Community Matrons and Long Term Conditions in the UK

Hospital Avoidance: alternatives to the Emergency Department

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Outline

- The context of 21st Century healthcare practice
- Links between long term conditions and hospital admissions. Community Care v Hospital Care
- Imperatives for health promotion
- The role of the community matron. Their professional development needs and evidence of impact
- Recommendations
INTRODUCTION

In the UK in the past 7 years there has been a 35% increase in emergency admissions to hospitals (Wanless 2007).

It is a complex problem with, unsurprisingly no single simple solution.

But as people aged over 65 occupy two thirds of hospital beds there is a urgent need to develop more efficient and appropriate services for this population group. (Keating et al 2008)
Back in 1979……..

- The Boomtown Rats didn’t like Mondays
- Maggie Thatcher became the UK Prime Minister
- UK Mortgage interest rates were 15%
- Sony Walkman’s were invented
- Louise Brown had her first birthday
  - And ……………………. 
Judith Roberts was a staff nurse in the A&E department of the Royal Liverpool Hospital, UK.

- No home pregnancy testing kits
- No ACE inhibitors nor Proton Pump Inhibitors
- No IT, or widespread EBM
- No clinically advanced roles for nurses
- Seminal texts still to be written - Roper, Logan, Tierney’s ‘Elements of Nursing’ & Benner’s ‘Novice to Expert’
- No winter pressures or LTC

- Empty A&E departments by 4am!
21st Century Healthcare
Challenging & Complex Times

- Growing populations, & changing demographics
- Rising numbers of people expected to develop dementia (NAO 2007)
- Patients with long term conditions filling A&E’s, clinics, GP surgeries.
- Increasing ‘problem and binge drinking’ underlies up to a third of all A&E attendances (Dawood 2008)
- Medical and technological advances - drugs, treatments, EBM.
- Changing lifestyles, work patterns, skill shortage
- Rising expectations – public, personal, policy makers
- Moving care from hospital to the community
- From ‘cut and cure’ to ‘promote & prevent’
- Needing to adapt to change one of the few professional certainties (Beasley 2007)
- And other fiscal demands – funding the clinical expectations of the governance agenda, security, environmental disasters, pension’s deficit, oil prices, food and water shortages etc etc
Yet slow recognition of the issues

- 2005 still an NHS that ‘rescued patients when they become ill, in an episodic manner’. (Wilson et al 2005)

- GP’s cannot co-ordinate all of the health and social care needs of highly complex patients with multiple long term conditions
Changing demographics and disease

- UK
- New South Wales
- World
UK’s Changing Population

# Population Demographics

**UK & NSW**

### UK 2007

- Increasing numbers of men aged 65+ and women aged 60+
- Currently they make up 19% of the population
- The 80 and over age group is 2.7 million

(NOS 2008)

### New South Wales 2007

- Population increase will be in people aged 65 years and older.
- Currently they make up 14% of the population
- By 2031 there will be 1.8 million aged 65 years and over.

WHO (2006)
Preventable Diseases

80% of:-
- Heart disease
- Stroke
- Type 2 diabetes

40% of cancer

Could be avoided if the common lifestyle risk factors of use of tobacco, lack of exercise and unhealthy diet were stopped.

The WHO approach

- Promote
- Prevent
- Treat
- Care

WHO (2006) 10 facts about chronic disease
http://www.who.int/features/factfiles/chp/10_en.html
The future can only get worse……

By 2025, Diabetes UK warns there will be over four million cases of diabetes in the UK population

Globally WHO (2006) estimated that there are already twenty-two million children under five years old who are overweight
if you let your kids get fat, they won't be able to fly because their jetpack will just burn their big fat arse...
But seriously think of the future..

- More people
- Who are more unwell
- Diabetes? The ‘Consumption’ of the 21st century?
So first - moving from a sickness model to a health model

Support from local and central government & integrated across health, social care, education and environment.

- Smoking cessation
- Exercise and public transport
- Diet (verb and noun). Food production and advertising
- Moderate alcohol intake
- Annual MOT
- Carer networks
- NB Paediatric long term conditions
- Personal responsibility – change the locus of action

NB Health Promotion is every nurses responsibility (NMC 2008)
Long Term Conditions Data
60% people aged over 60 in England suffer from a long-term condition and is set to rise by 23% over the next 25 years.

Incidence higher in the more disadvantaged groups.

