomes within the context in which they were working and how they saw themselves as nurses. It is possible that this stage was the start of realigning their values with that of the organisation. However, given there appeared to be a stronger influence of their professional identity rather than the organisational values over how they worked, their reinterpretation may not indicate any shift in their own values, but rather selecting parts of the organisational
outcomes that can be fitted into their values. Sullivan et al (2002 p. 249) argued that ‘people move toward those goals or actions that they are attracted to, while withdrawing from others that would prevent them from realising their values.’

Values are the invisible threads of culture (Henderson and Thompson, 2003). Within the context of the individual, their personal values are an automatic but often subliminal driving influence in determining their behaviour (Branson, 2005). However, in the context of a collective group of people, any nominated team or organisational values are only guiding concepts as they still require the people to choose to act in alignment with them (Branson, 2008). It is argued that values alignment is the foundation upon which successful organisational change occurs (Sullivan et al 2002; Branson, 2008). The findings in this study suggest that values alignment did not happen in any of the case study sites: community matrons valued quality of patient care and their duty of care to individual patients, whilst they considered that organisational values appeared embedded in numeric targets.

Dissonance between professional values and organisational values was also reported by Attree (2002). She described professional dissonance as

"...the psychological discomfort nurses experienced in relation to the perceived discrepancies between their professional aspirations and achievements, and also the professional dilemmas and difficulty nurses experienced deciding how to deal with their perceptions of compromised standards."

From interviews of 142 practising nurses from secondary care, Attree (2002) found that nurses demonstrated great determination to maintain their professional beliefs despite significant pressure to alter them to resolve the dissonance, and that the nurses perceived powerlessness prevented them from changing the factors affecting practice standards. She argued that her findings differed significantly from cognitive dissonance theory (Festinger, 1957) which asserts that individuals change their beliefs or actions to resolve their dissonance.

In this study, it could be argued that the community matrons and active case managers also experienced ‘professional dissonance’ where they felt that their aspirations to provide quality of care for patients were at odds with the organisational targets. Similarly their professional values appeared to dictate their actions, in that they did not change their practice to meet the organisational expectations. However, community matrons differed from the nurses in Attree’s study, in their level of perceived powerlessness: community matrons were flexing
organisational ‘rules’, such as the eligibility criteria for the service, so exercising power within their scope in order in part to meet their practice aspirations. They could not, however, change the organisational targets where they were determined outside of the organisation at a national (macro) level. So instead community matrons attempted to influence interpretation of targets at organisational (meso) level, such as activity numbers and how caseloads were counted, as seen in the debate in section 9.1.

There are parallels between ‘professional dissonance’ and sensemaking, in that the community matrons were experiencing a situation which they could not make sense, that is their underlying beliefs about what their role should be and the outcomes of their care were at odds with the organisational outcomes. As such they needed to resolve this inconsistency to restore meaning. Professional values appeared to be a powerful influence on community matrons’ sensemaking: they sought to make the organisational outcomes fit theirs by reinterpreting them in terms of their professional practice and presenting their interpretation back to the organisation. Therefore they did not appear to change their practice to solely focus on the organisational perspective, as would have been predicted if Festinger’s theory (1957) had been applied.

10.5.3 Organisational sensemaking and alignment of values
Lack of values alignment would be a characteristic of minimal organisational sensemaking, (Maitlis, 2005). However, in case study sites two and three it was suggested that there had been more guided sensemaking, in relation to management leadership, as described by community matrons. In this instance one would anticipate greater values alignment. It can be speculated that, even where guided organisational sensemaking is taking place, the values of individuals or a collective (such as a profession) within that organisation can exercise stronger influence than the organisation. From the community matrons’ perspectives in this study, the professional values appear to prevail to be the dominant influence. It could be considered, however, that this was more indicative of a point in time in the sensemaking process, so that different values would still be operating. This would reflect the findings of Reay et al (2006). In their four year study examining the nurse practitioner role in Canada, they found that nurse practitioners were still working with others to gain acceptance of the new role five years after the start of its introduction. So it would be expected that the introduction of a new role, and the embedding of shared values, would still be in progress in each of the case study sites.
10.6 Ambiguity: the stimulus or inhibitor of change?

The introduction of the national policy in England for the management of long term conditions generated the need for PCTs to develop a different model of care with the introduction of community matrons (DH, 2004a; DH, 2005e). This was within a period of pre-existing organisational turbulence generated by national policy (DH 2005b, c), as described in the context of the case study sites. The new policy appeared to initiate the sense of ambiguity, as described in the accounts of the community matron in developing their new role: in terms of organisational sensemaking, it triggered the processes of sensemaking, as it presented a different landscape for the provision of care to that being experienced where there was already wide variation in case management models in operation (Singh 2005a; Sargent et al 2007).

Across the three case study sites, there were different service models in terms of service structure and skill mix (see Figure 4, page 94). This suggests there was variation in the interpretation of the national policy in its implementation. Whilst at a micro level, the community matrons reported functions akin to the national model, as described in Chapter 7, this did not appear to be the case in the service structures, that is, at the meso level; structures seen in case study sites two and three (sections 6.1 and 6.2) did not reflect the Evercare or Unique Care models that had been used as exemplars nationally (DH 2005e; UnitedHealth Group Europe, 2005; Abdallah, 2005). Variation of service structure was also found by Reilly et al (2011) in their study of case management in ten PCTs within Greater Manchester. Here they used a cross-sectional survey of managers with lead responsibility for case management of long term conditions services, with 100% response rate.

Despite a high level of coordination across the geographical area, Reilly et al’s survey (2011) found variation in the organisation of case management between the PCTs. This included one example of case managers located in GP practices, and others where case managers worked in nurse teams. Another had an integrated healthcare and social care team pilot in addition to the case managers working in GP practices. Some skill mix was identified with community matrons, nurse consultants and trainee advanced practitioners providing care for very high intensity service users. These PCTs presented a similar approach to case study sites two and three in this study. However whilst the service structures did not necessarily reflect the Evercare or Unique Care model, Reilly et al (2011) reported that the majority also used the Castlefields tool and the Patient at Risk of Re-hospitalisation II (PARR II) tool (King’s Fund, 2006), which was also seen in the three case study sites. So, the variation in the policy
implementation in this study and in Reilly et al’s study (2011) suggests there may be an implementation gap as described by Hill and Hupe (2002) in section 2.4.1.

10.6.1 Implementation and sensemaking at a micro level: the community matrons’ perspective

In terms of the day to day role, community matrons had adopted comparable functions across the three case study sites, namely assessment, coordination, advising and promoting self care, and also medication reviews. These reflected the core functions described for the Evercare Nurse Practitioner (Abdallah, 2005; Fraser et al, 2005), for example clinician, coordinator, and coach, and also the roles described by the Department of Health (2005e). The comparison can be seen in Table 21 in section 7.8.

Sargent et al (2007) also reported similar types of care tasks undertaken by community matrons. They interviewed 72 patients and 52 carers from six PCTs to explore patient and carer perceptions of the community matron role, as part of a larger evaluation study. Their findings identified clinical care (including physical examinations and medication reviews), care coordination, education, advocacy and psychosocial support. They concluded that

“patient and carer descriptions of community matron psychosocial support and, to a lesser extent, patient education and advocacy, indicate that community matrons are delivering a model of case management that extends beyond Department of Health policy directives” (Sargent et al, 2007, p. 518).

They also reported that patients and carers identified psychosocial support as a crucially important function of the community matron, even though this was not included as a function of the community matron in the Department of Health guidance (Sargent et al, 2007).

Similarly, Chapman et al (2009) reported that community matrons addressed patients’ needs beyond their immediate medical needs but also included social needs. Their qualitative study comprised five focus group discussions involving 31 participants who were community matrons, district nurses, social workers and GPs. Participants shared their experiences of the community matron role in one community trust. They reported that community matrons addressed patients’ needs beyond their immediate medical needs, but also addressed social needs. These findings support those reported across all three case study sites in this study, where psychosocial support was also seen as an important function by the community matrons and patients. For example, community matrons supported patients with anxiety (CM10/site 2) and recognised dependency needs outside of patients’ physical conditions.
This, then, appeared to be a function that had developed from ‘grass roots’, identified with patients and practitioners.

Girot and Rickaby (2008) considered that national publications such as the Case Management Competences Framework (NHSMA and SfH, 2005) gave specific guidance for the implementation of the role. Sargent et al (2007), however, argued that national policy did not define the day to day role of the community matron, but instead described the objectives and principles of case management of long term conditions. The Department of Health (England) did outline core functions of the role (DH, 2005e) but the time between the announcement regarding the introduction of community matrons (DH 2004a) and this guidance appeared to create a vacuum for speculation. This may have generated ambiguity about the role, which was subject to potential variance through the sensemaking process.

Local development of the community matron role beyond the national model, as reported in all three case study sites, suggests there may be a stronger external influence on the sensemaking of community matrons. Identity construction is viewed as the pivotal property in sensemaking (Weick et al, 2005). Community matrons share a professional identity as nurses which is wider than their identity as employees in the PCT, as discussed in section 10.3. As such they may draw on their professional values about how they should practise and their responsibilities to respond to the needs of their patients, as articulated by the community matrons across the three case study sites (CM06/site 1; CM10/site 2; ACM11/site 3). This was also seen in this study where community matrons chose to exercise discretion with the eligibility criteria, in that they would override the PARR scores if they considered an individual would benefit from the service (CM11/site 3). In this way their professional experience and values appeared to determine their action rather than the organisational ‘rules’.

Similarly, Hall et al (2011) found variation in community matrons’ practice in relation to caseload selection. Whilst only four community matrons were observed and four interviewed about their patient selection and use of case finding tools, the observational study was reported to have sufficient data to reach saturation. Direct observation included the use of a ‘Think Aloud’ protocol where participants were asked to say what they were looking at, thinking, doing and feeling as they undertake patient selection. However any limitations of this method were not described. The study found that community matrons reported modifying case selection, depending on their personal experience and expertise, interpersonal relationships, and accessibility of computer systems. So community matrons in Hall et al’s
study would use their personal clinical judgement to override selection tools, in a similar manner to the community matrons in this study.

So this suggests that community matrons in this study used individual actions as personal cues to interpret their role, in the context of their wider nursing identity. This in turn appeared to shape their role development. This appeared to be reinforced by sensegiving between community matrons as seen in team meetings (OBS MT/site 1; site 2; site 3). A further cue may have been, for example, the emerging nursing literature about the role (Adler, 2005a,b,c; Cook, 2005), although this was not articulated specifically by the community matrons. In this respect immediate colleagues and the nursing profession could be considered to be acting as a key source of influence, that is, operating as stakeholder sensegivers.

In this study, community matrons had not reported that they felt any conflict within their role in using their professional discretion regarding eligibility for the service. Similarly they widened their original remit to address psychosocial needs of patients based on their professional judgement, so it became an integral part of their function (CM12/site 3). So in sensemaking terms, they had created meaning to the role that was plausible and subsequently translated this into action (Weick et al, 2005). It is unclear from the data in this study, however, whether this development has been formally acknowledged within the organisation, that is, whether it formed part of the stakeholder sensegiving, so that the organisation reinterprets the role accordingly. In a longitudinal study of sensegiving in three symphony orchestras, Maitlis and Lawrence (2007) identified conditions required to trigger sensegiving, such as a perception of a sensemaking gap, and conditions that enable it, such as opportunities through meetings, reports to appropriate levels of authority within the organisation. Community matrons in this study considered their role expansion as integral to their function, and therefore had not identified it as outside their expected role function; they appeared to have made the function make sense. As such it would not trigger stakeholder sensegiving to stimulate the ongoing cycle of organisational sensemaking.

This role development was reported to have occurred at an early stage of the role implementation whilst community matrons were still developing caseloads. At this stage the service was not operating at capacity. This may become an issue as there is increasing pressure on capacity; community matrons had raised concerns about what were appropriate caseload levels (CM02; CM04; CM06; CM08/site 1; CM10/site 2) in relation to being able to provide quality of care to patients. Caseload numbers were also found to be contentious by other studies (Adler, 2005b; Sargent, Boaden and Roland, 2008). Sargent et al (2008)
undertook an interview study of community matron case load sizes and manageability. They interviewed 46 case managers for long term conditions, five clinical leads and six programme leads across six PCTs which provided a good sample size. They reported variance in caseload sizes from 10 to 20 in one PCT compared with up to 42 to 55 in another. Those with small caseloads were recently recruited and still developing their caseloads. Participants ‘regarded caseloads over 40 patients as ‘heavy’ and having a negative effect on their ability to provide proactive care’ (Sargent et al, 2008, p.43). The study also found that caseload characteristics were not taken into consideration in determining caseload size. Similarly Reilly et al (2011) in their survey of ten PCTs found caseload sizes varied from 30 to 80 and that some respondents considered the target caseload of 80 was unrealistic.

So concerns about capacity were not unique to this study. However, should the organisation examine the pressure on capacity, the psychosocial function developed by community matrons in this and other studies, may not be recognised by the organisation. As it is particularly time intensive, a conflict may develop between the organisation and the community matrons: the view of community matrons regarding what is important and intrinsic to the role may then be at odds with the organisational view of importance, for example targets and outcome measures predicated on the nationally determined functions.

Flexibility in eligibility criteria and issues of capacity described by community matrons may highlight the power relationships that influence the outcome of sensemaking in organisational change at the micro and meso level (Helms Mills et al, 2010). Whilst community matrons had been able to steer their role development to a degree, it has been noted that new nursing roles have been driven externally rather than by the profession (Carnwell and Daly, 2003). They argued that drivers for new nursing roles in the UK, such as a shortage of doctors and the reduction of junior doctors’ hours, were similar to those seen in the USA where advanced nursing roles emerged in clinical settings that were either under resourced or had a shortage of doctors. However how the roles emerged differed between the USA and the UK; Fairman’s account (2008) of the US experience described how significant role developments in nursing, such as the nurse practitioner, have been driven by members of the profession rather than nationally or organisationally. The nurse practitioner movement was described as growing from doctors and nurses working together to develop ‘a collective practice identity that challenged the traditional system of health care based on the primacy of the physician’ (Fairman, 2008, p. 2). Even so, the role was only taken up by federal governments when they realised the cost saving implications (Fairman, 2008). So in this study the new community matrons appeared to be able to use professional power to a degree to influence the
organisations in which they worked. This resonates with Lukes’ theory of power (2005) in that the community matrons appeared to have capacity to exercise a degree of power within their organisations.

This differed from suggestions in the literature that suggested that the introduction of the role of the community matron was not driven by nursing or medicine, but initiated outside of the professions by the Department of Health (Agnew, 2004a). This view suggests a political influence and consequent interest in its outcome that is driven by agenda that may not be congruent with drivers of change within nursing (Drennan et al, 2011). The national political driver for change was argued to address the resource issue for health services, with increasing pressure to provide care for a growing older population and escalating demand for secondary care (Green and Thorogood, 1998; Weiner et al, 2001). These drivers translated into demands made of organisations through targets to improve health outcomes of local populations whilst addressing resource limitations (DH, 2004b).

Professional drivers for practitioners tend to be embedded in an ethos to improve the quality and outcomes of care, underpinned by a professional duty of care to individual patients (Burhans and Alligood, 2010). This was described in this study by community matrons and active case managers in terms of improving patients’ quality of life, regaining confidence and control of their lives. The dichotomy between organisational targets and professional priorities was summed up by one active case manager who said:

‘...we’re on a hiding for nothing in trying to stop admissions. But if we are going to be assessed and evaluated on patient outcomes then I think case management would be a resounding success.’ (ACM10/site 3 cited in section 9.3)

However, some practitioners may recognise and acknowledge the organisational drivers and targets, as seen in the community matrons’ and active case managers’ accounts of their roles and descriptions of activity figures and caseload numbers (CM01/CM02/site 1; ACM02/CM10/SM01/site 2; ACM08/ACM10/CM11/CM12/site 3). So do organisations ‘sell’ the ethos of improving care by representing the targets in this way, to get ‘buy in’ from practitioners? In terms of organisational sensemaking, organisations would use sensegiving to influence meaning construction or organisational members and stakeholders to create a unified view which would generate collective action.

Rouleau and Balogun (2011) examined two qualitative research projects about middle managers involved in organisational restructuring, one in a radio broadcasting company and another in a multinational engineering company. Full details of the studies were not given,
such as total sample size, but data sources were noted to include biographical data, interviews and focus group data. Vignettes of four managers taken from the two studies were described to demonstrate their process of sensemaking, which were reported to be illustrative of the wider study. Rouleau and Balogun (2011) reported that managers who were skilled at matching the right language and conversations with the stakeholder were able to influence others to adopt their point of view.

However this type of interaction between senior managers and community matrons was not evident in the accounts of community matrons from case study sites in this study, in particular case study site one. Community matrons did re-interpret the targets themselves in terms of improving patient care, so that they can make sense of their role and the organisation in which they work, as seen in how community matrons across the three case study sites described targets and improving patient care:

“I think we’ve made a difference to people’s lives... we’ve given people information, confidence...Keeping people at home is just amazing, it’s where they want to be...”
(CM07/site 1, cited in section 9.3)

However as community matrons develop in their role and increase their patient case load, pressure increases and the organisational targets and individual drivers may no longer be aligned. This may cause tension and confusion for practitioners so that they question the priority and importance of targets. This was seen by Sargent et al (2007) where community matrons were finding it difficult to achieve previously determined caseload numbers and were facing pressure to further increase caseload numbers. In this instance the previous sensemaking by community matrons appears to be challenged, causing ambiguity again. In doing so, the strong underlying influence within the community matron’s professional identity appears to dominate over the more recently constructed meaning of organisational targets which is less embedded. Parallels can be drawn with organisational role theory, where such role ambiguity arises where expectations are incomplete or insufficient to guide behaviour (Biddle, 1986).

This does not appear to be unique to the community matron role. Bergen and While (2005) examined the implementation of the community care policy in the UK which saw nursing taking on the role of care management as discussed in section 2.4.1. They found care managers identified coping mechanisms to deal with balancing need with resources but found ‘less amenable to resolution was the tension between competing individual and population perspectives of case [care] management, both as policy and within the nursing ideal.’ (Bergen and While, 2005, p. 5).
So again, the ambiguity and dissonance between organisational targets and professional values, as discussed in section 10.5, were factors in how the role of the community matron developed in this study.