In England it’s estimated there are currently over 250,000 people with highly complex clinical needs, with a further 560,000 with dementia. (NB some double counting)

6.4 million people are diagnosed hypertensive. Is estimated that a further 6 million have unidentified hypertension.

Evidence of systematic failures to proactively meet the physical health needs of people with mental health problems or with learning difficulties –despite known risk factors (DH 2006) Michael (2008)
Financial Consequences of LTC

- For the first time ever, there are more people of state pensionable age than under-16s

- It is estimated that the treatment and care of those with long-term conditions accounts for 69% of the primary and acute care budget in England

- The UK economy stands to lose £16 billion over the next 10 years through premature deaths due to heart disease, stroke and diabetes
It's not just about the economics, quality of life is also an issue.

<table>
<thead>
<tr>
<th>Day</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Phone GP surgery to arrange repeat prescription</td>
</tr>
<tr>
<td>Tuesday</td>
<td>See Cardiologist at hospital out at 8.30am for transport to hospital</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Ask daughter to pick up tablets from chemist</td>
</tr>
<tr>
<td>Thursday</td>
<td>Accompany husband for his eye test.</td>
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<tr>
<td>Friday</td>
<td>Chiropodist visit. Had a phone call from the practice nurse I need to pick up a new drug prescription following my visit to the hospital</td>
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In the words of a someone with 3 LTC aged 72yrs ….

“... My only social life is going for hospital visits. You need to be young and fit coping with all the doctors, various appointments and medicines, so it really is a bugger getting older, being so unwell. Everything is so complicated and tiring.”

NB Often unrecognised and untreated is the associated link between long term conditions and an increased risk of depression, as Moussavi et al (2007) report in their international research.
But it's not just the patient it effects..

In discussion with a lifelong friend

- We realised that our current lives had never been anticipated when we were young girls and ‘played house’. We had prams and dollies and daddies that went to work. But we never played having ill, confused, and helpless relatives, nor did we envisage the burden and sadness of caring and loving someone as they persistently deteriorate.
David Colin-Thome, the National Director for Primary Care

'Delivering improvements for people with long term conditions isn’t just about treating illness, it’s about delivering personalised, responsive, holistic care in the full context of how people live their lives.

(DH 2008)
Strategies for Hospital Avoidance and Sustainable Change

(particularly in relation to patients with Long Term conditions)
Road blocks are tempting!
At the point of acute ill health/exacerbation preventing an emergency admission….

<table>
<thead>
<tr>
<th>Alternatives to A&amp;E?</th>
<th>BUT</th>
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<tbody>
<tr>
<td>Out of Hours Services</td>
<td>Perfect triage is a myth</td>
</tr>
<tr>
<td>Ambulance Service Rapid Response Team</td>
<td>To be end-stage chronically ill and to die in A&amp;E is cruel and inappropriate palliative care.</td>
</tr>
<tr>
<td>NHS Direct</td>
<td>Who assess ‘appropriateness’?</td>
</tr>
<tr>
<td>Walk in Centre /Minor injuries</td>
<td>Local knowledge to signpost</td>
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<tr>
<td>Rapid access clinic / MAU/SAU</td>
<td>Confidence and competence to autonomously re-direct patients</td>
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<tr>
<td>Rapid access to diagnostics</td>
<td>Existence of agreed plans in event of rapid clinical deterioration</td>
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<tr>
<td>IV services in the Community</td>
<td></td>
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<tr>
<td>Outreach mental health/ addiction teams</td>
<td></td>
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<tr>
<td>Preferred Priorities of Care (PPC 2008) pathway in situ</td>
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<tr>
<td>Liverpool Care Pathway for the Dying Patient (LCP 2008) in situ</td>
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</tbody>
</table>
But what about the 250,000 people with already developed highly complex multiple long term conditions?
At the point of acute ill health or exacerbation - trying to prevent an emergency admission is about one year too late.

In these situations patients individual circumstance are so clinically complex, behaviours so entrenched, personal and unique, it takes more time than a GP, or clinical nurse specialist can spare to gain trust and really find out what triggers their hospital admission.
Produced a Plethora of Policy Initiatives

'The NHS Improvement Plan' (2004) identified long term conditions as one of the three top priorities for the NHS up to 2008

see www.dh.gov.uk www.nao.org.uk
The NHS and Social Care Long Term Conditions Model (DH 2008)
Introducing the Community Matron Role

- ‘will combine high level assessment, pharmacological management and anticipatory managed care, based on principles of least invasive care in least intensive settings.

- They help patients negotiate their way around the health and social care system. They refer to other professionals, make clinical decisions and mobilise resources. They enable patients to make personal choices about their care, including the decision to stay in their own home until the end of their life.’ (pg 11)

DH (2005) Supporting People with Long Term Conditions – Liberating the talents of nurses who care for people with long term conditions
Community Nursing - So What’s the Difference This Time?

The Community Matron will be:-

- ‘Up skilled’ to undertake clinical examination and diagnosis, prescribe, and establish person centred holistic solutions using emotional intelligence

- Expected to anticipate needs and offer pro-active interventions

- Time resourced. Once a patient is on a Community Matrons caseload they are on it for life - albeit when condition stable contact will be limited, or referred back to DN teams
Explicit National Targets

- To reduce unplanned hospital admissions by 10-20%

- Create a 5% reduction in emergency bed days by 2008
Local Context

5 of the Primary Care Trusts of North West:- Liverpool, Knowsley, Sefton, St. Helens, Warrington

Population 1.05 million Approx 25%+ LTC
• High Indices of deprivation
• SMR all above national rates
Initial Educational Preparation
Community Matron Development Programme

Cheshire and Merseyside Strategic Health Authority worked collaboratively with the 4 local Higher Education Institutions. University College Chester, University of Liverpool, Liverpool John Moore's University and Edge Hill University to develop a bespoke education Programme.

The SHA also agreed core job descriptions and person specifications for the Primary Care Trusts in its locality. See www.healthcareworkforce.nhs.uk for further details.

Content was linked to the role competences developed by the Skills for Health. www.skillsforhealth.org.uk/view_framework.php?id=91
The main aims of the programme were to:

- Develop strong theoretical understanding to support advanced professional practice in case management
- Enhance and expand skills in professional consultation and examination
- Develop critical reasoning and analytical skills
- Develop advanced and independent practice

Consists of three x 20 credit modules:

- **Context of Advanced practice**: preparation for autonomous role & examination & application of therapeutic communication
- **Clinical assessment and examination** of major body systems
- **Managing long term conditions** - case management
Expected a **lot of anxiety (and found it)** due to:-

- Role transition, amplified due to innovatory role with few role models.
- Studying at Master level
- Mature student with wealth of professional and personal experience – balanced by potential increased personal and family commitments
- As so new in post, bridging the theory practice gap could be hampered.

**In short:** In a new job, which is a new role, new levels of autonomy, on a new programme, learning totally brand new topics..........................
Characteristics of Edge Hill Students

- From total of 53 students (2 cohorts) they had over 900 years of cumulative vocational experience

- Majority were nurses, registered qualifications included General Nursing, Paediatrics, Midwifery, Health Visiting, Mental Health, District Nursing, Also AHP - OT, Podiatry, Social work

- Had degree level CPD study, most a first degree, some previous masters level study

- 100% pass rate for first cohort

- 2nd cohort awaiting ratification….
Curriculum Delivery

- Influenced by descriptions of the difficulties in managing role transition at this level of practice (McGee & Castledine 2002), (RCN 2005), (NMC 2006) the programme recognises the student’s vulnerability working in an innovatory, advanced role. Whilst also recognising the wealth of the experiential data base of the ‘mature practitioners’

- Informed by Kolb (1984) and Vogotsky’s (1978) ‘Zone of Proximal development’, Donaldson's (1978) ‘human sense’ the curriculum uses constructivist principles* (Bickmore–Brand 1994) to promote the learners ability to develop professional confidence in their skills, challenge practices and initiate quality care that is patient focused and based upon best available evidence.

* Context, Interest, Scaffolding, Meta cognition, Responsibility, Community and Modelling
Programme Evaluation.

- “Now think differently – quicker and much more clinically objective. I didn’t even know that level of knowledge existed”.

- “My increased clinical confidence has helped me to build effective working relationships with my GP”.