10.6.2 Implementation and sensemaking at a meso level: the community matrons’ perspective

When considering organisational sensemaking at a meso level, the PCT could be considered to be the leader sensegiver, and teams within the organisation, professional groups and individual employees, would become stakeholders. Here, the level of skill and involvement in sensegiving and sensemaking by strategic leaders, that is, directors and senior managers, within the PCT, would be expected to have a significant impact on effecting organisational change, as shown in studies of middle managers and chief executives in organisational change (Gioia and Chittipeddi, 1991; Maitlis and Lawrence, 2007). Gioia and Chittipeddi (1991) undertook an ethnographic study of the initiation of change in a large university in the US, and found that the sensegiving activity of the chief executive was key to the effectiveness of the change.

In this study, the role senior management played in the implementation of community matrons varied across the three case study sites. In case study site one, community matrons reported a lack of involvement of senior management (OBS MT3/site 1). In case study sites two and three, however, senior leadership was identified and meeting notes showed their close involvement in the development of the service (DOC STRAT2/site 2; DOC MIN2/site 3). This would have affected the level of control over the organisational sensemaking during the implementation and may contribute to the different approaches chosen (Maitlis, 2005). In addition, all case study sites were operating existing services that would in part provide care for long term conditions. Community matrons in all case study sites referred to such services in their descriptions of relationships with other professionals or with regard to their coordinating function. The knowledge of these may impact on the interpretation of the new model, as organisational members would extract cues from the proposed new model which were plausible (Weick et al, 2005). This is because such cues would support what was already known, that is, a new service model would be interpreted in a way that would fit with existing services (Weick et al, 2005). However, the variation of service model did not appear to be influenced by local population needs or existing services, for example disease prevalence or the number of single handed general practices (see Table 18, page 91).
Alternatively, variance in policy implementation may reflect the stage of maturation of organisational sensemaking. Case study site one was at an earlier stage of implementation at the time of data collection compared to the other case study sites. As such, there would have been less time for sensemaking activity that would influence change. The service in case study site three had been in operation the longest of all three case study sites, (see section 5.3) so there would have been more opportunity for sensemaking activity. As organisational sensemaking is a cyclical process (Thurlow, 2010), the service model and structure would evolve over time as an outcome of sensegiving and sensemaking activity. If this were the case the variation in service models between case study sites would reflect this.

10.6.3 Implementation and sensemaking at a macro level

Whilst the implementation of the community matron role was not examined at the macro level in this study, some consideration has been given here to its potential impact on the perceptions of the community matrons about their role. If the implementation of national policy by separate PCTs is considered in the context of organisational sensemaking, the variation may reflect the form of organisational sensemaking adopted nationally and locally. Such variation creates an implementation gap (Hill and Hupe, 2002). So, if Maitlis’ forms of organisational sensemaking (Maitlis, 2005) are considered at a macro level, the Department of Health (DH) can be viewed as the leader sensegiver; the DH sets out its expectations of the NHS in publishing the policy and setting associated targets such as the number of community matrons to be in post and reduction in emergency hospital admissions (DH, 2004b). However the DH is not able to have high levels of interactions with PCTs through the sensemaking process and so has low control over the process of policy implementation, even though implementation is mandated.

The stakeholders, here being the PCTs and other care providers, would not necessarily have high sensegiving activity at a national level: they would have limited control directly with the DH. Instead, at the early stage of policy announcement (DH2004a) the professional bodies appeared to have higher levels of sensegiving activity. This was seen in questions and concerns about the introduction of the role (Meldrum 2005; Agnew 2004a; Murphy 2004). However there is greater potential for higher sensegiving between stakeholders, as was seen later in each of the case study sites in working across the SHA (DOC EVAL/SHA), in terms of interpreting the policy implementation.

The degree of involvement in sensegiving by stakeholders, for instance PCTs, may be affected by how they determine the importance of the implementation of community matrons
against their pre-existing organisational changes requiring attention (DH 2005b,c), as described in the context of the case studies. So, if the Department of Health is undertaking minimal sensegiving, and the level of sensegiving by PCTs is subject to variation, there is likely to be variance between organisations in adopting fragmented or minimal organisational sensemaking. The implementation of the policy within the case study sites, from the community matrons’ perspective, suggests fragmented organisational sensemaking, given the reported inconsistency of emerging service structures.

10.7 Consideration of the research questions
The study aim was to develop insight and understanding of the role of community matron, and its implementation within three primary care trusts. Three questions were asked at the outset, with regard to how the community matron undertook the new role, how the role affected other practitioners and how community matrons negotiated their role boundaries with others. These questions focused on the micro level, that is, the individuals' activity in relation to role implementation. However, the role could not be considered out of context in which it was operating, and so consideration was given to the potential factor at play in the wider landscape at meso (organisational) and macro (national) levels. This helped in broadening the understanding of factors affecting community matrons in undertaking this new role. The flexibility of case study methodology facilitates such changes within a study, as its primary focus is on the case in question, which leads the direction of inquiry (Stake, 2006). Multiple case study design provided a comprehensive method which benefits from using multiple data sources that can capture the wider landscape (Yin, 2004).

10.7.1 How does the community matron undertake this new role?
The ways in which community matrons have developed this new role have been explored by describing the functions of the new role as reported and observed in practice and its fit with national policy (DH, 2005e). Chapter Eight provided a detailed account of role functions in assessment, coordination, advising and promoting self care and explored the issues within the role, in particular regarding advanced practice. Chapter Seven related the implementation of the role to the local service structure, eligibility criteria for the service, visiting schedules and dependency levels of service users. Findings revealed issues affecting role implementation in a climate of transition, and the ways in which community matrons appeared to flex organisational policy to fit their professional priorities. This fitted with Lukes’ theory of power (Lukes, 2005) where community matrons were utilising their capacity for power to influence the role implementation. This may have been facilitated by the minimal
organisational sensemaking (Maitlis, 2005), in that the organisation did not appear to exert its full capacity to lead and influence the role, from the community matrons’ perspective.

Exploration of the findings in the discussion has provided some possible explanations which might explain the decisions, actions and behaviours of the community matrons. This has provided some insight into how individuals develop, change and adapt their practice within the context of organisational and professional influences. The use of multiple case study has also elicited a snapshot of role implementation at different stages, with case study site one being at the initial six months phase of implementation to case study site three being operational for over two years. Therefore it is considered that the study has added to the evidence and aided understanding of this research question.

10.7.2 How does the introduction of this new nursing role affect existing practitioners working in the management of long term conditions?

The effect of the role on other practitioners was explored through reports of relationships and to a lesser degree through observations. Issues about relationships were reported in Chapter Nine. Findings showed how the new role was being perceived by others and the reactions the community matrons and active case managers were experiencing. Reports and discussion provided insight into those roles that were experiencing the larger impact on their role, for example district nurses and GPs, and those who were affected to a lesser degree, namely hospital health professionals. Some behaviours of both resistance and collaboration were evident amongst colleagues. Such findings reflected structuration theory (Bourdieu, 1991) where the implementation of the role was perceived by others to encroach on their ‘capital’, that being their domain of practice. However it is acknowledged that findings from this study were limited with regard to the perspectives of other professionals and managers, due to the low numbers recruited to the study. In addition the findings did not reveal whether there were any significant changes in function or activity for such roles or fully determine how the role fitted into the existing landscape of services for long term conditions. Therefore this research question was partially addressed.

Case study method provided an appropriate vehicle to explore this question but in this study greater focus was placed on the community matron teams with lesser data collection from interviews, observation and documentary material in relation to other roles. Wider data collection using interviews, focus groups and observation within the case study method, with participants in associated roles, for example GPs, practice nurses, district nurses, social workers and allied health professionals might have enabled this question to be explored more
fully. However this could not be pursued during this study due to time and resource constraints.

10.7.3 How have community matrons negotiated their role boundaries and has this affected the boundaries of other community nursing roles?

Ways in which community matrons negotiated role boundaries were described in accounts about relationships, as reported in Chapter Eight. This included formal routes in discussions about the role with other professional groups, as observed with social workers and GPs, and also the personal tactics they adopted in one to one relationships in their daily work. Discussion of shifting boundaries and managing strategies provided further insight into possible explanations for the approaches used by community matrons. The interface with other roles was described in relation to the coordination function described in Chapter Seven. The discussion explored the perception of shifting boundaries. However the findings did not go as far as to reveal whether other community nursing roles had changed as a result of the community matron role, and so the impact on role boundaries could not be determined. Instead, the role boundary in debate that emerged from the findings was with GPs. This may in part be due to the greater focus on community matrons than on other community nurses in the data collection, as discussed earlier. Again, wider data collection from more sources and different participants within a case study method would have enabled this part of the question to be explored more fully.

10.8 Consideration of multiple case study method

Multiple case study has been an effective method by which to explore the role of the community matron in the context of the organisation in which it operates. Multiple case study sites enabled further insight into the impact of different organisational cultures and local interpretation of national policy.

It is recognised that the case study sites provided a description of the role implementation at a point in time. The use of multiple case study sites was useful in reflecting the process of implementation at different stages. It also gave insight into the nature of transition by virtue of data collection being undertaken at different stages of implementation in each case study site, which would not have been captured by a single case study.

The large volume of data from different sources required a systematic logging and retrieval mechanism. NVivo7 was effective in supporting data management and analysis. Its use also provided transparency of the analysis process. In this study the data sources did not cause
any anomalies, that is, the findings from different sources converged rather than conflicted. However had data been conflicting in nature some consideration would need to be given to how data sources are presented in terms of how they inform the overall findings.

Interviews and observations were the richest sources of data from which to describe experiences and behaviours in relation to the implementation of the community matron role. A qualitative interview and observation study could have been used, but this would not have provided the richer context that was gained from documentary material. Furthermore, the case study design provided greater flexibility for the researcher to enter each of the case study sites on repeated occasions to consolidate data.

Whilst case study does not claim to be generalisable, the use of multiple case study sites does highlight commonalities and differences which might indicate potential factors that could be transferable to other examples of role implementation. This also provided insight with regard to theories that may underpin the findings. It was not intended to generate theory from the findings. Instead, the method generated findings that were considered in relation to existing theories, such as critical sensemaking. This was consistent with the methodological approach selected for this study (section 3.2.3).

10.9 Limitations of the study
The limitations of the study have been considered with regard to the research method, presentation of the findings and changes that could have been made to the study to mitigate these limitations.

10.9.1 Critical examination of the method
As the qualitative case study was exploratory in nature, it has provided an in depth description of the early implementation of the community matron role, through the lens of the community matron. It is however limited in that it describes a point of time in role implementation that was subject to contextual factors at that time, and so it is not presented as directly transferable to the experiences of others developing new roles. However it does provide insight into the experience of role implementation.

Recruitment of participants other than the community matrons and active case managers was challenging, and the low numbers of these participants limited the scope of the study to an examination of the role from the perspective of the community matron. Had wider recruitment
been achieved, role implementation could have been explored further with regard to its impact on other roles, and in terms of organisational change.

A further limitation was in the sampling method for health and social care colleagues and patients via community matrons. It was recognised that potential bias could be generated should the community matron select only those who would give a positive perspective of the community matron role. However this approach was considered the most appropriate for recruiting patients, so that their confidentiality was protected until they consented to participate. It was also considered the most effective way to recruit colleagues who would be able to inform the study, as they would have direct experience of working with the role. This also meant recruitment could be achieved within the time and resource limitations of the study. The potential bias of positively selected colleagues and patients was mitigated by using data triangulation and multiple case study sites (Andrew and Halcomb, 2006; Creswell and Plano Clark, 2011).

10.9.2 Presentation of findings
Data were limited due to the low numbers of participants from other professions and disciplines of nursing, for example hospital doctors and GPs; hospital based nurses and district nurses, and social workers. As such findings were from the perspectives of community matrons rather than being able to present views from these groups. Whilst documentary material included local policies and implementation plans, the use of such evidence was limited without participants from senior management to present their perspective. Therefore there were minimal data in relation to organisational perspective which limited the findings with respect to role implementation at the meso and macro level.

There was a predominance of data from community matrons in case study site one, which may bias the findings to the community matrons’ perspectives. In case study site one, all potential community matron participants wanted to take part, and it was considered that it would enhance the study to utilise the breadth and diversity of experience offered by this group. This was in keeping with case study design, where the study is led by the case in question (Stake, 2006). The potential bias was mitigated by the multiple case study design: cross case analysis between all case study sites served to reduce this potential bias, by providing a wide cross section of participants.
10.9.3 Reflection on limitations of the study and potential remedies

This PhD study was limited by time and other constraints. Had time and resources been unlimited the study could have been expanded in a number of ways. Extending the period of data collection within each case study site would have facilitated examination of role implementation beyond its early stages. This would have given the opportunity to explore how such roles become embedded or evolve over time, and how contextual change influences and affects role implementation (for example the ongoing organisational change within the NHS).

Wider sampling from clinical colleagues across organisations, for example GPs and district nurses, organisational leads, senior managers and directors would have given a wider perspective of the community matron role implementation and the opportunity to explore potential different views. This would have widened the scope of the study.

The study could have been further strengthened by examining the organisational perspective through increasing observations to include other participants, such as clinical colleagues, organisational leads and senior managers. Greater use of documentary material such as organisational policies could have enhanced the organisational aspect of the study. This could have widened the perspective in relation to understanding organisational change, through greater observation of organisational meetings and interactions between community matrons and managers.

10.9.4 Reflection on my personal learning

Undertaking this study has been a lengthy journey towards becoming a reflexive researcher, which has been a challenging but rewarding developmental process. My knowledge and skills have been developed in all aspects of the research process. For example, I learned how to undertake a literature review where there was a paucity of existing research. I developed skills in considering a research topic laterally, whilst maintaining the focus on the context of the study in reviewing literature for relevance. The research process has enabled me to develop personal strategies to be able to step outside of my day to day role in order to embrace the researcher role, whilst understanding the interrelationship between the two through reflexivity. Developing reflective practice within a research role has enhanced skills in being my own ‘critical friend’.

Adopting case study as a methodology developed my skills in planning, coordinating and implementing a complex research approach which provided depth and breadth to data
collection and analysis. This included developing skills in managing multiple data sources. The process of analysis and interpretation of a large volume of data in a time of continuing change and increasing complexity in the NHS developed my analytical thinking. The task of presenting findings and analysis developed skills in identifying the key messages from the research to be conveyed in an accessible way, through the use of narrative and selecting data that articulates concisely the key messages from participants. Through this my presentation and writing skills have been improved.

Finally the research process, conducted part time over a period of seven years, has developed my resilience in the face of challenge, to address competing priorities, and to remain true to the voices of participants in the study.

10.10 Consideration of critical sensemaking as a heuristic for analysis

Critical sensemaking (Helms Mills et al, 2010) was useful as a heuristic to explore the findings of this study. This may be in part due to sensemaking being set within the constructivist paradigm (Denzin and Lincoln, 2003; Schwandt, 2003). This fitted with the social constructivist epistemology that underpinned the approach used with this case study, as discussed in section 3.2.1. The findings generally fitted with Helm Mills et al's concepts of critical sensemaking (Helms Mills et al, 2010). Again the constructivist perspective of sensemaking allowed exploration of possible explanations and different perspectives of participants.

Critical sensemaking was most helpful in considering the interactions between the macro, meso and micro levels that impacted on the implementation of policy and providing insight into the processes that can support or hinder organisational change. In this respect the application of sensemaking by Maitlis (2005) and the four forms of organisational sensemaking identified from her study were particularly informative.

The critical sensemaking framework (Helms Mills et al, 2010) did not, however, fully address the broader context of organisational power and culture, in these findings. In order to understand the findings in greater depth, other social theories such as Bourdieu (1991), Strauss (1978) and Lukes (2005) were drawn upon. These complemented the critical sensemaking perspective.
10.11 Summary of discussion

Four key themes emerged from the findings of this study, in relation to the implementation of the community matron role. The themes were: identity within a changing nursing role, from findings in relation to role function and levels of practice; shifting boundaries from findings in relation to role function and relationships; making sense of organisational and professional values, from findings about outcomes and effectiveness; and ambiguity, from findings relating to service model and role function. The concepts of change and implementation ran through all these four themes.

The implementation of the community matron role appeared to be practitioner driven at the micro level, within the parameters set up by the organisation at the meso level. Professional nursing values appeared to be a key influence in the development of the role functions in all three case study sites. These included assessment (including medical examinations and diagnosis), care coordination, advising and promoting self care, and also medication reviews. These reflected the core functions from the national policy (DH, 2005) and were also seen in implementation of the role elsewhere in the country (Sargent et al, 2007; Chapman et al, 2009). In addition, community matrons developed a further function in relation to psychosocial support which was reported across case study sites and in other research findings (Sargent et al, 2007). It appeared that the community matron’s past experience in nursing practice was also a factor as to how they undertook the role, emphasising the importance of individuals’ role identity through transition and its influence on their individual sensemaking.

The introduction of the advanced practitioner role with the community matron role brought issues about the degree of medical influence over the role and whether this was indeed advancing nursing practice (Adams et al, 2000). This differed between case study sites, where in case study site one it was still to be determined whether the advanced practitioner and community matron were the same or two complementary roles. In case study sites two and three, advanced practice was an integral part of the community matron role, underpinned by the service skill mix. In all cases, though, the community matrons were taking traditionally medical functions such as examination and diagnosis, and making them integral to nursing functions, reaffirming their identity firmly as nurses, and not aligning themselves with medicine.

The theme of shifting boundaries drew from findings about relationships with colleagues. The community matrons managed issues of shifting boundaries; they appeared to be a major factor in the degree of success in the acceptance of the new role. However, there were
limitations in data from colleagues due to the small number of participants from district nursing, social workers and GPs, which meant interpretations, were predominantly formed from the perspective of the community matron. So it appeared that the community matrons presented themselves as the instruments of change in all case study sites; they undertook organisational sensemaking at the micro level to be sensegivers in promoting the new role with other professions and with patients (Maitlis, 2005). Community matrons’ accounts of behaviours of resistance from district nurses in particular could be associated with structuration theory (Bourdieu, 1991), where district nurses appeared to be trying to protect their ‘capital’, or domain of practice.

The approaches used by community matrons to negotiate boundaries varied with different professions. This may reflect previous history of working together and the importance of the personal dynamic in managing strategies. The level of perceived threat experienced by other professions also affected the negotiation of boundaries. Strategies used to negotiate boundaries with GPs fitted with negotiated order theory (Strauss, 1978).