- “Much more confident to question other health professionals and hospital consultants”

- “Aware I talk and think differently – both academically and clinically. With patients I have a more lateral peripheral awareness of differential diagnosis with a significantly increased confidence in my clinical examination skills which I use with my patients every day”

- “More confident at this level of study, much more aware of my own practice implications and limitations and own strengths. Feel much more authoritative and knowledgeable”
Implementation of the Community Matron role
National Picture
Initial consequences of swift imposition

- Did not establish national ‘robust evaluation framework’ first, with no comparative non-intervention group
- The 2 measurable outcomes (avoidance of unplanned admission, and reduction of emergency bed days) – does not give full or fair analysis of the impact of the role, further compounded by poor data collection and inaccurate admission codes
- Role was imposed on top of existing services, sometimes with little initial introduction or work stream planning which hampered multi-professional, multi-service co-ordination and collaboration.
- High proportion of staff appointed to post needed substantial clinical development to meet advanced clinical competencies
Current evaluation of role

- National picture blurred as not all appointments been made, and limited published evaluations/research

- Patient satisfaction results are ‘water off an finance officer’s back’ - need ‘hard’ data. However it demonstrates improved quality of life, which is an objective of the role (Clegg, Bee 2008)

- Changing entrenched mal-adaptive behaviours takes time and sustained effort. Need a very good understanding of psycho-sociological determinants of health and behaviour – anxiety management strategies are as important as GTN

- Finding un-met ‘un-recorded’ need increases case finding at expense of case solution –victims of own success

- Also data ambiguous, for these patients are very very ill and will deteriorate not matter how effective the clinician,
Successful Implementation - Liverpool PCT

Last year has doubled number of Community Matrons employed. (At salary band 8a maximum of £44,000pa = approx AU$ 92,000)

Why additional appointments?
- Proved clinical gain outcomes and cost savings due to CM activity

How?
- Strong strategic planning and leadership by visionary senior nurses within the PCT prior to implementation – Trish Bennett and Claire Heneghan
- Sought and got ‘fantastic by-in’ from local hospital consultants and GP’s
- Tariffed each avoidance so could demonstrate cost savings at board level
- Re-designed community nursing teams to include community matrons, district nurses and support staff to facilitate case management and continuity of care. Improves capability and hence capacity of the service
- Also addressed needs of people living in local nursing and residential care homes by allocating Community Matrons to each establishment
- Continued commitment and support for staff development.
Successful Implementation - Liverpool PCT

What financial impact?

- Saved over £2 million after costs over 2 years.
- Also evidence of more cost effective prescribing.
- Less 999 calls, less calls to Out of Hours services.
- If patient did get admitted less Length of Stay and less admission to residential care with associate reduction in costs.
- Has the local A&E departments noticed the change? ......................
Now 18 District Nursing Teams  
Each led by a triumvirate of senior nurses:-

Plans for sustainability and succession

1. Clinical Manager (management function, HR, clinical support)
2. Professional Development Manager (Governance, CPD, competency development, clinical supervision, skill development)
3. Community Matron (Own case load of complex patients, also involved in clinical supervision and teaching of DN staff and own continued CPD)

District Nursing teams operate 8am to 8pm / 8pm to 8am. Includes district nurses and support staff.

CM referrals: GP, Hospital, CNS, DN teams, self-referral (criteria 2 or more unplanned hospital admissions and more than 2 LTC)

CM based with the District Nursing teams but allocated to GP’s and/or nursing homes

All supported by Director of Nursing, Lead Nurse, senior practice facilitators and Nurse Consultant for Older Persons
Frank: prior to CM attended A&E every 2 weeks
Now in 3ys has had 1 unplanned admission due to a fall

- Lives alone in First floor flat
- Has carers four times a day
- His ex wife Sally is his main co-coordinator

PMH
- Ex heavy drinker
- Right CVA with expressive dysphasia
- Postural hypertension
- Ischemic heart disease 2xMI
- Heart failure
- Aortic re-gurgitation
- Falls
  (Knowsley PCT)

- Weekly bloods taken at home by phlebotomist
- CM interprets results rings cardiologist direct and adjusts dose of medications PRN

Arranged referral to:-
- Respite care
- Stroke association
- Physiotherapy
- Chiropody,
- ‘Life Line alert,
- Community independence team
- Manages family dynamics
### Clinical Assessment
- Active listening and therapeutic dialogue
- Medication review

### Referral for
- Physiotherapy
- Pulmonary rehabilitation
- ‘Fag ends’ stop smoking
- OT
- Re-housing
- Police – crime reporting

### Now in sheltered accommodation
very content and much less anxious. No longer smokes. ‘Discharged’ back to practice nurse.
Has put a nursing voice and perspective at an executive level and on the hospital ward round

Clinical development for all members of the team—much more proactive anticipation and motivated staff