A theme that emerged was about making sense of values. Community matrons appeared to present different value systems in operation between the organisation and themselves. As a consequence the community matrons appeared to be experiencing professional dissonance. Their response to this was similar to previous research (Attree, 2002) where professional values dominated behaviours to resolve such dissonance. This highlighted the importance of professional values for community matrons to be able to make sense of organisational outcomes and values. Community matrons in this study used professional values to reinterpret organisational outcome measures. They did not change their own practice but instead sought to influence and use power within own sphere of practice to determine how outcome measures such as activity levels are counted.

From the community matrons’ perspective, there appeared to be ambiguity generated from the policy implementation gap (Hill and Hupe, 2002), between national policy (DH, 2005) and local implementation. In terms of sensemaking, it is speculated that national policy generated ambiguity about existing service provision and roles, so creating the impetus for change. There also appeared to be fragmented organisational sensemaking from macro to meso level (Maitlis, 2005), in that nationally there was high animation in the form of documents from the Department of Health (DH, 2004a; DH, 2005a; DH, 2005b; DH, 2005c), and professional debates (Agnew, 2004a; Murphy, 2004; Meldrum, 2005) about the new role of community matron. However there was limited data within this study to determine whether this was the
case here. If so, it could be interpreted that low control could only be exercised from the macro level nationally to the meso level within each organisation, which would generate the conditions in which variation could occur (Weick, 1995). This could indicate the importance of the organisational approach to the implementation but further research would be required to determine this.

Differences were identified between the case study sites in the implementation of the role, in terms of service structure, the inclusion of advanced practice skills in the role, and the degree of autonomy given to the community matrons themselves to develop the role. This, from the reports of the community matrons, appeared to reflect different approaches to organisational sensemaking between the case study sites. In particular there were differences in case study site one, where there appeared to be minimal organisational sensemaking to the extent that variation in the role was emerging within the team. The community matrons’ accounts in case study sites two and three suggested more guided organisational sensemaking, in the form of service structures, reporting mechanisms and managerial involvement. In all case study sites, however, there was a powerful influence exerted by professional nursing values. This appeared to be generated from the individual practitioners themselves, and to a lesser degree externally from external professional nursing organisations (Cook, 2005).

Critical sensemaking was found to be a useful concept to gain insight into role implementation. However it does not provide sufficient depth when considering the degree of influence of power, culture within an organisation and external influences such as professional values. As critical sensemaking draws on existing social theories, these need to be considered in their own right in order to gain depth of understanding, particularly in relation to negotiated order, power and structure, and how these affect actions arising from sensemaking activity.

Multiple case study method is effective in exploring organisational and role change in nursing. The research questions were largely addressed but the study also raised further questions about role implementation. Wider data collection over a longer period, for example a longitudinal study, within case study framework would provide further insight into the implementation of the community matron, particularly in relation to its impact on other professions.

So the key themes identified in relation to the implementation of the community matron role were the fluidity of the nursing role, shifting boundaries, making sense of values and role
ambiguity. These emerged as crucial elements in role implementation, which could serve to inform the introduction of future new roles in nursing. The conclusions of this study are presented in the final chapter.
CHAPTER 11: CONCLUSION

This study explored the role of the community matron as a new role within the health service in England. The Department of Health mandated the role be introduced by PCTs across the country (DH, 2004a; DH, 2005e). There was considerable speculation within health and social care professions about the role’s place in the existing health and social care provision for the management of long term conditions (Agnew, 2004a; Wilkinson, 2004; Fisher, 2005; Hunter, 2005). This was in the context of continual organisational change within the NHS (DH, 2000; DH, 2004a; DH 2005b), where SHAs and PCTs were being reconfigured and GPs were gaining increasing control in commissioning services (DH, 2005c). In addition community services were being separated from primary care trusts, so that practitioners were facing uncertainty with regard to the nature of their employment in the future.

As the policy was at an early stage of implementation at the outset of this study, there was very little research that examined the role of the community matron and none that specifically considered the community matron role in the context of changing organisations. There were some evaluative studies from the USA into the role of the Evercare advanced primary nurse, the role on which the community matron was based (Kane et al, 2001; Abdallah, 2005; Abdallah et al, 2005; Dick and Frazier, 2006). Whilst these showed the key areas of activity for these nurses, they did not consider the organisational environment in which they practised. Given the different health care system operating in the USA, these findings were not directly transferable to the UK.

Only one small qualitative study explored the experiences of five advanced primary care nurses in a pilot site within the UK (Adler 2005a; Adler 2005b; Adler 2005c). Whilst this recognised the newness of the role, it did not consider the relationship of the role with those already working in the management of long term conditions. Therefore there was a significant gap in the research literature at the start of the study. It is recognised that studies have been published whilst this study was in progress, and these have been considered in discussion of the findings. However, this study offers a unique contribution to the research evidence in providing an in depth understanding of the implementation of the community matron role within an organisational context.

The application of multiple case study method was particularly apposite to address the research question as it enabled the role of the community matron to be explored in context (Anthony and Jack, 2009). The use of multiple case study sites where role implementation
was at different stages of implementation also provided insight into the process of transition which had not been captured by the existing literature or research published during the period of the study. This study contributes to the body of case study methodology in demonstrating its applicability to policy implementation from multiple perspectives, namely macro (national), meso (organisational) and micro (team and individual) level.

Four key themes emerged from analysis of the findings, which were the fluidity of the nursing role, shifting boundaries, making sense of values and role ambiguity. Findings showed that the introduction of the community matron role reflected the national model (DH, 2005e) but practitioners appeared to use professional discretion to widen the role. As such they appeared to tailor it to fit with their professional values and what they considered to meet patient need. Variation in implementation could be explained by variation in organisational sensemaking; where there was more fragmented or minimal organisational sensemaking, the greater the potential for variation in interpretation and implementation of the policy (Maitlis, 2005). Ambiguity may have been generated by an implementation gap (Hill and Hupe, 2002). The degree of organisational sensemaking also may have been a factor in determining the parameters of professional discretion bestowed on the community matrons.

The fluidity of the nursing role reflected how the community matron role appeared to flex and be adapted in its development, influenced by the community matrons and by external factors. The influence exerted by the medical profession in determining the future development of the community matron role was present in this study, through the involvement of consultants and GPs as key mentors in the training for advanced practitioners. The adoption of the advanced practitioner role as synonymous with the community matron role draws on the medical model, taking functions that were traditionally undertaken by doctors. This could challenge the concept of nursing itself. It remains unanswered whether this is a problem for the identity of nursing. Maybe the strength of the profession is its flexibility to respond to patients’ needs, drawing in new roles and making them its own, as seen by the community matrons in this study. This suggests that the definition of nursing should not be confined by functions but be allowed to flourish and evolve with nursing philosophy as its underlying ethos. However the skills and expertise needed to import new functions into nursing models should be better understood. In this study, the reports of the community matrons suggested that there was not a clear picture of professional leadership from a national perspective and in some instances within organisations either. It is essential that nursing leadership is examined further to ensure that it is effective in influencing and directing future role developments.
At a micro level, the findings uncovered the pivotal role played by individual practitioners as change agents in the implementation of policy. This role was particularly evident in shifting role boundaries, which was the second key theme that emerged from analysis of findings. This study provides insight into the complexity of drivers and subsequent behaviours of those initiating change in practice, and by others whose existing roles are affected by such changes. By studying the implementation of the community matron role in the context of the practice setting, this study has added to the understanding of how role change occurs within an organisation and its interface with existing roles.

In overlaying a new role on an existing service provision, previous research and theory would have suggested that resistance would be generated by existing roles. It was anticipated that social workers would have shown resistance to the role of community matron given that the national model proposed straddling health and social care. However this study showed the converse in that social workers were heralded by community matrons to be the best collaborators. Rather, findings suggested that the level of resistance was affected by the degree of perceived threat by existing roles. Most resistance was encountered from district nurses and GPs. Here previous working relationships were an important dynamic in acceptance of the new role; however it remained unclear as to whether it was the individual or the role itself that was accepted.

It appeared that nurses were playing a new ‘game’ in their relationships with other professions, notably doctors: no longer following the doctor’s cue but playing to their ‘rules’ to get what they needed from the relationship. The findings suggest that some community matrons used subversion, behaviours which were found in research into district nurses interactions with GPs (Speed and Luker, 2006). Other community matrons, however, reported they directly challenged or questioned of doctors’ actions. This may relate to the growing confidence of their professional knowledge. Some doctors, however, still appeared to be following the ‘old rules’ described by Stein (1967). These findings provide further insight into the complexities of inter-professional relationships and how these are changing over time as roles change. Further research is needed to better understand the shift in the patterns of nurse doctor interactions.

This study highlighted the importance of individual professional values and the level of influence this can exert on role implementation. The way in which individuals dealt with dissonance between organisational and professional values reflected the findings of Attree (2002): professional values were more powerful than organisational demands in affecting
behaviours and practice. This needs to be considered in the introduction of new roles to optimise this rather than ignore the potential dissonance between professional values and organisational values which could make it more difficult for practitioners to practise in such roles.

11.1 Recommendations

This study has provided a descriptive account of the early implementation of the community matron role, and in doing so it has raised issues for consideration with regard to future policy, nursing practice, education and research.

11.1.1 Implications of this study for policy

The accounts of the community matrons about their roles described functions that mirrored those set out in the national policy (DH, 2005e). However there was variation between case study sites with regard to how the role had been implemented, for example as seen in service structures and eligibility criteria. This in itself may not be an issue for policy implementation, but it needs to be considered whether such variation will, in time, result to variation in outcomes of the policy in terms of services available for people living with long term conditions. It raises questions about the roles played at meso and macro level that affect the implementation of policy.

The use of critical sensemaking in this study gives a unique practitioner perspective on the implementation of national policy, specifically in relation to nursing role development and the ways in which variation can occur. This is important to consider for future policy implementation both nationally and organisationally so that sensemaking can be used as a conscious strategy in policy implementation to realise the desired outcomes.

11.1.2 Implications of this study for nursing practice

This study has provided an in depth description of the implementation of the new nursing role, the community matron, from the perspective of the practitioner. It has highlighted the issues of blurring boundaries with existing roles and the importance of relationships with colleagues in the success of role implementation. There is a risk when implementing new roles that focus is placed on the functional changes at the expense of interpersonal relationships that are affected. Where new roles are developed in the future, consideration needs to be given to the interface of the new role with existing roles, and for the implementation plan to pay due attention to supporting practitioners in developing relationships with colleagues.
Professional identity appeared to remain strong throughout the new role implementation as individuals reframed the demands of their roles, as articulated in organisational targets, to fit with professional values. There needs to be further examination of the potential dissonance between professional values and organisational values within nursing practice, particularly during change, so as to maintain the integrity of role development within professional values.

The accounts of the community matrons chronicled the start of their journeys in developing advanced nursing practice within their roles. There was a clear medical influence on this aspect of role development, but, with the strength of individual professional identity described, the community matrons were beginning to emerge in roles that they defined within the body of nursing. However it was challenging for individuals embarking on new roles in that they had to reconsider what nursing practice meant to them. The nursing profession needs to continue to examine the concept of advanced nursing practice to support such practitioners developing new roles at the forefront of professional practice, and to lead in redefining nursing and advanced practice within it.

11.1.3 Implications of this study for education
Whilst this study did not focus in detail on the education programmes supporting the development of the community matron role, important factors emerged in relation to preparation for new roles and the educational component in such preparation. There was a lack of clarity between case study sites regarding the educational requirements and qualifications needed for the role of community matron, where the advanced practitioner qualification was a prerequisite in two of the three case study sites. This appeared to exacerbate confusion about the level of practice that constituted the role. In future role implementation it would be beneficial to have clarity about the educational requirements underpinning new roles.

Community matrons described the challenges in meeting both service demands and undertaking educational programmes. The impact of time away from the clinical service in order to complete an educational programme did not appear to have been factored into the targets for service outcomes: whilst caseload numbers had been reduced for some undertaking the advanced practitioner course, maintaining the service delivery placed extra pressure on others. There is a need to ensure that plans for future role development and service outcomes reflect the educational component and the time commitment required.
As this study examined the early implementation of the community matron policy, it was premature to consider whether the educational programmes were appropriate for the preparation for this new role. It would be helpful to evaluate this once the role has been established, to inform the development of future community matrons.

11.1.4 Implications of this study for research
This study provides an example of the application of case study methodology to examine policy implementation in nursing, from the perspective of the practitioner. As the discussion has shown there are unexplored aspects to be considered from the perspectives of other professions, managers and directors. Further research is needed to widen the scope to explore and better understand policy implementation in nursing at an organisational and national level.

Sensemaking was a useful concept to provide insight into policy implementation from the community matrons’ perspective. Use of the concept highlighted areas where sensemaking activity may be impacting on policy implementation and the role of nursing leadership at organisational and national levels. Further research could also examine the role of sensegiving in nursing leadership, to consider how this may be effective in changing organisations.

The focus of this study was the early implementation of policy due to the time period of the data collection. There would be benefits in undertaking a longitudinal study to gain insight into the longer term implications of policy implementation, in particular in relation to its sustainability and applicability within a changing health care system. This is also of importance in understanding the impact of policy changes.

This study has highlighted the fluidity of the nursing role, in relation to developing new roles such as the community matron, which embrace aspects of roles traditionally undertaken by others, for example doctors. This study did not determine whether this was creating a problem of identity for nursing or whether it was a natural evolution; further research is needed to understand how nursing is being defined and by whom, in order to consider the future identity of nursing in a changing health care landscape.

Shifting boundaries and the importance of inter-professional relationships came to the fore in this study. The complexities of such relationships need further investigation to better
understand the shift of inter-professional interactions and the impact this may have in being able to be effective in one’s role.

Professional values were found to be of high importance to practitioners in this study, which needs further investigation as to how individuals manage potential conflict of professional, personal and organisational values, and the impact this may have on role implementation.

Ambiguity appeared to be a key issue in relation to role implementation but there was limited data within this study to determine whether this was part of the sensemaking process or would be explained by other factors. Further research is required to understand the conditions that generate ambiguity within nursing role implementation at a micro, meso and micro level, so as to inform future role developments.

11.2 Contribution made by this study

This study has contributed insight into the factors affecting role implementation and the behaviours of practitioners and colleagues. This is important in the consideration of future role implementation, for example the new role of the health visitor and the family practice nurse, where existing roles will be challenged and individual practitioners will need to become the ambassadors of change. Lessons can be learned from this study to support both practitioners adopting new roles and also their colleagues in learning how to work collaboratively with such roles without exacerbating a feeling of threat. In this way the transition can be managed more effectively by an organisation.

Research is now emerging about the role of the community matron, as highlighted in the discussion. However, none of these studies reflect the role in its context or the depth of insight generated by multiple case study as seen here. As such, this study provides a unique contribution to further the understanding of the role of the community matron, in the context of employing organisations. It also provides insight into the processes that occur during the implementation of policy that lead to variation and confusion. Critical sensemaking, supported by theories affecting change, power and culture of organisations, can provide a valuable insight at a macro, meso and micro level which can be used to influence and shape policy implementation in the future.

So this study has made a unique contribution to understanding in depth the complexities of policy implementation and its implications for nursing roles from a practitioner perspective, using case study methodology. It adds to the debate about advanced nursing practice, by
describing the experience and practice of the new role of the community matron, which has been strongly influenced from outside the profession, rather than from within. The findings of this study may inform practice in its descriptions of relationships with colleagues, to better understand behaviours and interactions when introducing change.

This study presents implications for management in highlighting the importance of leadership through change particularly with regard to the leader sensegiving role described by Maitlis (2005). The findings of this study have also contributed to a better understanding of professionals’ approach to dealing with conflicting values which has implications for organisations and practitioners. This could support the start of more open debate in organisations about explicit and hidden value systems.

Finally this study has contributed to a more in depth understanding of the potential for policy implementation gap in relation to the nursing profession. This has implications for the introduction of new roles or changing roles in nursing through policy initiatives. Further research could explore role ambiguity, from policy to practice, to identify where intervention could better facilitate the implementation process: in better understanding how ambiguity affects implementation, lessons can be learned to ensure sustainable and effective nursing roles in the future.
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APPENDICES

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Appendix 1: Approval letter from Local Research Ethics Committee

05/Q1405/49

Local Research Ethics Committee

16 June 2005

Dear,

Full title of study: The new community matron: a multiple case study to explore the development and impact of the role in the management of care for people with long term conditions

REC reference number: 05/Q1405/49

The Research Ethics Committee has reviewed the above application in accordance with the standard operating procedures for RECs.

The Committee has issued a favourable ethical opinion of the application.

The Chief Investigator has been notified of the Committee's opinion in our letter of 16 June 2005. The letter gives full details of the documents reviewed.

The Committee has designated this study as having "no local investigators". There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Statement of compliance

The Committee is fully compliant with the Regulations as they relate to ethics committees and the conditions and principles of good clinical practice.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

05/Q1405/49 Please quote this number on all correspondence

Yours sincerely

Committee Co-ordinator

Email

[Signature]

list of approved sites
Appendix 2: Approval letter from University Ethics Committee

ref: TPCS/CA/ethics/05110

10th October 2005

Miss S Savage,

Dear Miss Savage,

Committee on the Ethics of Research on Human Beings

05110 Savage: The new community matron: a multiple case study to explore the development and impact of the role in the management of care for people with long-term conditions.

I write to confirm that at its meeting on 6th October 2005, the Committee received the report on the above project, which had been approved by a recognised ethics committee. That approval is therefore endorsed by the University Ethics Committee.

If you have cause to inform the REC of any unusual or unexpected results that raise questions about the safety of the research, you should also forward a copy to our office.

Yours sincerely

Catherine Atkinson
Secretary to Dr T P C Stibbs

Catherine Atkinson
Division of Corporate Services
0161 275 2295
0161 275 5697
Catherine.atkinson@manchester.ac.uk
Appendix 3: Approval letter for access to case study sites

Our ref: RMG/05/021

26th August 2005

Ms Susan Savage

Dear Ms Susan Savage

Re: The new community matron: a multiple case study to explore the development and impact of the role in the management of care for people with long-term conditions

Thank you for supplying information for the above study. I am pleased to inform you that your study has now been approved by the following PCTs:

I will send an approval letter for the remaining PCT once they have approved the project.

Please note: All research must comply with the Department of Health’s Research Governance Framework. Progress reports should be submitted annually to the main REC and the Central RM&G Partnership office. PCT until the end of the study. On completion of the study you will be required to submit a “Declaration of End of Study” form. Please ensure copies of progress reports and the end of study form are forwarded, along with a copy of the final report and details of any resulting publications, to the Central RM&G Partnership office.

Any serious adverse events or governance issues related to the research must be notified to the central office.