Role models for staff and nursing students

Avoids a narrow medical model and gives ‘credence to someone's environment’

Forecasts clinical role will become mainstream

Predicts massive career opportunities

Is planning for sustainability and succession

Developing politically savvy—”the next leaders”
Community Matron - 2 years on

- Increased authority is very empowering, as need the status to get things done E.g. referral for spirometry, previously needed GP referral. CM challenged this decision as it was delaying access to treatment. Now service accepts CM referral

- Got much better dialogue between PCT and Acute trusts and use of intermediate care beds. Now there is a wider team to promote the patients best interests

- Getting better at rationing themselves as a resource

- Need to be a Non medical prescriber to fully engage in the role

- “Best job I have ever had”!
Warnings … burnout

- Highly intensive role with patients majority of whom are terminally ill
- Lack of integrated IT systems means significant time needed to update and record events and decisions
- Victims of own success. Case load needs to be managed to no more than 50 for, as found in other studies (Sargent et al 2008) increasing this number again makes staff reactive not proactive
- Need a case load of mixed dependency to cope with exacerbations
  - RED 10-15 highly dependant visit 3-5 x week
  - Orange 20 ‘middling’ coping visit x1 per week
  - Green 15-20 Expert patients 3/12 -6/12
- Need to be able to discharge back to competent community team and therefore foster independence in the patient and /or CM needs to recognise when end stage palliative care needed and again refer back to district nursing team
The Future

- Depends upon the ‘public’s engagement with health’ (Wanless 2004) If healthier lifestyles not adopted demand will grow exponentially. Limited political attraction to be the party in power who rations healthcare.

- Continuation of role in current format possibly nationally in the balance – not enough of a critical mass to shape evaluation. Busy managers to be encouraged to publish their success.

- Despite initial wariness, GP’s want to employ CM due to good outcomes.

- Role more effective if a non-medical prescriber.

- I predict these students will have a valuable contribution to make in whatever health system is devised and implemented. Need to find their political power and voice – assert for their profession as well as the patient.

- Nurse education curriculum needs to adapt to changing health care needs incorporating clinical examination skills and critical thinking.
Is it Transferable to Other Countries?

- American models (Kaiser, EverCare, Pfizer) approaches been modified for UK NHS operational systems and funding, and further adapted in every region.

- In UK there is no absolute standard approach, but overall its constituents are similar to Australia’s National Model of Chronic Disease Prevention and Control and New Zealand’s Outcomes Intervention Model.

- However there needs to be a new allocation of funding for this ‘new’ community service…. which is then used to prevent hospital admissions. WIFM?

- But of course culture and language is not totally transferable as I found to my cost…. 
In the UK these are called flip flops!
And these are thongs!
Message for this audience

- Similar problems, similar solutions – albeit with different funding system (at present). Inaction is not an option – if you don’t develop a similar role then you will have to decide what else you are going to do.

- Global increase in western type disease, you will not be able to rely on the health professional who qualified aboard to plug your gaps.

- Need to grow your own….. By advancing the clinical skills of your non-medical registered professionals, but cannot be a token few torch bearers. Work with HEI’s, Royal Colleges etc. In UK taken 15 yrs plus to introduce nurses as advanced practitioners, against a lot of resistance. Has only happened when combined with other factors.

- Have to hope that your population has a good birth rate – to provide carers for your older generations.

- Invest in quality residential care facilities and community services (mental and physical health).

- Triple funding – health promotion, existing patients, invest in staff development, IT etc etc.
Quality in Healthcare

Back in 2000 Mike Nolan suggested that nurses were losing the caring and enabling side of their work, as they were adopting a biomedical approach to the care of older people. He raised a rallying cry that there was a need to

‘move beyond the rhetoric and to make person centred care visible’ (Nolan 2000 p24)

Perhaps case management and the Community Matron does just that.
Quality is never an accident, it is always the result of high intention, sincere effort, intelligent directions and skilful execution; it represents the wise choice from many alternatives (Foster 2001) in Thorsteinsson L (2002)
Further Reading /Contacts

- [www.dh.org.uk](http://www.dh.org.uk) Department of Health search for Long Term conditions /Community Matrons
- [www.institute.nhs.uk](http://www.institute.nhs.uk) ‘The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership’
- [www.skillsforhealth.org.uk](http://www.skillsforhealth.org.uk) Community matron role competencies

Contacts

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Claire Heneghan  claire.heneghan@liverpoolpct.nhs.uk
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