This study will be registered with the National Research Register as part of the PCTs continuous efforts to disseminate ongoing research.

Yours Sincerely
Appendix 4: Interview Guide

Background to role: prompts
How the role was introduced and explained?
What preparation was given for new role? (for post holder, patients and colleagues)
What skills and abilities are needed for the role?
What skills and abilities were required to apply for the role?

Role functions: prompts
What duties are undertaken by the community matron?
What is the most important part of the community matron role?
Are there any duties undertaken by the community matron that the role should not do?
Are there any duties that the community matron role should do, but does not?
Who else is involved in the patient’s care?
How does the role work with other health care workers? What about social care workers, informal carers and voluntary agencies?

Patients:
  • Who do you ask about, for example, a) your medication b) your appointments c) any worries about your health?

Matron and colleagues:
  • Is it clear who is responsible for what, i.e. role boundaries, authority for decisions?
  • Are links and relationships with colleagues formal, i.e. in structures and procedures, or are they still being developed?

Role support: prompts
Matron:
  • What support have you received in undertaking this new role?
  • What support have you asked for?
  • What clinical supervision do you have access to? How often do you use this?
  • Which colleagues do you feel you work well with and why?
  • Which colleagues do you feel you have difficulty working with and why?
  • Are there any areas of your role you find difficult?
  • Do you feel you receive the right amount and type of support for this role?

Role impact: prompts
What has changed since the introduction of the community matron?
Patients:
  • What, if any, has improved in your care since you have seen the community matron?
  • What, if any, is not as good since you have seen the community matron?
  • Is there anything you think the community matron could do differently?

Matron:
  • Do you feel you fulfil your role?
  • What do you feel you have been able to improve and why?
  • What do you feel you have been unable to improve and why?
  • What has been your biggest achievement since being in post and why?
  • What has been your biggest disappointment since being in post and why?
  • Is there anything you would want to do differently, and why?

Colleagues:
  • What has improved since the introduction of the community matron role?
  • What is not as good since the introduction of the community matron role?
  • How has the role of the community matron affected your role?
  • How do you work with the community matron?
  • Is there anything you think the community matron should do differently and why?
Appendix 5: Information Leaflet– community matron

Research study about the community matron

You are being invited to take part in a research study about the community matron. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
As you are well aware the role of community matron is new. I want to find out about how the role works- the type of work you do, what skills you use, what helps you do your job well, what patients think of the role and how the new role works with other health care workers who care for people with long term conditions. I also want to learn how the role affects the PCT’s performance in caring for people with long term conditions. If you agree to participate I will collect information about your role over 3 months. This will be part of a larger study involving three other PCTs which will last about 2 years.

Why have I been chosen?
As a community matron you will know first hand about the role and what has changed in how care is provided for people with long term conditions. I want to learn about your experience and hear your views. Your PCT has expressed interest in participating in the study and your manager has suggested you may want to be involved.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you decide to take part you will be asked to sign a consent form. You can keep this information to read again later. If you decide to take part you can stop at any time and without giving a reason. A decision not to take part, or to stop taking part, will not affect your employment in any way.

What will happen to me if I take part?
You will be asked to participate in the following ways:
Interview: You will be interviewed by me about your experience as a community matron. The interview will last about one hour. The interview will be tape recorded (if you agree).
Reflective diary: You will be asked to complete a reflective diary about your practice over a period of 3 months which you would share with me.
Observation: I wish to observe the type of work you do and ways of working with patients and colleagues. This would involve spending about 3 hours with you.
Seeking patient involvement: in order to protect patient confidentiality you will be asked to identify and seek consent from patients. This will include patients who I may come into contact with when spending time with you and around 5 to 10 patients who may agree to be interviewed by me. You will be given information and consent forms in order to do this.
Seeking staff involvement: You will be asked to identify around 10 to 20 key colleagues who may be willing to participate in the study through interviews or focus groups.
What to I have to do?
If you wish to take part you need to forward your contact details to me. I will contact you to arrange a
time that suits you to discuss the study in more detail. I will then ask you to sign a consent form if you
agree to participate.

What are the possible disadvantages of taking part?
You will be giving up your time to participate within your working day. I am not able to pay any
expenses for you to take part.

What are the possible benefits of taking part?
There are no direct benefits to you in taking part. Your participation may help you to develop the role of
the community matron and working relationships so that patients’ needs are met in the best way. This
will contribute to the larger study to inform the development of the role in other organisations.

What if something goes wrong?
If you are unhappy about how you have been involved in the study you can complain to my supervisors
in the first instance on 0161 275 5333.

Will my taking part be kept confidential?
The PCT and your manager will know that you are taking part. What you tell me will be confidential.
Any information you give me will have your name removed afterwards so you can not be identified.

What will happen to the results of the study?
The results of this part of the study will be made available to the primary care trust. This will form part
of a larger report involving three other primary care trusts. The results should be published in three
years time. An executive summary of the report can be sent to you if you wish, provided you can be
contacted through the primary care trust at the time of publication.

Who is organising the research?
I am responsible for this study. I became a registered nurse in 1987 and have worked in hospitals and
as a health visitor. I now work as the Professional Nurse Lead for Rochdale PCT. I am doing this
research as a postgraduate student at the University of Manchester towards an MPhil/PhD.

Who has reviewed the study?
The study was approved by the Oldham Local Research Ethics Committee, participating PCTs and the
University of Manchester Senate Committee.

How can I contact you?
My details are:
Susan Savage Professional Nurse Lead
Telegraph House, Baillie Street, Rochdale OL16 1JA   Tel: 01706 652828
email:susan.savage@rochdalepct.nhs.uk
CONSENT FORM
Research study: The role of the community matron
Matron participation

1. I confirm that I have read and understand the information leaflet dated…….. (Version……) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.

3. I agree to take part in the above study which includes:
   • I agree for the researcher to interview me
   • I give permission for my interview to be tape recorded and used by the researcher in the study
   • I agree to complete a reflective diary which I will share with the researcher
   • I agree for the researcher to observe my practice subject to consent from service users as required

Name of Participant        Date        Signature

Name of person taking consent (if different from researcher)        Date        Signature

Name of researcher        Date        Signature
Research study about the community matron

You are being invited to take part in a research study about the community matron. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
The role of community matron is new. I want to find out about how the role works- what work does the community matron do, what skills she uses, what helps her do her job well and how does the new role work with other health care workers such as doctors, nurses and physiotherapists who care for people with long term conditions.

I am collecting information with your community matron over 3 months, as part of a larger study which will last about 2 years.

Why have I been chosen?
You will know first hand about the role of the community matron and what has changed in how your care is provided. I want to hear your views. Your community matron has given you this information as she thinks you may want to be involved. I want to talk with between 5 and 10 people.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you decide to take part you will asked to sign a consent form. You can keep this information to read again later if you wish. If you decide to take part you can stop at any time and without giving a reason. A decision not to take part, or to stop taking part, will not affect your care in any way.

What will happen to me if I take part?
You will be interviewed by me about your experience of care by the community matron. The interview will last about one hour. You can choose whether you want me to visit you at home or meet you, such as at the local clinic. The interview will be tape recorded (if you agree).
What to I have to do?
If you wish to take part you need to tell your community matron and sign the consent form. Or you can contact me directly if you wish. My telephone number is at the end of this leaflet. I will contact you to arrange a time that suits you for the interview.

What are the possible disadvantages of taking part?
You will be giving up your time to talk to me. I am not able to pay any expenses for you to take part.

What are the possible benefits of taking part?
There are no direct benefits to you in taking part. Your views and other information from the study may help us to develop the role of the community matron so that patients’ needs are met in the best way.

What if something goes wrong?
If you are unhappy about how you have been involved in the study you can complain to my supervisors in the first instance on [contact information]. If you are unhappy with your care you should contact the Primary Care Trust (PCT) on [PCT tel. no].

Will my taking part be kept confidential?
Your community matron will know that you are taking part unless you choose to contact me directly. I will let your GP know that you are taking part unless you tell me not to. What you tell me in your interview will be confidential. Any information you give me will have your name removed afterwards so you can not be identified. If you say something about your health that I think your GP or community matron needs to know I will tell you.

What will happen to the results of the study?
The results of this part of the study will be made available to the primary care trust. This will form part of a larger report involving three other primary care trusts. The results should be published in three years time. An executive summary of the report can be sent to you if you wish, provided you can be contacted through the primary care trust at the time of publication.

Who is organising the research?
I am responsible for this study. I became a registered nurse in 1987 and have worked in hospitals and as a health visitor. I now work as the Professional Nurse Lead for [PCT name] PCT. I am doing this research as a postgraduate student at the University of Manchester towards an MPhil/PhD.

Who has reviewed the study?
The study was approved by the [research ethics committee name] Local Research Ethics Committee, participating PCTs and the University of Manchester Senate Committee.

How can I contact you?
My details are:
Susan Savage Professional Nurse Lead
[contact information]
Appendix 8: Consent form – service user

School of Nursing, Midwifery and Social Work
The University of Manchester
Oxford Road
Manchester M13 9PL

CONSENT FORM
Research study: The role of the community matron
Interview

1. I confirm that I have read and understand the information leaflet dated 06/05/05 (Version 1.0) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care or legal rights being affected.

3. I agree to take part in the above study which includes:
   - I agree for the researcher to interview me
   - I give permission for my interview to be tape recorded and used by the researcher in the study
   - I give permission for the researcher to inform my GP that I am participating in the study

Name of Patient ___________________________ Date ____________ Signature ___________________________

Name of person taking consent (if different from researcher) ___________________________ Date ____________ Signature ___________________________

Name of researcher ___________________________ Date ____________ Signature ___________________________
Appendix 9: Information Leaflet – staff colleagues

Research study about the community matron

You are being invited to take part in a research study about the community matron. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
The role of community matron is new. I want to find out about how the role works- what work does the community matron do, what skills she uses, what helps her do her job well and how the new role works with other health care workers like you who care for people with long term conditions.

I am collecting information with the community matron over 3 months, as part of a larger study which will last about 2 years.

Why have I been chosen?
You will know first hand about the role of the community matron and what has changed in how care is provided for people with long term conditions. I want to hear your views. The community matron has suggested you may want to be involved or you may have volunteered to participate. I want to talk with between 10 and 20 people who work with the community matron.

Do I have to take part?
No. It is up to you to decide whether or not to take part. If you decide to take part you will asked to sign a consent form. You can keep this information to read again later if you wish. If you decide to take part you can stop at any time and without giving a reason. A decision not to take part, or to stop taking part, will not affect your employment in any way.

What will happen to me if I take part?
You can take part in either an interview or a focus group.
Interview: You will be interviewed by me about your experience of working with the community matron. The interview will last about one hour. The interview will be tape recorded (if you agree).

Focus group: You will meet with a group of 5 to 10 colleagues to discuss your views on the role of the community matron. The discussion will last about one hour. It will be tape recorded (if the whole group agrees).
What to I have to do?
If you wish to take part you need to sign the consent form and return it to me with your contact details. I will contact you to arrange a time that suits you for the interview or focus group.

What are the possible disadvantages of taking part?
You will be giving up your time to talk to me. I am not able to pay any expenses for you to take part.

What are the possible benefits of taking part?
There are no direct benefits to you in taking part. Your views and other information from the study may help us to develop the role of the community matron and working relationships so that patients’ needs are met in the best way.

What if something goes wrong?
If you are unhappy about how you have been involved in the study you can complain to my supervisors in the first instance on [redacted].

Will my taking part be kept confidential?
The community matron will know that you are taking part unless you choose to contact me directly. What you tell me in your interview will be confidential. Any information you give me will have your name removed afterwards so you can not be identified.

What will happen to the results of the study?
The results of this part of the study will be made available to the primary care trust. This will form part of a larger report involving three other primary care trusts. The results should be published in three years time. An executive summary of the report can be sent to you if you wish, provided you can be contacted through the primary care trust at the time of publication.

Who is organising the research?
I am responsible for this study. I became a registered nurse in 1987 and have worked in hospitals and as a health visitor. I now work as the Professional Nurse Lead for [redacted] PCT. I am doing this research as a postgraduate student at the University of Manchester towards an MPhil/PhD.

Who has reviewed the study?
The study was approved by the [redacted] Local Research Ethics Committee, participating PCTs and the University of Manchester Senate Committee.

How can I contact you?
My details are:
[redacted]
Appendix 10: Consent form – staff colleagues

School of Nursing, Midwifery and Social Work
The University of Manchester
Oxford Road
Manchester M13 9PL

PCT Code
Community matron code
Participant Identification No.

CONSENT FORM
Research study: The role of the community matron
Interview/ focus group

1. I confirm that I have read and understand the information leaflet dated 06/05/05 (Version 1.0) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my employment or legal rights being affected.

3. I agree to take part in the above study which includes:
   • I agree for the researcher to interview me
   • I agree to participate in a focus group
   • I give permission for my interview to be tape recorded and used by the researcher in the study

Name of Participant Date Signature

Name of person taking consent
(if different from researcher) Date Signature

Name of researcher Date Signature

Please initial box
### Appendix 11: Themes and categories used for indexing data on NVivo

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Subcategory</th>
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<tbody>
<tr>
<td>Service model</td>
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<td>Issues affecting role function</td>
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<td>Autonomy and influence</td>
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<td>Avoiding admissions</td>
<td>Capacity</td>
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<td>Improving patient lives</td>
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<td>Issues affecting performance</td>
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<td>Reducing GP visits or time</td>
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<td>Theme</td>
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<td>Interface with other roles</td>
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<td>With social workers</td>
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## Appendix 12: Example of application of Framework Analysis: Role Function

<table>
<thead>
<tr>
<th>Raw data related to theme of role function</th>
<th>Indexing</th>
<th>Charting</th>
<th>Mapping and Interpretation</th>
<th>Final themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think when you’ve been in this job a long time you kind of, it’s like a sixth sense, it’s ridiculous, you just sort of know really from observing somebody whether they’re ill enough to go into hospital or whether they just need a bit of TLC, and that’s all he needed, somebody to feed him up, look after him and just get him back on his feet. He didn’t need any IV antibiotics or IV fluids; he needed a good wash and some food. A few weeks later he’s in rehab, back home, haircut, walking round everywhere.... but thinking back if I had been a district nurse, I might have just sent him into hospital, I wouldn’t have had the cost effectiveness, it’s the only sort of option you would think of really whereas we think of different things.” (CM11/site 3)</td>
<td>Transition and development Boundaries Assessment Level of practice</td>
<td>Synthesis of data into themes: Changing roles Changing practice Changing professional identity</td>
<td>Reconstructing role identity</td>
<td>Fluidity of the nursing role</td>
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<tr>
<td>“I’m still utilising my nursing skills in the assessment of the physical, psychological, social perspective, and drawing up the management plan as to what I’m going to be doing with the patient, in agreement with the patient, but I’m mixing it now with medical bit, which I didn’t do as a district nurse because I didn’t have the skill. And the only reason why I can do it now is because I’ve got the advanced clinical skill, passed my clinical skills assessment, at level 2 initially and level 3 and 4, which is like an autonomous practitioner... or as an expert practitioner who uses research and all that in evidence based practice, that kind of thing, but I couldn’t have done that, even at the beginning of the course.” (CM12/site 3)</td>
<td>Assessment Levels of practice Boundaries Transition and development</td>
<td>Nursing- medical interface</td>
<td>Competing or converging identities- Advanced practitioner vs ‘traditional nurse’ - Medical vs nursing</td>
<td>Making sense of role</td>
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<tr>
<td>“I see it as to know all the normal properly and just to pick up the red flags and know who to refer to, and I don’t see it as I’ll be diagnosing and such because I don’t think I’m going to have the confidence to do that… I’ll know this wheeze doesn’t sound right or that sounds right, and know what it could be, and then refer on, I think. I don’t know, It would be nice to be that confident in the end…I could probably diagnose an infection and if I could prescribe antibiotics, that part, but if there was anything else I think I’d refer on, I know I don’t see it as a fully fledged doctor’s role.” (CM04/site 1)</td>
<td>Levels of practice Referral Boundaries Transition and development</td>
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<td>Shifting boundaries</td>
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</tbody>
</table>

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Appendix 13: Example of application of Framework Analysis: Outcomes and Effectiveness

<table>
<thead>
<tr>
<th>Raw data related to theme of outcomes and effectiveness</th>
<th>Indexing</th>
<th>Charting</th>
<th>Mapping and Interpretation</th>
<th>Final theme</th>
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</thead>
<tbody>
<tr>
<td>“Yes, but that’s hospital admissions not my main focus really... but I hope to do that in my job but if I don’t do that, and improve their quality of life then I think I’m doing a good job.” (CM06/site 1)</td>
<td>Improving patient lives</td>
<td>Synthesis of data into themes: Competing priorities</td>
<td>Competing value systems</td>
<td>Making sense of values</td>
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<tr>
<td>“The main thing is that you’re giving them a quality of life, because there are times when some of the patients you work with might be in level 3, tier 3, the really complex needs, but, they still have to go into hospital, and you won’t prevent that with some of them, but the times when they’re not in hospital, they’ve got a better quality of life maybe... so it’s not all about preventing hospital admissions...” (CM08/site 1)</td>
<td>Improving patient lives Avoiding admissions Personal vs organisational expectations</td>
<td>Avoiding admissions vs improving patients lives Professional value vs organisational expectation</td>
<td>Managing dissonance Aligning values</td>
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<td>“...job has become too focused on one aspect, the idea of keeping patients out of hospital for the benefit of the hospital rather than the benefit of the patient. If benefit for the patient means you need to keep going in, then that’s not recognised. The target for hospital admission becomes the driver rather than improving the life longevity for the patient. ...confidence, whether or not they’re feeling supported, that maybe they’re able to, basically to feel more confident in managing themselves at home, and so that they feel less alone. So if a patient feels that those changes have taken place, then I feel we’ve had a success.” (ACM10/site 3)</td>
<td>Avoiding admissions Improving patient lives Personal vs organisational expectations</td>
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<td>You quite often find you visit somebody, do a little bit of work with them, but they end up in hospital quite soon afterwards, and that is because they didn’t have that trust to ring your number and say, it’s me, can you come out and see me, whereas it’s such a nice feeling when someone does that, because you’ve broken it then, and they ring you up, and say I don’t feel well, will you come and have a look. And it maybe that they need to be in hospital, which is fine, or if they need a GP visit, which is fine, but it maybe that they’re not taking their tablets right, or they need to increase something...” (CM05/site 1)</td>
<td>Avoiding admissions Autonomy and influence</td>
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